2021 Child Maltreatment Fatality Annual Report

COLORADO
Division of Quality Assurance
& Quality Improvement
Administrative Review Division

This page intentionally left blank.

Executive Summary

The 2021 Colorado Department of Human Services (CDHS) Child Fatality Review Annual Report focuses on data gathered from fatal, near fatal, and egregious incidents of child maltreatment that occurred in calendar year (CY) 2021. The 2021 data provides an overview of the trends, characteristics and demographics of children and families involved with such incidents, and is presented in an effort to better understand and identify the factors associated with such incidents of abuse or neglect. Through the years of reviewing incidents of fatal, near fatal, and egregious incidents of child maltreatment, we have established that mitigating such incidents of child maltreatment is a community responsibility. It is important to share learnings and data from such tragedies with the community and other professionals who are responsible for providing services to children and families, so we can continue to reflect on strategies that may help prevent future incidents of child maltreatment. When available, Colorado data from CY 2021 is presented along with national data for federal fiscal year (FFY) 2020. The report also highlights learnings and recommendations for improvements to the systems responsible for providing services to children and families in Colorado.

The CDHS Child Fatality Review Team (CFRT) currently operates under relevant criteria for excellence in child death reviews, as published by the National Center for Fatality Review and Prevention in 2018. Recent understandings have emerged on a national level that reviews should focus on system level changes and the CDHS CFRT has also come to understand the importance of adopting a systems model approach to case reviews; an approach that helps create a space to have vulnerable conversations with county departments of human/social services about their practices and lessons learned from these tragedies, while keeping children and families at the center of the review. While child welfare is responsible for intervening with families when there is an allegation of child abuse or neglect, and providing appropriate and necessary services to families in order to keep children safe, all systems and communities have a responsibility to help make families in our communities healthier and more resilient.

In CY 2021, there were 87 children involved in 73 substantiated fatal, near fatal, and egregious incidents of child maltreatment. From the group of 87 children in 73 substantiated fatal, near fatal, and egregious incidents of child maltreatment occurring in CY 2021, 59 children in 51 incidents met statutory criteria for a review by the CFRT.

Child Characteristics. National and Colorado data continue to show that victims of fatal child maltreatment incidents tend to be younger. Younger children rely solely on their caregivers to meet their needs and have little to no ability to self-protect from maltreatment. Additionally, research continues to show that a child's young age is a key risk factor associated with child maltreatment fatalities. In CY 2021, in Colorado, 33.3% (11/33) of the fatalities involved victims younger than one year old, and 66.7% (22/33) were three or younger. Nationally, in FFY 2020, 46.4% were under the age of one, and 67.8% of all victims were age three or younger. In Colorado, a similar pattern of younger-aged victims exists for the near fatalities, as 50% (9/18) of the victims were under the age of one, and 88.9% (16/18) were age three or

under. The pattern of age of victims of egregious incidents has followed its own trend within Colorado. Prior to 2018, victims of egregious incidents were older in age than in fatal and near fatal incidents. However, in CYs 2018, 2019, 2020, and 2021 the majority of victims were three or younger. In CY 2021, 50% (18/36) of victims were three or younger.

For CY 2021, Colorado data showed that 57.6% of victims in substantiated child maltreatment fatalities were males. Colorado and national data trends note that males typically have a higher rate of child fatality by abuse and neglect. In FFY 2020, 60.1% of victims in child maltreatment fatalities were males.

For fatalities, most of the victims were White (39.4%) followed by Hispanic (21.2%). For near fatal incidents, most of the victims were either White (38.9%) or Hispanic (38.9%). For egregious incidents, most victims were White (33.3%), closely followed by Multiracial (27.8%).

Family Characteristics. In 2021, 40.2% (35/87) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents. This family structure was also the most frequent for incidents occurring in 2015, 2016, 2017, 2018, 2019, and 2020. The second most common type of family structure across substantiated fatal incidents in 2021 was one parent at 21.2% (7/33). For near fatal incidents in 2021, there were two different family structures that were the second most common; one parent and one parent and one related caregiver, both represented at 16.7% (3/18). The second most common type of family structure across egregious incidents was one parent and one unrelated caregiver at 27.8% (10/36).

Perpetrator Relationship. A child's caregiver is most often the perpetrator of a fatal incident of child maltreatment, and it usually involves one or two parents. National data continuously indicates the mother as the most common perpetrator of a fatal incident of child maltreatment. In FFY 2020, 80.6% of fatal incidents of child maltreatment involved one or both parents, sometimes acting alone and sometimes involving another person. For 2021, in Colorado, there were six distinct perpetrator types: 1. Mothers; 2. Fathers; 3. Partner of Parent (male); 4. Relative (male); 5. Other; and 6; Unknown.

Prior Involvement with Child Protective Services. In 2021, for those families with prior child protective services involvement, 20% (4/20) of families involved with a fatal incident of child maltreatment had a prior and/or current case(s), which was lower than trends in 2014, 2015, 2019 and 2020. In 2021, the most common level of prior involvement with the child welfare system was a prior and/or current assessment (11/20; 55%). This mirrored trends in CYs 2016, 2017, 2018, 2019, and 2020, where a prior and/or current assessment was also the most common level of prior involvement.

Near fatal incidents in 2021 fell in line with trends seen in 2014, 2017, 2018, and 2019, with assessments as the most common level of prior and/or current involvement with the child welfare system (7/13; 53.8%). The second most common level of prior involvement in 2021 for near fatal incidents was a current and/or prior case (6/13; 46.2%). For egregious incidents, the most common level of prior and/or current involvement with families involved with

egregious incidents of child maltreatment was a prior and/or current assessment (12/18; 66.7%) which followed 2015, 2016, 2018, 2019, and 2020 trends.

Other Family Stressors. Substance abuse, mental health, and domestic violence are often identified as stressors for caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment. There were 40 incidents reviewed by the CFRT in 2021; 16 fatal incidents, 9 near fatal incidents, and 15 egregious incidents. Some incidents will not have any of the stressors identified during the review process, while others will have more than one identified.

Of the fatal child maltreatment incidents which met criteria for review by the CFRT, 37.5% (6/16) had a history of identified mental health issues, and 43.8% (7/16) were identified to have had some history of domestic violence.

Nationally, in FFY 2020, 5.7% of child fatalities were associated with a caregiver known to abuse alcohol, while 17.6% of child fatalities were associated with a caregiver who abused drugs. Of the fatal child maltreatment incidents reviewed, which met criteria for review by the CFRT, 56.3% (9/16) of the incidents reviewed had some identified caregiver history of substance abuse issues.

Findings and Recommendations. Specific findings, strengths, and gaps/deficiencies identified through the CFRT reviews are also included in this report. Please note, CFRT reviews may not conclude in the same year in which the incident occurred. Therefore, some sections within this report also summarize information from incidents which occurred prior to 2021 and were reviewed by the CFRT and/or posted to the public notification website in 2021.

Across the 34 fatal, near fatal, or egregious incidents of child maltreatment reviewed by the CFRT and posted to the public notification website, the team noted 104 systemic strengths in the delivery of services to children and families. Systemic strengths acknowledged by the team were organized into the following categories: 1) Collaboration; 2) Engagement with Family; 3) Case Practice; 4) Safety; 5) Services to Children and Families; and 6) Documentation. The three systems most frequently mentioned were: 1) County Departments of Human Services (both alone and alongside other entities); 2) Medical Providers; and 3) Family and Friends.

A total of 12 recommendations were made across the 34 reports posted between 4/1/2021 and 3/31/2022. These included four related to systemic gaps and deficiencies and eight related to policy findings.

CFRT Recommendation Steering Committee. In 2020, a Steering Committee was formed with a vision to ensure each CFRT recommendation is prioritized, acted upon, and implemented in a timely manner to address known systemic gaps and prevent future child maltreatment deaths. The Committee is responsible for providing high-level strategic direction for each CFRT recommendation, and oversees and supports implementation of

recommendations. The relevant group to review and act on CFRT recommendations will vary and will often involve participants from multiple offices, agencies or sectors. The current committee has members from four different CDHS offices, two county departments, and a representative from the Colorado Department of Public Health and Environment's Child Maltreatment Prevention Unit. Representation from CDHS includes the Office of Children Youth and Families, the Office of Behavioral Health, the Administrative Review Division, the Office of Early Childhood, and Community Partnerships.

Since September of 2020, the committee has been reviewing recommendations and assigning impact and effort scores to determine prioritization efforts. Overall, it has been clear that while several CFRT recommendations remain in progress, a good deal of work is already underway through existing initiatives and pending legislation. The Committee continues to demonstrate that getting the right people together to share information and expertise across disciplines improves the Department's effectiveness and efficiency in tackling improvements to systemic gaps.

Models and Frameworks. The CDHS CFRT was codified in 2011, and has since been conducting multidisciplinary reviews under the authority of Colorado Revised Statute 26-1-139. Through the years of reviewing fatal, near fatal, and egregious incidents of child maltreatment, it has been established that mitigating such incidents of child maltreatment is a community responsibility. It is important to share learnings from such tragedies with the community and other professionals who are responsible for providing services to children and families so efforts can continue to reflect on strategies that may help prevent future incidents of child maltreatment. This section of the report shares information about models, frameworks, and guides that have been useful to county department staff and members of the multidisciplinary CFRT when reviewing fatal, near fatal, and egregious incidents of child maltreatment.

Background

Legislative History

In 2011, House Bill (HB) 11-1181 provided CDHS statutory authority (Colorado Revised Statutes § 26-1-139) for the provision of a child fatality review process, and funded one staff position at the CDHS to conduct these reviews. The CFRT function was programmatically located within the Office of Children, Youth and Families' Division of Child Welfare (DCW). HB 11-1181 also established criteria for determining which incidents would be reviewed by the CFRT. The review criteria included incidents in which a child fatality occurred and the child or family had previous involvement with a county department within the two years prior to the fatality. The legislation also outlined exceptions to reviews if the previous involvement: a) did not involve abuse or neglect; b) occurred when the parent was seventeen years of age or younger and before he or she was the parent of the deceased child or; c) occurred with a different family composition and a different alleged perpetrator.

In 2012, Senate Bill (SB) 12-033 added the categories of near fatal and egregious incidents to the review responsibilities of the CFRT. It also added reporting and public disclosure requirements. This change aligned Colorado statute with federal requirements under the 1996 Child Abuse and Prevention Treatment Act (CAPTA), which mandates that states receiving federal CAPTA funds adopt "provisions which allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality" (42 U.S.C. 5106 § a(b)(2)(A)(x)). As SB 12-033 became effective April 12, 2012, any impact of adding egregious and near fatal incidents to the total number of incidents requiring review was not fully determined until calendar year 2013.

In January 2013, responsibility for managing the CFRT program was moved under the CDHS Administrative Review Division (ARD). With the passing of SB 13-255 in 2013, legislative changes to the CFRT process occurred once again. Criteria for incidents qualifying for a review by the CFRT were changed. This included lengthening the time considered for previous involvement from two years to three years, and removing the exceptions related to previous involvement (noted above). These changes expanded the population of incidents requiring a CFRT review. SB 13-255 also provided funding for two additional staff for the CFRT review process, bringing the total staff dedicated to this function to three. SB 13-255 became effective May 14, 2013.

In 2014, SB 14-153 made small changes to the membership stipulations for the state legislative members of the Child Fatality Review Team. SB 14-153 made no changes to the CFRT processes, criteria for qualifying incidents, or incident reporting requirements.

Due to statutory changes over the prior years, specifically between 2011-2013, which modified the criteria for incidents requiring review, there was limited ability to interpret trends in the data. Any change in the final number of incidents between 2012 and 2013 may have been due to definitional changes rather than to changes in the number of actual

incidents. For example, 78 children were reported as alleged victims of a fatal, near fatal or egregious child maltreatment incident during CY 2012. This increased to a total of 116 children reported as alleged victims during CY 2013. The increase was likely due to increased awareness of the reporting requirements and procedures, the expanded definition and the relevant time period of previous involvement. Since 2013, there have not been any significant statutory changes. Broad trends can therefore now be considered for the past nine calendar years.

Statute requires an annual report to the legislature on or before July 1st of each year, reflecting aggregate information with regard to fatal, near fatal, and egregious incidents of child maltreatment that occurred in the prior calendar year. This annual report focuses on several different subsets of information: all reported incidents, regardless of whether or not the incident was substantiated for abuse or neglect; incidents substantiated for abuse or neglect; incidents substantiated for abuse or neglect with prior involvement in the child welfare system; and, incidents with reports finalized and posted since the completion of the prior year's annual report.

Table 1 provides an overview of the overall number and type of incidents since 2012. As shown below, there are variances in the total number of types of incidents over the past ten years.

Table 1: Total Statewide Incidents Reported Over Time* and Statutory Change**

Year	Fatal Incidents	Near Fatal Incidents**	Egregious Incidents**	Total Incidents
2012	59	14	5	78
2013	55	21	35	111
2014	60	30	22	112
2015	43	23	20	88^
2016	71	25	17	115^^
2017	62^^^	25	20	108^^^^
2018	64	21	22	107
2019	40	29	26	95
2020	60*	34	31*	125
2021	74	27	28	129

**Not all incidents reported met criteria for CFRT review.*
***Near fatal and egregious incidents were not statutorily mandated for inclusion until April 12, 2012.*
^ Two of the reported incidents reported in 2015 were determined to not fit the definitions of fatal, near fatal, or egregious abuse or neglect. While they are included in the total, they do not appear in the incident specific columns.
^^Two of the reported incidents reported in 2016 were determined to not fit the definitions of fatal, near fatal, or egregious abuse or neglect. While they are included in the total they do not appear in the incident specific columns.
^^^There were two additional fatalities that occurred in 2017, but were not initially determined to be suspicious for abuse or neglect, and reported, until after the finalization of the 2017 Annual Report.
^^^^One reported incident in 2017 was determined to not fit the definitions of fatal, near fatal, or egregious abuse or neglect. While this incident is included in the total, it does not appear in the incident specific columns.
**One egregious incident and one fatal incident were added to the 2020 counts after the completion of the 2020 annual report.*

Table 2 provides an overview of the overall number of substantiated incidents, by type, since 2012. The numbers reflect all fatal, near fatal, and egregious incidents that were determined to be the result of abuse or neglect, regardless of whether or not there was prior child welfare history preceding the fatal, near fatal, and/or egregious incident of child maltreatment.

Table 2: Total Statewide Substantiated Incidents

Year	Fatal Incidents	Near Fatal Incidents	Egregious Incidents	Total Incidents
2012	26	9	2	37
2013	23	15	34	72
2014	23	22	23	68
2015	21	15	19	55
2016	35	20	16	71
2017	30^	20	18	69
2018	34	18	19	71
2019	17	22	24	63
2020	28	28	28	84
2021	30	17	26	73

^The fatal substantiated incident number for 2017 is different from what was published in previous Maltreatment Fatality Reports as one incident was determined not to be substantiated at the fatal severity level; therefore, lowering the substantiated fatal incidents by one.

Identification and Reporting of Incidents

Statute requires that county departments provide notification to the CDHS of any suspicious incident of egregious abuse or neglect, near fatality, or fatality of a child due to abuse or neglect within 24 hours of becoming aware of the incident. County departments have worked diligently to comply with this requirement.

As part of the data integrity process for 2021 data were extracted on a quarterly basis from the comprehensive child welfare information system (Trails) for any assessment with an egregious, near fatal, or fatal allegation of child maltreatment. Additionally, data were pulled for any child with a date of death entered into Trails. The data were then compared to the number of reported incidents received from counties over the course of CY 2021. The data integrity checks identified 70 potential incidents. Of those incidents, 7 incidents involving 7 children met criteria for public notification, with one of those incidents meeting criteria for a full review. The ARD will continue this data integrity process and will provide technical assistance to county departments as necessary.

Child Fatality Review Team Process and Timelines

The CFRT reviews incidents of fatal, near fatal, and egregious abuse or neglect determined to be a result of child maltreatment, when the child or family had previous involvement with the child welfare system within the last three years. The process includes a review of the incident, identification of contributing factors that may have led to the incident, the quality and sufficiency of service delivery from state and local agencies, and the families' prior involvement with the child welfare system. After considering the identified strengths, as well as systemic gaps and/or deficiencies, the CFRT makes recommendations regarding policy and practice considerations that may help prevent future incidents of fatal, near fatal, or egregious abuse or neglect, and/or strengthen the systems that provide direct service delivery to children and families. Table 3 offers a comparison of incidents meeting criteria for review over the past seven years. It is important to reiterate that as the statutory and definitional changes over the prior years (2012-2013) have modified the population of incidents requiring review, there are limitations to interpretation of trends in past data.

Table 3: Number of Incidents Meeting Statutory Criteria to be Reviewed by CFRT*

Year	Fatal Incidents	Near Fatal Incidents	Egregious Incidents	Total Incidents°
2012	9	2	1	12
2013	8	10	21	39
2014	18	14	13	45
2015	13^	9	13	35^^
2016	21	11	8	40
2017	18^^^	13	9	40^^^^
2018	16	10	11	37
2019	10	11	16	37
2020	21	14	17	52
2021	20	13	18	51

**There was a change in state statute from 2012 to 2013 that increased the time span for prior involvement from two years to three years. Near fatal and egregious incidents were not statutorily mandated for inclusion until April 12, 2012.*
^The fatal incidents number is different from what was published in the 2015 Child Maltreatment Fatality Report as one child in one fatal incident was pending disposition at the time the 2015 report was finalized.
^^The total incident number is different from what was published in the 2015 Child Maltreatment Fatality Report as one child in one fatal incident was pending disposition at the time the 2015 report was finalized.

^^^The fatal incident number is different from what was published in the 2017 Child Maltreatment Fatality Report as one incident was determined not to be substantiated at the fatal severity level; therefore lowering the overall total of fatal incidents that met criteria by one.

^^^^The total incident number for 2017 is different from what was published in the 2017 Child Maltreatment Fatality Report as one incident was determined not to be substantiated at the fatal severity level; therefore lowering the overall total of incidents that met criteria by one.

Statute requires that county departments provide the CDHS with all relevant information and reports to inform the CFRT's review within 60 days of becoming aware of an incident which was determined to be the result of fatal, near fatal or egregious abuse or neglect. County departments only need to submit such documentation if the incident meets the aforementioned statutory criteria to be reviewed by CFRT. Because some of this information comes from other agencies (e.g. law enforcement, coroners), statute also provides the CDHS with the authority to provide extensions to county departments to allow time to gather necessary information that is outside their direct control. Extensions are granted for 30 days at a time, with the ability to grant additional extensions as necessary. The need for extensions affects the total length of time needed to complete any individual review. To date, 48.1% (62/129) of incidents that occurred in 2021 were afforded at least one extension, with the total number ranging from one to sixteen extensions. The average number of extensions afforded per report is 5.

Incidents Reviewed in 2021

As required by Volume 7 (25 CCR 2509-2), the CFRT must review all incidents within 45 business days of the CDHS receiving all required and relevant reports and information necessary to complete a review. During CY 2021, the CFRT was able to review 40 incidents. It is important to note not all incidents are reviewed within the calendar year in which they occurred.

