July 1, 2023

The Honorable Jared Polis
Governor, State of Colorado

The Honorable Rhonda Fields
Chair, Senate Heath and Human Services Committee

The Honorable Dafna Michaelson Jenet
Chair, House Public and Behavioral Health and Human Services Committee

Representative Michaelson Jenet, Senator Fields and Governor Polis:

The Colorado Department of Human Services, in response to reporting requirements set forth in Section 26-1-139, C.R.S., respectfully submits the attached Child Maltreatment Fatality Review report.

> *"(4)(i) To develop and distribute the following reports, the content of which shall be determined by rules promulgated by the state department pursuant to subsection (7) of this section:*
>
> *(I) On or before July 1, 2014, and on or before each July 1 thereafter, an annual child fatality and near fatality review report, absent confidential information, summarizing the reviews required by subsection (5) of this section conducted by the team during the previous year. The report must also include annual policy recommendations based on the collection of reviews required by subsection (5) of this section. The recommendations must address all systems involved with children and follow up on specific system recommendations from prior reports that address the strengths and weaknesses of child protection systems in Colorado. The team shall post the annual child fatality and near fatality review report on the state department's website and distribute it to the Colorado state child fatality prevention review team established in the Department of public health and Environment pursuant to section 25-20.5-406, C.R.S., the governor, the health and human services committee of the senate, and the public health care and human services committee of the house of representatives, or any successor committees. The annual child fatality and near fatality review report must be prepared within existing resources.*
> *(II) The final confidential, case-specific review report required pursuant to subsection (5) of this section for each child fatality, near fatality, or incident of egregious abuse or neglect. The final confidential, case-specific review report shall be submitted to the Colorado state child fatality prevention review team established in the Department of public health and Environment pursuant to section 25-20.5-406, C.R.S.*
> *(III) A case-specific executive summary, absent confidential information, of each incident of egregious abuse or neglect against a child, near fatality, or child fatality reviewed. The team shall post the case-specific executive summary on the state department's website."*

If you have any questions, please contact Kevin Neimond, CDHS' Director of Policy and Legislative Affairs, at 303-620-6450.

Sincerely,

Kevin Neimond

Kevin Neimond
Interim Co-Executive Director, Colorado Department of Human Services

2022 Child Maltreatment Fatality Annual Report

Colorado Department of Human Services
Child Fatality Review Team

COLORADO
Department of Human Services

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Table of Contents

Executive Summary

The 2022 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) 2022. The 2022 data provides an overview of the trends, characteristics, and demographics of children and families involved with such incidents, and are presented in an effort to better understand and identify the factors associated with such incidents of abuse or neglect. The report also highlights learnings and recommendations for improvements to the systems responsible for providing services to children and families in Colorado.

Colorado's comprehensive system for reviewing and preventing future child deaths is one component of a broader strategy to promote the overall health and well-being of children and families. Colorado's system consists of two separate, but complementary review processes. All deaths resulting from child abuse and neglect receive a thorough review through one or both systems. The CDHS Child Fatality Review Team (CFRT) reviews fatal, near fatal, and egregious incidents of child maltreatment when the family, child, and/or alleged perpetrator had prior involvement with the child protection system in the prior three years. 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. Reviews focus on system level changes. Systems model approach to case reviews 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.

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. 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 implement strategies that may help prevent future incidents of child maltreatment.

While any death due to child maltreatment is too many, it should be noted that in CY 2022, there were a total of 11,173 substantiated findings in Colorado's child welfare system. Of those 11,173 findings, there were 81 substantiated incidents involving 93 children at the fatal, near fatal, and/or egregious severity level. Of the 81 substantiated incidents, 55 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.

Overview. The report includes detailed data and trends on these incidents to help us determine what systems strategies are needed to prevent fatalities. Research continues to show that a child's young age is a key risk factor associated with child maltreatment fatalities. We know younger children rely solely on their caregivers to meet their needs and have little to no ability to self-protect from maltreatment. 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.

Findings and Recommendations. Specific findings, strengths, and gaps/deficiencies identified through the CFRT reviews are also included in this report. Systemic strengths acknowledged by the review team included the following categories: 1) Collaboration; 2) Engagement with Family; 3) Case Practice; 4) Safety; and, 5) Services to Children and Families.

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) Practice; 2) Prevention; and 3) Services. Each systemic gap and deficiency, whenever possible, corresponded with a recommendation to address the identified concern. Details on those recommendations are outlined in Appendix C and Appendix D.

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. 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.

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.

Identification and Reporting of Incidents

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 eleven years. 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. Table 1 numbers reflect those incidents that were reported by county departments, as well as those found through quarterly data integrity processes. As part of the data integrity process for 2022, 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 reported incidents received from counties over the course of CY 2022. The data integrity checks identified 69 potential incidents. Of those incidents, 4 incidents involving 4 children met criteria for public notification, with none 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.

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

Calendar 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
2022	57	31	26	114

**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

Calendar 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	68
2018	34	18	19	71
2019	17	22	24	63
2020	28	28	28	84
2021	30	17	26	73
2022	33	26	22	81

^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.

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*

Calendar 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
2022	26	18	11	55

**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, 60.5% (69/114) of incidents that occurred in 2022 were afforded at least one extension, with the total number ranging from one to thirteen extensions. The average number of extensions afforded per report is 5.

Incidents Reviewed in 2022

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 2022, the CFRT reviewed 42 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.

In CY 2022, of the 42 incidents reviewed, final non-confidential case-specific executive summary reports were posted for 33 of them. For 9 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.

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 39 of this document.

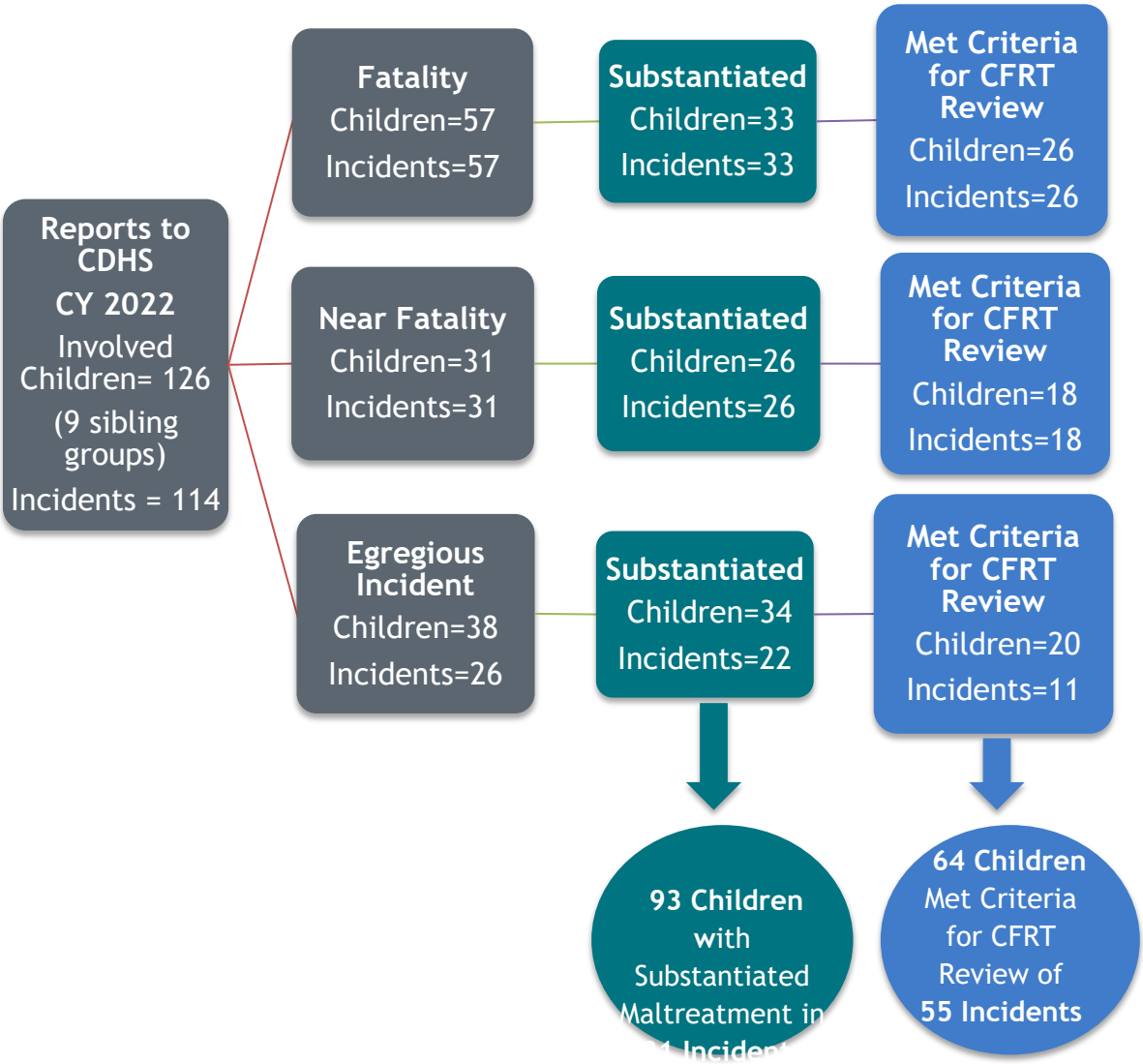
Overview of the 2022 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

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 2022, counties reported 114 incidents involving 126 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. Of the 126 children, 57 children were associated with 57 fatal incidents, 31 children were associated with 31 near fatal incidents, and 38 children were associated with 26 egregious incidents.

Upon completion of an assessment, county departments found that 33 incidents involving 33 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 2022, 81 substantiated incidents included 93 children. Of the 81 substantiated incidents, 55 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 2022. 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 2022



For purposes of this report, the majority of the analysis in the following section focuses on the 93 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 93 substantiated victims of incidents that occurred in CY 2022.

