COLORADO
Department of Human Services

July 1, 2024

The Honorable Jared Polis
Governor, State of Colorado

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

The Honorable Lindsey Daugherty
Chair, House Health and Human Services

Representative Daugherty, 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 Angelica Granados , CDHS' Legislative Analyst, at 303-877-0562.

Sincerely,

Christina Beisel

Christina Beisel
Acting Deputy Director of Financial Services

2023 Child Maltreatment Fatality Annual Report

Colorado Department of Human Services
Child Fatality Review Team

COLORADO
Department of Human Services

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Executive Summary

The 2023 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) 2023. The 2023 data provides an overview of the trends, characteristics, and demographics of children and families involved with such incidents, and is presented in an effort to better understand and identify the factors associated with such incidents of abuse or neglect. 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 previous 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. The 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 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 to prevent future incidents of child maltreatment.

While any death due to child maltreatment is too many, it should be noted that in CY 2023, there were a total of 11,305 substantiated findings involving 10,065 children in Colorado's child welfare system. Of those 11,305 findings, there were 117 substantiated incidents involving 136 children at the fatal, near fatal, and/or egregious severity level. Of the 117 substantiated incidents, 76 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 eight 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. When possible, the CFRT makes recommendations corresponding with the gaps and deficiencies 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. Since 2013, there have not been any significant statutory changes. Broad trends can therefore now be considered for the past eleven 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 twelve 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 2023, data was 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 was pulled for any child with a date of death entered into Trails. The data was then compared to the reported incidents received from counties over the course of CY 2023. The data integrity checks identified 86 potential incidents. Of those potential incidents, 7 incidents involving 7 children met criteria for public notification, with 2 of those incidents meeting criteria for a full review. Additionally, the data integrity check identified 1 additional child that met criteria for public notification in an incident already known to the CFRT. That incident did not meet criteria for a full review. The ARD will continue this data integrity process and will continue to 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	63	30	23	116^
2015	43	23	20	88^^
2016	71	25	17	115^^^
2017	63	25	20	109^^^^
2018	64	21	22	107
2019	40	29	26	95
2020	60	34	31	125***
2021	76	27	29	132****
2022	59	31	26	116*****
2023	61	41	58	160

**Not all incidents reported met criteria for CFRT review.*
***Near fatal and egregious incidents were not statutorily mandated for inclusion until April 12, 2012.*
^There were three additional fatalities and one additional egregious incident that occurred in 2014, which were determined to be suspicious for abuse or neglect, and reported, after the finalization of the 2014 Annual Report.
^^ Two of the 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 three additional fatalities that occurred in 2017, which were determined to be suspicious for abuse or neglect, and reported after the finalization of the 2017 Annual Report, as well as one reported incident that 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.*
*****There were two additional fatalities and one additional egregious incident that occurred in 2021, which were determined to be suspicious for abuse or neglect, and reported, after the finalization of the 2021 Annual Report.*
******There were two additional fatal incidents involving three children that occurred in 2022, which were determined to be suspicious for abuse and neglect, and reported, after the finalization of the 2022 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	24	69^
2015	21	15	19	55
2016	35	20	16	71
2017	31	20	18	69^^
2018	34	18	19	71
2019	17	22	24	63
2020	28	28	28	84
2021	32	17	27	76^^^
2022	33	26	22	81^^^^
2023	30	39	48	117

^There was one additional substantiated egregious incident in 2014 that was published in previous Child Maltreatment Fatality Reports.
^^The number of substantiated incidents for 2017 is different from what was published in previous Child Maltreatment Fatality Reports, as one fatal incident was determined not to be substantiated at the fatal severity level, while another fatal incident was reported and substantiated after the finalization of the 2017 Annual Report.
^^^The number of substantiated incidents for 2021 is different from what was published in previous Child Maltreatment Fatality Reports, as there were two fatalities and one egregious incident that were reported and substantiated after the finalization of the 2021 Annual Report.
^^^^ The number of substantiated incidents for 2022 is different from what was published in previous Child Maltreatment Fatality Reports, as there were two fatalities, involving three children, that were reported and substantiated after the finalization of the 2022 Annual Report.