Completion and Posting of Case Specific Executive Summary Reports

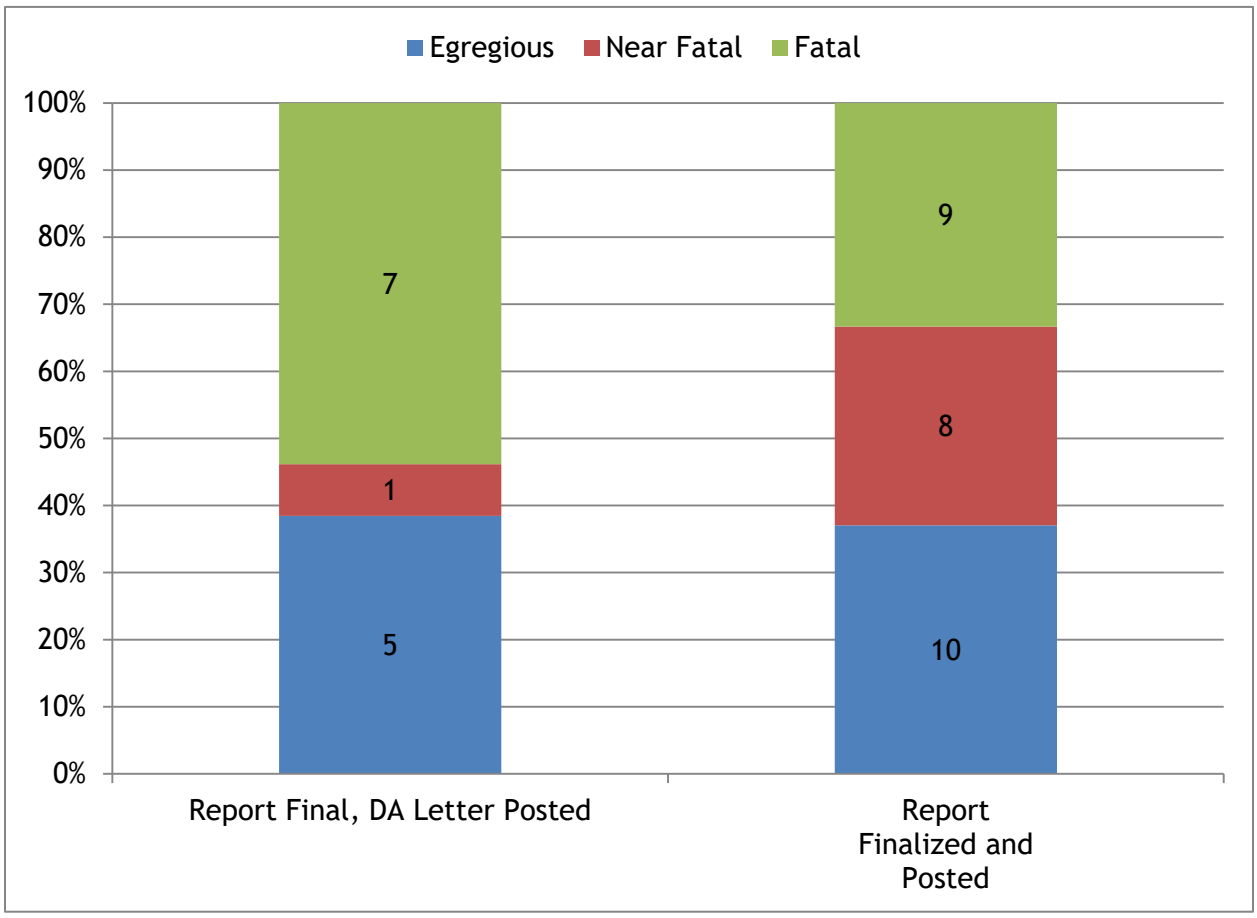
Each incident reviewed by the CFRT results in a written report that is posted to the CDHS public notification website (with confidential information redacted). Specifically, statute requires that a case-specific executive summary, absent confidential information, be posted on the CDHS website within seven (7) days of finalizing the confidential case-specific review report. In 2019, case-specific reports for fatal, near fatal, and egregious incidents reviewed by CFRT underwent changes in order to align with the review philosophy of a systems model approach.

Colorado Revised Statute 26-1-139(5)(j)(I) allows the CDHS to not release the final non-confidential case-specific executive summary report if it is determined that doing so may jeopardize "any ongoing criminal investigation or prosecution or a defendant's right to a fair trial," or "any ongoing or future civil investigation or proceeding or the fairness of such proceeding." As such, the CFRT consults with applicable county and/or district attorneys prior

to releasing the final non-confidential report when there is, or likely will be, a criminal or civil investigation and/or prosecution. In these instances, CDHS requests county and district attorneys to make known their preference for releasing or withholding the final non-confidential case-specific executive summary report. When a determination is made not to post a case-specific executive summary report, a copy of a letter from the county or district attorney in regards to that request is posted to the website in lieu of the case-specific executive summary report. CDHS staff maintain contact with the county or district attorney to determine when the criminal or civil proceedings are completed and release of the report would no longer jeopardize those proceedings. At that time, CDHS requests a letter from the county or district attorney authorizing the release of the final non-confidential case-specific executive summary report. The ARD then posts the case-specific executive summary report on the public notification webpage.

Chart 1 shows the posting status of all CFRT reports for incidents reviewed in 2021. Of the 40 incidents reviewed, final non-confidential case-specific executive summary reports were posted for 27 of them. For 13 of the incidents reviewed, it was determined that releasing the final non-confidential report could jeopardize criminal or civil proceedings and a letter from the district attorney or county department was posted in lieu of the report.

Chart 1: Report Status of all Incidents Reviewed by the CFRT in 2021



Child Fatality Review Team Membership and Attendance

The CFRT is a multidisciplinary team of up to twenty members, as outlined in C.R.S. 26-1-139. Representation includes, but is not limited to: members from CDHS, the Colorado Department of Public Health and Environment (CDPHE), field of mental health, law enforcement, district attorneys, county commissioners, county departments of human and/or social services, legislators, and many more critical disciplines responsible for representing and/or providing services to the children and families of Colorado. Additionally, there are three full-time ARD staff members who are dedicated to the review process. The team meets monthly to review incidents of egregious, near fatal, or fatal child maltreatment when the child or family has also had previous involvement with the child welfare system within three years prior to the incident. Team membership and attendance are detailed in Appendix A, with the grayed-out months indicating an individual was not appointed for participation in that CFRT review meeting.

Colorado Department of Human Services and Department of Public Health and Environment Collaboration

The CDHS CFRT staff work closely with the Colorado Department of Public Health and Environment's (CDPHE) Child Fatality Prevention System (CFPS) team to consider data from each system and make joint recommendations based upon these findings. Each review process serves a different purpose and each process is supported by the respective agency. The CFPS staff members at the CDPHE serve as the two state appointees from the CDPHE to the CDHS CFRT, and the CFRT staff are involved with and participate in CFPS workgroups and state review meetings. SB 13-255 requires that, as a result of collaboration, the two child fatality review teams make joint recommendations. These recommendations can be found on page 44 of this document.

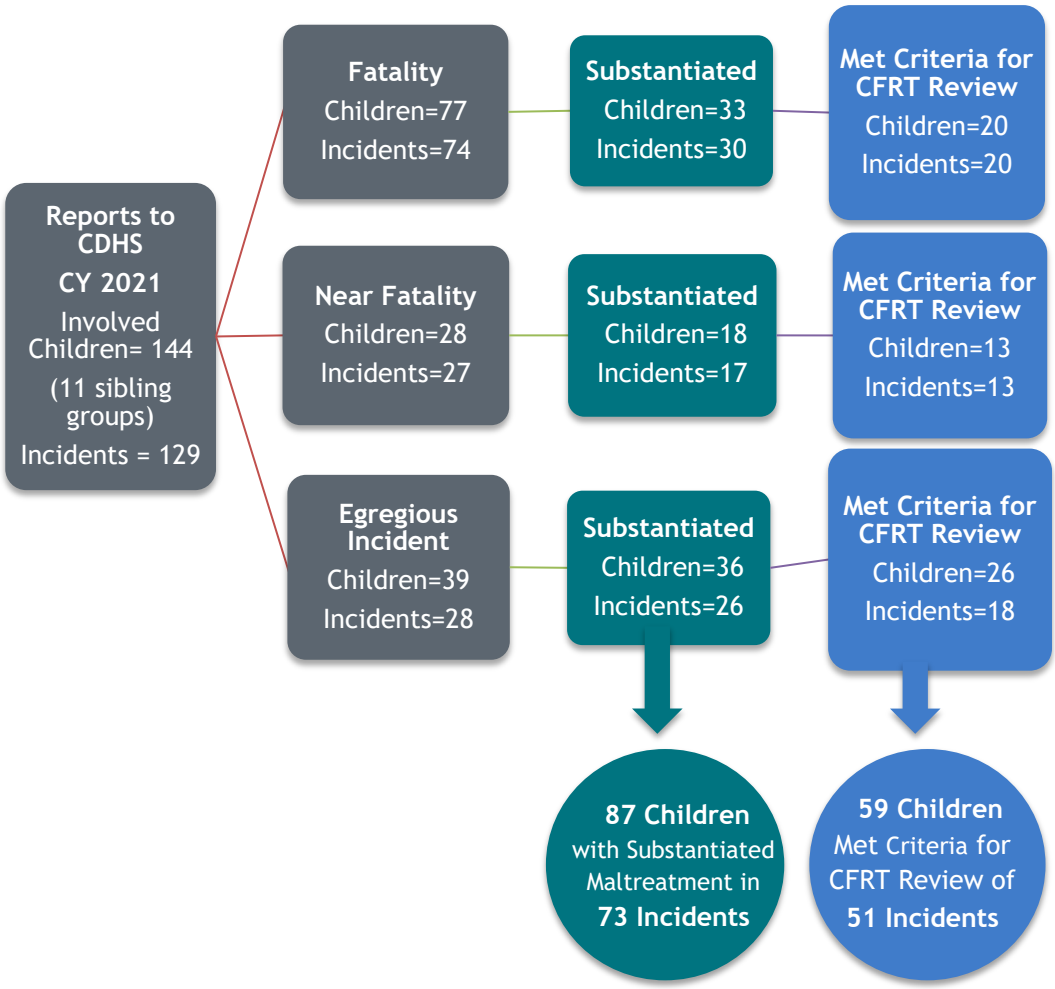
Overview of the 2021 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

As previously discussed, county departments of human/social services (DHS) are required to report all egregious incidents, near fatalities, and fatalities suspicious for child abuse and neglect to the state department (ARD). Each incident may involve more than one child. In CY 2021, counties reported 129 incidents involving 144 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. Of the 144 children, 77 children were associated with 74 fatal incidents, 28 children were associated with 27 near fatal incidents, and 39 children were associated with 28 egregious incidents.

Upon completion of an assessment, county departments found that 56 incidents involving 57 children were unsubstantiated for abuse or neglect. These incidents were determined not to be the result of child maltreatment, and were therefore not reviewed by the CFRT. Incidents deemed substantiated are considered to be the result of child maltreatment and there is a founded disposition against the person(s) responsible for the abuse or neglect. At the time of authoring this report, there is one pending incident involving one child that does not yet have a finding associated.

In CY 2021, 73 substantiated incidents included 87 children. Of the 73 substantiated incidents, 51 of them involved families who had prior involvement with DHS within the statutorily defined time period of three years prior to the incident, thus indicating the need for review by the CFRT. Figure 1 depicts the breakdown of the incidents reported in CY 2021. Appendix B contains a list of the counties by incident type.

Figure 1: Children Involved in Suspected and Substantiated Incidents of Fatal, Near Fatal, and Egregious Child Maltreatment in 2021



For purposes of this report, the majority of the analysis in the following section focuses on the 87 substantiated victims of fatal, near fatal, and egregious incidents of child maltreatment reported to the CDHS, or discovered through the data integrity check (described in the background section). When available, comparisons are made across calendar years and to national data. Table 4 provides an overview of the demographic characteristics of the 87 substantiated victims of incidents that occurred in CY 2021.

Table 4: Summary information of all 87 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2021

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	11	33.3%	9	50.0%	11	30.6%
	One	7	21.2%	6	33.3%	2	5.6%
	Two	2	6.1%	0	0.0%	4	11.1%
	Three	2	6.1%	1	5.6%	1	2.8%
	Four	3	9.1%	1	5.6%	2	5.6%
	Five	1	3.0%	0	0.0%	2	5.6%
	Six	1	3.0%	0	0.0%	1	2.8%
	Seven	0	0.0%	0	0.0%	4	11.1%
	Eight	0	0.0%	0	0.0%	1	2.8%
	Nine	0	0.0%	0	0.0%	1	2.8%
	Ten	3	9.1%	0	0.0%	2	5.6%
	Eleven	1	3.0%	0	0.0%	1	2.8%
	Twelve	0	0.0%	0	0.0%	0	0.0%
	Thirteen	0	0.0%	1	5.6%	0	0.0%
	Fourteen	1	3.0%	0	0.0%	3	8.3%
	Fifteen	1	3.0%	0	0.0%	0	0.0%
	Sixteen	0	0.0%	0	0.0%	0	0.0%
	Seventeen	0	0.0%	0	0.0%	1	2.8%
Race/Ethnicity	Black or African American	3	9.1%	1	5.6%	7	19.4%
	Asian	1	3.0%	0	0.0%	0	0.0%
	White	13	39.4%	7	38.9%	12	33.3%
	Hispanic	7	21.2%	7	38.9%	5	13.9%
	Multiracial	5	15.2%	1	0.0%	10	27.8%
	Missing/Unknown	4	12.1%	2	11.1%	2	5.6%
Sex	Female	14	42.4%	4	22.2%	15	41.7%
	Male	19	57.6%	14	77.8%	21	58.3%
Family Structure	One parent	7	21.2%	3	16.7%	7	19.4%
	One parent and one related caregiver	1	3.0%	1	5.6%	0	0.0%
	One parent and one unrelated caregiver	4	12.1%	3	16.7%	10	27.8%
	Two parents	14	42.4%	9	50.0%	12	33.3%
	Two parents and relatives	5	15.2%	1	5.6%	2	5.6%
	One parent and relatives	2	6.1%	0	0.0%	2	5.6%
	One legal caregiver with relatives and one unrelated caregiver	0	0.0%	1	5.6%	1	2.8%
	One related caregiver and one unrelated caregiver	0	0.0%	0	0.0%	2	5.6%
	One related caregiver	0	0.0%	1	3.4%	0	0.0%
	One related caregiver and one unrelated caregiver	1	3.6%	0	0.0%	0	0.0%
	One legal caregiver with relatives and one unrelated caregiver	0	5.9%	0	0.0%	0	0.0%
Incidents with Additional Family Stressors*	Substance Abuse	9	40.9%	9	50.0%	11	40.7%
	Mental Health	6	27.3%	4	22.2%	4	14.8%
	Domestic Abuse	7	31.8%	5	27.8%	12	44.4%

**This is counted at the family level for incidents which met criteria for review, and were reviewed in CY 2021.*

Data and Demographics

Within the field of child welfare, there is a large body of research regarding a number of risk factors related to maltreatment, including but not limited to: inappropriate expectations of children, lack of parenting knowledge and child developmental stages, substance abuse, domestic violence, past history of abuse, financial stress, mental health issues, and other complicating factors. While fatalities may share certain characteristics that can be used as indicators of risk factors, there is no one profile that will allow child protection workers to identify either future perpetrators, or children who will become victims. Please note that there has been minimal research conducted on near fatal or egregious incidents of abuse or neglect.

Child Characteristics

The U.S. Department of Health and Human Services Administration for Children and Families Child Maltreatment[1] report is published annually and provides the most current data available on key demographic characteristics of the children reported to the National Child Abuse and Neglect Data System (NCANDS) for deaths "caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor." Nationally, for FFY20, it was estimated that 1,750 children were victims of fatal abuse or neglect. The determination of when abuse or neglect is considered a contributing factor is left to each individual state. Throughout this section, demographic data from Colorado child maltreatment fatalities will be compared to the most recent national child maltreatment fatalities (FFY 2020) to illustrate similarities and differences. National data is not available for near fatal or egregious incidents.

Race/Ethnicity

In analyzing data in this section, it is important to note how race was determined for this report. In the comprehensive child welfare information system, referred to as Trails in Colorado, race and ethnicity/origin are captured as two separate variables. For the purposes of this report, these two variables were combined into one overall variable. As an example, if a child's race was entered into Trails as White with Hispanic origin, the child was considered Hispanic. This matches an approach proposed by the U.S. Census Bureau. The U.S. Census Bureau[2] estimated race and ethnicity data from population estimates for Colorado in 2021, the latest year of finalized census data. The estimates indicated that Colorado's population in 2021 was 67.7% White (alone, not reporting another race/ethnicity), 21.8% Hispanic, and 4.6% Black or African American. The balance of the population estimates included the following ethnicities: American Indian, Asian, Native Hawaiian, Native American, etc.

1 U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment. 2 https://www.census.gov/quickfacts/CO

For fatalities, most of the victims were White (39.4%) followed by Hispanic (21.2%). For near fatal incidents, most of the victims were either White (38.9%) or Hispanic (38.9%). For egregious incidents, most victims were White (33.3%), closely followed by Multiracial (27.8%). Chart 2 is a graphic depiction of race/ethnicity breakdown.

Chart 2: Race/Ethnicity of 87 victims in all Substantiated Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment in Colorado for CY 2021