Table 4: Summary information of all 93 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2022

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	12	36.4%	13	50.0%	9	26.5%
	One	5	15.2%	2	7.7%	2	5.9%
	Two	1	3.0%	5	19.2%	3	8.8%
	Three	3	9.1%	0	0.0%	0	0.0%
	Four	4	12.1%	2	7.7%	1	2.9%
	Five	2	6.1%	1	3.8%	3	8.8%
	Six	1	3.0%	1	3.8%	2	5.9%
	Seven	0	0.0%	0	0.0%	1	2.9%
	Eight	1	3.0%	0	0.0%	3	8.8%
	Nine	0	0.0%	0	0.0%	1	2.9%
	Ten	1	3.0%	1	3.8%	3	8.8%
	Eleven	0	0.0%	0	0.0%	0	0.0%
	Twelve	1	3.0%	1	3.8%	3	8.8%
	Thirteen	0	0.0%	0	0.0%	1	2.9%
	Fourteen	0	0.0%	0	0.0%	2	5.9%
	Fifteen	1	3.0%	0	0.0%	0	0.0%
	Sixteen	1	3.0%	0	0.0%	0	0.0%
	Seventeen	0	0.0%	0	0.0%	0	0.0%
Race/Ethnicity	Black or African American	7	21.2%	6	23.1%	3	8.8%
	Asian	0	0.0%	0	0.0%	0	0.0%
	White	10	30.3%	8	30.8%	7	20.6%
	Hispanic	11	33.3%	10	38.5%	18	52.9%
	Native American	1	3.00%	0	0.00%	0	0.00%
	Multiracial	3	9.1%	2	7.7%	4	11.8%
	Missing/Unknown	1	3.0%	0	0.0%	2	5.9%
Sex	Female	17	51.5%	11	42.3%	19	55.9%
	Male	16	48.5%	15	57.7%	15	44.1%
Family Structure	One parent	8	24.2%	3	11.5%	4	11.8%
	One parent and one related caregiver	2	6.1%	1	3.8%	7	20.6%
	One parent and one unrelated caregiver	4	12.1%	2	7.7%	3	8.8%
	Two parents	14	42.4%	15	57.7%	14	41.2%
	Two parents and relatives	1	3.0%	2	7.7%	4	11.8%
	One related caregiver	2	6.1%	0	0.0%	1	2.9%
	One parent and relatives	2	6.1%	2	7.7%	0	0.0%
	One legal caregiver with relatives and one unrelated caregiver	0	0.0%	0	0.0%	1	2.9%
	One related caregiver and one unrelated caregiver	0	0.0%	1	3.8%	0	0.0%
Incidents with Additional Family Stressors*	Substance Abuse	10	45.5%	12	48.0%	6	35.3%
	Mental Health	6	27.3%	6	24.0%	3	17.6%
	Domestic Abuse	6	27.3%	7	28.0%	8	47.1%

**This is counted at the family level for incidents which met criteria for review, and were reviewed in CY 2022.*

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 FFY21, it was estimated that 1,820 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 2021) 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 2022. The estimates indicated that Colorado's population in 2022 was 67% White (alone, not reporting another race/ethnicity), 22.3% Hispanic, and 4.7% Black or African American. The balance of the population estimates included the following ethnicities: American Indian, Asian, Native Hawaiian, Native American, two or more races, etc.

1 U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2023). Child Maltreatment 2021. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment. 2 https://www.census.gov/quickfacts/CO

For fatalities, near fatalities, and egregious incidents in Colorado for CY 2022, most victims were of Hispanic ethnicity. For fatalities, 33.3% of victims were Hispanic, and 30.3% were White. For near fatal incidents, 38.5% of victims were Hispanic, followed by White at 30.8%. For egregious incidents, 52.9% of victims were Hispanic, and 20.6% were White. Hispanic victims were disproportionately represented based on Colorado's population estimates. Chart 2 is a graphic depiction of race/ethnicity breakdown.

Chart 2: Race/Ethnicity of 93 victims in all Substantiated Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment in Colorado for CY 2022

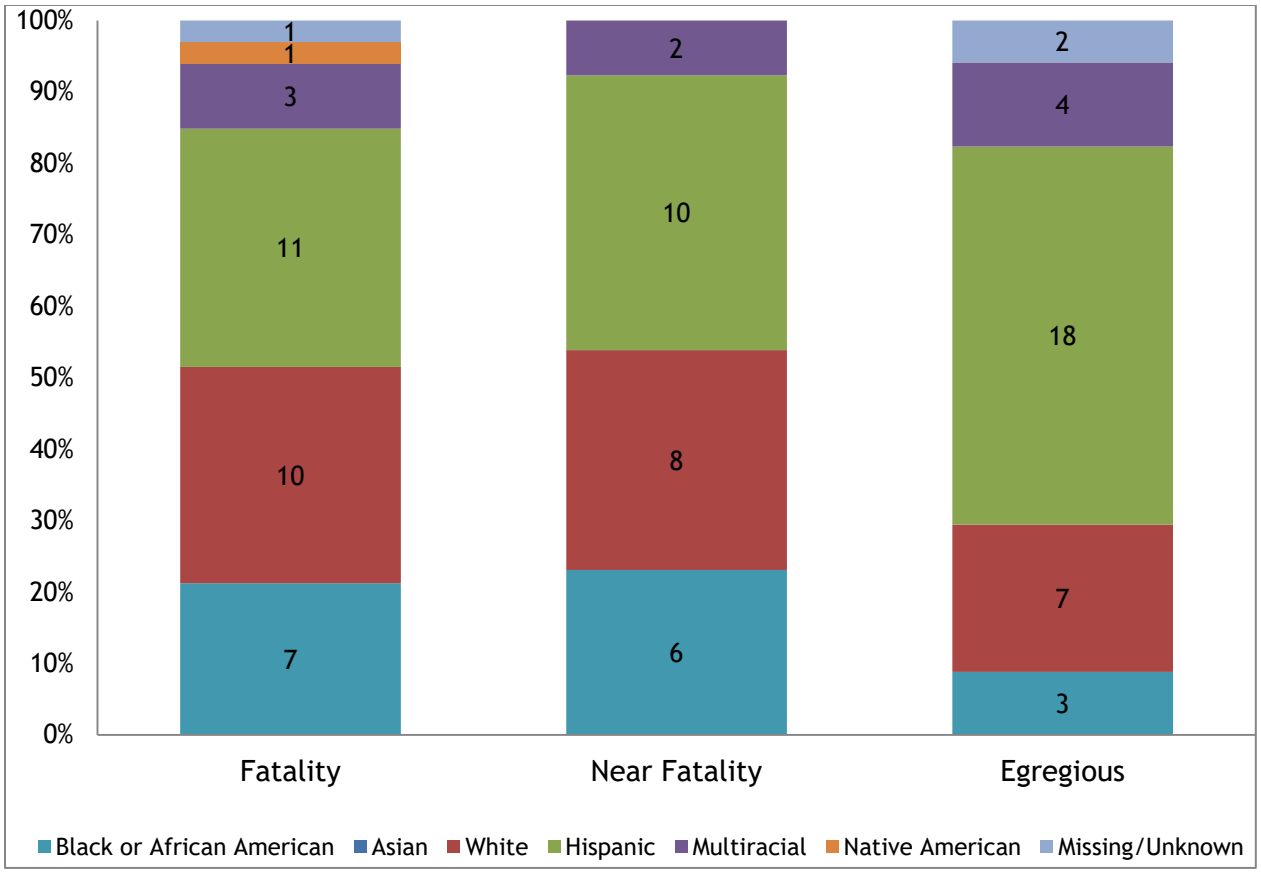
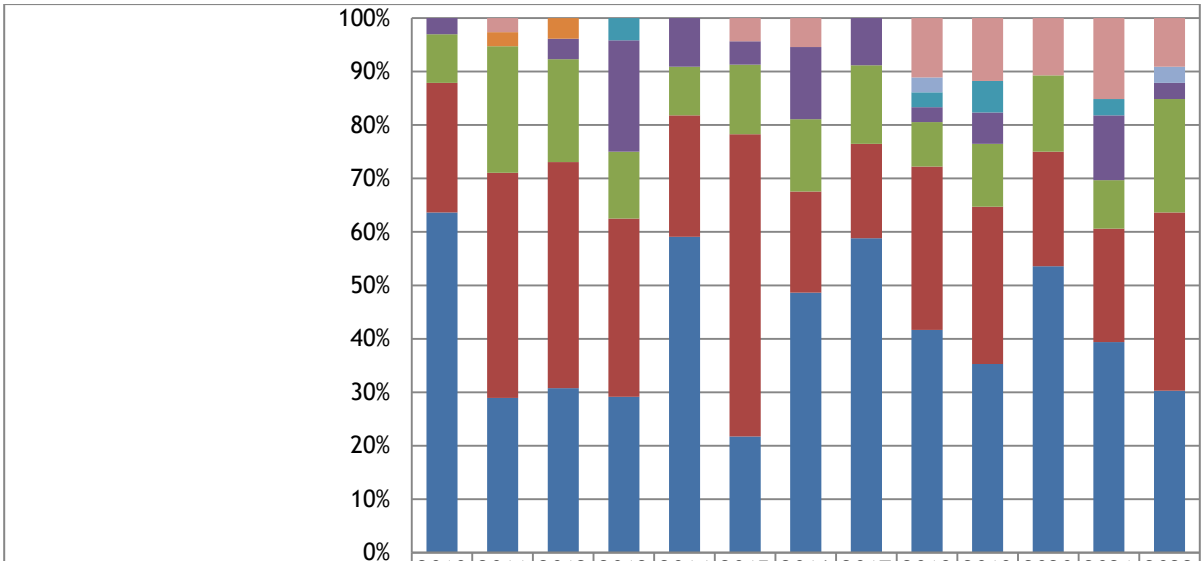


Chart 3 shows the trends related to the most common race/ethnicity of all child maltreatment fatalities in Colorado from 2010-2022. For Colorado's population trends, Hispanic child victims were disproportionately represented in fatal, near fatal, and egregious incidents in 2022. Additionally, Hispanic child victims were also 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 Thirteen Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Multiracial	0	1	0	0	0	1	2	0	4	2	3	5	3
American Indian or Alaska	0	0	0	0	0	0	0	0	1	0	0	0	1
Native Hawaiian/ Other Pacific Islander	0	1	1	0	0	0	0	0	0	0	0	0	0
Asian	0	0	0	1	0	0	0	0	1	1	0	1	0
Missing or Unknown	1	0	1	5	2	1	5	3	1	1	0	4	1
Black or African American	3	9	5	3	2	3	5	5	3	2	4	3	7
Hispanic	8	16	11	8	5	13	7	6	11	5	6	7	11
White	21	11	8	7	13	5	18	20	15	6	15	13	10

Sex of Victim

For CY 2022, Colorado data showed that 51.5% of victims in substantiated child maltreatment fatalities were females and 48.5% were males. Chart 4 displays the breakdown of differences in the sex of the victims for the 93 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and neglect in CY 2022.

Colorado and national data trends note that males typically have a higher rate of child fatality by abuse and neglect. However, in Colorado for CYs 2016, 2017, 2019, and 2022 female victims surpassed male victims in substantiated incidents of fatal child maltreatment. Chart 5 further demonstrates the trends of sex of victims involved in all substantiated child maltreatment fatalities in Colorado over the last twelve years.

In FFY 2021, 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 93 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and neglect in CY 2022.