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 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 twelve 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	19	13	9	41^^
2018	16	10	11	37
2019	10	11	16	37
2020	21	14	17	52
2021	21	13	19	53^^^
2022	27	18	11	56^^^^
2023	20	30	26	76

**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 and total incident numbers are different from what was published in the previous Child Maltreatment Fatality Report, as one fatal incident was pending disposition at the time the 2015 report was finalized.
^^The fatal incidents and total incident numbers are different from what was published in previous Child Maltreatment Fatality Reports, as one incident was determined not to be substantiated at the fatal severity level, while another fatal incident was reported, substantiated, and reviewed after the finalization of the 2017 Annual Report.
^^^The fatal incidents, egregious incidents, and total incident numbers for 2021 are different from what was published in the previous Child Maltreatment Fatality Reports, as one fatal incident and one egregious incident were reported, substantiated, and reviewed after the finalization of the 2021 Annual Report.
^^^^The fatal incidents and total incident numbers for 2022 are different from what was published in the previous Child Maltreatment Fatality Reports, as one fatal incident involving two children was reported, substantiated, and reviewed after the finalization of the 2022 Annual Report.

Statute requires that county departments provide 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 provides 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, 56.25% (90/160) of incidents that occurred in 2023 were afforded at least one extension, with the total number ranging from one to fifteen extensions. The average number of extensions afforded per report is 6.5.

Incidents Reviewed in 2023

As required by Volume 7 (25 CCR 2509-2), the CFRT must review all incidents within 45 business days of CDHS receiving all required and relevant reports and information necessary to complete a review. During CY 2023, 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) business 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 the systems model approach.

Colorado Revised Statute 26-1-139(5)(j)(I) allows 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 in regards to that request from the county or district attorney 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 notification in writing from the county or district attorney authorizing the release of the final non-confidential case-specific executive summary report. CFRT then posts the case-specific executive summary report on the public notification webpage.

In CY 2023, 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, as well as representation from the Attorney General's office. The team meets monthly to review substantiated 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 also 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. This year's recommendation was informed by an increase in incidents related to firearms, and is highlighting the joint recommendation made by CFPS and CFRT in CFRT's 2017 Child Maltreatment Fatality Annual Report, as well as the recommendation made in CDPHE's 2023 CFPS Legislative Report. In CY 2022, the CFRT noted that there were nine children involved in eight fatal, near fatal, or egregious incidents who were impacted or killed by firearms. This year's joint recommendation can be found on page 44 of this document.