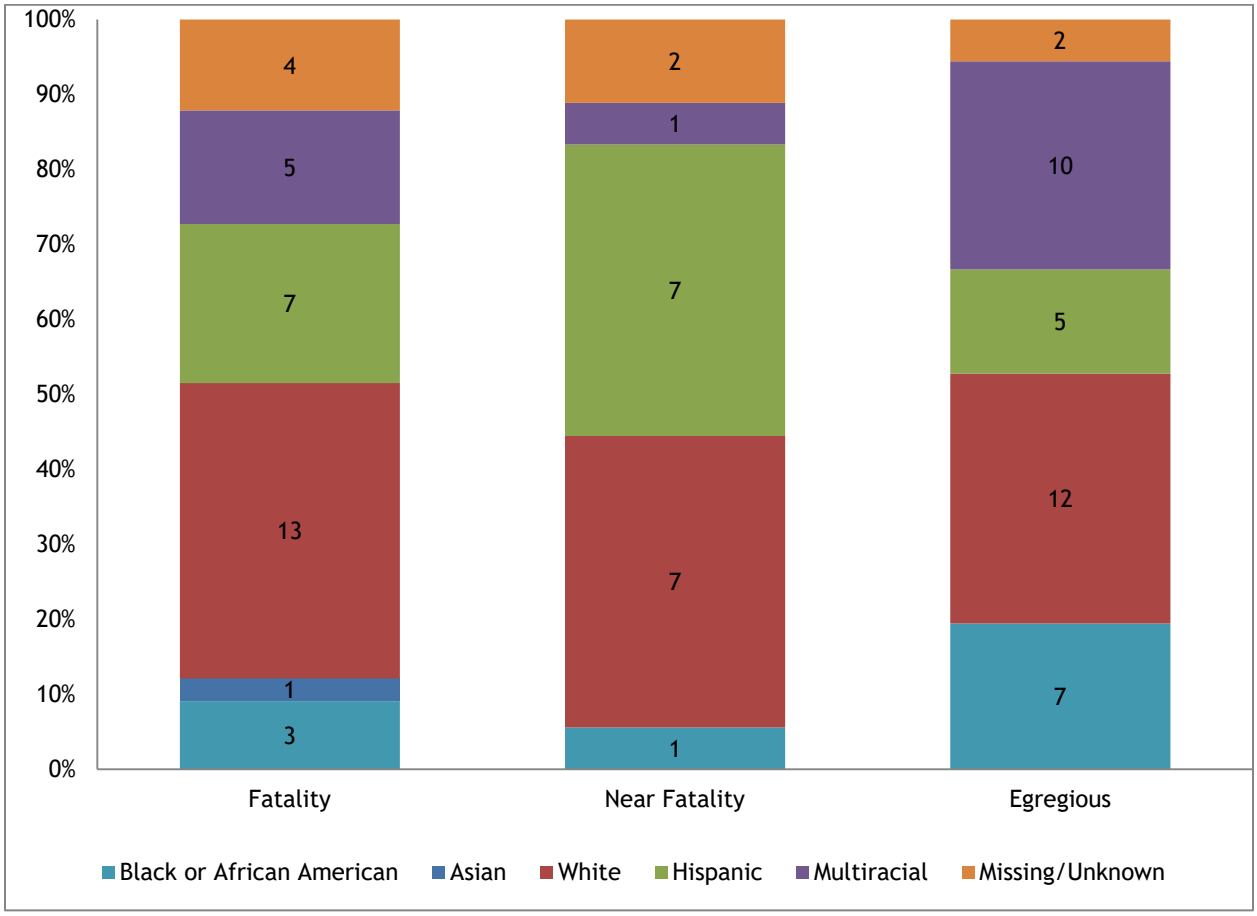
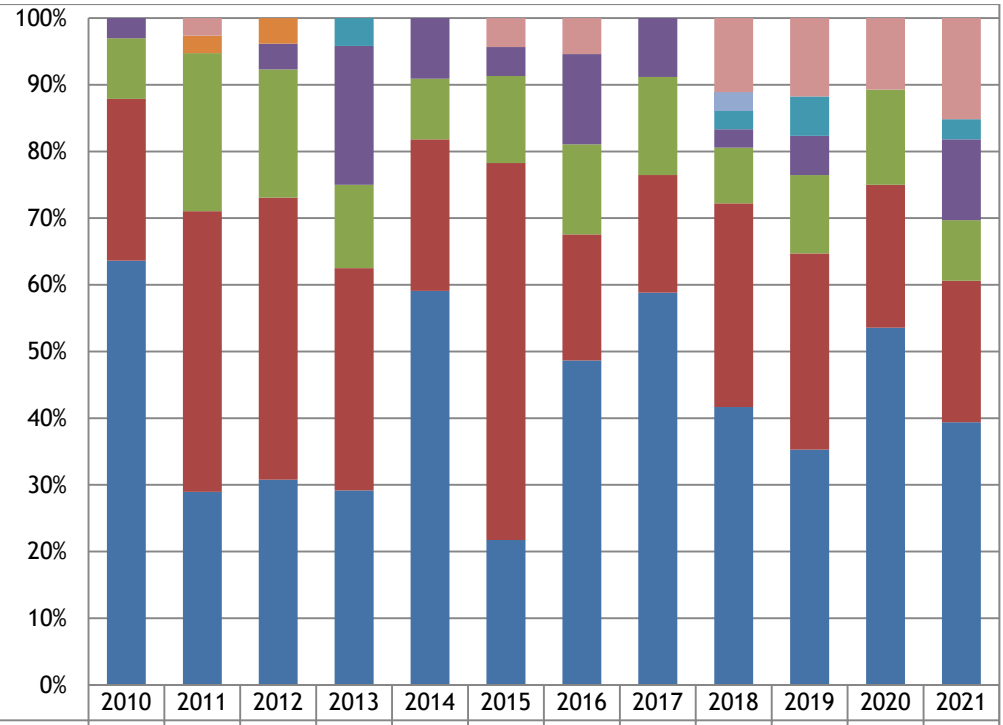


Chart 3 shows the trends related to the most common race/ethnicity of all child maltreatment fatalities in Colorado from 2010-2021. For Colorado's population trends, Hispanic child victims were disproportionately represented in fatal incidents during the years of 2011, 2012, 2013, and 2015. The chart depicts the three most common race/ethnicities of children involved in fatal incidents of abuse and neglect as being of White, Hispanic, Black or African American or Multiracial, which also mirrors national trends.

Chart 3: Race/ethnicity of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Twelve Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Multiracial	0	1	0	0	0	1	2	0	4	2	3	5
American Indian or Alaska	0	0	0	0	0	0	0	0	1	0	0	0
Native Hawaiian/ Other Pacific Islander	0	1	1	0	0	0	0	0	0	0	0	0
Asian	0	0	0	1	0	0	0	0	1	1	0	1
Missing or Unknown	1	0	1	5	2	1	5	3	1	1	0	4
Black or African American	3	9	5	3	2	3	5	5	3	2	4	3
Hispanic	8	16	11	8	5	13	7	6	11	5	6	7
White	21	11	8	7	13	5	18	20	15	6	15	13

Sex of Victim

For CY 2021, Colorado data showed that 57.6% of victims in substantiated child maltreatment fatalities were males. Colorado and national data trends note that males typically have a higher rate of child fatality by abuse and neglect. In FFY 2020, 60.1% of victims in child maltreatment fatalities were males. Chart 4 displays the breakdown of differences in the sex of the victims for the 87 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and neglect in CY 2021.

Chart 4: Sex of 87 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2021

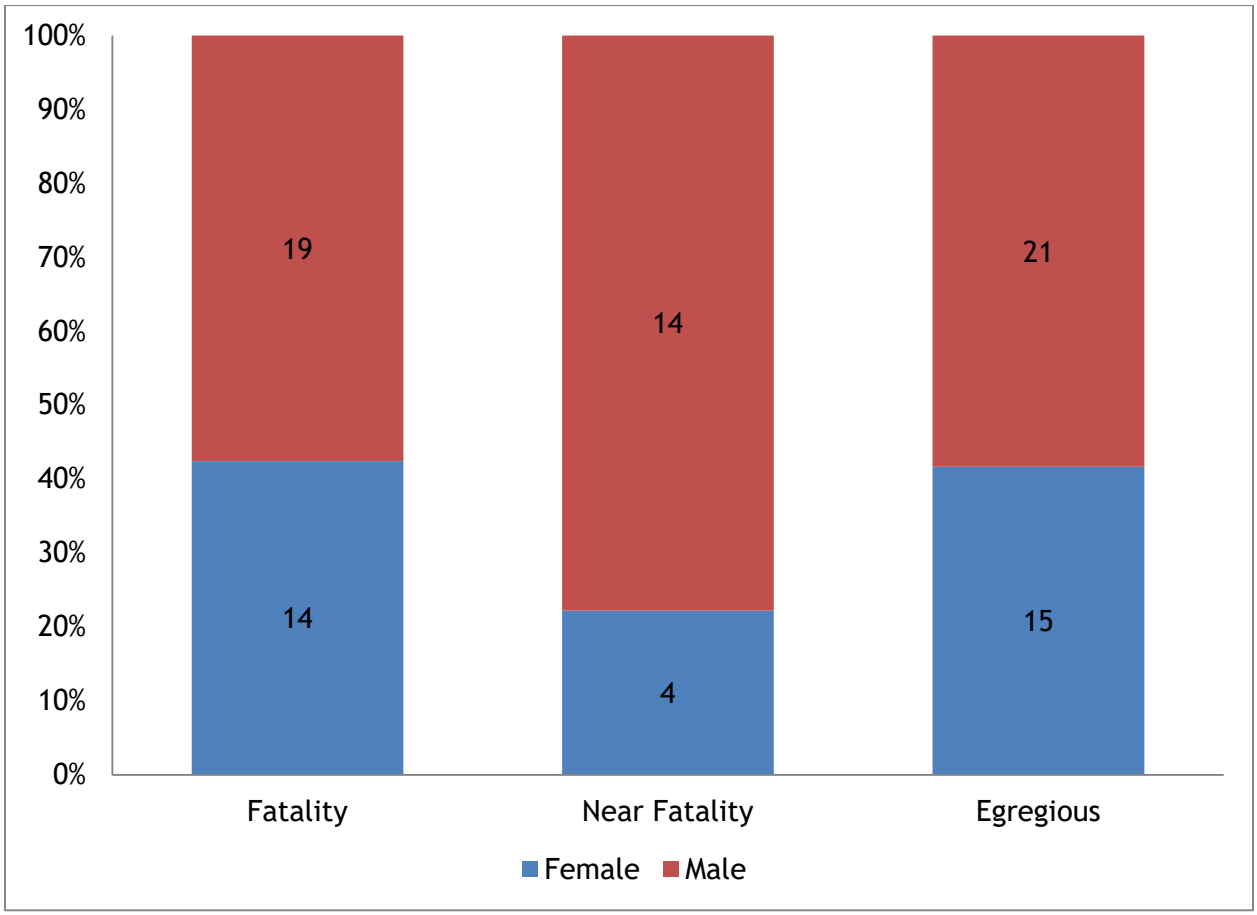
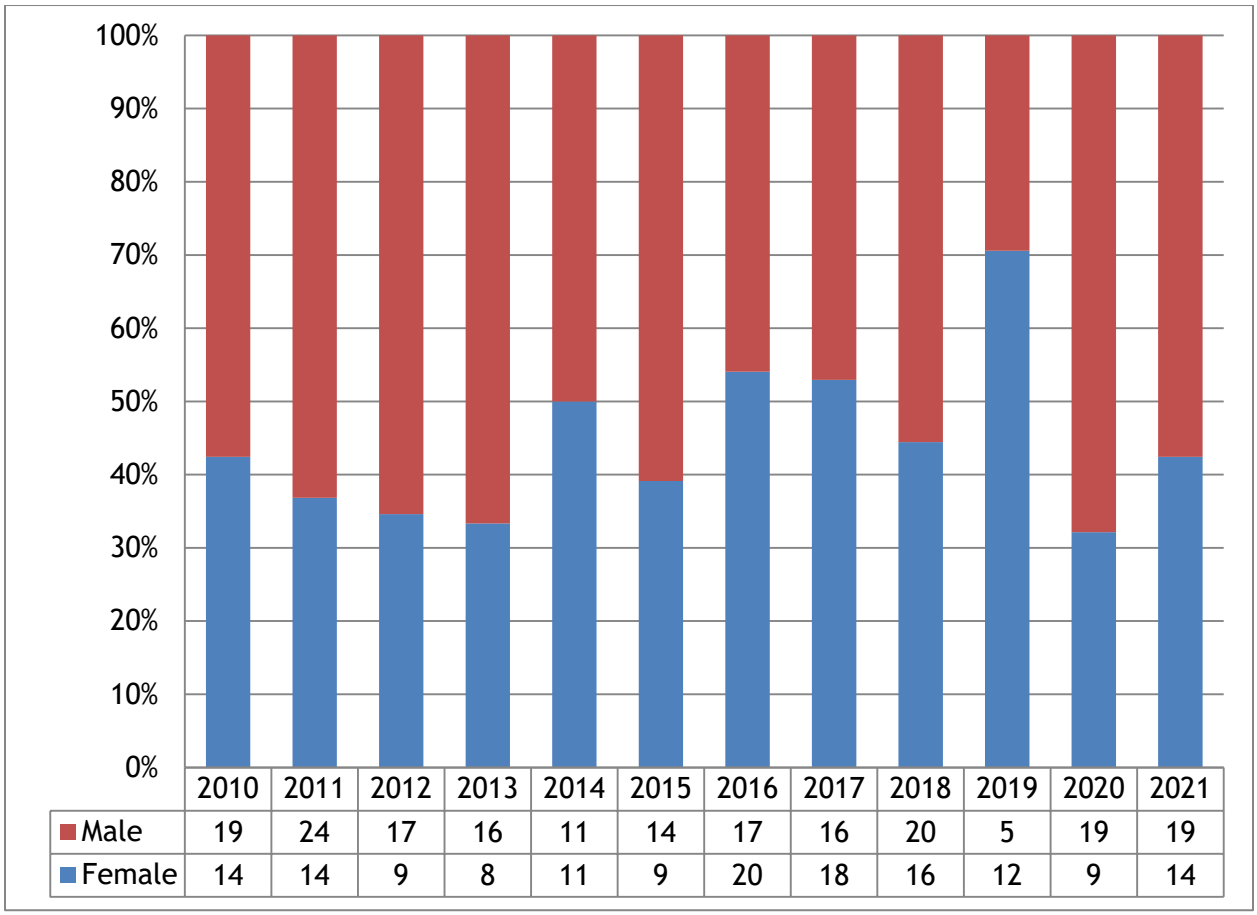


Chart 5 demonstrates the trends of sex of victims involved in all substantiated child maltreatment fatalities in Colorado over the last twelve years. Colorado trends mirrored national trends, with the exception of CYs 2016, 2017 and 2019, where female victims surpassed male victims in substantiated incidents of fatal child maltreatment.

Chart 5: Sex of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Twelve Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Male	19	24	17	16	11	14	17	16	20	5	19	19
Female	14	14	9	8	11	9	20	18	16	12	9	14

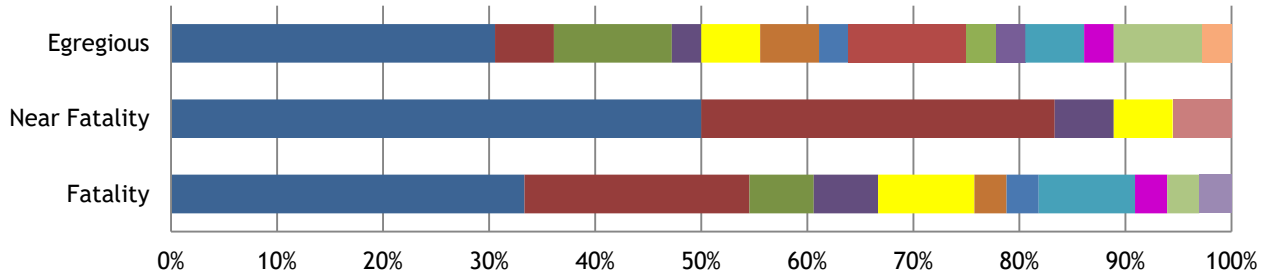
Age at Time of Incident

National and Colorado data continues to show that victims of fatal child maltreatment incidents tend to be younger. Younger children rely solely on their caregivers to meet their needs and have little to no ability to self-protect from maltreatment. Additionally, research continues to show that a child's young age is a key risk factor associated with child maltreatment fatalities. As displayed in Chart 6, 33.3% (11/33) of the fatalities involved victims younger than one year old, and 66.7% (22/33) were three or younger. Nationally, in FFY 2020, 46.4% were under the age of one, and 67.8% of all victims were age three or younger.

In Colorado, a similar pattern of younger-aged victims exists for the near fatalities, as 50% (9/18) of the victims were under the age of one, and 88.9% (16/18) were age three or under (see Chart 6). The pattern of age of victims of egregious incidents has followed its own trend within Colorado. In CYs 2018, 2019, 2020, and 2021 the majority of victims were three or

younger. In CY 2021, 50% (18/36) of victims were three or younger. The remaining CYs depicted in Chart 6, show years in which egregious victims trended older.

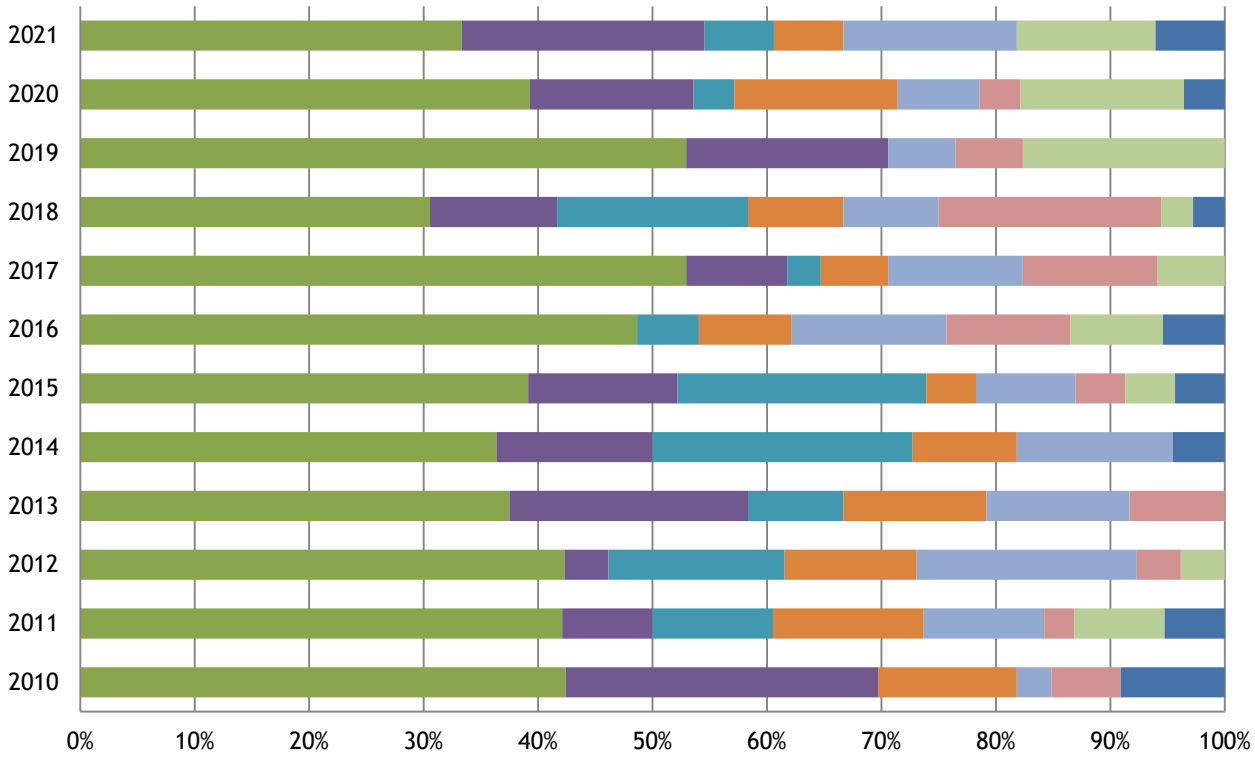
Chart 6: Age of 87 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2021



	Fatality	Near Fatality	Egregious
<1	11	9	11
1	7	6	2
2	2	0	4
3	2	1	1
4	3	1	2
5	1	0	2
6	1	0	1
7	0	0	4
8	0	0	1
9	0	0	1
10	3	0	2
11	1	0	1
12	0	0	0
13	0	1	0
14	1	0	3
15	1	0	0
16	0	0	0
17	0	0	1

Chart 7 displays the trends in ages of victims in child maltreatment fatalities over the past twelve calendar years. The data further depicts that children under the age of one year old are the most frequent victims of fatal child maltreatment. Furthermore, when looking at victims age three or younger, this can range from approximately 62-81% of all victims in child maltreatment fatalities. There continues to be an opportunity to look at how our systems and our communities can help support families and the well-being and safety of this age group by focusing on prevention efforts and social determinants of health.