Chart 4: Sex of 93 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2022

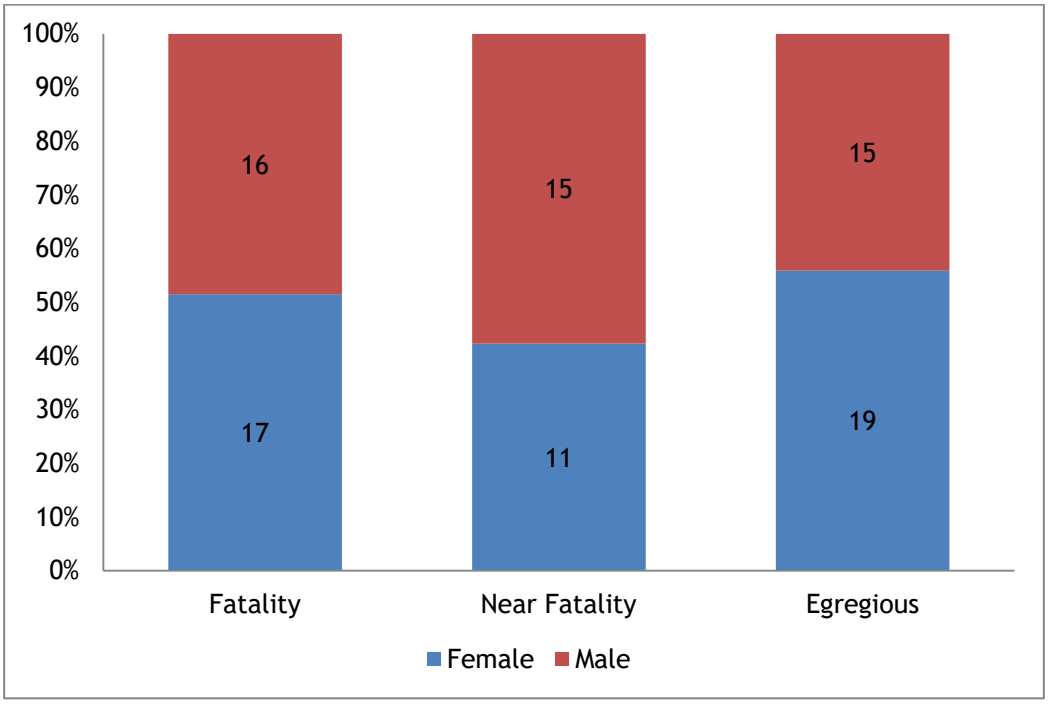
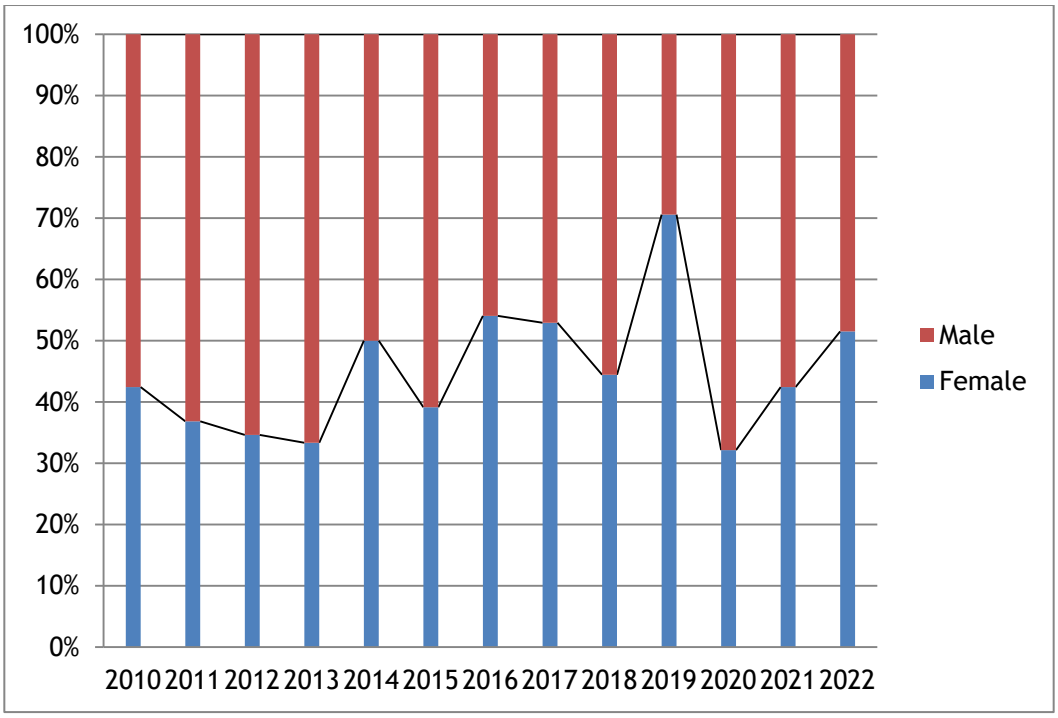


Chart 5: Sex of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Thirteen Years

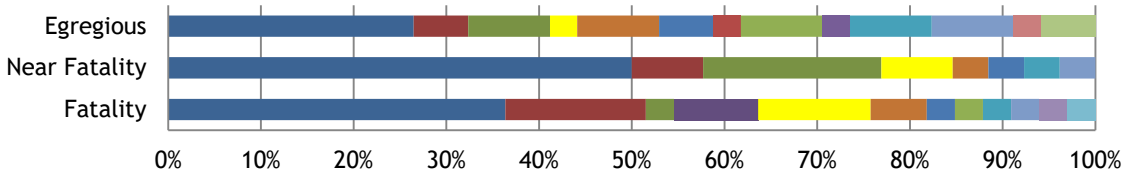


Age at Time of Incident

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, 36.4% (12/33) of the fatalities involved victims younger than one year old, and 63.6% (21/33) were three or younger. Nationally, in FFY 2021, 45.6% were under the age of one, and 66.2% of all victims were age three or younger.

In Colorado, a similar pattern of younger-aged victims exists for the near fatalities, as 50% (13/26) of the victims were under the age of one, and 76.9% (20/26) 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 - 2021 the majority of victims were three or younger. In CY 2022, less than half (41.2%) of all victims were three or younger.

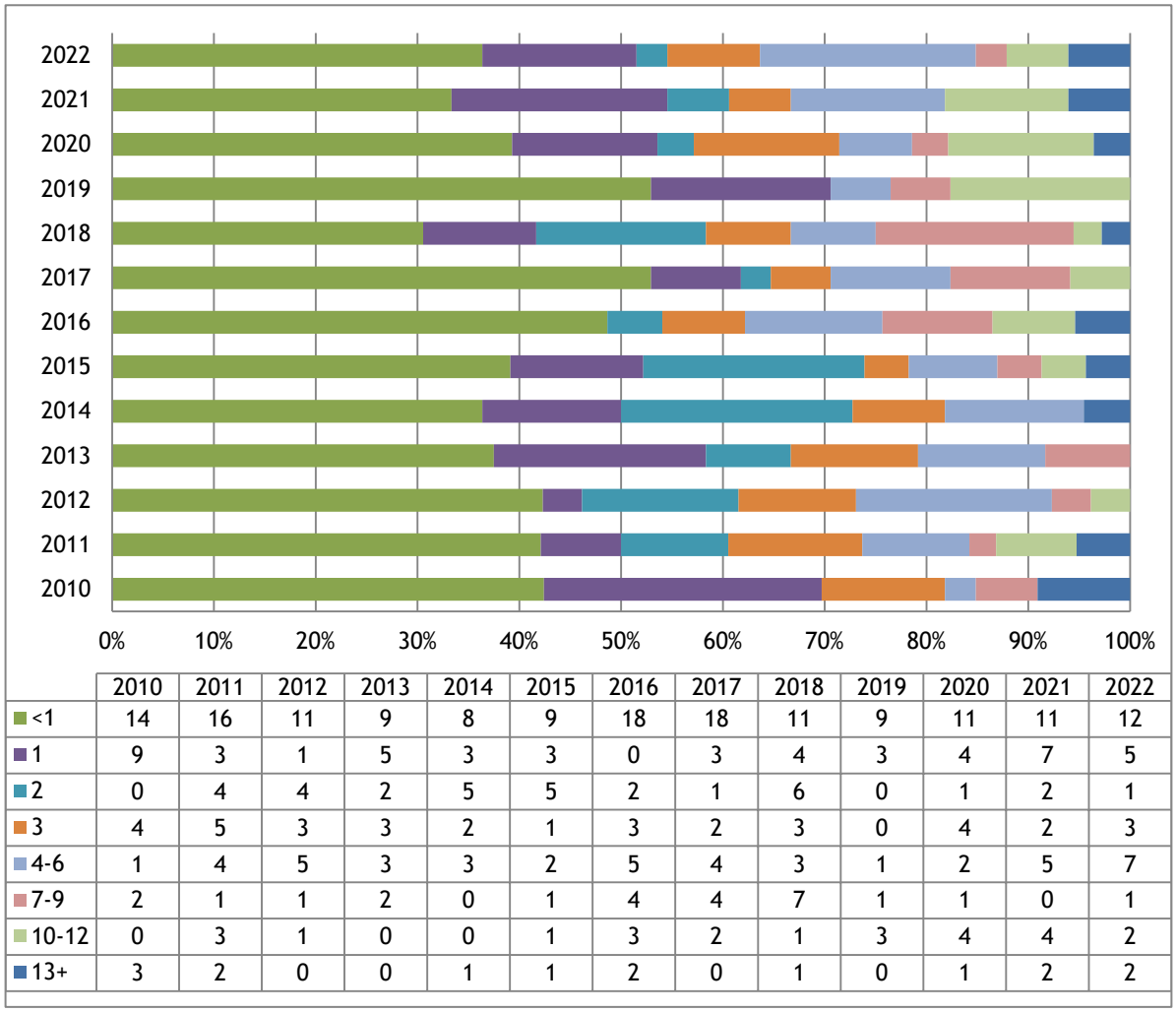
Chart 6: Age of 93 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2022



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

Chart 7 displays the trends in ages of victims in child maltreatment fatalities over the past thirteen 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% to 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	2022
<1	14	16	11	9	8	9	18	18	11	9	11	11	12
1	9	3	1	5	3	3	0	3	4	3	4	7	5
2	0	4	4	2	5	5	2	1	6	0	1	2	1
3	4	5	3	3	2	1	3	2	3	0	4	2	3
4-6	1	4	5	3	3	2	5	4	3	1	2	5	7
7-9	2	1	1	2	0	1	4	4	7	1	1	0	1
10-12	0	3	1	0	0	1	3	2	1	3	4	4	2
13+	3	2	0	0	1	1	2	0	1	0	1	2	2