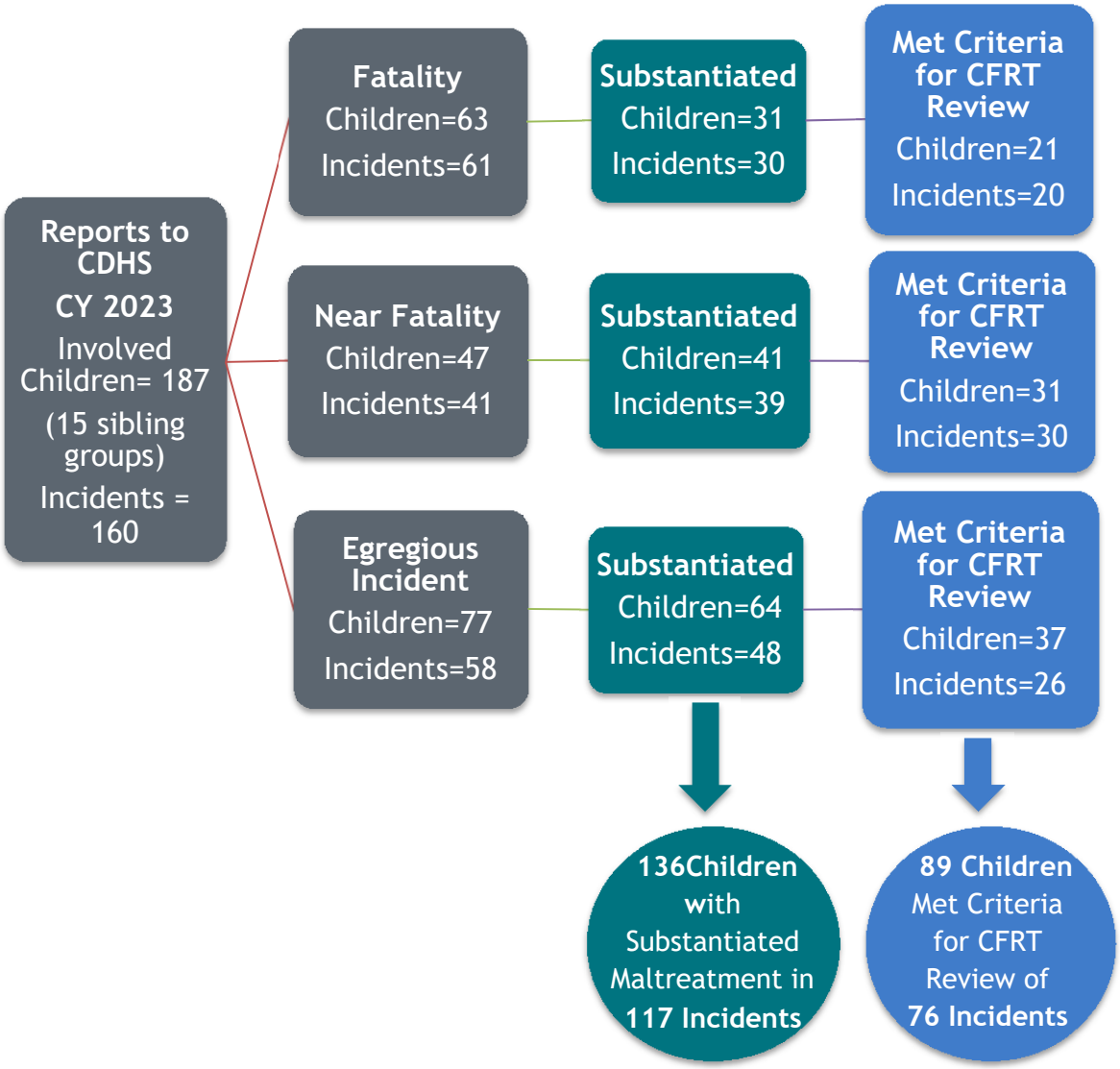
Overview of the 2023 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

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 2023, counties reported 160 incidents involving 187 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. Of the 187 children, 63 children were associated with 61 fatal incidents, 47 children were associated with 41 near fatal incidents, and 77 children were associated with 58 egregious incidents. It should be noted that one child was harmed in two separate egregious incidents.

Upon completion of an assessment, county departments found that 42 incidents involving 51 children were not substantiated 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 are no pending incidents. However, there was 1 incident involving 1 child that was screened out after being initially assigned for assessment.

In CY 2023, 117 substantiated incidents included 136 children. Of the 117 substantiated incidents, 76 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 2023. 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 2023



For purposes of this report, the majority of the analysis in the following section focuses on the 136 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 136 substantiated victims of incidents that occurred in CY 2023.

Table 4: Summary information of all 136 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado in CY 2023.