Chart 7: Age of Substantiated Victims in Child Maltreatment Fatalities in Colorado over the Past Twelve Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<1	14	16	11	9	8	9	18	18	11	9	11	11
1	9	3	1	5	3	3	0	3	4	3	4	7
2	0	4	4	2	5	5	2	1	6	0	1	2
3	4	5	3	3	2	1	3	2	3	0	4	2
4-6	1	4	5	3	3	2	5	4	3	1	2	5
7-9	2	1	1	2	0	1	4	4	7	1	1	0
10-12	0	3	1	0	0	1	3	2	1	3	4	4
13+	3	2	0	0	1	1	2	0	1	0	1	2

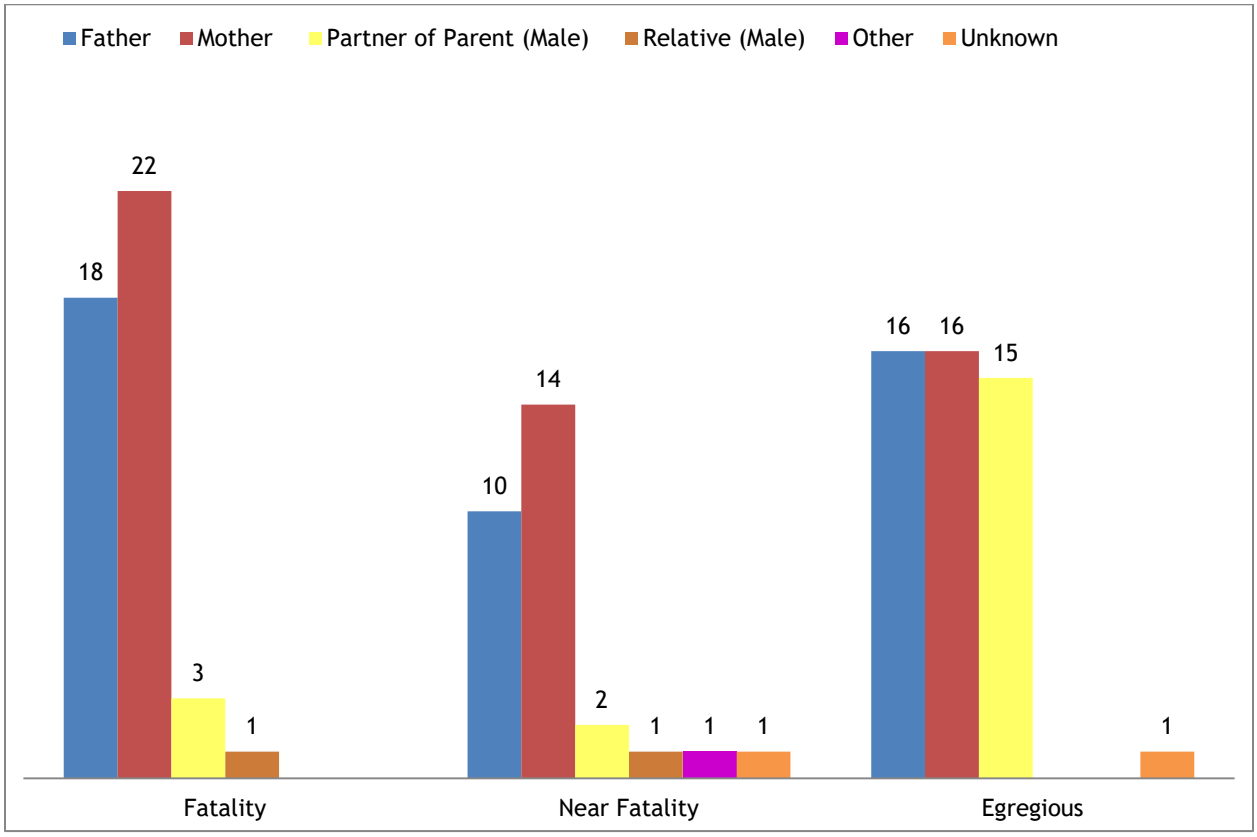
Perpetrator Relationship

A child's caregiver is most often the perpetrator of a fatal incident of child maltreatment, and it usually involves one or two parents. National data continuously indicates the mother as the most common perpetrator of a fatal incident of child maltreatment. In FFY 2020, it was noted that 80.6% of fatal incidents of child maltreatment involved one or both parents, sometimes acting alone and sometimes involving another person. For 2021, in Colorado, there were six distinct perpetrator types: 1. Mothers, 2. Fathers, 3. Partner of Parent (male), 4. Relative (male), 5. Other, and 6. Unknown.

In Colorado for CY 2021, for fatal and near fatal incidents of child maltreatment, mothers were the most common perpetrator at 50% (22/44) and 48.3% (14/29) respectively. Fathers were identified as the second most common perpetrator for fatal and near fatal incidents of child maltreatment at 40.9% (18/44) and 34.5% (10/29) respectively. Regarding egregious incidents of child maltreatment, mothers and fathers were equally represented as the most common perpetrator both at 33.3% (16/48), with a partner of parent (male) being the second most common, only slightly below, at 31.3% (15/48).

For all substantiated incidents in 2021, two perpetrators were unknown in egregious incidents of child maltreatment, which means through assessment and investigation it was determined that abuse or neglect had occurred and a perpetrator of the incident was unable to be determined. Chart 8 further displays the relationship between the perpetrator(s) and the victim(s) of fatal, near fatal, and egregious incidents of child maltreatment. There can be more than one perpetrator per child and incident.

Chart 8: Perpetrator Relationship to 87 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2021

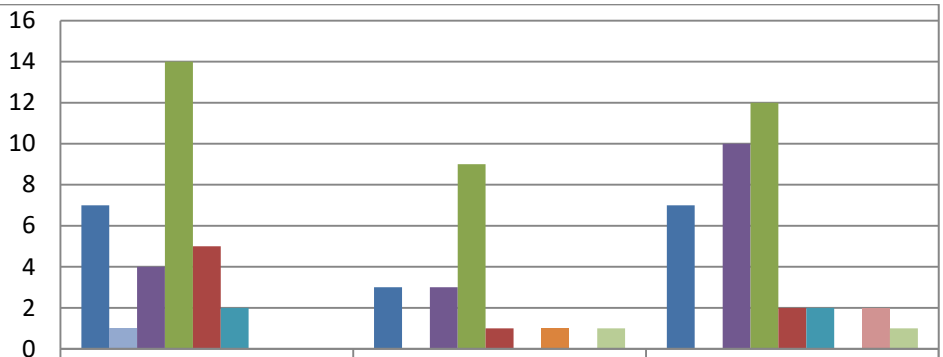


**More than one perpetrator exists for several children.*

Family Structure

In 2021, 40.2% (35/87) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents (see Chart 9). This family structure was also the most frequent for incidents occurring in 2015, 2016, 2017, 2018, 2019, and 2020. The second most common type of family structure across substantiated fatal incidents in 2021 was one parent at 21.2% (7/33). For near fatal incidents in 2021, there were two different family structures that were the second most common; one parent and one parent and one related caregiver, both represented at 16.7% (3/18). The second most common type of family structure across egregious incidents was one parent and one unrelated caregiver at 27.8% (10/36).

Chart 9: Family Structure of 87 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2021



	Fatality	Near Fatality	Egregious
One parent	7	3	7
One parent and one related caregiver	1	0	0
One parent and one unrelated caregiver	4	3	10
Two parents	14	9	12
Two parents and relatives	5	1	2
One parent and relatives	2	0	2
One related caregiver	0	1	0
One related caregiver and one unrelated caregiver	0	0	2
One legal caregiver with relatives and one unrelated caregiver	0	1	1

Family Characteristics

Collecting and analyzing characteristics associated with families involved in incidents of fatal, near fatal, and egregious child maltreatment, can help the child welfare system and community better identify and understand risk factors, stressors, and contributing factors associated with such incidents. Income, education, public benefits, and stressors are outlined

in the next sections of this report and includes data from fatal, near fatal, and egregious incidents reviewed by the CFRT in 2021 (40 incidents). Since this information is only collected for families when the incident of fatal, near fatal, or egregious child maltreatment meets the statutory criteria for review, the scope of analysis is limited. Information on public assistance is at the family level of the legal caregiver(s), while information on the income and education are on the legal caregiver level.

Income and Education Level of Legal Caregivers

Income and education level of legal caregivers, as well as government assistance or services received by legal caregivers at the time of the incident, is required to be included in the final confidential case-specific executive summary for those incidents of fatal, near fatal, and egregious child maltreatment that meet criteria for review by the CFRT. This information continues to prove difficult to collect and report on, as it is not always part of the available documentation from county departments of human/social services. Income and education level of caregivers are not variables consistently collected during child protection assessments. For example, there were 67 unique caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed by the CFRT in 2021 (40 incidents); income information was only known for 12/67 of these individuals (17.9%). Of those caregivers with known income information, the average income for legal caregivers involved in fatal incidents is approximately $38,144.00. For near fatal and egregious incidents the average known income is $16,666.67 and $43,666.67, respectively.

Educational level was known for 58.2% (39/67) of the legal caregivers involved in fatal, near fatal, and/or egregious incidents of child maltreatment reviewed by the CFRT in 2021. The most common level of completed education of legal caregivers across fatal, near fatal, and egregious incidents of child maltreatment was a high school diploma/GED. This accounted for 79.5% (31/39) of the legal caregivers with a known educational attainment level.

Supplemental Public Benefits

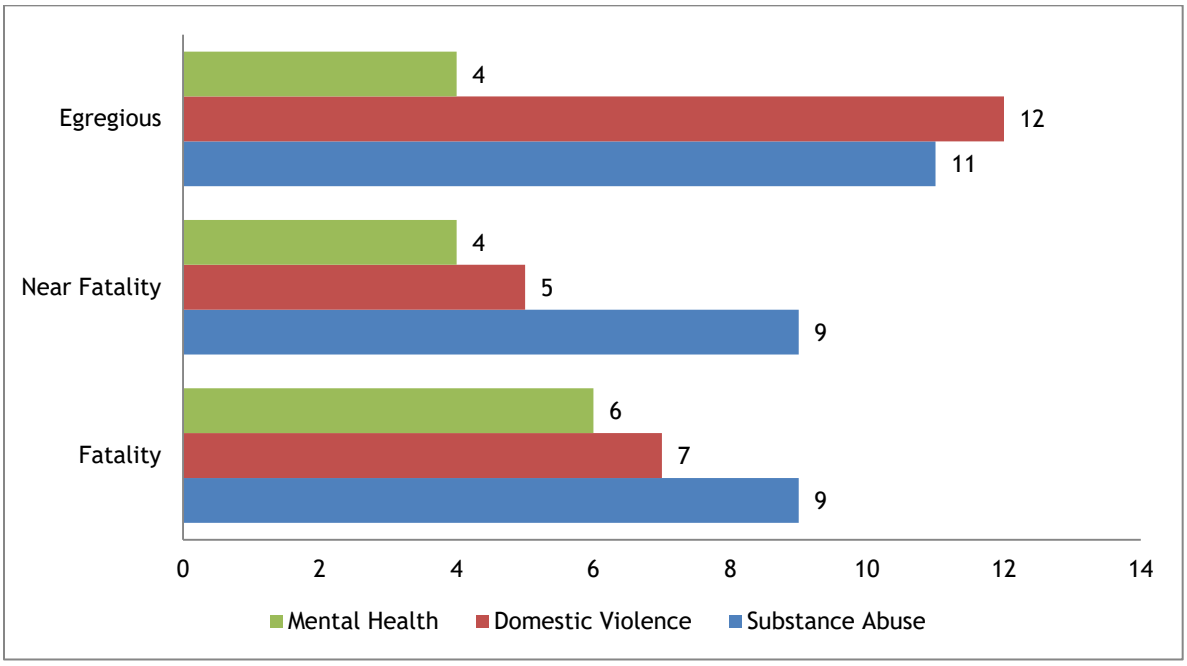
In CY 2021, information regarding supplemental public benefits was gathered for the 40 incidents of fatal, near fatal, and/or egregious child maltreatment reviewed by the CFRT. Information regarding supplemental public benefits is tracked by incident, rather than by the unique caregivers. Information collected indicated that the most frequently received supplemental benefit was Medicaid (23/40; 57.5%). In 16 of the 40 incidents reviewed, 40% of families were receiving Supplemental Nutrition Assistance Program (SNAP) benefits. Other types of benefits received included Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Special Supplemental Nutrition Program-Women, Infants, Children (WIC), Housing Assistance, and Child Care Assistance Program (CCAP).

Other Family Stressors

Substance abuse, mental health, and domestic violence are often identified as stressors for caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment. There were 40 incidents reviewed by the CFRT in 2021; 16 fatal incidents, 9 near fatal incidents, and 15 egregious incidents. Some incidents will not have any of the stressors identified during the review process, while others will have more than one identified. Of the fatal child maltreatment incidents which met criteria for review by the CFRT, 56.3% (9/16) had a history of identified mental health issues, and 43.8% (7/16) were identified to have had some history of domestic violence.

Nationally, in FFY 2020, 5.7% of child fatalities were associated with a caregiver known to abuse alcohol, while 17.6% of child fatalities were associated with a caregiver who abused drugs. Of the fatal child maltreatment incidents reviewed, which met criteria for review by the CFRT, 56.3% (9/16) of the incidents reviewed had some identified caregiver history of substance abuse issues. Chart 10 further identifies stressors identified/associated with caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2021.

Chart 10: Other Stressors in Families of the Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents Reviewed by the CFRT in 2021



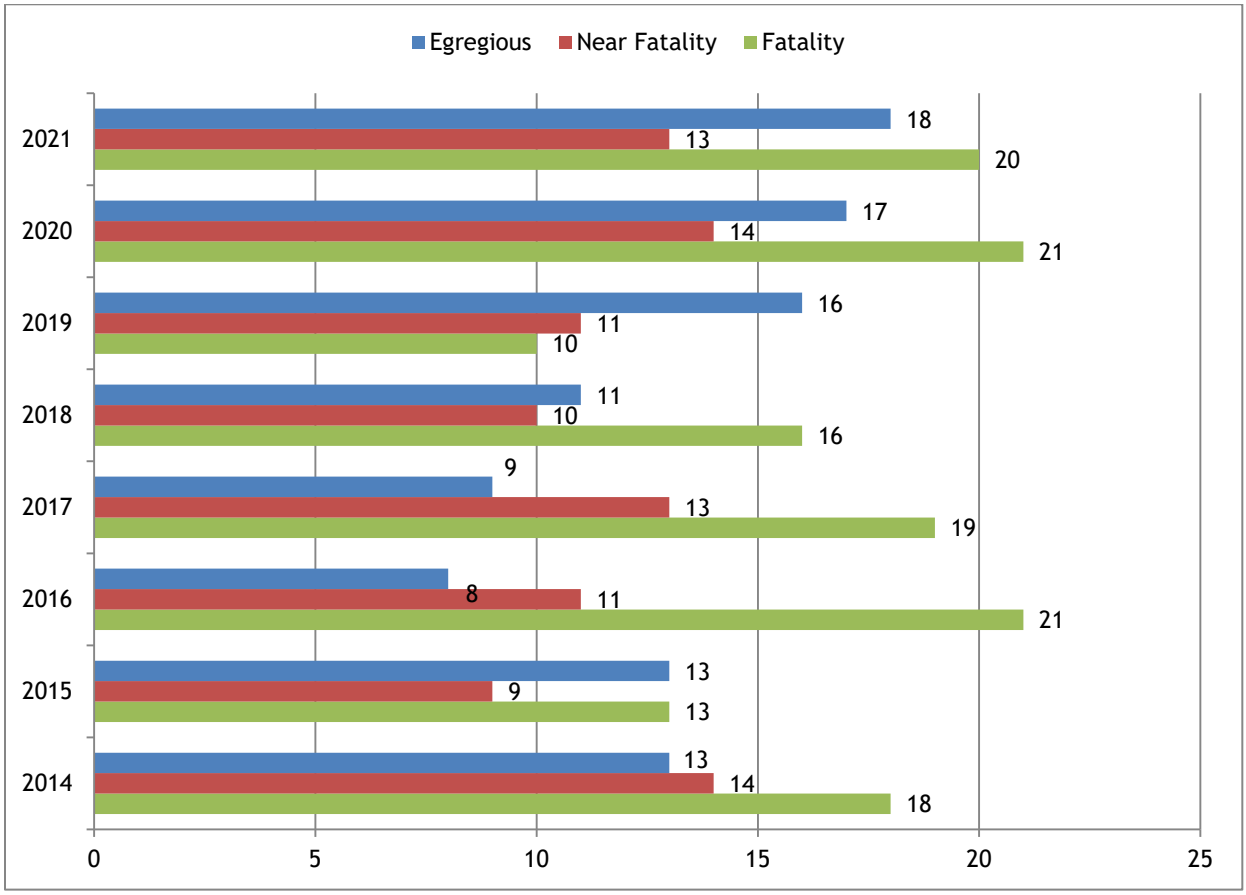
Prior Involvement

In CYs 2014 - 2021 the percentage of families in Colorado involved in a substantiated incident of fatal child maltreatment that also had prior involvement with the child welfare sysytem within three years preceding the incident has ranged between 35% and 82%. In 2021, 66.7% of

substantiated fatal child maltreatment incidents, the child, child's family, and/or alleged perpetrator had prior involvement with the child welfare system. This is a decrease from 2020, when 75.0% of fatal incidents substantiated for abuse or neglect had prior involvement with the child welfare system. The most common type of prior involvement for all three incident types in 2021 was a prior and/or current assessment, also mirroring 2020 data.

The number of families with prior history and/or current involvement for near fatalities and egregious incidents substantiated for child maltreatment has varied throughout the years. The percentage of families involved in near fatal incidents of child maltreatment, who also had prior history and/or current involvement, has ranged from 50% - 65% between 2014 and 2020, and rose to 76.5% in 2021. Families involved in egregious child maltreatment incidents who had prior history and/or current involvement followed a similar trend to near fatal incidents, ranging from 48.5% to 68.4%, and rising to 75% in 2021. Chart 11 details the trends in incidents with prior and/or current involvement for the past eight calendar years.

Chart 11: Prior and/or Current CPS Involvement of Families in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado from 2014-2021



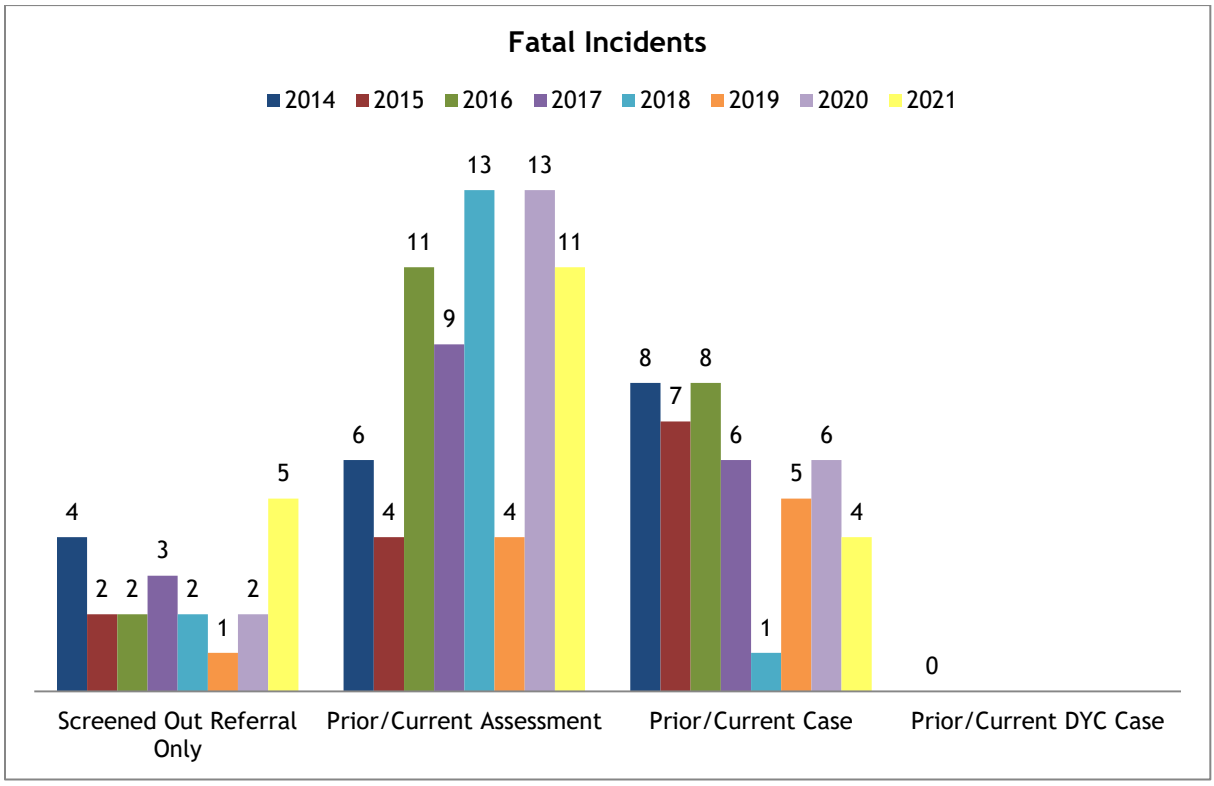
Since 2014, given the statutory stability around the scope and definition of prior involvement, information related to prior involvement is available for analysis. Trends related to the type of prior and/or current involvement over the past seven years is illustrated in Charts 12 a-c. In determining the type and scope of prior involvement, this section follows the prior history to the furthest level of prior involvement/intervention the family had within the child welfare system. For example, if a county department of human/social services received a referral regarding a family, and that referral was accepted for assessment, the prior history will be counted only in the category for "Prior/Current Assessment." If the referral was not accepted for assessment, it would be counted in the "Prior/Current Referral" category.