Perpetrator Relationship

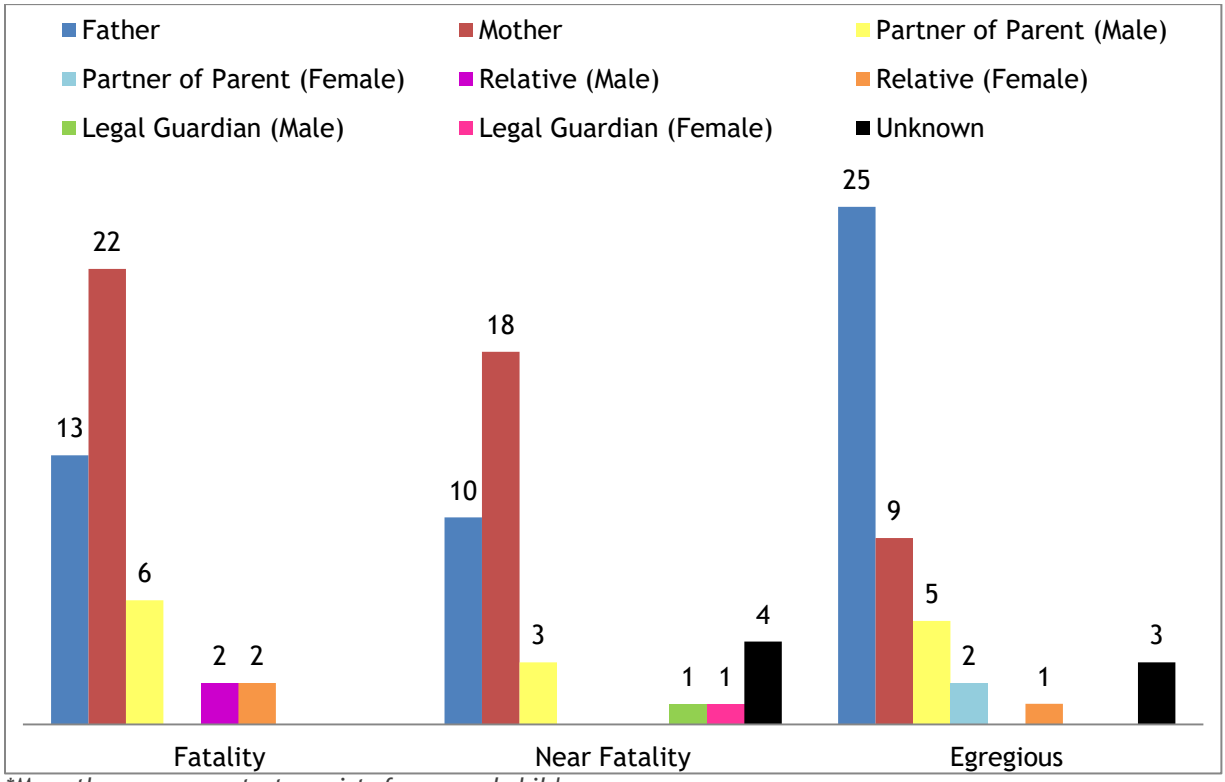
A child's caregiver is most often the perpetrator of a fatal incident of child maltreatment, and it usually involves one or two parents. National data continuously indicates the mother as the most common perpetrator of a fatal incident of child maltreatment. In FFY 2021, it was noted that 80.3% of fatal incidents of child maltreatment involved one or both parents,

sometimes acting alone and sometimes involving another person. For CY 2022, in Colorado, there were nine distinct perpetrator types across substantiated fatal, near fatal, and egregious incidents: 1. Mothers, 2. Fathers, 3. Partner of Parent (male), 4. Partner of Parent (female), 5. Relative (male), 6. Relative (female), 7. Legal Guardian (male), 8. Legal Guardian (female), and 9. Unknown.

In Colorado for CY 2022, for fatal and near fatal incidents of child maltreatment, mothers were the most common perpetrator at 48.9% (22/45) and 48.6% (18/37) respectively. Fathers were identified as the second most common perpetrator for fatal and near fatal incidents of child maltreatment at 28.9% (13/45) and 27% (10/37) respectively. Regarding egregious incidents of child maltreatment, fathers were the most common perpetrator at 55.6% (25/45), with mothers as the second most common at 20% (9/45).

For all substantiated incidents in 2022, three perpetrators were unknown in egregious incidents of child maltreatment and four were unknown in near fatal 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 93 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2022

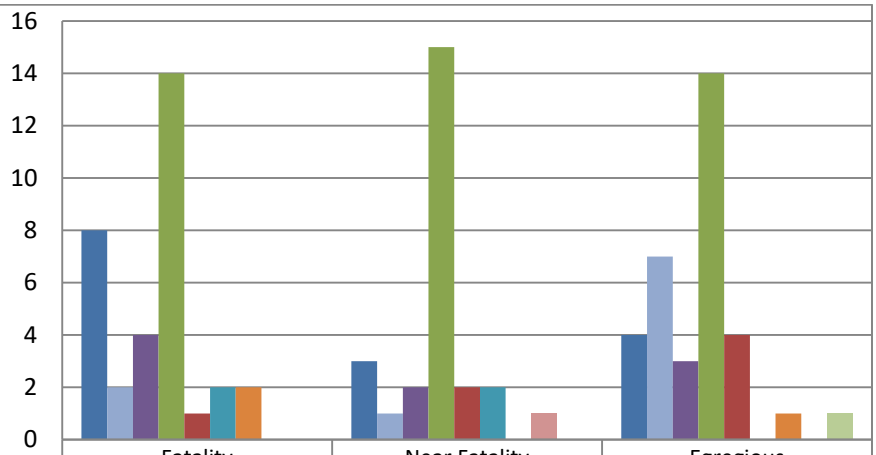


More than one perpetrator exists for several children.

Family Structure

In 2022, 46.2% (43/93) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents (see Chart 9). For fatal and near fatal incidents, the second most common type of family structure was one parent at 24.2% (8/33) and 11.5% (3/26), respectively. The second most common type of family structure across egregious incidents was one parent and one related caregiver at 20.6% (7/34).

Chart 9: Family Structure of 93 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2022



	Fatality	Near Fatality	Egregious
One parent	8	3	4
One parent and one related caregiver	2	1	7
One parent and one unrelated caregiver	4	2	3
Two parents	14	15	14
Two parents and relatives	1	2	4
One parent and relatives	2	2	0
One related caregiver	2	0	1
One related caregiver and one unrelated caregiver	0	1	0
One legal caregiver with relatives and one unrelated caregiver	0	0	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 2022 (42 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, 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 the family 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 76 unique caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed by the CFRT in 2022 (42 incidents); income information was only known for 13/76 of these individuals (17.1%). Of those caregivers with known income information, the income in fatal incidents was reported as $0.00. For near fatal and egregious incidents the average known income is $18,200.00 and $24,000.00, respectively.

Educational level was known for 35.5% (27/76) of the legal caregivers involved in fatal, near fatal, and/or egregious incidents of child maltreatment reviewed by the CFRT in 2022. 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 53.1% (26/49) of the legal caregivers with a known educational attainment level.

Supplemental Public Benefits

In CY 2022, information regarding supplemental public benefits was gathered for the 42 incidents of fatal, near fatal, and/or egregious child maltreatment reviewed by the CFRT. Information regarding supplemental public benefits is tracked by family, rather than by the unique caregivers. Information collected indicated that the most frequently received supplemental benefit was Medicaid (27/42; 64.3%). In 16 of the 42 incidents (38.1%) reviewed, 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).

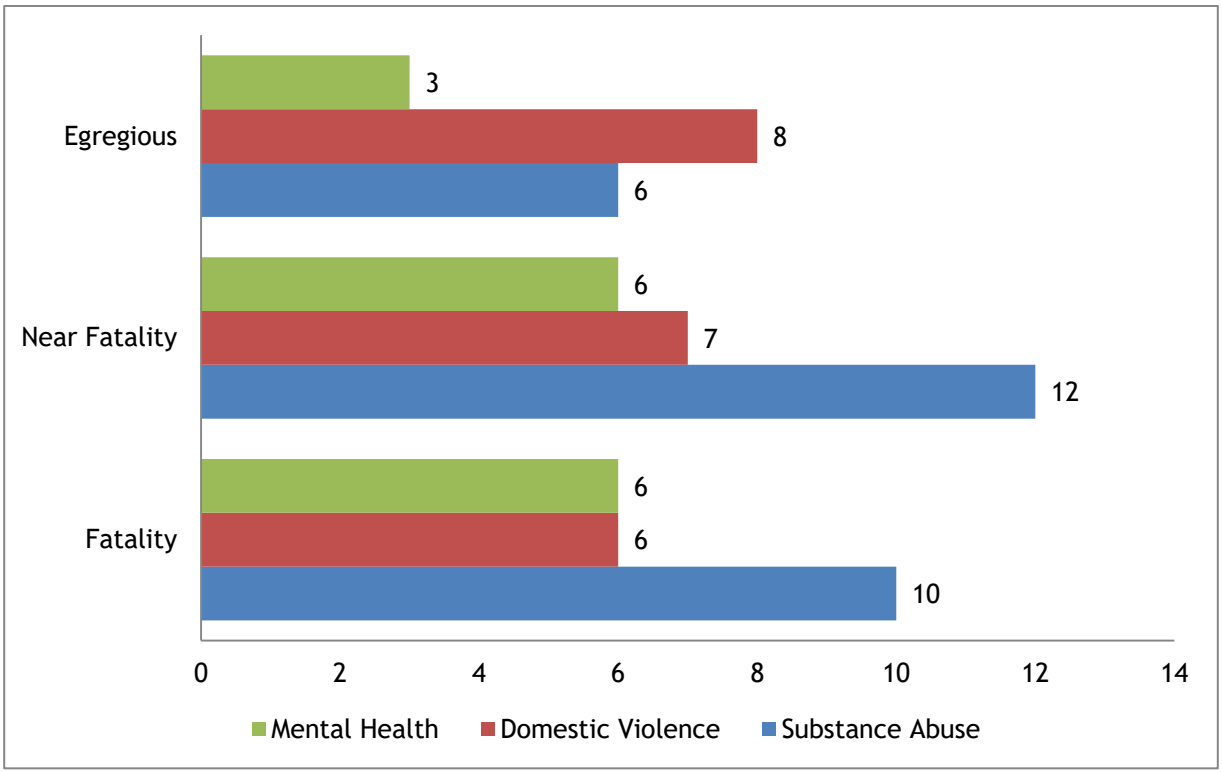
Other Family Stressors

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 42 incidents reviewed by the CFRT in 2022; 15 fatal incidents, 15 near fatal incidents, and 12 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, 40% (6/15) had a history of identified mental health issues, and 40% (6/15) were identified to have had some history of domestic violence.

Nationally, in FFY 2021, 7.6% of child fatalities were associated with a caregiver known to abuse alcohol, while 22.4% 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, 66.7% (10/15) 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 2022.