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	15	48.4%	20	48.8%	33	51.6%
	One	5	16.1%	11	26.8%	1	1.6%
	Two	2	6.5%	0	0.0%	1	1.6%
	Three	1	3.2%	3	7.3%	2	3.1%
	Four	0	0.0%	2	4.9%	1	1.6%
	Five	2	6.5%	2	4.9%	1	1.6%
	Six	1	3.2%	0	0.0%	3	4.7%
	Seven	1	3.2%	0	0.0%	1	1.6%
	Eight	0	0.0%	0	0.0%	3	4.7%
	Nine	1	3.2%	0	0.0%	2	3.1%
	Ten	0	0.0%	0	0.0%	0	0.0%
	Eleven	0	0.0%	2	4.9%	2	3.1%
	Twelve	0	0.0%	1	2.4%	1	1.6%
	Thirteen	0	0.0%	0	0.0%	1	1.6%
	Fourteen	1	3.2%	0	0.0%	4	6.3%
	Fifteen	1	3.2%	0	0.0%	3	4.7%
	Sixteen	1	3.2%	0	0.0%	2	3.1%
	Seventeen	0	0.0%	0	0.0%	3	4.7%
Race/Ethnicity	Black or African American	2	6.5%	7	17.1%	5	7.8%
	Asian	0	0.0%	0	0.0%	0	0.0%
	White	17	54.8%	8	19.5%	26	40.6%
	Hispanic	8	25.8%	18	43.9%	24	37.5%
	Native American	0	0.00%	0	0.00%	1	20.00 %
	Multiracial	2	6.5%	4	9.8%	3	4.7%
	Missing/Unknown	2	6.5%	4	9.8%	5	7.8%
Sex	Female	9	29.0%	24	58.5%	32	50.0%
	Male	22	71.0%	17	41.5%	32	50.0%
Family Structure	One parent	5	16.1%	8	19.5%	5	7.8%
	One parent and one related caregiver	2	6.5%	2	4.9%	3	4.7%
	One parent and one unrelated caregiver	5	16.1%	2	4.9%	5	7.8%
	Two parents	9	29.0%	20	48.8%	37	57.8%
	Two parents and relatives	3	9.7%	7	17.1%	8	12.5%
	Two related caregivers	1	3.2%	0	0.0%	0	0.0%

	One related caregiver	1	3.2%	0	0.0%	1	1.6%
	One unrelated caregiver	1	3.2%	0	0.0%	1	1.6%
	One parent and relatives	3	9.7%	1	2.4%	2	3.1%
	One legal caregiver with relatives and one unrelated caregiver		0.0%	0	0.0%	2	3.1%
	One related caregiver and one unrelated caregiver	1	3.2%	1	2.4%	0	0.0%
Incidents with Additional Family Stressors*	Substance Abuse	14	51.9%	6	60.0%	8	38.1%
	Mental Health	6	22.2%	1	10.0%	5	23.8%
	Domestic Abuse	7	25.9%	3	30.0%	8	38.1%

**This is counted at the family level for incidents which met criteria for review, and were reviewed in CY 2023.*

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, housing instability, 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 Federal Fiscal Year 2022 (FFY22), it was estimated that 1,990 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 2022) to illustrate similarities and differences. National data is not available for near fatal or egregious incidents.