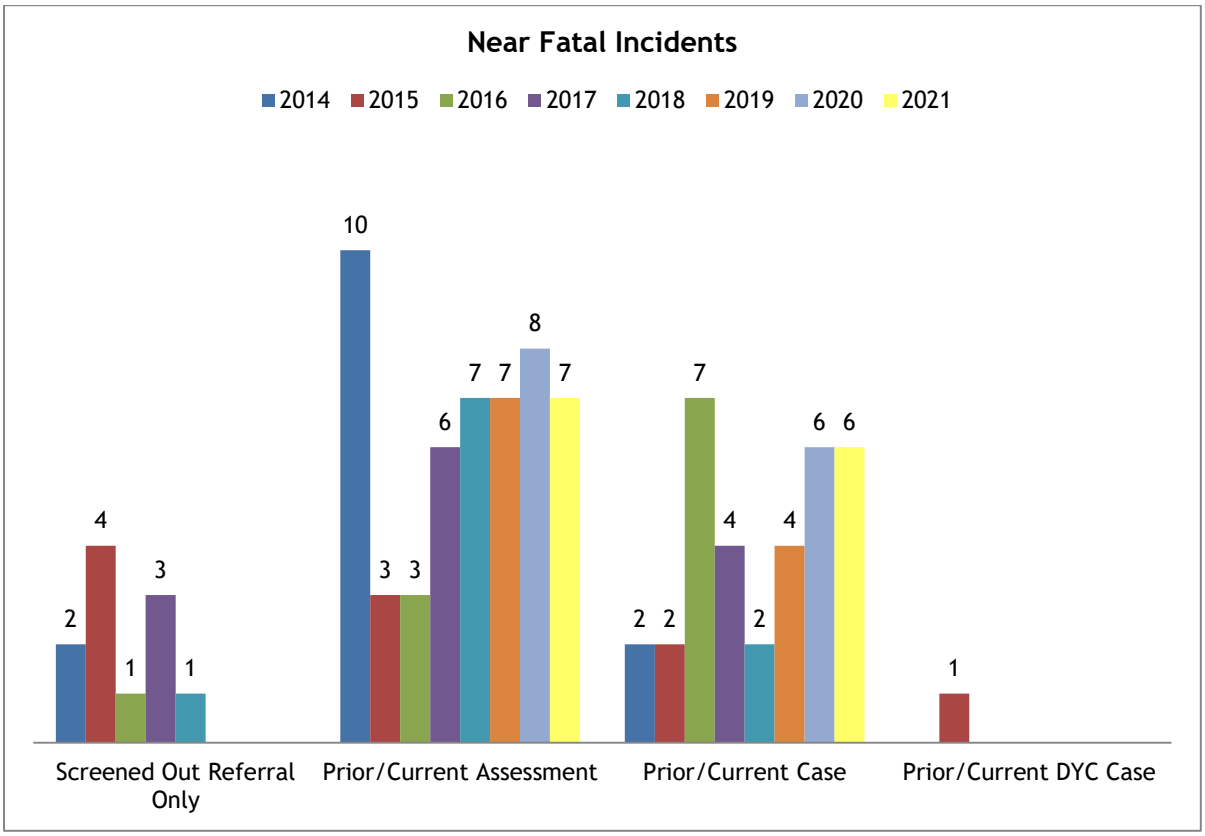
In 2021, for those families with prior involvement, 20% (4/20) of families involved with a fatal incident of child maltreatment had a prior and/or current case(s), which was lower than trends in 2014, 2015, 2019 and 2020. In 2021, the most common level of prior involvement with the child welfare system was a prior and/or current assessment. This mirrored trends in CYs 2016, 2017, 2018, 2019, and 2020.

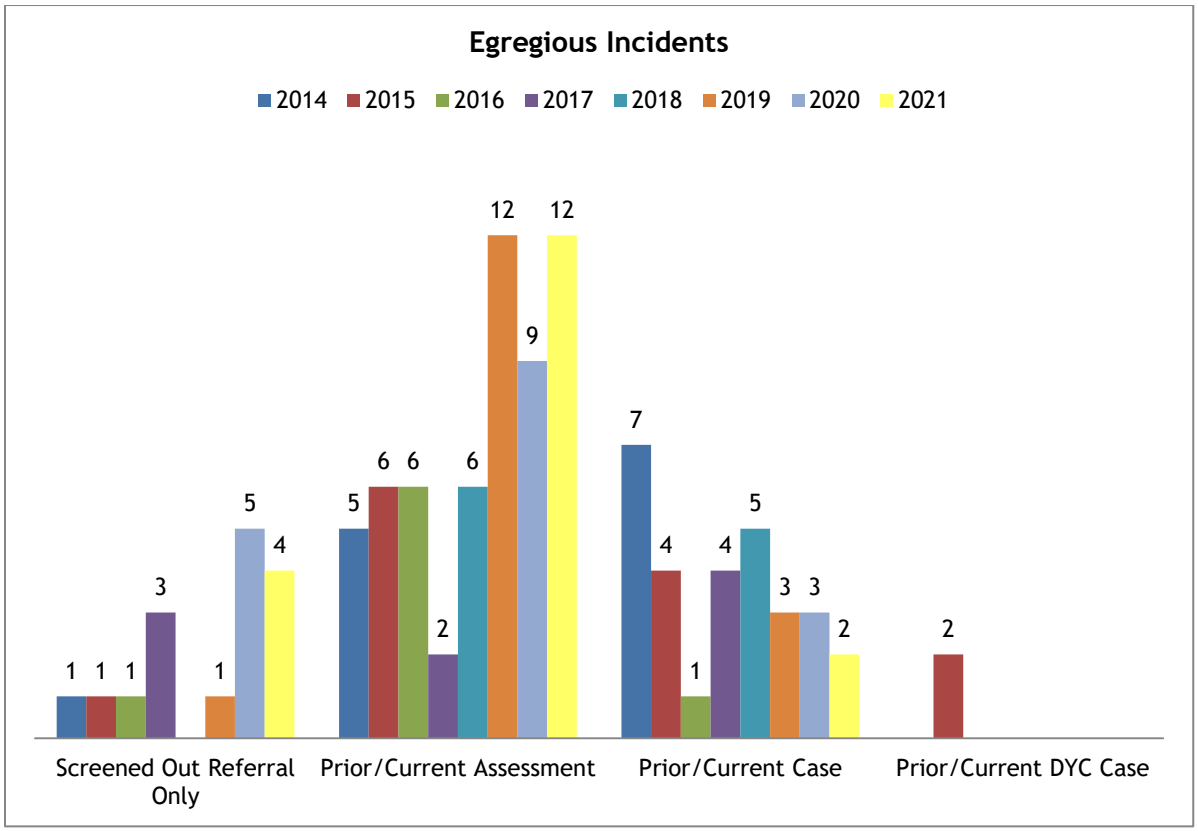
Near fatal incidents in 2021 fell in line with trends seen in 2014, 2017, 2018, and 2019, with assessments as the most common level of prior and/or current involvement with the child welfare system (7/13; 53.8%). The second most common level of prior involvement in 2021 for near fatal incidents was a current and/or prior case (6/13; 46.2%).

In 2021, the most common level of prior and/or current involvement with families involved with egregious incidents of child maltreatment was a prior and/or current assessment (12/18; 66.7%) which followed 2015, 2016, 2018, 2019, and 2020 trends. In 2014 and 2017, the most common level of prior and/or current involvement in a family's child welfare history associated with substantiated egregious incidents of abuse or neglect, was a prior and/or current case.

Chart 12 a-c: Detail of Prior Involvement of Families in Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment







Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 34 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 34 reports completed and/or posted to the CDHS public notification website after the cut-off date for inclusion in the 2020 CFRT Annual Report (4/1/2021) and prior to and including the cut-off date for inclusion in this year's report (3/31/2022). Each of the 34 reports contains an overview of systemic strengths identified by the CFRT, as well as systemic gaps and deficiencies identified in each particular report. The aggregate data from the 34 reports point to the strengths and gaps in the child welfare system surrounding fatal, near fatal, and egregious incidents of child maltreatment.

Using the expertise provided by the CFRT multi-disciplinary review, members identified gaps and deficiencies that ultimately resulted in recommendations to strengthen the child welfare system. Reviewers identified policy findings based on Volume 7 and Colorado Revised Statutes. Each report contained a review of both past involvement and the involvement related to the incident itself.

This section first summarizes systemic strengths found by the CFRT across the 34 reports. Then, the section provides an overview of systemic gaps and deficiencies, as well as any corresponding recommendations and progress. This section also summarizes policy findings from the 34 reports that resulted in a recommendation, alongside resulting recommendations and progress.

Summary of Identified Systemic Strengths in the Delivery of Services to Children and/or Families

Across the 34 fatal, near fatal, or egregious incidents of child maltreatment reviewed by the Child Fatality Review Team and posted to the public notification website, the team noted 104 systemic strengths in the delivery of services to children and families. Systemic strengths acknowledged by the team were organized into the following categories: 1) Collaboration; 2) Engagement with Family; 3) Case Practice; 4) Safety; 5) Services to Children and Families; and 6) Documentation. The three systems most frequently mentioned were: 1) County Departments of Human Services (both alone and alongside other entities); 2) Medical Providers; and 3) Family and Friends.

Collaboration

The CFRT uses multi-disciplinary expertise to examine coordination and collaboration between various agencies as reflected in documents from multiple sources. The CFRT identified that collaboration between county offices and other professional entities was a systemic strength on 25 occasions across 21 reports. Most often, collaboration which occurred *after* the fatal, near fatal, or egregious incident was noted as a strength. For example, county departments collaborated well with other agencies (e.g., another state's department of human services, local community agencies, law enforcement, family and friends of child(ren), and medical providers). These collaborations often provided important information to the county child welfare professionals about the incident of child maltreatment, and helped to inform decisions regarding coordination of services and the outcome of the assessment.

Engagement of Family and Friends

Engagement of family members and friends during the assessment was noted as a strength 16 times across 11 reports. County departments of human/social services were often recognized for engaging friends and family members to find placements after an egregious, near fatal, and/or fatal incident of child maltreatment. Engagement efforts also involved engagement with parents after the incident occurred, ensuring the surviving sibling's safety, and finding relatives, instead of foster homes, for placement. Several of the strengths noted the ability of caseworkers to positively engage with families during the assessment of the fatal, near fatal, or egregious incident in order to better assess safety and risk concerns, mitigate concerns, and plan for the future safety and permanency of the children.

Case Practice

The CFRT identified caseworkers who excelled in case practice 35 different times across 20 reports. Some examples of case practices that were identified as strengths included: thorough documentation of a family's history and utilization of a timeline in order to help organize information and identify themes and/or patterns of behavior, a thorough analysis of risks, strengths, and prior child welfare involvement can help inform decisions regarding child safety, future risk of maltreatment and necessary interventions, services provided to the child and/or family prior to the fatal, near fatal, and/or egregious incident of child maltreatment, and caseworkers diligently working to find family to use as placement when necessary.

Safety

The CFRT identified eight instances across six reports where systems surrounding children and families promoted child safety. Oftentimes, efforts to assess, advocate for, and achieve safety for the victim and/or surviving siblings were notable. Safety also included efforts in caseworkers developing safety plans with the family, working with law enforcement, making swift decisions about child safety, and connecting families to resources.

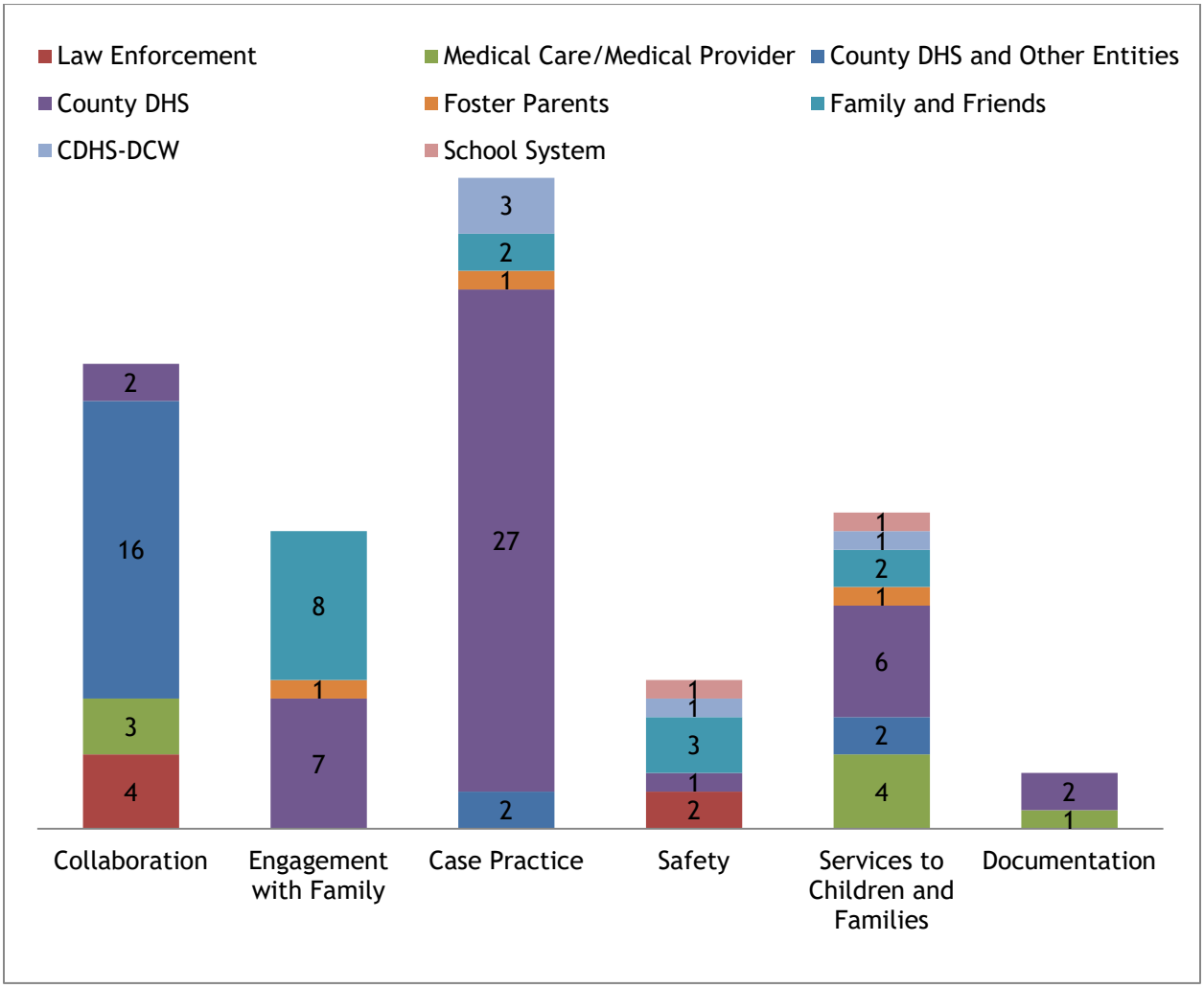
Documentation

The CFRT identified three instances across two reports where documentation in the case record was a strength. These strengths specifically noted documentation completed by county departments and by a coroner’s office. Thorough and high-quality documentation achieved effective information sharing and helped inform agency responses.

Services to Children and Families

Finally, service provision to children and families, both before and after fatal, near fatal, and/or egregious incidents of child maltreatment, was noted as a strength 17 times across 12 reports. Service provision often included services that were provided to the family as a result of the fatal, near fatal, and/or egregious incident of child maltreatment, which included but were not limited to: medical evaluations, developmental assessments, trauma informed services, and placements with family members.

Chart 13: Systemic Strengths



Summary of Identified Systemic Gaps and Deficiencies in the Delivery of Services to Children and Families

In the 34 fatal, near fatal, or egregious child maltreatment incidents reviewed by the Child Fatality Review Team, with case specific executive summary reports posted to the public notification website between April 1, 2020 and March 31, 2021, the CFRT identified four gaps and deficiencies in the delivery of services to children and families, and issued corresponding recommendations. Systemic gaps and deficiencies were organized into the following categories: 1) Communication; 2) Training/Technical Assistance; and 3) Available Services. Each systemic gap and deficiency, whenever possible, corresponded with a recommendation

to address the identified concern. Appendix C contains the recommendations resulting from these 34 incident reviews, as well as information about their implementation status.

Policy Findings

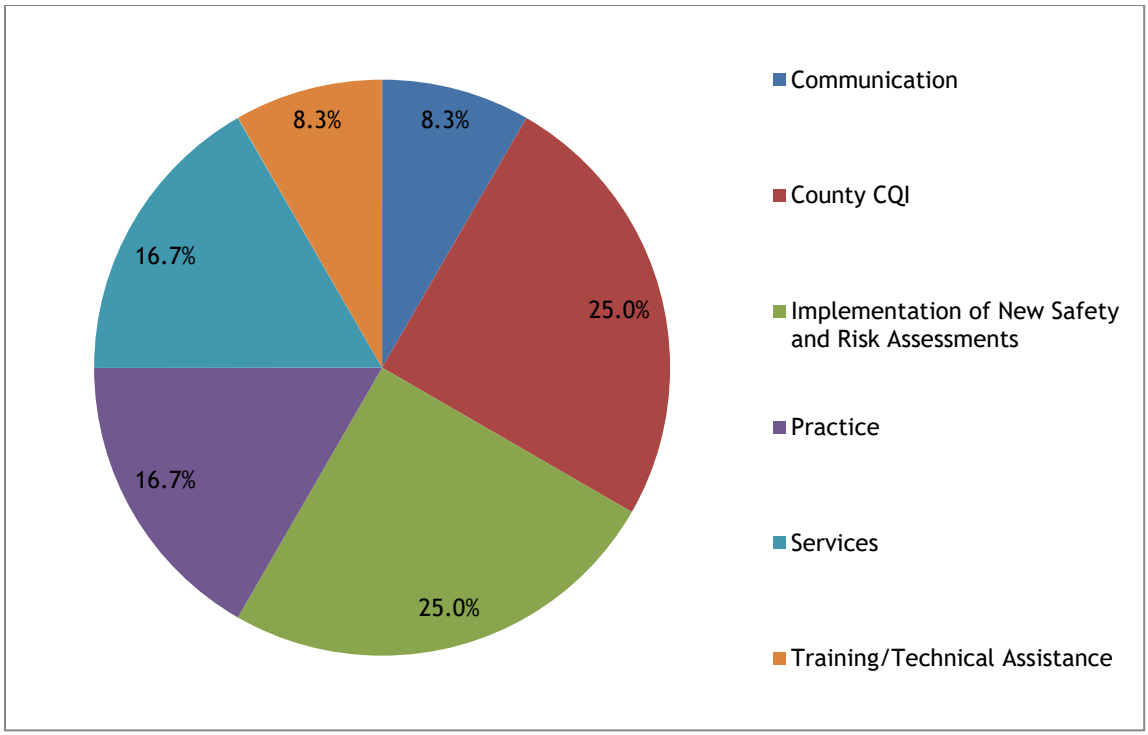
In October of 2019, changes were implemented to the policy finding and associated recommendation process for various reasons. Mainly, the inclusion of this information tends to steer conversation towards specific policy findings that were really not related to the incident. To be in alignment with a systems model approach to case reviews, we needed to shift the focus of reviews to the statutory intent of identifying systems level issues that the team could make recommendations about, that may be more pertinent to preventing future incidents. Second, ARD no longer has the staffing capacity to conduct the Assessment and In-home reviews, and we no longer have data to use to indicate whether or not these particular policy findings are a systemic issue. However, the CFRT staff still methodically review county agency documentation regarding the assessment of the fatal, near fatal, and egregious incidents of child maltreatment and prior involvement. In each review, the CFRT staff identify areas of noncompliance with Volume 7 and the Colorado Revised Statutes. This information is provided to the counties and CFRT members for review.