Chart 10: Other Stressors in Families of the Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents Reviewed by the CFRT in 2022



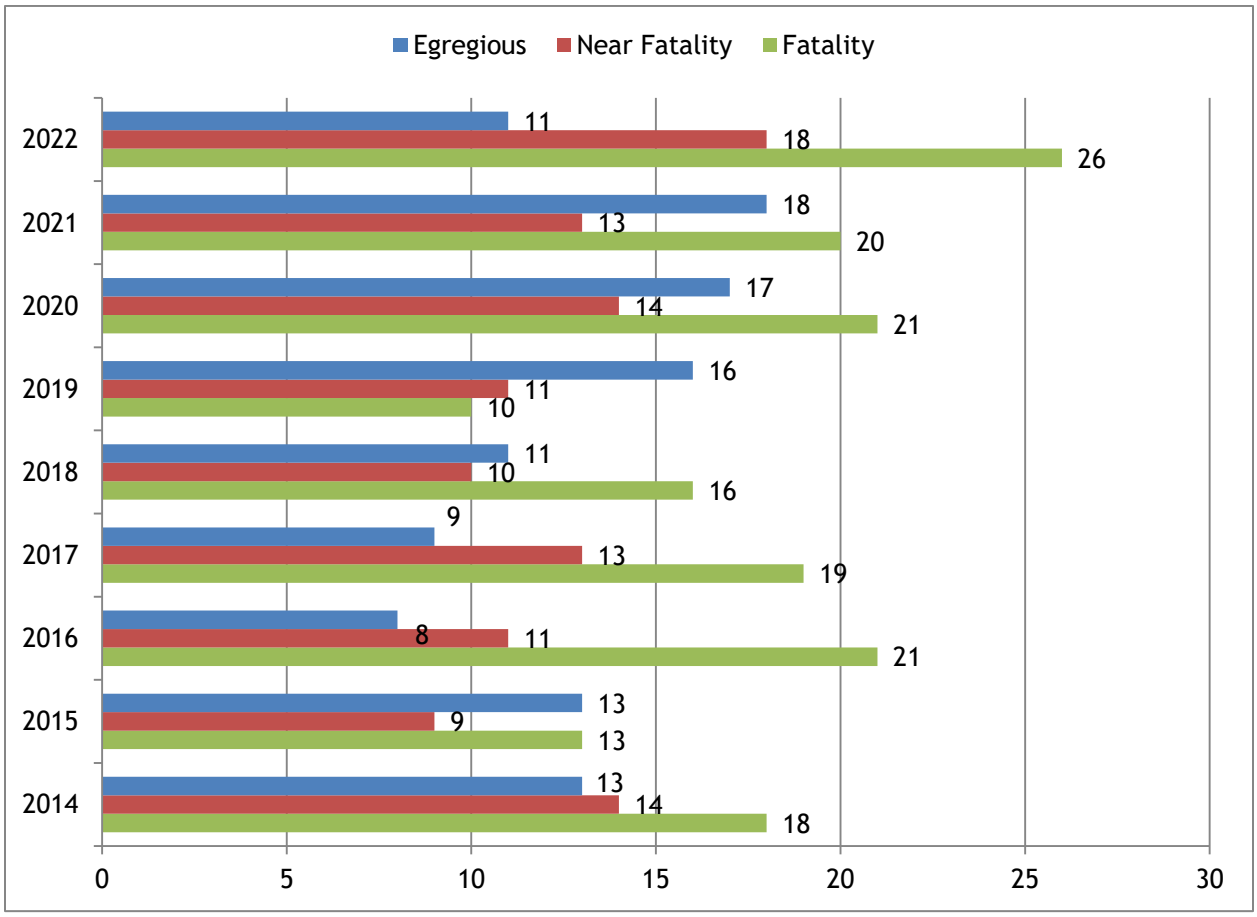
Prior Involvement

In CYs 2014 - 2022 the percentage of families in Colorado involved in a substantiated incident of fatal child maltreatment that also had prior involvement with the child welfare system within three years preceding the incident has ranged between 35% and 82%. In 2022, 78.8% 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 an increase from 2021, when 66.7% 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 2022 was a prior and/or current assessment, also mirroring 2020 and 2021 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% to 76.5% between 2014 and 2021, and was 69.2% in 2022. 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 75%, and was 50% in 2022. Chart 11 details the trends in incidents with prior and/or current involvement for the past nine 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 2014-2022



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 nine 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

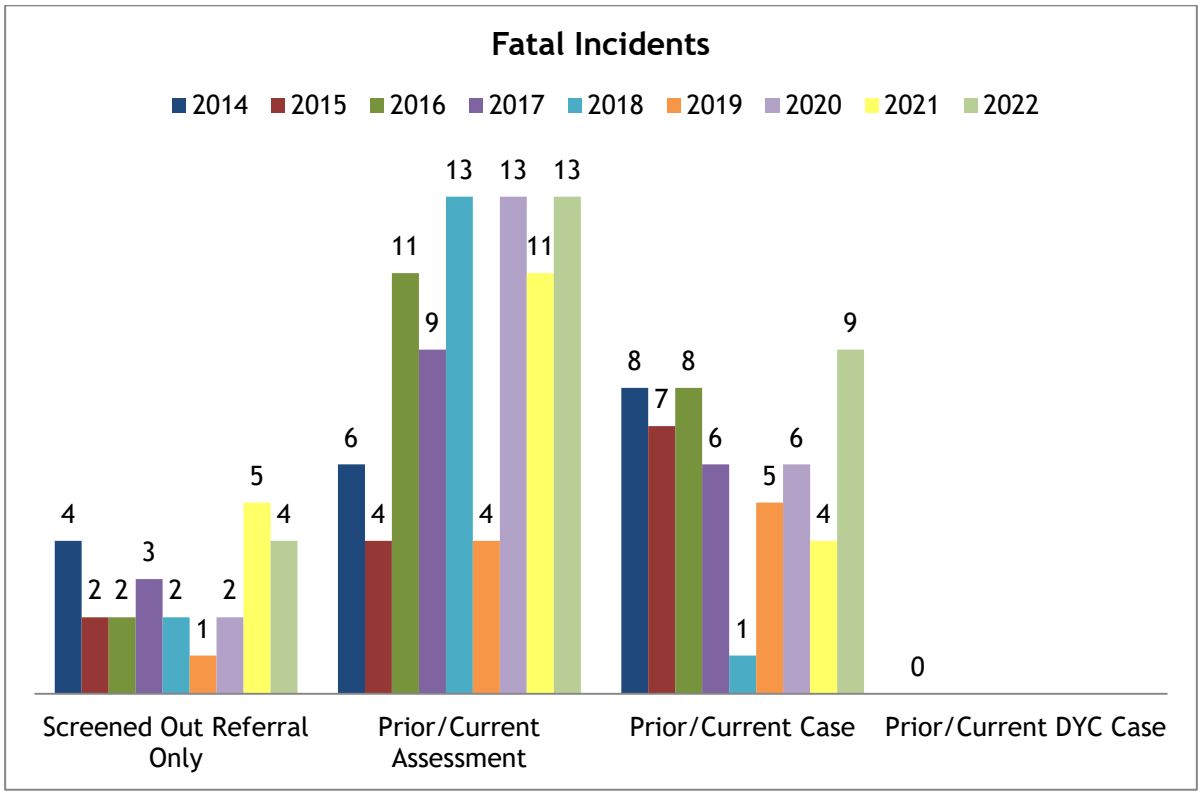
system. For example, if a county department of human/social services received a referral regarding a family, and that referral was accepted for assessment, the prior history will be counted only in the category for "Prior/Current Assessment." If the referral was not accepted for assessment, it would be counted in the "Prior/Current Referral" category.

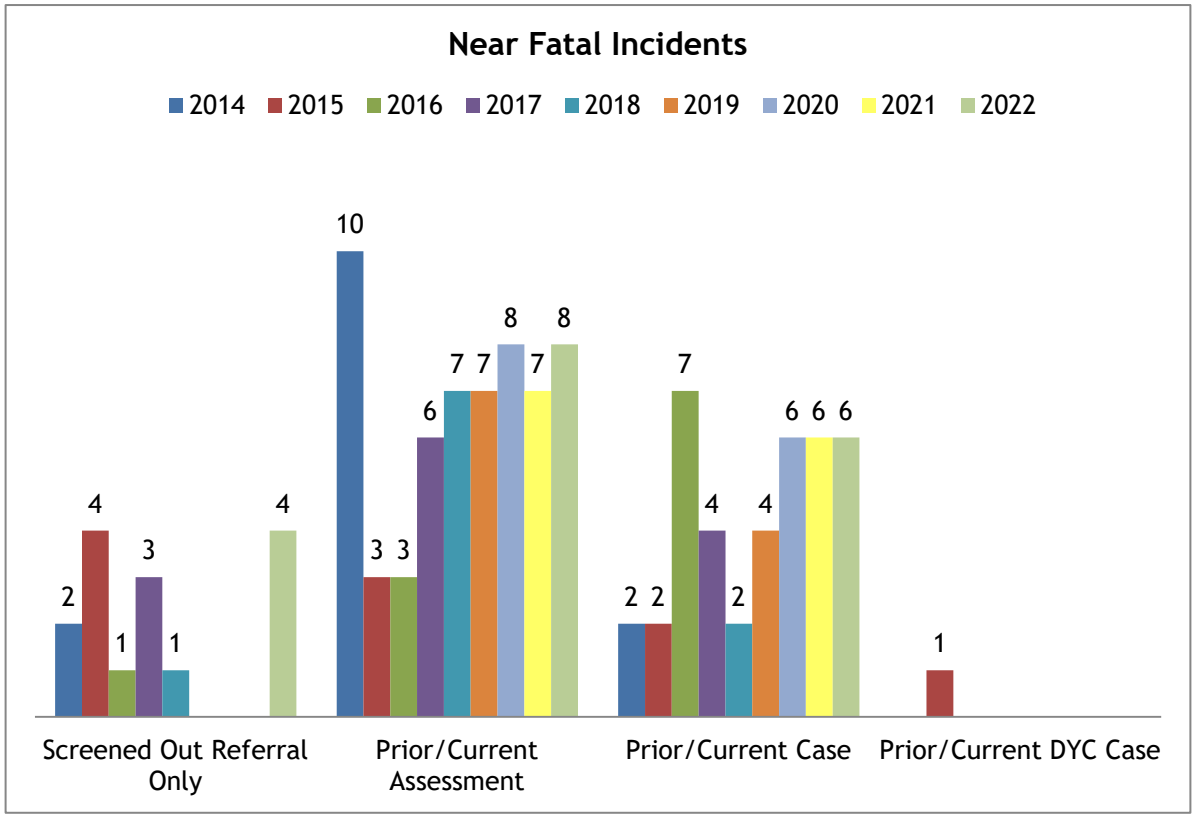
In 2022, for those families with prior involvement, 50% (13/26) of families involved with a fatal incident of child maltreatment had a prior and/or current assessment. This was also the most common level of prior involvement with child welfare in CYs 2016, 2017, 2018, 2019, 2020, and 2021. In 2022, for those families with prior involvement, 34.6% (9/26) of families involved with a fatal incident of child maltreatment had a prior and/or current case(s).