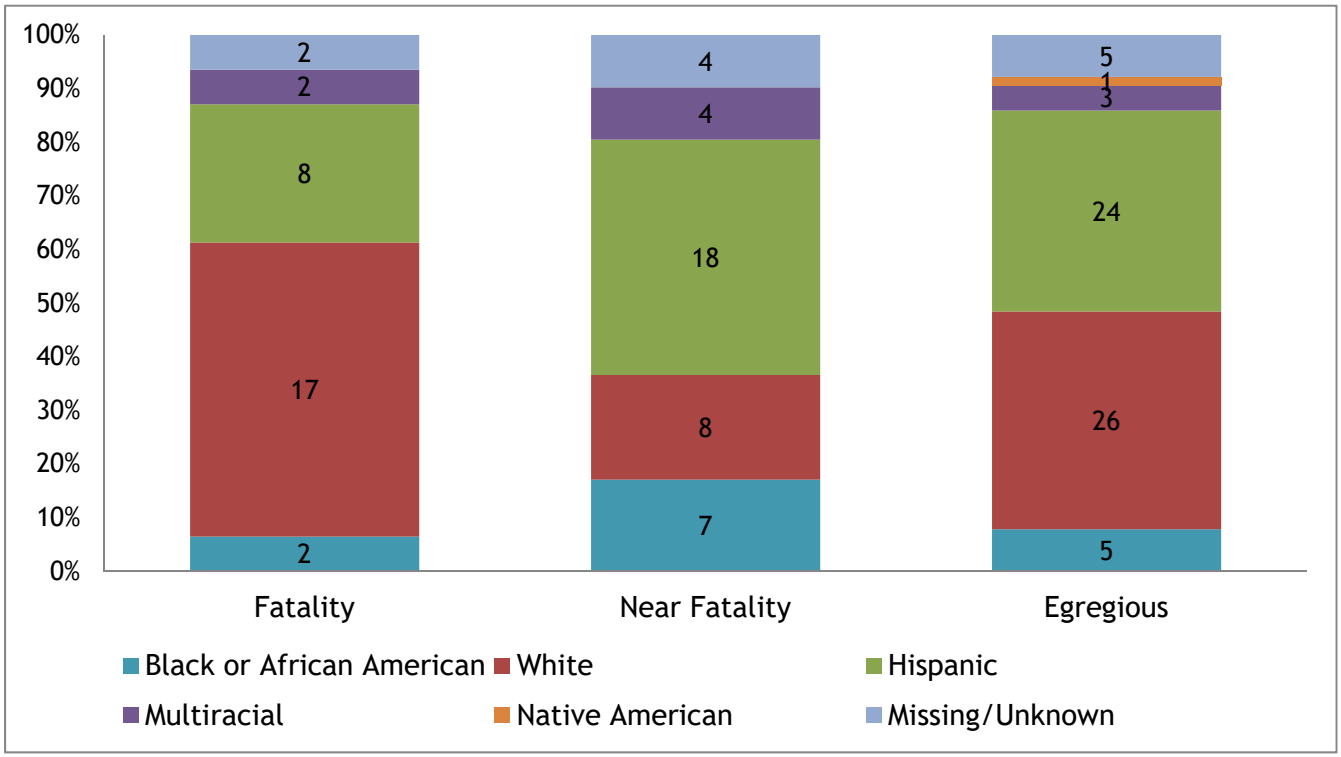
1 U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2023). Child Maltreatment 2022. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

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 2023. The estimates indicated that Colorado's population in 2023 was 66.5% White (alone, not reporting another race/ethnicity), 22.5% 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.

For fatalities, near fatalities, and egregious incidents in Colorado for CY 2023, most victims were of either Hispanic or White ethnicity. For fatalities, 25.8% of victims were Hispanic, and 54.8% were White. For near fatal incidents, 43.9% of victims were Hispanic, followed by White at 19.5%. For egregious incidents, 37.5% of victims were Hispanic, and 40.6% were White. Hispanic victims were disproportionately represented based on Colorado's population estimates. Chart 1 is a graphic depiction of race/ethnicity breakdown.