Each policy finding represents an instance where caseworkers and/or county departments did meet the specific requirements of statute or rule. However, there are limitations to interpreting policy findings in the aggregate across the varied history and circumstances of multiple incidents. For example, an individual policy finding related to the accuracy of the safety assessment tool may indicate that a caseworker selected an item on the tool that did not rise to the severity criteria outlined in rule, and this may or may not have adversely impacted overall decision making in the assessment. Similarly, policy findings related to screening represent referrals where the county incorrectly applied statute and rule, both for referrals that were assigned for assessment *and* referrals that were not assigned for assessment. The findings also refer to the documented classification of referrals not assigned for assessment. Individual policy findings should not be directly correlated with the occurrence of fatal, near fatal, and egregious incidents, but rather present a snapshot of performance in county departments and can direct efforts toward continuous quality improvement.

Recommendations from Posted Reports

A total of 12 recommendations were made across the 34 reports posted between 4/1/2021 and 3/31/2022. This included four related to systemic gaps and deficiencies and eight related to policy findings. As mentioned in the above section, changes to the policy finding and recommendations process occurred in October of 2019, so any recommendations associated to specific policy findings noted in this section were authored/completed prior to the implemented changes. As illustrated in Chart 15, the top areas of recommendations are related to: 1) County Continuous Quality Improvement; 2) Implementation of New Risk and Safety Assessments agencies; and 3.) Services.

Chart 15. Focus of Recommendations in the 24 Reports Posted Between 4/1/2021 and 3/31/2022



The full text of all 12 recommendations are contained in Appendix C, as well as the status of the progress on these recommendations. As illustrated in Chart 16, 66.7% of the recommendations have been completed and 16.7% are in progress. Adding recommendations to the tracking spreadsheet is an ongoing process, therefore, a number of recommendations will not be started at the time of each year's annual report if the reports were just finalized, and the recommendations were recently added to the tracking spreadsheet. This year, 16.7% of the recommendations were not started at the time of this report.

Chart 16: Status of Recommendations(n=12) for Reports Posted Between 4/1/2021 and 3/31/2022

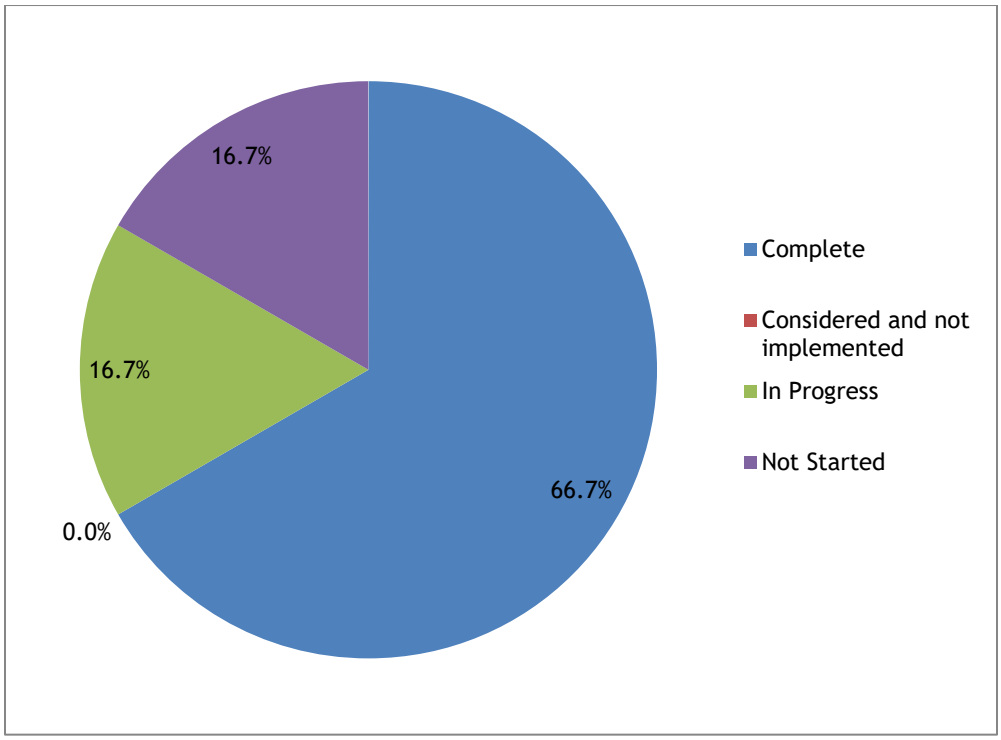
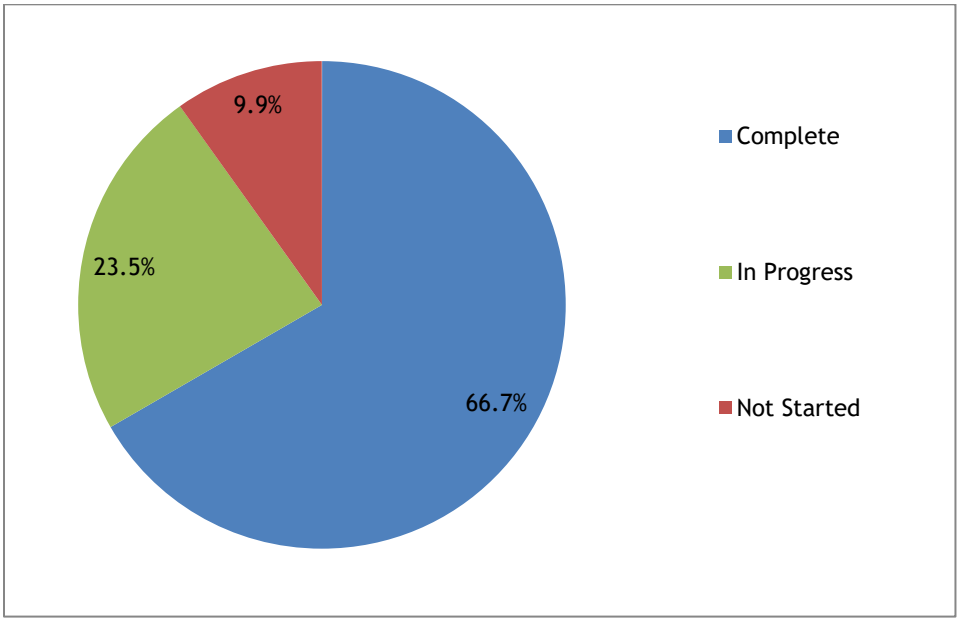


Chart 17: Status of Recommendations (n=81) Not Previously Completed From Reports Posted Prior to 4/1/2021



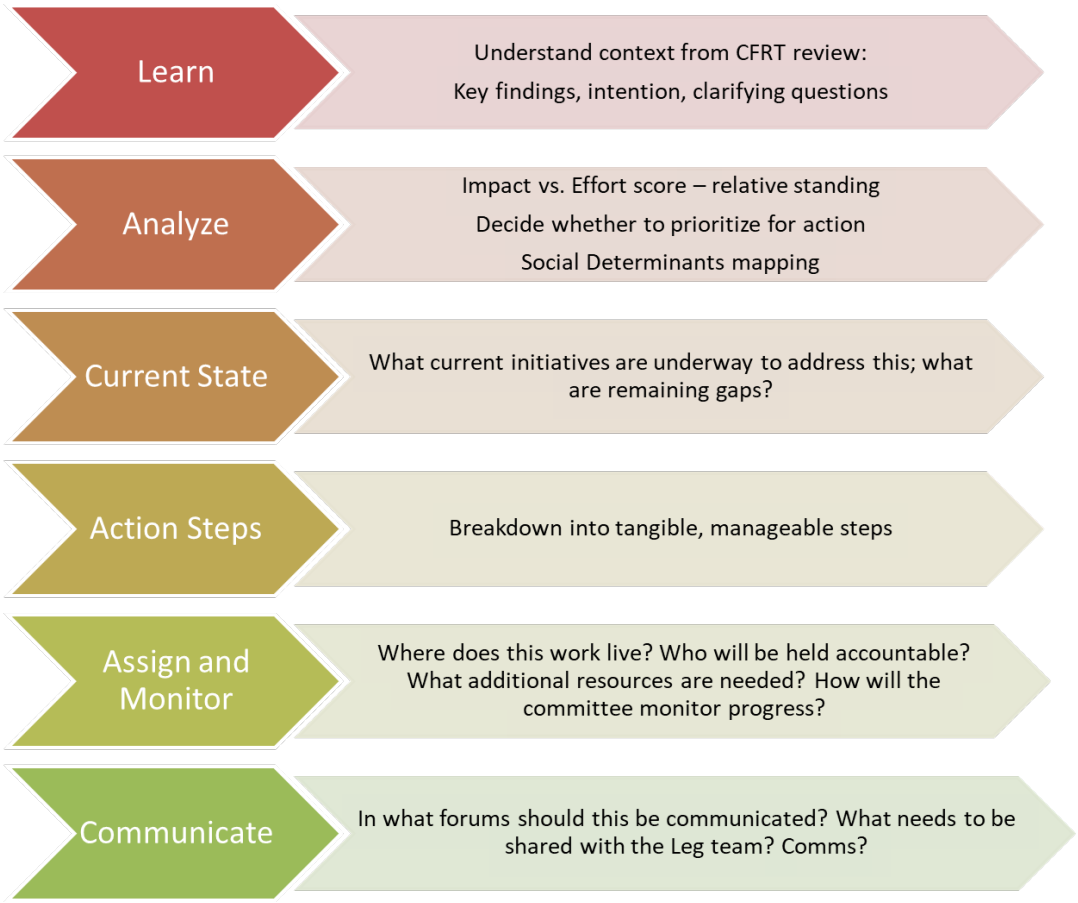
An update on the implementation status of the 81 recommendations previously presented in the 2020 CFRT Annual Report that were not completed at that time is presented in full detail in Appendix D, as well as summarized in Chart 17 above.

CFRT Recommendation Steering Committee

In 2020, a Steering Committee was formed with a vision to ensure each CFRT recommendation is prioritized, acted upon, and implemented in a timely manner to address known systemic gaps and prevent future child deaths. The Committee is responsible for providing high-level strategic direction for each CFRT recommendation, and oversees and supports implementation of recommendations. The relevant group to review and act on CFRT recommendations will vary and will often involve participants from multiple offices, agencies or sectors. The current committee has members from four different CDHS offices as well as two counties, and a representative from the Colorado Department of Public Health and Environment Child Maltreatment Prevention Unit. Representation from CDHS includes the Office of Children Youth and Families, the Office of Behavioral Health, the Administrative Review Division, the Office of Early Childhood, and Community Partnerships.

Systemic recommendations vary greatly in terms of the named systems, scope and intensity. CFRT has maintained a running list of recommendations issued and their status. Based on a history of CFRT reviews and recommendations, it is clear that the underlying contributing factors of child deaths often go beyond the scope of child welfare, and even human services. Implementing recommendations does not live with any one office within CDHS -- preventing child deaths and promoting child and family well-being is everyone’s responsibility. The purpose of the Committee is to ensure that the recommendations are not just issued by the CFRT, but also prioritized and implemented in a timely manner.

Since September of 2020, the committee has been reviewing recommendations and assigning impact and effort scores to determine prioritization efforts. Overall, it has been clear that while several CFRT recommendations remain in progress, a good deal of work is already underway through existing initiatives and pending legislation. The Committee continues to demonstrate that getting the right people together to share information and expertise across disciplines improves the Department’s effectiveness and efficiency in tackling improvements to systemic gaps. Members of the committee also meet with senior executive leadership at CDHS to report out, share information, and strategize action plans around recommendations. Below is an image that helps illustrate the way in which the committee is moving through recommendations into action:



Models and Frameworks

The CFRT was codified in 2011 and has since been conducting multidisciplinary reviews under the authority of Colorado Revised Statute 26-1-139. Through the years of reviewing incidents of fatal, near fatal, and egregious incidents of child maltreatment, we have established that mitigating such incidents of child maltreatment is a community responsibility. It is important to share learnings from such tragedies with the community and other professionals who are responsible for providing services to children and families so we can continue to reflect on strategies that may help prevent future incidents of child maltreatment. This section of the report shares information about models, frameworks, and guides that have been useful to county department staff and members of the multidisciplinary CFRT.

A Systems Model Approach to Case Reviews

The CFRT operates under relevant criteria for excellence in child death reviews, as published by the National Center for Fatality Review and Prevention in 2018. Recent understandings have emerged on a national level that reviews should focus on system level changes and the CFRT has also come to understand the importance of adopting a systems model approach to case reviews; an approach that helps create a space to have vulnerable conversations with

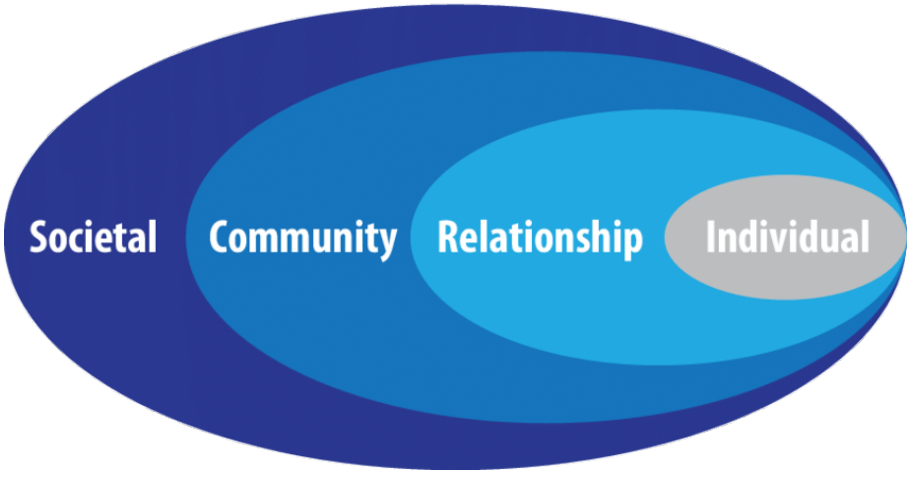
counties of human or social services about their practices and lessons learned from these tragedies, while keeping the child(ren) and families at the center of the review.

Traditional approaches to child death reviews, which aim to focus on where something went wrong, stimulate a sense of fear and blame among professionals and organizations. While it's important to evaluate our work, it's equally important to understand the complex nature of human behavior, and look at families through a larger system lens (i.e. public health approach). In the next section of this guide, we offer a framework to help guide you through a county internal review.

The Social-Ecological Model: A Framework for Prevention

Many factors contribute to a child and/or family who is involved in an incident of fatal, near fatal, and/or egregious child maltreatment, and it is important to consider the totality and influence of these factors in order to better understand why such incidents may occur. The social- ecological framework is broadly used in the context of child maltreatment prevention. The following information is presented by the National Center for Injury Prevention and Control.

The ultimate goal is to stop violence before it begins. Prevention requires understanding the factors that influence violence. The Center for Disease Control (CDC) uses a four-level social-ecological model to better understand violence and the effect of potential prevention strategies. This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The overlapping rings in the model illustrate how factors at one level influence factors at another level.



Besides helping to clarify these factors, the model also suggests that in order to prevent violence, it is necessary to act across multiple levels of the model at the same time. This approach is more likely to sustain prevention efforts over time than any single intervention.

Individual

The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include conflict resolution and life skills training.

Relationship

The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-peers, partners and family members-influences their behavior and contributes to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs and mentoring and peer programs designed to strengthen problem-solving skills and promote healthy relationships.

Community

The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level impact the social and physical environment. For example, by reducing social isolation, improving economic and housing opportunities in neighborhoods, as well as the processes, policies, and social environment within school and workplace settings.

Societal

The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

Content source: National Center for Injury Prevention and Control, Division of Violence Prevention

Timelines

Timelines help illustrate relevant events, patterns, relationships, behaviors, risks, and protective factors associated with these incidents of fatal, near fatal, and/or egregious child maltreatment. Plotting out a family's major life events (i.e. dates of marriage, childbirth, divorce, treatment, criminal charges) and dates of contact with relevant systems and/or providers, has shown to be an effective way of analyzing families' risks and contributing factors which may have led to the incident.

COMMUNITY CRISIS RESPONSE

SUPPORT POLICIES THAT INCREASE FUNDING TO SUPPORT NON-POLICE COMMUNITY-BASED CRISIS RESPONSE.

Pursuant to C.R.S. 25-20.5-407 (1) (i), the Child Fatality Prevention System (CFPS) State Review Team collaborates with the Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT) to make joint recommendations to prevent child fatalities. Based on the systematic review of cases reviewed by both systems, CFRT and CFPS jointly recommend supporting policies that increase funding to support non-police community-based crisis response. The process to identify this recommendation began with CFRT and CFPS staff meeting to review prevention recommendations across the two programs for child deaths reviewed in 2020 by both CFRT and CFPS. Also for the first time ever, CFRT and CFPS team members met in February 2022 to learn about each team's work and how the two programs partner as part of a comprehensive child death review and prevention process, hear updates on past joint recommendations, and discuss possible joint recommendations. CFRT and CFPS members discussed options and identified the need for comprehensive behavioral health crisis response as a common theme and possible recommendation.

This is a joint Colorado Department of Human Services (CDHS) Child Fatality Review Team and CFPS State Review Team recommendation. The CDHS CFRT reviews incidents of fatal, near-fatal, or egregious abuse or neglect determined to be a result of child maltreatment when the child or family had previous involvement with the child welfare system within the last three years. CFRT identifies factors that may have led to the incident and assesses the sufficiency and quality of services provided to families and their prior involvement with the child welfare system. CFRT puts forth policy and practice recommendations based on identified strengths and systemic gaps and/or deficiencies that may help prevent future incidents of abuse or neglect. These recommendations also strengthen systems that deliver services to children and families.

Young people in Colorado have many unmet behavioral health needs, especially during acute crisis situations. Crises are typically short-term, acute instances where individuals can help those in crisis in a non-traumatizing way, leading to better long-term outcomes. While Colorado has made strides to increase access to behavioral health care for young people, such as the creation of the I Matter Program, which provides at least three free behavioral health sessions for Colorado youth and passage of HB22-1052 (Promoting Crisis Services To Students) during the 2022 legislative session to make sure that all schools provide information about how to reach Colorado Crisis Services to their students, more efforts are needed to support young people in crisis. One potential solution is to ensure that youth have access to crisis care in their communities. Community crisis response means care that is available quickly, without extensive travel, and provided by people who know or who are from their cultures and communities. Young people who do not have access to this type of care for their behavioral health may have an increased risk of thoughts of suicide or suicidal ideation, meaning that community crisis care may also decrease suicide among young people in Colorado.

Research shows that community crisis response has shown to reduce unnecessary hospitalizations for individuals in crisis.[1] Involuntary hospitalization and coersive care

experiences are associated with higher rates of future suicide attempts and deaths.[5] The Colorado Suicide Prevention Commission designated a workgroup investigating the use of forced treatment with people experiencing suicidal thoughts in January of 2019. The workgroup reviewed relevant research and data and developed recommendations which included that there are significant equity-related concerns with forced hospitalization, including methods like seclusion and physical restraints being disproportionately utilized on people of color, and LGTBQ + individuals.[5] Therefore, community-based alternatives should be prioritized and promoted such as: community health workers, doulas, and promotoras.