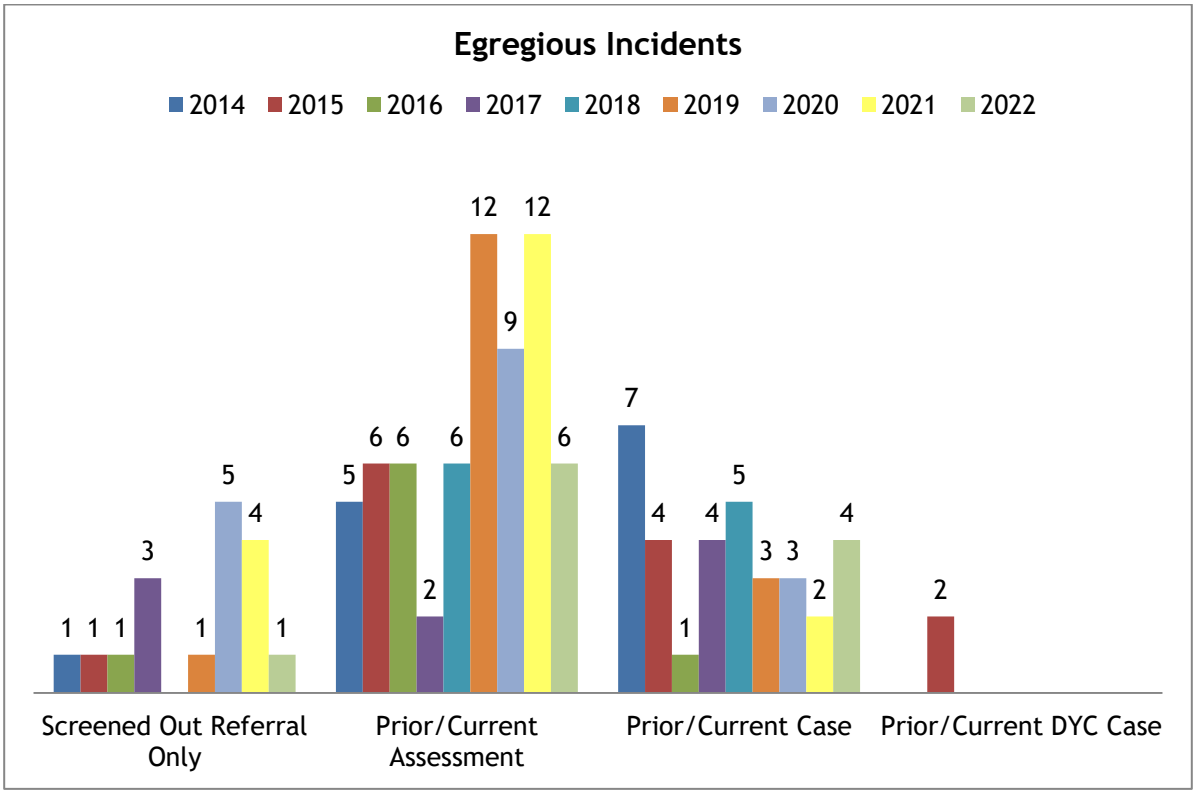
Near fatal incidents in 2022 fell in line with trends seen in 2014, 2017, 2018, 2019, and 2021 with assessments as the most common level of prior and/or current involvement with the child welfare system (8/18; 44.4%). The second most common level of prior involvement in 2022 for near fatal incidents was a current and/or prior case (6/18; 33.3%).

In 2022, 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 (6/11; 54.5%) which followed 2015, 2016, 2018, 2019, 2020 and 2021 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




Near Fatal Incidents
2014
2015
2016
2017
2018
2019
2020
2021
2022
2 4 1 3 1
4
10 3 3 6 7 7 8 7 8
2 2 7 4 2 4 6 6 6
1
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case
Prior/Current DYC Case


Egregious Incidents
2014
2015
2016
2017
2018
2019
2020
2021
2022
1 1 1 3
1 5 4 1
5 6 6 2 6 12 9 12 6
7 4 1 4 5 3 3 2 4
2
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case
Prior/Current DYC Case

Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 36 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 36 reports completed and/or posted to the CDHS public notification website after the cut-off date for inclusion in the 2021 CFRT Annual Report (4/1/2022) and prior to and including the cut-off date for inclusion in this year's report (3/31/2023). Each of the 36 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 36 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 36 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 36 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 36 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 81 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; and, 5) Services to Children and Families. The two systems most frequently mentioned were: 1) County Departments of Human Services (both alone and alongside other entities) and 2) Medical Care/Medical Provider.

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 18 occasions across 14 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 five times across five 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 34 different times across 18 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

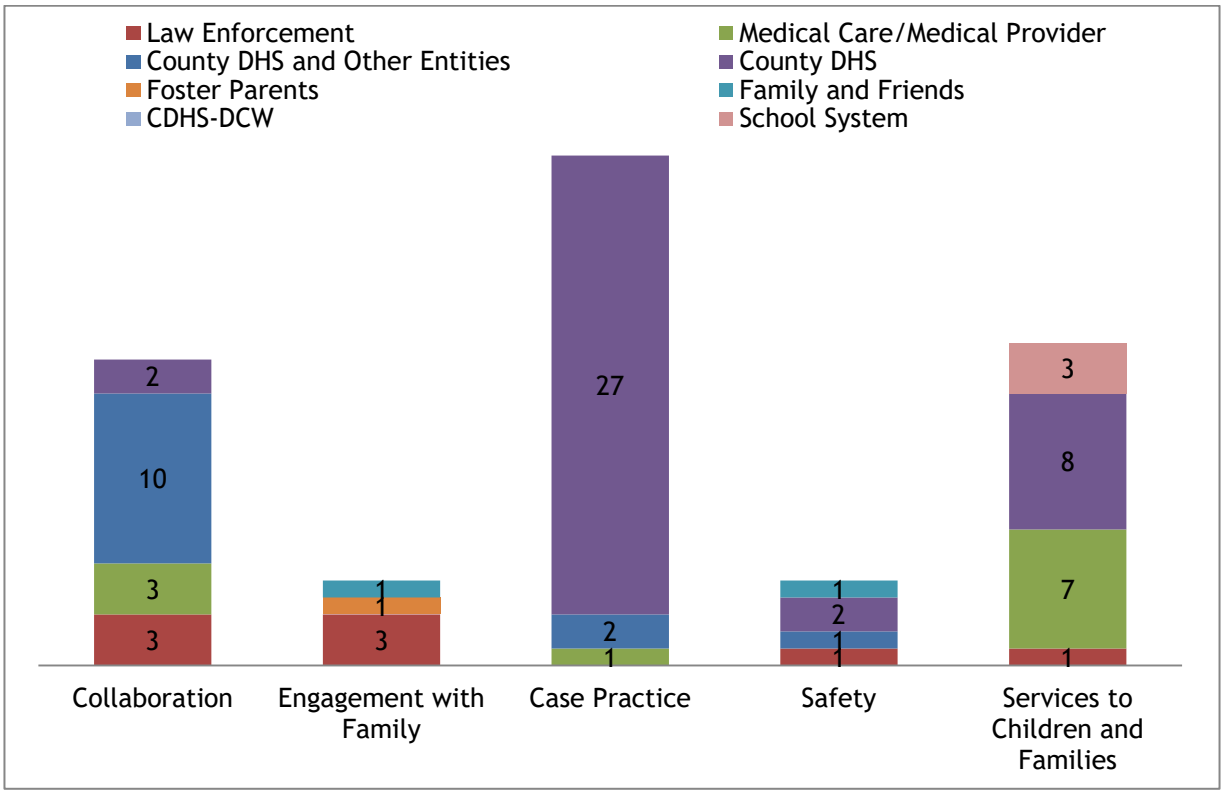
The CFRT identified five instances across five reports where systems surrounding children and families promoted child safety. Oftentimes, efforts to assess, advocate for, and achieve safety for the victim and/or surviving siblings were notable. Safety also included efforts in caseworkers developing safety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

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 19 times across 18

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 36 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, 2022 and March 31, 2023, 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) Practice; 2) Prevention; and 3) 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 36 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.

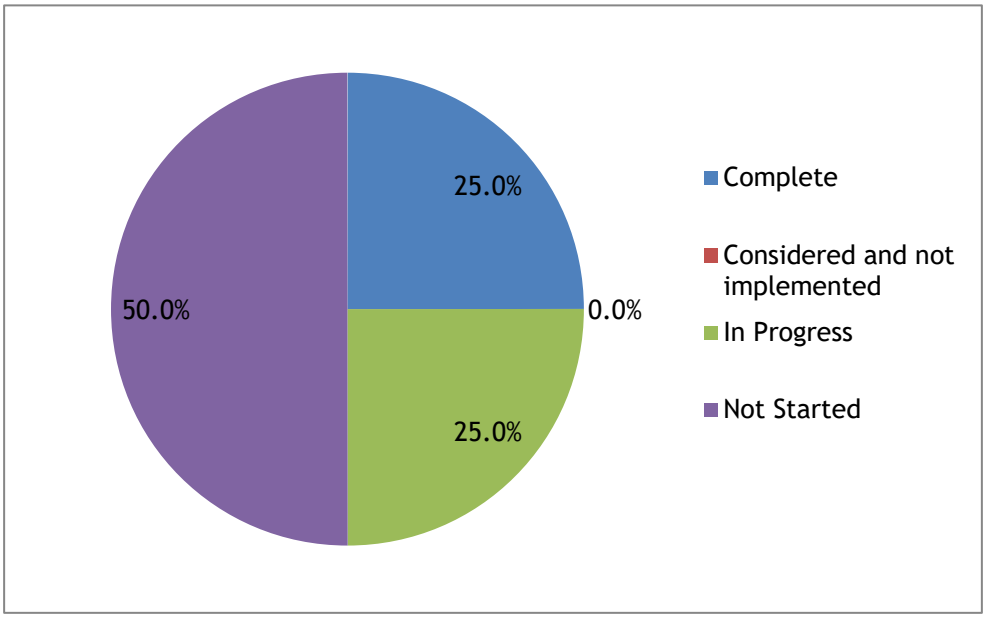
Recommendations from Posted Reports

A total of 4 recommendations were made across the 36 reports posted between 4/1/2022 and 3/31/2023. 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.

The full text of all 4 recommendations are contained in Appendix C. 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,

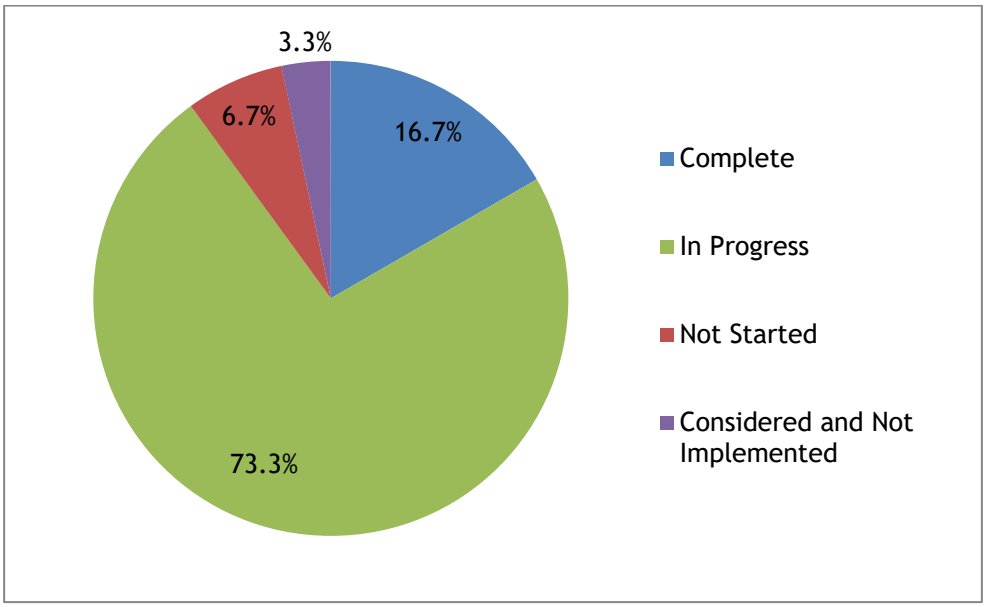
and the recommendations were recently added to the tracking spreadsheet. The status of the recommendations is illustrated in Chart 16.