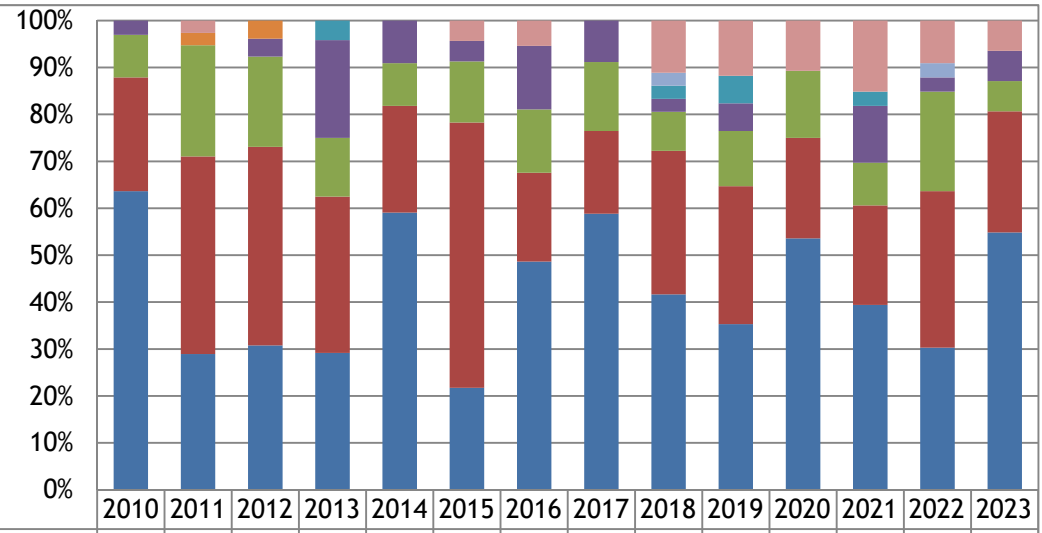
Chart 1 Race/Ethnicity of 136 victims in all Substantiated Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment in Colorado for CY 2023



2 https://www.census.gov/quickfacts/CO

Chart 2 shows the trends related to the most common race/ethnicity of all child maltreatment fatalities in Colorado from 2010-2023. For Colorado's population trends, Hispanic child victims have been disproportionately represented in fatal, near fatal, and egregious incidents in 2023. Additionally, Hispanic child victims were also disproportionately represented in fatal incidents during the years of 2011, 2012, 2013, 2015, and 2022. 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 2 Race/ethnicity of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Fourteen Calendar Years