Community-based workers have shown to lead to improved health outcomes. For example, doula-based care reduces the need for hospitalizations among pregnant and birthing people.[6] Doulas play an integral part of crisis response by focusing on building a meaningful, trusting relationship with individuals and their families. Doulas not only lead to better health outcomes, but support individuals and families with continuous emotional and physical support they provide before, during, and after a crisis as well as connecting people with resources in the community.[6,7] While the majority of current research shows that doulas have an impact on reducing adverse health outcomes specifically for pregnant or birthing people, the same model and approach to crisis intervention could be translated to youth crisis intervention. Currently, states like New Jersey and Oregon mandate coverage of doula services under Medicaid. In Colorado, communities are investing in community-based crisis response programs including: AIM GRASP, a peer-run, community violence response program helping divert youth from gang involvement, and Metro Family Health Navigators, hospital-based family advocates, as two examples.

Another option to create more community-based crisis response are mobile crisis teams (MCTs). MCTs serve as alternatives to emergency department admission and are a widely accepted, effective approach to emergency service delivery.[1,2] Such services are thought to also reduce and even completely eliminate the need for law enforcement intervention, and instead divert those in crisis to a community-based treatment center.[3] Law enforcement response to someone is in crisis can escalate a situation, which can be attributed to a lack of training and expertise in de-escalation. MCTs can provide psychiatric assessment and crisis stabilization services by meeting the person in crisis where they are. Peer support is also an important aspect of MCTs, as they can often share lived experience, strengthen engagement with the individual in crisis, and build rapport.[4] All modalities of community crisis response should be culturally relevant for those in crisis, including for their families and communities and ensure timely referrals to resources available in the community. Given the benefits of community-based crisis response, policymakers should support this recommendation in order to improve the lives and outcomes of those experiencing crisis in Colorado.

References:

1. Guo, S., Biegal, D.E., Johnsen, J.A., Dyches, H. (2001). Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization. *Psychiatry Services Psychiatry Online, 52*(2), 223-228.
2. Currier, G. W., Fisher, S. G., & Caine, E. D. (2010). Mobile crisis team intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: a randomized controlled trial. *Academic emergency medicine: official journal of the Society for Academic Emergency Medicine*, *17*(1), 36–43.
3. Waters, R. (2021). Enlisting Mental Health Workers, Not Cops, in Mobile Crisis Response. *Health Affairs, 40*(6).

4. Substance Abuse and Mental Health Services Administration. (2020). *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*.
5. Investigating the Use of Forced Treatment with People Experiencing Suicidal Thoughts Workgroup. (2021). *Recommendations to Support Coloradans Experiencing Suicidal Despair to Reduce Harm and to Support Alternatives to Forced Treatment*. Suicide Prevention Commission of Colorado, Office of Suicide Prevention, Colorado Department of Public Health and Environment.
6. Robles-Fradet, A. (2021). *Medicaid Coverage for Doula Care: State Implementation Efforts*. National Health Law Program.

Safon, C.B., McCloskey, L., Ezekwesili, C., Feyman, Y., Gordon, S.H. (2021). Doula Care Saves Lives, Improves Equity, and Empowers Mothers. State Medicaid Should Pay for it. *Health Affairs*.

Appendix A: 2020 CFRT Attendance

	1.4.21 (virtual)	2.1.21 (virtual)	3.1.21 (virtual)	4.5.21 (virtual)	5.3.21 (virtual)	6.7.21 (virtual)	7.12.21 (virtual)	8.2.21 (virtual)	9.13.21 (virtual)	10.5.21 (virtual)	10.29.21 Retreat (virtual)	11.1.21 (virtual)	12.6.21 (virtual)
Lucinda Connelly *CDHS, Child Protection Manager*	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Korey Elger	---	---	---	---	---	---	---	---	---	---	---	---	---
Beth Collins *CDHS, Domestic Violence Program Specialist*	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Allison Gonzales *Administrative Review Division, Manager*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Marc Mackert	---	---	---	---	---	---	---	---	---	---	Yes	---	---
Kate Jankovsky *CDPHE, Child Fatality Prevention System Coordinator*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Christal Garcia *CDPHE, Violence and Injury Prevention*	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Angela Sneddon *Morgan County Human Services*	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes
Casey Tighe *Jefferson County Commissioner*	Yes												
Ray Douglas *Park County Commissioner*				Yes	Yes	No*	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Liz Smith *Gunnison County Commissioner*						No	Yes	Yes	Yes	No	Yes	No	Yes

	1.4.21 (virtual)	2.1.21 (virtual)	3.1.21 (virtual)	4.5.21 (virtual)	5.3.21 (virtual)	6.7.21 (virtual)	7.12.21 (virtual)	8.2.21 (virtual)	9.13.21 (virtual)	10.5.21 (virtual)	10.29.21 Retreat (virtual)	11.1.21 (virtual)	12.6.21 (virtual)
Senator Jim Smallwood *Senate Majority Leader appointment*	No	No	No	No	No	No	No	No					
Vacant (Legislative)													
Representative Jonathan Singer *House of Representatives Majority Leader appointment*	Yes												
Representative Stephanie Luck *House of Representatives Minority Leader appointment*									Yes	No	No	Yes	Yes
Claire Hooker *Office of Colorado's Child Protection Ombudsman*	Yes	---	Yes	Yes	Yes	---	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Amanda Pennington	---	Yes	---	---	---	Yes	---	---	---	---	---	---	---
Sgt. Brian Cotter *Denver Police Department*	Yes	Yes	Yes	No	Yes	---	No	Yes	No	Yes	No	No	Yes
→**Backup:** Sgt. Eric Denke					---	Yes	---	---	---	---	---	---	---
Dr. Andrew Sirotnak *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Dr. Antonia Chiesa	---	---	---	---	---	---	---	---	---	---	---	---	---
Allyson Baber *Chief Deputy District Attorney, 17th Judicial District*	Yes	Yes	Yes	No	Yes	Yes	Yes	---	Yes	No	No	Yes	Yes
→**Backup:** Shelby Conney	---	---	---	---	---	---	---	Yes	---	---	---	---	---

	1.4.21 (virtual)	2.1.21 (virtual)	3.1.21 (virtual)	4.5.21 (virtual)	5.3.21 (virtual)	6.7.21 (virtual)	7.12.21 (virtual)	8.2.21 (virtual)	9.13.21 (virtual)	10.5.21 (virtual)	10.29.21 Retreat (virtual)	11.1.21 (virtual)	12.6.21 (virtual)
Mara Kailin, PsyD *Aurora Mental Health Center, Director*	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
→**Backup:** Kathy Snell	---	---	---	---	---	---	---	---	---	---	---	---	---
Jenny Bender, *Executive Director of Colorado CASA*	Yes	Yes	No	No	Yes	Yes	No	No	No	No	Yes	No	No
Lea Bernstein-Holmes *Mental Health Coordinator, Sheridan School District*	No	No	No								Yes	Yes	Yes
Heather Porter *Child Find Coordinator, Sheridan School District*				Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Dan Makelky *Douglas County Department of Human Services*	---	---	---	---	---	---							
→**Backup:** Ruby Richards/Nicole Adams	Yes, NA	Yes, RR	No	Yes, RR	Yes, RR	Yes, RR							
Nicole Adams *Douglas County Department of Human Services*							Yes	Yes	Yes	Yes	Yes	Yes	---
→**Backup:** Ruby Richards							---	---	---	---	---	---	Yes
Angela Mead *Larimer County Human Services*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No
Jill Calvert *El Paso County Department of Human Services*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
→**Backup:** April Jenkins/Kris Reed	---	---	---	---	---	---	---	---					
Alysse Nemecek *Jefferson County Department of Human Services*										Yes	Yes	Yes	Yes

	1.4.21 (virtual)	2.1.21 (virtual)	3.1.21 (virtual)	4.5.21 (virtual)	5.3.21 (virtual)	6.7.21 (virtual)	7.12.21 (virtual)	8.2.21 (virtual)	9.13.21 (virtual)	10.5.21 (virtual)	10.29.21 Retreat (virtual)	11.1.21 (virtual)	12.6.21 (virtual)
Cheryl Hyink *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Angela Myers *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nada Pavlovich *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sarah Richelson *Attorney General's Office*	Yes	---	Yes	---	Yes	---	---	---	Yes	---	---	---	Yes
Anita Schutte *Attorney General's Office*	---	---	---	---	---	---	---	Yes	---	---	---	---	---
Bianca Miyata *Attorney General's Office*	---	Yes	---	Yes	---	Yes	---	---	---	---			
Aaron Pratt *Attorney General's Office*						Yes	Yes	---	---	Yes	---	Yes	---

Appendix B: 2014-2021Incidents Qualified for CFRT Review by County and Type

County*	Fatal Incidents								Near Fatal Incidents								Egregious Incidents								2014 Total	2015 Total	2016 Total	2017 Total	2018 Total	2019 Total	2020 Total	2021 Total
	2014	2015	2016	2017	2018	2019	2020	2021	2014	2015	2016	2017	2018	2019	2020	2021	2014	2015	2016	2017	2018	2019	2020	2021								
Adams		2	1	2	2	1	1	4	1		3	1					2			1	1	2	1		3	2	4	4	3	3	2	4
Alamosa																																0
Arapahoe	1	1	4	1	2	1		3		1		2		1	2	1		2	1	1	2	2	1	1	1	4	5	4	4	4	3	5
Archuleta					1												1								1				1			0
Broomfield				1										1														1		1		0
Boulder	1					1				1	2			1							1	2			1	1	2		1	4		0
Chaffee				1																								1				0
Crowley								2																								
Clear Creek	1																								1							0
Denver	4	1	1		2	1	6	2	3	3	1	1	2	1	2	5	3	3	3	3	4	7	5	4	10	7	5	4	8	9	13	11
Douglas			1	1		1						1							1			1		1			2	2		2		1
Eagle		1																								1						0
Elbert																							1								1	0
El Paso	2		4	4	4	2	7	3	1	1	1	5	2	3	4	2	1	1	1	1	1	1	5	9	4	2	6	10	7	6	16	14
Fremont									1							1	2	1			1		1		3	1			1		1	1
Garfield		1				1		1																		1				1		1
Huerfano	1																								1							0
Jefferson	2	2	2	3			3		4		1	1	1	2	3		1	3					2		7	5	3	4	1	2	8	0
La Plata			1		1					1		1	1							1						1	1	2	2			0
Larimer	1	1	1	3	1	1		1								1		2				1			1	3	1	3	1	2		2
Las Animas		1																								1						0
Lincoln																		1								1						0
Logan	1																								1							0
Mesa	1	1	2		1	1		1		1			2	1									1	2	1	2	2		3	2	1	3
Moffat			1		1			1			1																2		1			1
Montezuma			1														1								1		1					0
Montrose			1																								1					0
Morgan	1						1	1	1		1			1						1					2		1	1		1	1	1
Otero				1					1							1									1			1				1
Park			1																								1					0
Phillips																																0
Prowers															1																1	0
Pitkin																	1								1							0
Pueblo	1				1		2		2	1	1					1	1			1					4	1	1	1	1		2	1
Rio Blanco													1			1													1			1
Routt	1											1							1						1		1	1				0
Saguache							1																								1	0
San Miguel				1																								1				0
Teller													1																1			0
Weld		1		1				1							2				1		1			1		1	1	1	1		2	2
Total	**18**	**12**	**21**	**19**	**16**	**10**	**21**	**20**	**14**	**9**	**11**	**13**	**10**	**11**	**14**	**13**	**13**	**13**	**8**	**9**	**11**	**16**	**17**	**18**	**45**	**34**	**40**	**41**	**37**	**37**	**52**	**51**

* Numbers represented above are indicative of the investigating county for the incident, not of all counties having prior involvement

Appendix C: Recommendations from 2021 Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
21-012	CFRT	The CFRT recommended supporting policies and funding for telehealth services to be more accessible and universal, especially in rural and frontier areas, as it would allow for broader access to services and providers. The COVID-19 pandemic has shown the ability to do this and the invaluable support provided to all communities through telehealth and other modalities. In conjunction, the Colorado Department of Public Health and Environment (CDPHE) is also developing a formal recommendation to provide broadband internet options across the state, which would make participating in telehealth options even more accessible and universal for Colorado's rural and frontier communities.	Not Started
21-061	CFRT	The CFRT team recommended a continuation of a previous recommendation related to access to universal home visiting programs. The team identified that there was a need to provide universal home visiting nurse to all families, not just first time parents. Therefore, the CFRT team recommends that all families with newborns should have access to a universal home visiting program.	In Progress
20-067	CFRT	The team recommended that there should be continued funding at the local public health level for disseminating information about safe storage of marijuana and the dangers associated with not keeping marijuana stored securely and away from children.	Not Started
19-030	CFRT	The CFRT recommended the need to explore the current training/curriculum for kinship and foster families to ensure they are receiving information about caring for children with trauma histories and self-harming behaviors in order to ensure the kinship and foster families are as prepared as possible and able to safely meet the children's needs. Likewise, the team recommended for the same exploration into the training/curriculum for caseworkers to ensure they are able to make safe and appropriate decisions regarding placement for children.	In Progress

18-031	Policy Finding	The policy finding related to not interviewing all required parties during the assessment does reflect a systemic practice issue for ACDHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of December 2017 to June 16, 2018, showed that ACDHS interviewed all required parties 72.4% of the time, which is above the Ten Large County average (not including ACDHS) of 67.6% for a comparable time span. It is recommended that ACDHS implement a process in which barriers to interviewing all required parties are identified and solutions to the identified barriers are implemented.	Complete
18-031	Policy Finding	The Department has determined that the Trails Modernization has impacted performance data regarding interviewing/observing the alleged victim within the assigned response time in the Colorado Child Welfare Results Oriented Management (ROM) system, for June 2018. The Department suspended reporting out this data measure for the September 2018 C-Stat. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of September 17, 2017 to March 17, 2018, showed DDHS at 60.7% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including DDHS) of 69.7% for a comparable time span. It is recommended that DDHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete
18-031	Policy Finding	The policy finding related to holding a family engagement meeting when the Colorado Family Risk Assessment scores “high” does reflect a systemic practice issue for DDHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of September 17, 2017 to March 17, 2018, showed DDHS at 66.7% for holding a family engagement meeting to discuss the next steps and documenting the family engagement meeting in the framework. It is recommended that DDHS employ a process in which barriers to holding a family engagement meeting when the Colorado Family Risk Assessment scores “high” are identified and solutions to the identified barriers are implemented.	Complete

18-031	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017 to March 17, 2018, DDHS completed the Colorado Family Safety Assessment Tool when required 51.8% of the time. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete
18-031	Policy Finding	Additionally, the policy finding related to the Colorado Family Safety Assessment Tool not being completed with all required individuals does reflect a systemic issue for DDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017 to March 17, 2018, DDHS completed the current or impending danger section of the Colorado Family Safety Assessment with all required individuals in 69.6% of assessments. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool with all required individuals are identified and solutions to the identified barriers are implemented.	Complete
15-039	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the November 2017, C-Stat, DDHS' performance for September 2017, was 93.5%, with a statewide goal of 95%. It is recommended that DDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete

15-039	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does not reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the November 2017, C-Stat, DDHS' performance for August 2017, was 93.6% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of September 11, 2016, through March 11, 2017, showed DDHS at 71.4% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including DDHS) of 69.7% for the same time span. It is recommended that DDHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented. It should be noted that the Division of Child Welfare (DCW) issued Policy Memo PM-CW-2016-0003 effective July 1, 2016, which stated, "During the assessment of a child fatality, near fatality or egregious incident, the caseworker shall not be expected to observe a deceased child or a child who is on life support or is in critical condition in a hospital environment." This assessment was completed prior to the issuance of the Policy Memo.	Complete
15-082	Policy Finding	In a recent review of a random sample of In-Home Reviews that were conducted during a period from March 16, 2015 to October 13, 2015, ACHSD had accurate documentation in the FSP treatment plan of services directed at the areas of need identified in assessment, 92% of the time. There are no recommendations for this policy violation. ACDHS addressed all required parties in the treatment plan 89% of the time. There are no recommendations for this policy violation. ACHSD's documentation of objectives and action steps documented clear expectations in order to achieve the permanency goal, 62% of the time. It is recommended that ACHSD employ a process in which barriers to ensuring the FSP treatment plan contains documentation of objectives and action steps that document clear expectations in order to achieve the permanency goal are identified and solutions to the identified barriers are implemented.	Complete

Appendix D: Status Update for Recommendations from Previously Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
20-008	CFRT	The CFRT made a formal recommendation to explore recruitment, training, and retention efforts in Colorado to assist in expanding the number of appropriate and available foster homes across the state for the LGBTQ children and youth who are in need of out-of-home care.	In Progress
20-034	CFRT	The CFRT identified a need for the expansion of substance abuse treatment and services in our communities to help support pregnant mothers, who have past and current substance abuse history	In Progress
19-009	CFRT	The CFRT recommended that the Administrative Review Division (ARD), with assistance from county departments of human or social services, ensure that Child Placement Agency (CPA) personnel are invited to reviews of fatal, near fatal, and egregious child maltreatment incidents when those incidents occur in foster homes licensed by CPAs.	Complete
19-003	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the June 2019 C-Stat, ACDHS's performance for April 2019 was 90.1 %, with a statewide goal of 95%. It is recommended that ACDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented	Complete

19-003	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the June 2019 C-Stat, ACDHS's performance for March 2019 was 81.6% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of September 25, 2018-February 22, showed ACDHS at 54.5% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including ACDHS) of 67.9% for a comparable time span. It is recommended that ACDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented	Complete
19-003	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for ACDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 25, 2018-February 22, 2019, ACDHS completed the Colorado Family Safety Assessment Tool when required 56.4% of the time, which is below the Ten Large County average (not including ACDHS) of 63.1% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented. Additionally, the policy finding related to the Colorado Family Safety Assessment Tool not being completed with all required individuals does not reflect a systemic issue for ACDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from September 25, 2018-February 22, 2019, ACDHS completed the current or impending danger section of the Colorado Family Safety Assessment with all required individuals in 80% of assessments, which is above the Ten Large County average (not including ACDHS) of 79.1% for a comparable time span. The Department encourages ACDHS to continue monitoring performance in this area of practice.	In Progress

19-003	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for ACDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 25, 2018-February 22, 2019, ACDHS completed the Colorado Family Safety Assessment Tool accurately 23.6% of the time, which is below the Ten Large County average (not including ACDHS) of 39.4% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented	Complete
19-009	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for JCDCYFAP. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the August 2019 C-Stat, JCDCYFAP's performance for May 2019 was 94.8% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of July 11, 2018 through January 11, 2019, showed JCDCYFAP at 76.4% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including JCDCYFAP) of 66.5% for a comparable time span. It is recommended that JCDCYFAP employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete
19-009	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for ACDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from July 29, 2018 through January 29, 2019, ACDHS completed the Colorado Family Safety Assessment Tool when required 56.4% of the time, which is below the Ten Large County average (not including ACDHS) of 63.1% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete

19-027	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for Arapahoe County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the September 2019 C-Stat, Arapahoe County DHS's performance for July 2019, was 83.2%, with a statewide goal of 95%. It is recommended that Arapahoe County DHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
19-035	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 23, 2018, through March 23, 2019, DDHS completed the Colorado Family Safety Assessment Tool accurately 39.3% of the time, which is above the Ten Large County average (not including DDHS) of 34% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete
19-035	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for JCDCYFAP. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the September 2019 C-Stat, JCDCYFAP's performance for July 2019, was 90.7%, with a statewide goal of 95%. It is recommended that JCDCYFAP implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
19-035	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for JCDCYFAP. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the September 2019 C-Stat, JCDCYFAP's performance for June 2019, was 81.9% with a statewide goal of 95%. It is recommended that JCDCYFAP implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete

19-063	CFRT	The CFRT recommended a continuation of a previous recommendation related to creating a stronger working relationship and communication between DHS and law enforcement. It was recommended that additional training be considered for law enforcement officers in how to communicate their concerns to DHS when law enforcement responds to a call and there are older children/adolescents present.	In Progress
19-074	CFRT	The CFRT recommended the development of a workgroup that can review domestic violence cases in Colorado to see if there are better ways to work with perpetrators and victims in order to prevent further lethal outcomes for children and families.	In Progress
19-074	CFRT	The CFRT recommended creating dual track court systems for families involved in multiple court actions (i.e. domestic relations, criminal, and civil). This would allow for professionals to collaborate and coordinate services, case management, and participation/compliance with the families involved.	Not Started
19-074	CFRT	The CFRT recommended proposing and supporting a legislative change for domestic violence and parental alienation to be included in the Colorado Children's Code definitions of abuse and neglect.	Complete
18-012	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Safety Assessment Tool when required 51.8% of the time, which is below the Ten Large County average (not including DDHS) of 79.6% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete

18-012	Policy Finding	Additionally, the policy finding related to the Colorado Family Safety Assessment Tool not being completed with all required individuals does reflect a systemic issue for DDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Safety Assessment accurately with all required individuals in 69.6% of assessments, which is below the Ten Large County average (not including DDHS) of 89.5% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool with all required individuals are identified and solutions to the identified barriers are implemented.	Complete
18-012	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Safety Assessment Tool accurately 30.4% of the time, which is below the Ten Large County average (not including DDHS) of 35.2% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete
18-012	Policy Finding	The policy finding related to the inaccurate completion of the Colorado Family Risk Assessment Tool does reflect a systemic issue for DDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Risk Assessment Tool accurately in 39.3% of assessments, which is below the Ten Large County average (not including DDHS) of 50.9% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Family Risk Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete

18-012	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for EPCDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the August 2018 C-Stat, EPCDHS's performance for May 2018 was 94.8% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of August 23, 2017, to February 23, 2018, showed EPCDHS at 58.9% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including EPCDHS) of 71.4% for a comparable time span. EPCDHS made reasonable efforts to observe/interview alleged victims 85.7% of the time, which is below the Ten Large County average (not including EPCDHS) of 88.6% for a comparable time span. It is recommended that EPCDHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete
18-013	CFRT	The CFRT recommended that there is a need for an alert in Trails that notifies Departments of Human Services agencies that have open cases/assessments/referrals when a mutual client is added to another case/assessment/referral.	In Progress
18-016	CFRT	The CFRT recommended that the ARD and the Division of Child Welfare should convene a workgroup to analyze the risk factors from the cases reviewed by the CFRT in order to evaluate the responses needed from DHS and to make recommendations. The Colorado Revised Statutes, 26-1-139 (1) (c), states that one of the goals of the CFRT is "to identify and understand where improvements can be made in the delivery of child welfare services, and to develop recommendations for mitigation of the future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect."	In Progress
18-016	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACHSD. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the July 2018 C-Stat, ACHSD's performance for May 2018 was 89.7%, with a statewide goal of 95%. It is recommended that ACHSD implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete

18-026	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for EPCDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from August 23, 2017, to February 23, 2018, EPCDHS completed the Colorado Family Safety Assessment Tool when required 69.1% of the time. It is recommended that EPCDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete
18-026	Policy Finding	The policy finding related to the inaccurate completion of the Colorado Family Risk Assessment Tool does reflect a systemic issue for EPCDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from August 23, 2017, to February 23, 2018, EPCDHS completed the Colorado Family Risk Assessment Tool accurately in 40% of assessments. It is recommended that EPCDHS employ a process in which barriers to accurately completing the Colorado Family Risk Assessment Tool accurately are identified and solutions to the identified barriers are implemented.	Complete
18-043	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for EPCDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from August 23, 2017 to February 23, 2018, EPCDHS completed the Colorado Family Safety Assessment Tool when required 69.1% of the time. It is recommended that EPCDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete
18-043	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for EPCDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from August 23, 2017 to February 23, 2018, EPCDHS completed the Colorado Family Safety Assessment Tool accurately 23.6% of the time. It is recommended that EPCDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete

18-043	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for EPCDHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of August 23, 2017 to February 23, 2018, showed that EPCDHS's assessments contained the required content 66.7% of the time, which is below the Ten Large County average (not including EPCDHS) of 81.7% for a comparable time span. It is recommended that EPCDHS employ a process in which barriers to documentation of the assessment containing all required content are identified and solutions to the identified barriers are implemented.	Complete
18-044	CFRT	The CFRT formally recommended the need for accessible and affordable child care for all families. The CFRT recommended for CDHS to partner with the Colorado Department of Public Health and Environment (CDPHE) and the Office of Early Childhood (OEC) to determine the best action steps on how to work towards the recommendation of accessible and affordable child care for all families.	In Progress
18-044	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACHSD. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the February 2019 C-Stat, ACHSD's performance for December 2018, was 86.8%, with a statewide goal of 95%. It is recommended that ACHSD implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
18-044	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for ACHSD. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the February 2019 C-Stat, ACHSD's performance for November 2018, was 90.5% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of February 25, 2018, to August 25, 2018, showed ACHSD at 54.5% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including ACHSD) of 69.4% for a comparable time span. It is recommended that ACHSD employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete

18-044	Policy Finding	The policy finding related to making reasonable efforts to observe/interview the alleged victim does reflect a systemic practice issue for ACHSD. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of February 25, 2018, to August 25, 2018, showed ACHSD making reasonable efforts to observe/interview alleged victims 46.2% of the time, which is below the Ten Large County average (not including ACHSD) of 51.3% for a comparable time span. It is recommended that ACHSD employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete
18-044	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for ACHSD. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from February 25, 2018, to August 25, 2018, ACHSD completed the Colorado Family Safety Assessment Tool accurately 25.5% of the time, which is below the Ten Large County average (not including ACHSD) of 44.2% for a comparable time span. It is recommended that ACHSD employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete
18-044	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for ACHSD. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from February 25, 2018, to August 25, 2018, ACHSD completed the Colorado Family Safety Assessment Tool when required 67.3% of the time, which is above the Ten Large County average (not including ACHSD) of 66.2% for a comparable time span. It is recommended that ACHSD employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete

18-044	Policy Finding	The policy finding related to all required parties being interviewed as part of the assessment does reflect a systemic practice issue for ACHSD. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of February 25, 2018, to August 25, 2018, showed that ACHSD interviewed all required parties 40.7% of the time, which is below the Ten Large County average (not including ACHSD) of 76.4% for a comparable time span. It is recommended that ACHSD employ a process in which barriers to interviewing all required parties as part of the assessment are identified and solutions to the identified barriers are implemented.	Complete
18-070	Policy Finding	The policy finding related to the Assessment Closure Summary not containing all required content does reflect a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, 50% of the Assessment Closure Summaries contained the required content. It is recommended that DDHS employ a process in which the barriers to documentation of all required content in the Assessment Closure Summary are identified and solutions to the barriers are implemented.	Not Started
18-091	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the April 2019 C-Stat, ACHDS's performance for February 2019, was 91.7%, with a statewide goal of 95%. It is recommended that ACDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete

18-091	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the April 2019 C-Stat, DDHS's performance for January 2019, was 84.9% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of March 30, 2018, through September 30, 2018, showed DDHS at 76.4% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including DDHS) of 68.5% for a comparable time span. It is recommended that DDHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Not Started
18-091	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from of March 30, 2018, through September 30, 2018, DDHS completed the Colorado Family Safety Assessment Tool when required 49.1% of the time, which is below the Ten Large County average (not including DDHS) of 67.4% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete
18-091	Policy Finding	Additionally, the policy finding related to the Colorado Family Safety Assessment Tool not being completed with all required individuals does reflect a systemic issue for DDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from of March 30, 2018, through September 30, 2018, DDHS completed the current or impending danger section of the Colorado Family Safety Assessment with all required individuals in 60% of assessments, which is below the Ten Large County average (not including DDHS) of 85.6% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool with all required individuals are identified and solutions to the identified barriers are implemented.	Complete

18-091	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from of March 30, 2018, through September 30, 2018, DDHS completed the Colorado Family Safety Assessment Tool accurately 29.1% of the time, which is below the Ten Large County average (not including DDHS) of 43.8% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete
18-095	Policy Finding	The policy finding related to the timeliness of notification of the near fatal incident does reflect a systemic practice issue for Rio Blanco County DHHS. During the year time span from May 12, 2018, through May 13, 2019, Rio Blanco County DHHS provided timely notification to CDHS in 0% of incidents. It should be noted that Rio Blanco County DHHS only had this one incident that met criteria for notification to CDHS during this review span. It is recommended that Rio Blanco County DHHS consider creating a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS.	Complete
18-095	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for Mesa County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the April 2019 C-Stat, Mesa County DHS's performance for January 2019, was 91.7% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of April 12, 2018, through October 13, 2018, showed Mesa County DHS at 67.3% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including Mesa County DHS) of 69.9% for a comparable time span. It is recommended that Mesa County DHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Not Started

18-104	CFRT	The CFRT formally recommended for legislative changes to be made that would enhance and streamline the cooperation between county departments of human/social services and law enforcement in order to make those professional relationships more consistent and reciprocal across the state. The CFRT recommended exploring the possibility of creating a more defined legislative statement regarding the relationship between county departments of human/social services and law enforcement, which would also provide further guidance on what information could be shared between them to assist with their respective assessments and investigations.	Not Started
18-104	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the June 2019 C-Stat, ACDHS's performance for April 2019, was 90.1%, with a statewide goal of 95%. It is recommended that ACDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
18-104	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the June 2019 C-Stat, ACDHS's performance for March 2019, was 81.6% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of July 29, 2018, to January 29, 2019, showed ACDHS at 47.4% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including ACDHS) of 67.9% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete

18-104	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for ACDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from July 29, 2018, to January 29, 2019, ACDHS completed the Colorado Family Safety Assessment Tool accurately 31.6% of the time, which is below the Ten Large County average (not including ACDHS) of 39.4% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete
18-104	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for ACDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from July 29, 2018, to January 29, 2019, ACDHS completed the Colorado Family Safety Assessment Tool when required 57.9% of the time, which is below the Ten Large County average (not including ACDHS) of 63.1% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Not Started
18-104	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for ACDHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of July 29, 2018, to January 29, 2019, showed that ACDHS's assessments contained the required content 60.5% of the time, which is below the Ten Large County average (not including ACDHS) of 79.2% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to documentation of the assessment containing all required content are identified and solutions to the identified barriers are implemented.	Complete

18-104	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the June 2019 C-Stat, DDHS's performance for March 2019, was 87.4% with a statewide goal of 95%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of March 30, 2018, to September 30, 2018, showed DDHS at 76.4% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including DDHS) of 68.5% for a comparable time span. DDHS made reasonable efforts to observe/interview alleged victims 87.3% of the time, which is below the Ten Large County average (not including DDHS) of 88.8% for a comparable time span. It is recommended that DDHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete
18-104	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from March 30, 2018, to September 30, 2018, DDHS completed the Colorado Family Safety Assessment Tool accurately 29.1% of the time, which is below the Ten Large County average (not including DDHS) of 43.8% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete
18-104	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from March 30, 2018, to September 30, 2018, DDHS completed the Colorado Family Safety Assessment Tool when required 49.1% of the time, which is below the Ten Large County average (not including DDHS) of 67.4% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Complete

17-006	CFRT	It is recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	In Progress
17-007	CFRT	The State CFRT noted that there was an opportunity to explore rules around egregious, near fatality, and fatality assessments in regard to a previously assigned caseworker completing an assessment on an egregious, near fatality or fatality assessment.	Complete
17-035	Policy Finding	The policy finding related to not engaging the mother's boyfriend in case planning does reflect a systemic practice issue for OCDHS. In the most recent Out-of-Home Administrative Review period from January 1, 2018, to March 31, 2018, OCDHS engaged the father in case planning 16.7% of the time. It is recommended that OCDHS employ a process in which the barriers to engaging fathers in case planning are identified and solutions to the identified barriers are implemented.	Complete
17-039	CFRT	The CFRT recommended that the Division of Child Welfare (DCW) provide formal guidance regarding what counties should do when they have accepted a referral for assessment and then are unable to locate the family.	Complete
17-039	CFRT	The CFRT recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	In Progress
17-050	CFRT	It is recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	In Progress
17-071	CFRT	It is recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	In Progress

17-071	CFRT	The CFRT recommended that the Division of Child Welfare (DCW) provide formal guidance regarding what counties should do when they have accepted a referral for assessment and then are unable to locate the family.	Complete
17-073	CFRT	The CFRT recommended that the ARD and the Division of Child Welfare should convene a workgroup to analyze the risk factors from the cases reviewed by the CFRT in order to evaluate the responses needed from DHS and to make recommendations. The Colorado Revised Statutes, 26-1-139 (1) (c), states that one of the goals of the CFRT is "to identify and understand where improvements can be made in the delivery of child welfare services, and to develop recommendations for mitigation of the future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect."	In Progress
17-073	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for Arapahoe County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the May 2018 C-Stat, Arapahoe County DHS's performance for March 2018, was 94.4%, with a statewide goal of 95%. It is recommended that Arapahoe County DHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
17-077	CFRT	It is recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	In Progress
17-079	Policy Finding	The policy finding regarding the Family Services Plan review not meeting Volume 7 requirements does reflect a systemic practice issue for ACHSD. In the most recent Out-of-Home Administrative Review period from October 1, 2017, to December 31, 2017, ACHSD completed the Family Services Plan review in Trails according to Volume 7, 60.9% of the time, which is below the statewide average (excluding ACHSD) of 65.5% for the same time span. It is recommended that ACHSD employ a process in which the barriers to completing the Family Services Plan review in accordance with Volume 7 are identified and solutions to the identified barriers are implemented.	Complete

17-080	CFRT	The CFRT recommended for the Administrative Review Division to further explore and/or implement the process outlined in C.R.S. 26-1-139 (6) (e), which states, "For the purposes of participating in a specific case review, additional members may be appointed at the discretion of the members described in paragraphs (a) to (c) of this subsection (6) to represent agencies involved with the child or the child's family in the twelve months prior to the incident of egregious abuse or neglect against a child, a near fatality, or fatality." The CFRT discussed the benefits of having additional stakeholders as participants during the reviews for the applicable incidents.	Complete
17-094	CFRT	The CFRT recommended that ACHSD provide internal training regarding treatment plan monitoring with respect to progress made and assessing for safety and risk during the course of ongoing cases.	Complete
17-094	Policy Finding	The policy finding related to the frequency of monthly contact with the father does reflect a systemic practice issue in ACHSD. In a recent review of a generalizable sample of In-Home cases that were open during the period from September 27, 2017 to March 27, 2018, in all of the months requiring contact with the father, ACHSD agency staff had contact with the father in 63% of the months. It is recommended that ACHSD employ a process in which barriers to the monthly contact with fathers are identified and solutions to the identified barriers are implemented.	Complete
17-108	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for El Paso County. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of August 25, 2018 through February 25, 2019, showed that El Paso County's assessments contained the required content 79.6% of the time, which is above the Ten Large County average (not including El Paso County) of 73% for a comparable time span. It is recommended that El Paso County employ a process in which barriers to documentation of 18 the assessment containing all required content are identified and solutions to the identified barriers are implemented	Complete

17-108	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for Boulder County. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from October 28, 2018 through April 28, 2019, Boulder County completed the Colorado Family Safety Assessment Tool accurately 34.6% of the time, which is below the Ten Large County average (not including Boulder County of 34.7% for a comparable time span. It is recommended that Boulder County employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Not Started
17-108	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for Boulder County. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of October 28, 2018 through April 28, 2019, showed that Boulder County's assessments contained the required content 67.3% of the time, which is below the Ten Large County average (not including Boulder County) of 72.9% for a comparable time span. It is recommended that Boulder County employ a process in which barriers to documentation of the assessment containing all required content are identified and solutions to the identified barriers are implemented.	Complete
16-012	CFRT	It is recommended that there be a discussion between County Trails User Group (CTUG) and CFRT members regarding an alert in the state automated case management system (Trails) that notifies Departments of Human Services agencies that have open cases/assessments/ referrals when a mutual client is added to another case/assessment/ referral.	In Progress
16-023	Policy Finding	The policy finding regarding the 90-Day review/Court Report not being in Trails does reflect a systemic practice issue for Prowers County DSS. In the most recent Out-of-Home Administrative Review data for First Quarter SFY (July 1, 2016 through September 30, 2016), Prowers County DSS completed the 90-Day review/Court Report in Trails according to Volume 7, 16.7% of the time, which is below the statewide average (excluding Prowers County DSS) of 65.3% for the same time span. It is recommended that Prowers County DSS employ a process in which the barriers to completing the 90-Day review/Court report in accordance with Volume 7 are identified and solutions to the identified barriers are implemented.	Complete

16-036	Policy Finding	The policy finding regarding the 90-Day review/Court report not being documented in Trails does reflect a systemic practice issue for the Adams County HSD. In the most recent Out-of-Home Administrative Review data, 1st Quarter SFY17, Adams County HSD completed the 90-Day review/Court report in Trails according to Volume 7, 52.5% of the time, which is below the statewide average (excluding the Adams County HSD) of 65.9% for the same time span. It is recommended that Adams County HSD employ a process in which barriers to the FSP: 5A Review/Court report are identified and solutions to the identified barriers are implemented.	Complete
16-047	CFRT	The CFRT recommended the addition of a critical alert component be added to the state automated case management system when an individual has been involved in a fatal, near fatal, or egregious incident of abuse or neglect. The critical alert component would allow for child welfare staff to be notified if a client identified in a new allegation of abuse or neglect has been involved in a previous fatal, near fatal, or egregious incident. This alert function will also help ensure child welfare staff have critical information to help make well-informed decisions about child safety and well-being.	In Progress
15-006	CFRT	It is recommended that the Colorado Trails system be changed to alert caseworkers when a county staff member adds a client into demographics on a referral and/or assessment if that client is open in another Colorado Trails case/assessment/referral.	In Progress
15-025	CFRT	It is recommended that DCW define type of allegations in Volume VII which correspond to those that are listed in Trails.	In Progress
14-089	CFRT	It is recommended that DCW work with Trails to develop a way for DHS staff to research foster families and gain a complete and accurate picture, ensuring educated decisions can be made around the placement for children.	In Progress
12-033	Incident Specific Report	Assessment tools should be created and used in Program Area 4: Youth in Conflict assessments/cases as they are in Program Area 5: Child Abuse and Neglect assessments/cases.	Complete

2012	Annual Report	Tracking egregious incidents of child maltreatment began in August 2012. While there is a small sample size to date, data reflects that egregious incidents are much more likely to occur with older youth. Assupported within the case specific recommendations, this indicates the need for enhanced assessment of safety and risk for families and youth involved in Program Area 4: Youth in Conflict cases. Program Area 4: Youth in Conflict practice tends to focus on the behaviors of the youth. It is recommended that policy be modified to support the practice of conducting a broader assessment of familial strengths and needs specific to dealing with difficult behavior in youth. Specifically, tools and policy should be created supporting assessments of the family's needs for supportive services. These services may help parents develop increased coping skills and more appropriate responses to difficult behavior in their children.	Complete