Chart 16: Status of Recommendations (n=4) for Reports Posted Between 4/1/2022 and 3/31/2023



An update on the implementation status of 30 recommendations previously presented in the 2021 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 below.

Chart 17: Status of Recommendations (n=30) Not Previously Completed From Reports Posted Prior to 4/1/2022



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.

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

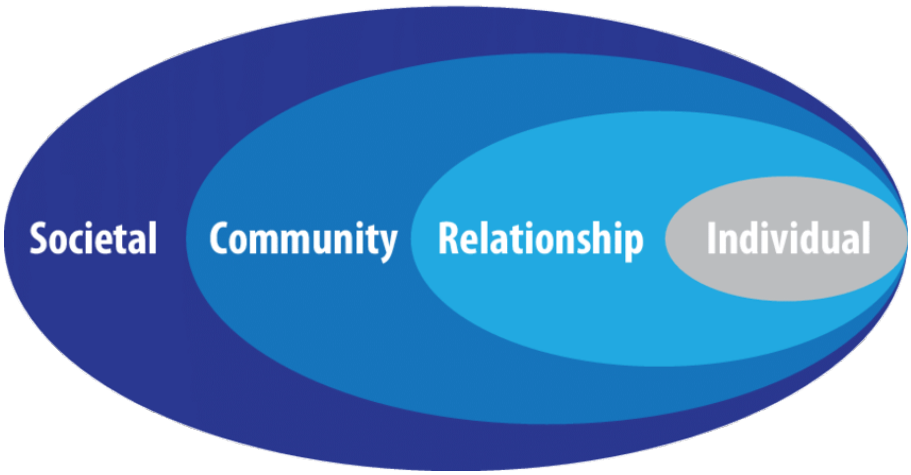
The CFRT operates under relevant criteria for excellence in child death reviews, as published by the National Center for Fatality Review and Prevention in 2018. Recent understandings have emerged on a national level that reviews should focus on system level changes and the CFRT has also come to understand 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.

OVERDOSE PREVENTION

Provide information to parents and communities in their preferred language about the risks associated with substance misuse and overdose and evidence-informed strategies to reduce these risks, including:

1) How to access and use naloxone and fentanyl test strips;
2) How to respond to a suspected drug overdose, including information on Colorado's Good Samaritan Law;
3) How to safely store and dispose of both prescription and illegal drugs;
4) How to avoid accidental ingestion of drugs by young children; and
5) How to have conversations with children about overdose and poisoning prevention in age-appropriate ways.

**Pursuant to §25-20.5-407(1)(i) C.R.S., 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. 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. This recommendation was informed by an increase in the number of unintentional overdose deaths among very young children.

Overdose deaths among those under age 18 in Colorado increased significantly between 2017 and 2021. The rate of overdose in 2017 was 0.3 per 100,000 (n=4) and significantly increased to 2.5 per 100,000 (n=31) in 2021. In total, 77 children and youth died of overdose from 2017-2021. The overall rate of overdose deaths for this period was 1.2 per 100,000 population in Colorado, significantly higher than the national rate over the 2018-2021 period (0.6 per 100,000 population).27 Youth ages 15-17 accounted for 76% (n=57) of overdose deaths reviewed by CFPS during this period. Youth in this age group had significantly higher overdose rates when compared to younger children and died from overdose at a rate 17 times higher than youth ages 10 to 14. In 2019, 33% (n=4) of overdose deaths among children and youth involved fentanyl. This increased to 77% (n=20) in 2020 and remained high at 66% (n=21) in 2021. This is consistent with national data showing rises in fentanyl-involved deaths. CFPS will monitor this trend closely.

Also concerning are the racial and ethnic disparities in overdose deaths. From 2020-2021, Black children and youth (less than 15 years old) in Colorado were nine times more likely to die by overdose than their white peers. Similarly, Hispanic children and youth were twice as likely to die by overdose in Colorado than their non-Hispanic peers. The causes for racial and ethnic disparities in overdose deaths are complex, but may be related to factors like inequitable access to mental health care and treatment due to racism.28

Overdose deaths include those of accidental and undetermined manners of death, as determined by the coroner. These can include deaths due to overdose by prescription, illicit, or over-the-counter drugs or may also result from poisoning with other substances, such as household cleaners, carbon monoxide, plants, or pesticides. It does not include intentional deaths (i.e., deaths that are the result of homicide or suicide), although making those determinations in some deaths can be difficult.

Due to the increasing number of overdose deaths in Colorado among people under age 18, and particularly youth of color, as well as the concern about the increase in overdose deaths involving fentanyl, more resources are needed to support evidence-based educational campaigns to inform Coloradans about fentanyl and to expand availability of harm reduction resources. A synthetic opioid that is up to 50 times more potent than heroin and 100 times more potent than morphine, fentanyl causes overdose symptoms more quickly than heroin or other opioids, underlining the importance of education on how to respond in a timely manner.

In addition to education about the risks associated with fentanyl, xylazine, and other emerging overdose trends, education should encompass a full spectrum of substances including alcohol, marijuana, prescription drugs, and other legal and illegal substances that have the potential for misuse and overdose.

Partners critical in providing this information include agencies and organizations that serve children and families, including public health, child welfare, health care and behavioral health care providers, and youth programs. Information should be provided in culturally and linguistically appropriate ways and address the underlying causes of substance use, including adverse childhood experiences.29 Education can take place anywhere including schools, churches, sports teams, harm reduction centers, libraries, community centers, and child care centers.

Access to naloxone and fentanyl test strips. Fentanyl is widespread in the drug supply in Colorado and comes in pills, pure powders, and powder mixed with other illicit drugs such as methamphetamine, cocaine, heroin, and benzodiazepines. It cannot be seen, tasted or smelled when mixed into other drugs. Naloxone and fentanyl test strips are both tools used in harm reduction efforts related to opioid use. Naloxone is a medication that can reverse an opioid overdose. Naloxone is widely available at no cost through organizations that distribute it through the Colorado Naloxone Bulk Purchase Fund or it can be purchased without a prescription from pharmacies. Naloxone is for everyone who knows someone, or may come into contact with someone, who uses opioids, not just for people who use opioids. In fact, it is not possible to self-administer naloxone, if an overdose occurs. Someone else will need to administer it, which is why education for family and friends is key.

Fentanyl test strips are used to test drugs for the presence of fentanyl and should be made widely available from pharmacies and community organizations that provide harm reduction services. It is important to continue the expansion of free naloxone distribution and other state and local resources to make naloxone and fentanyl test strips widely available in communities.

Responding to a suspected overdose or poisoning. Responding to a suspected drug overdose or poisoning can be a critical and lifesaving situation. It is important for all members of the community to know the signs of an overdose and respond quickly. Increasing awareness of Colorado's Good Samaritan Law (§18-1-711 C.R.S.), which provides legal protection to individuals who seek medical assistance for someone experiencing a drug overdose, can help ensure people act quickly if there is a suspected overdose or poisoning. The law is designed to encourage people to seek medical help without fear of prosecution for drug-related offenses.

Safe storage and disposal. Safely storing and disposing of prescription and illegal drugs is important to prevent unintentional access and potential harm to others, as well as to prevent drugs from being misused or illegally diverted. Prescription and illegal drugs in the home should be stored in a secure location and out of reach of children, such as in a locked box or cabinet or in a locking pill bottle. It is also critical to promote and expand safe medication and drug disposal sites like those happening through the Colorado Medication Takeback Program. Additional information on safe use, safe storage, and safe disposal of prescription medications can be found on the Take Meds Seriously website.

Avoid accidental ingestion by young children. There is an alarming trend regarding fatal and near fatal incidents of child maltreatment due to fentanyl exposure/ingestion. Substance misuse has been a key risk factor associated with incidents of child maltreatment for many years, but the lethality of fentanyl is changing the landscape of working with families experiencing substance misuse. In 2021, fentanyl exposure/ingestion accounted for 35.3% (6/17) of near fatal child maltreatment incidents. Tragically, the number of fatal incidents of child maltreatment that were related to fentanyl exposure/ingestion in 2021 was 15.6% (5/32). In 2022, there have been 7 reported incidents of fatal child maltreatment due to fentanyl exposure/ingestion, and 5 reported incidents of near fatal child maltreatment due to fentanyl (*2022 numbers are provisional).

To avoid accidental ingestion by young children, it is critical to educate parents/caregivers on the importance of not leaving medication where children can access them. This means storing all medications or illegal drugs in a locked box or pill bottle, located in a high cabinet or drawer that is out of reach of children. Parents/caregivers also need to understand that if they suspect their child has accidentally ingested prescription medication or illegal drugs, they need to seek medical attention immediately. Additionally, because treatment options vary based on the size and age of the child, it is critical for parents/caregivers to share as much information as possible with first responders on the potential dosage and type of substance that was ingested.

Discuss overdose and poisoning prevention with children in age-appropriate ways. Early childhood is a period of transition where education is critically important. New mothers and caregivers of substance-exposed newborns should receive education as part of a plan of safe care established upon hospital discharge. Once home, the Smart Choices Safe Kids resource helps parents and caregivers understand ways to prevent exposure to multiple types of substances throughout the life of their child.

Having conversations with children about overdose and poisoning prevention should start early and be done in age-appropriate ways. Children as young as 3-4 years old can learn that taking too much medication or taking medication that is not given to them by an adult can be very dangerous. As children grow older, using more detailed explanations and real-life examples can illustrate the importance of avoiding medications not prescribed for them or that are provided to them by strangers.

Combining efforts to reduce the harms of opioid use, making sure families have the information and tools they need to keep young people safe, and safer disposal and storage practices creates a powerful multi-pronged approach that can save the lives of children and young people in Colorado.