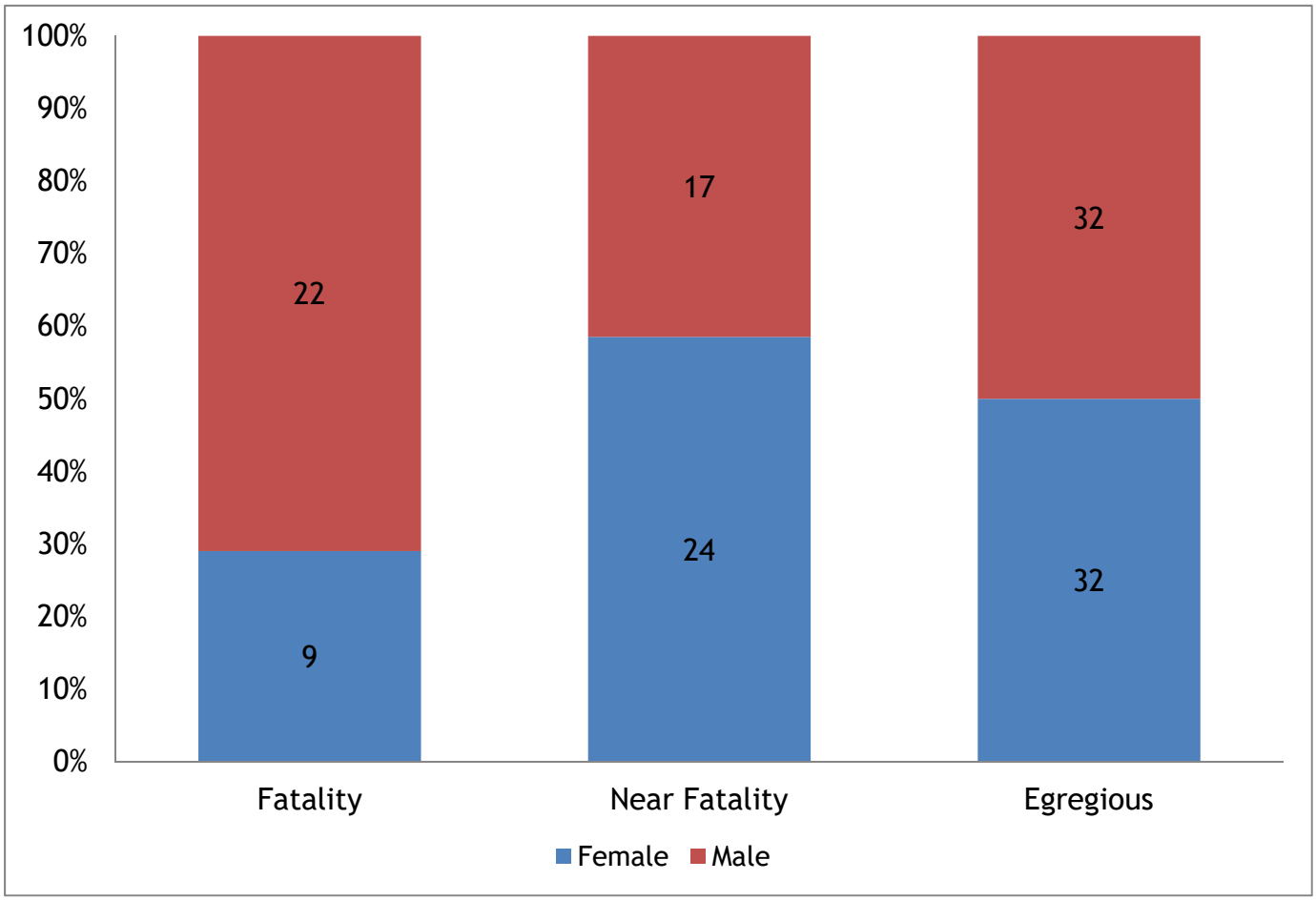


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Multiracial	0	1	0	0	0	1	2	0	4	2	3	5	3	2
American Indian or Alaska	0	0	0	0	0	0	0	0	1	0	0	0	1	0
Native Hawaiian/Other Pacific Islander	0	1	1	0	0	0	0	0	0	0	0	0	0	0
Asian	0	0	0	1	0	0	0	0	1	1	0	1	0	0
Missing or Unknown	1	0	1	5	2	1	5	3	1	1	0	4	1	2
Black or African American	3	9	5	3	2	3	5	5	3	2	4	3	7	2
Hispanic	8	16	11	8	5	13	7	6	11	5	6	7	11	8
White	21	11	8	7	13	5	18	20	15	6	15	13	10	17