Appendix A: 2022 CFRT Attendance

CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	**1.3.22 (virtual)**	**2.7.22 (virtual)**	**3.7.22 (virtual)**	**4.4.22 (virtual)**	**5.2.22 (virtual)**	**6.6.22 (virtual)**	**7.11.22 (virtual)**	**8.1.22 (virtual)**	**9.12.22 (virtual)**	**10.4.22 Mini Retreat (virtual)**	**11.7.22 (virtual)**	**12.2.22 Retreat (virtual)**	**12.5.22 (virtual)**
Lucinda Connelly *CDHS, Child Protection Manager*	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes					
→**Backup:** Korey Elger	---	---	---	---	---	---	---	---					
Lisa Mayer *CDHS, Ongoing Child Protection Manager*								Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Lucinda Connelly								---	---	---	---	---	---
Beth Collins *CDHS, Domestic Violence Program Director*	---	---	---	---	---	Yes**	---	---	---	---	---	Yes	---
→**Backup: Shelley Reader** *CDHS, Domestic Violence Program Specialist*	Yes	Yes	Yes	Yes	Yes	Yes**	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, Childhood Adversity Prevention Manager*	Yes	Yes	Yes	**No**	Yes	Yes	**No**	Yes	Yes	Yes	**No**	Yes	Yes
Christal Garcia *CDPHE, Violence and Injury Prevention*	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Angela Sneddon *Morgan County Human Services*	**No**	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes
Ray Douglas *Park County Commissioner*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	**No**	Yes
Liz Smith *Gunnison County Commissioner*	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Vacant (Legislative)													
Representative Stephanie Luck *House of Representatives*	Yes	**No**	**No**	**No**	**No**	**No**	Yes	Yes	**No**	Yes	**No**	**No**	**No**

CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	**1.3.22 (virtual)**	**2.7.22 (virtual)**	**3.7.22 (virtual)**	**4.4.22 (virtual)**	**5.2.22 (virtual)**	**6.6.22 (virtual)**	**7.11.22 (virtual)**	**8.1.22 (virtual)**	**9.12.22 (virtual)**	**10.4.22 Mini Retreat (virtual)**	**11.7.22 (virtual)**	**12.2.22 Retreat (virtual)**	**12.5.22 (virtual)**
Minority Leader appointment													
Claire Hooker *Office of Colorado's Child Protection Ombudsman*	Yes	Yes	Yes	Yes	Yes	---	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Amanda Pennington	---	---	---	---	---	Yes	---	---	---	---	---	---	---
Sgt. Brian Cotter *Denver Police Department*	No	Yes	No	No	No	No	No	No	Yes	Yes	Yes	No	No
→**Backup:** Sgt. Eric Denke	---	---	---	---	---	---	---	---	---	---	---	---	---
Dr. Andrew Sirotnak *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No
→**Backup:** Dr. Antonia Chiesa	---	---	---	---	---	---	---	---	---	---	---	---	---
Allyson Baber *Chief Deputy District Attorney, 17th Judicial District*	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No		
→**Backup:** Shelby Conney (Fyles)	---	---	---	---	---	---	---	---	---	---	---		
Shelby Fyles *Senior Lead Deputy District Attorney, 17th Judicial District*												No	No
Mara Kailin, PsyD *Aurora Mental Health Center, Director*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
→**Backup:** Kathy Snell	---	---	---	---	---	---	---	---	---	---	---	---	---
Jenny Bender, *Executive Director of Colorado CASA*	No	No	No	No	No	No	No	No	No	No	No	Yes	Yes
Lea Bernstein-Holmes *Mental Health Coordinator, Sheridan School District*	Yes	Yes	---	Yes	---	Yes**	Yes	No	Yes**	No	Yes**	---	---
→**Backup:** Heather Porter			Yes	---	Yes	Yes**	---	---	Yes**	---	Yes**	Yes	Yes
Nicole Adams *Douglas County Department of Human Services*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Ruby Richards	---	---	---	---	---	---	---	---	---	---	---	---	---

CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	**1.3.22 (virtual)**	**2.7.22 (virtual)**	**3.7.22 (virtual)**	**4.4.22 (virtual)**	**5.2.22 (virtual)**	**6.6.22 (virtual)**	**7.11.22 (virtual)**	**8.1.22 (virtual)**	**9.12.22 (virtual)**	**10.4.22 Mini Retreat (virtual)**	**11.7.22 (virtual)**	**12.2.22 Retreat (virtual)**	**12.5.22 (virtual)**
Angela Mead *Larimer County Human Services*	Yes	Yes	Yes	Yes	Yes								
Michael Stumph *Fremont County Human Services*							Yes	Yes	**No**	**No**	Yes	Yes	Yes
Alysse Nemecek *Jefferson County Department of Human Services*	Yes	---	Yes	Yes	---	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes
→**Backup:** Erin Dowler		Yes	---	---	Yes	---	---	---	---	---	---	---	---
Cheryl Hyink *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	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	**No**	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes
Sarah Richelson *Attorney General's Office*	---	Yes	---	Yes	---	Yes	---	Yes	Yes	Yes	---	---	---
Anita Schutte *Attorney General's Office*	---	---	---	---	---	---	---	---					
Aaron Pratt *Attorney General's Office*	Yes	---	Yes	---	Yes	---	Yes	---					
Niki Rust *Attorney General's Office*									Yes	Yes	Yes	---	Yes

Appendix B: 2014-2022 Incidents 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	2022 Total
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2014	2015	2016	2017	2018	2019	2020	2021	2022	2014	2015	2016	2017	2018	2019	2020	2021	2022									
Adams		2	1	2	2	1	1	4	4	1		3	1					2	2			1	1	2	1		2	3	2	4	4	3	3	2	4	8
Alamosa																																				
Arapahoe	1	1	4	1	2	1		3	2		1		2		1	2	1	2		2	1	1	2	2	1	1	1	1	4	5	4	4	4	3	5	5
Archuleta					1														1									1				1				
Broomfield				1											1																1		1			
Boulder	1					1					1	2			1								1	2				1	1	2		1	4			
Chaffee				1																											1					
Crowley								2																										2		
Clear Creek	1																											1								
Denver	4	1	1		2	1	6	2	4	3	3	1	1	2	1	2	5	3	3	3	3	3	4	7	5	4	1	10	7	5	4	8	9	13	11	8
Douglas			1	1		1			1				1								1			1		1				2	2		2		1	1
Eagle		1																											1							
Elbert									1																1									1		1
El Paso	2		4	4	4	2	7	3	8	1	1	1	5	2	3	4	2	4	1	1	1	1	1	1	5	9	3	4	2	6	10	7	6	16	14	15
Fremont										1							1	1	2	1			1		1			3	1			1		1	1	1
Garfield		1				1		1																			1		1				1		1	1
Huerfano	1																											1								
Jefferson	2	2	2	3			3		1	4		1	1	1	2	3		1	1	3					2		2	7	5	3	4	1	2	8		4
La Plata			1		1						1		1	1								1						1	1	2	2					
Larimer	1	1	1	3	1	1		1	4								1			2				1				1	3	1	3	1	2		2	4
Las Animas		1																											1							
Lincoln																				1									1							
Logan	1																											1								
Mesa	1	1	2		1	1		1			1			2	1			1							1	2		1	2	2		3	2	1	3	1
Moffat			1		1			1				1																		2		1			1	
Montezuma			1															1	1									1		1					1
Montrose			1																											1					
Morgan	1						1	1		1		1			1							1						2		1	1		1	1	1	
Otero				1						1							1											1			1				1	
Park			1																											1						
Phillips																																				
Prowers																1																		1		
Pitkin																			1									1								
Pueblo	1				1		2			2	1	1					1	1	1			1						4	1	1	1	1		2	1	1
Rio Blanco														1			1															1			1	
Routt	1												1								1							1		1	1					
Saguache							1																											1		
San Miguel				1																											1					
Teller														1																		1				
Weld		1		1				1	1							2		2			1		1			1	1		1	1	1		2	2	4
Total	**18**	**12**	**21**	**19**	**16**	**10**	**21**	**20**	**26**	**14**	**9**	**11**	**13**	**10**	**11**	**14**	**13**	**18**	**13**	**13**	**8**	**9**	**11**	**16**	**17**	**18**	**11**	**45**	**34**	**40**	**41**	**37**	**37**	**52**	**51**	**55**

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

Appendix C: Recommendations from 2022 Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
21-032	CFRT	The CFRT made a formal recommendation to track the CFRT incidents in which a child ingests, or is exposed to, illicit substances that cause the child to die or to be in serious, critical, or life threatening condition. The purpose of tracking the prevalence of these incidents would be to implement legislative changes, to share data with the Office of Behavioral Health and their work with the opioid crisis, and to track the cycle of substance use and related criminal charges and/or consequences.	Complete
21-096	CFRT	The CFRT made a formal recommendation to focus more on prevention efforts, for women who use substances during their pregnancies, in order to remove the barriers and stigmas around accessing services and supports.	In Progress
21-097	CFRT	The CFRT made a recommendation that a small workgroup of CFRT members and stakeholders look at the systems and practices in place that can help support decision making during the screening process. This includes, but is not limited to: looking at Trails functionality, screen out codes, and the use of timelines and enhanced screening. The CFRT proposes that this workgroup make some final recommendations to help support decision making during the screening process.	Not Started
21-121	CFRT	The team recommended a review of the mandatory reporter training in order to determine if there is a need for more education and/or training for mandatory reports regarding identification of injuries.	Not Started

Appendix D: Status Update for Recommendations from Previously 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.	In Progress
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
20-008	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

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.	In Progress
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
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.	In Progress
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

18-044	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
18-070	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 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

18-104	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.	In Progress
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
17-039	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
17-077	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
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
16-047	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

15-006	Policy Finding	The Policy Finding related to not interviewing others who may have information regarding the alleged maltreatment during the assessment phase does reflect a systemic practice issue for Arapahoe County DHS. 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 28, 2014 to June 28, 2015, showed that Arapahoe County DHS interviewed all required parties 60%of the time. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure improvement.	Complete
15-006	Policy Finding	The Policy Finding related to the assessment containing the required content does reflect a systemic practice issue for Arapahoe County DHS. 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 28, 2014 to June 28, 2015, showed that Arapahoe County DHS's assessments contained the required content 83.6% of the time, which is slightly below the statewide average (not including Arapahoe County DHS) of 84.7% for the same time span. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure improvement.	Complete
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
15-038	Policy Finding	The policy finding related to Family Service Plan: 5A Review/Court report does reflect a systemic practice issue in Mesa County. In a recent review of a random sample of In-Home Reviews that were conducted during a period from November 8, 2014 to June 1, 2015, Mesa County completed the required FSP: 5A according to Volume VII in 66% of the cases, which is below the statewide average (not including Mesa County) of 74% for the same time span. It is recommended that Mesa County employ a process in which barriers to the FSP: 5A Review/Court report are identified and solutions to the identified barriers are implemented.	Complete

15-059	CFRT	It is recommended that DCW work with the Child Welfare Training Academy to provide training around gathering information from collaterals and use of the information provided to make informed decisions rather than relying solely on a child(ren)'s disclosure.	Considered and not implemented
14-087	Policy Finding	The policy finding related to the timeliness of notification of the egregious incident reflects a systemic practice issue for JCDCYF. From January 1, 2015 to June 11, 2015, JCDCYF provided timely notification to CDHS for 75% (3/4) of incidents. It is recommended that: a. The JCDCYF create a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
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
14-108	Policy Finding	The policy finding related to the timeliness of notification reflects a systemic practice issue for DDHS. From January 1, 2015 until August 28, 2015, DDHS provided timely notification to CDHS in 71.4% (5/7) of incidents. It is recommended that: a. DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS;	Complete