Sex of Victim

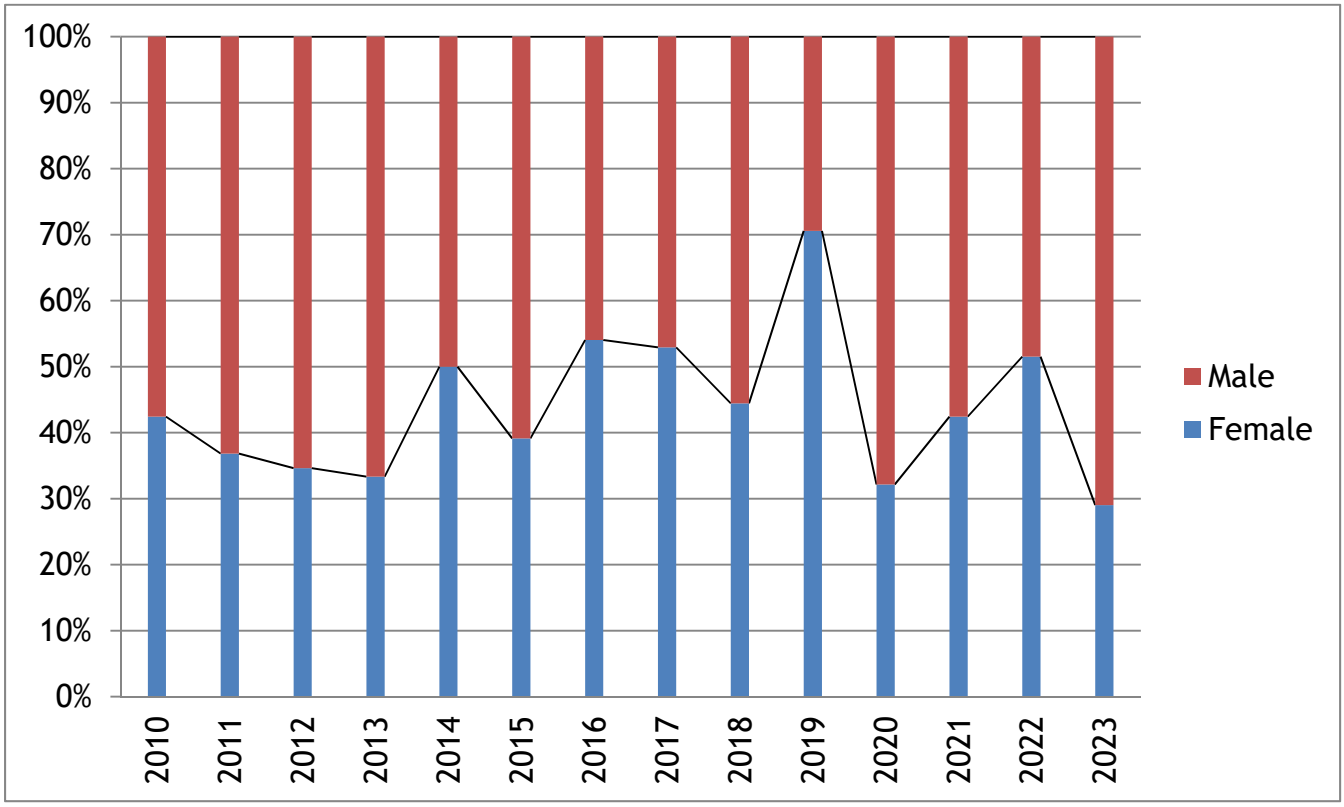
For CY 2023, Colorado data showed that 29% of victims in substantiated child maltreatment fatalities were females and 71% were males. In FFY 2022, 60.3% of victims in child maltreatment fatalities were males. Chart 3 displays the breakdown of differences in the sex of the victims for the 136 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and neglect in CY 2023.

Chart 3: Sex of 136 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2023



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 4 further demonstrates the trends of sex of victims involved in all substantiated child maltreatment fatalities in Colorado over the last fourteen years.

Chart 4 Sex of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Fourteen Years

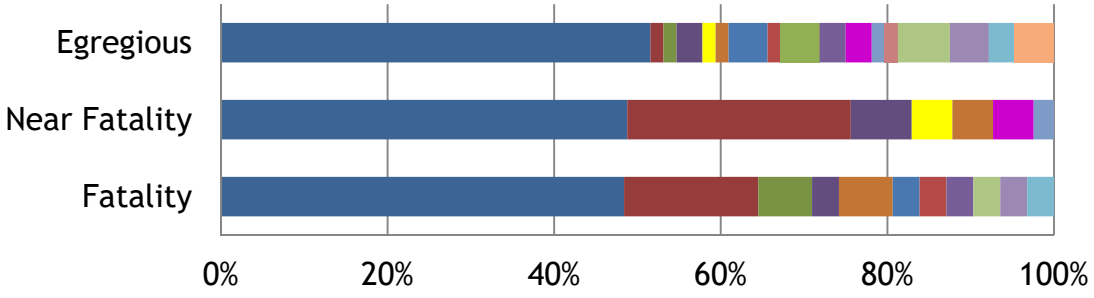


Age at Time of Incident

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 5, 48.3% (15/31) of the fatalities involved victims younger than one year old, and 74.1% (23/31) were three or younger. Nationally, in FFY 2022, 44.7% were under the age of one, and 66.1% of all victims were age three or younger.

In Colorado, a similar pattern of younger-aged victims exists for the near fatalities, as 48.7% (20/41) of the victims were under the age of one, and 82.9% (34/41) were age three or under (see Chart 5). 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, while in CY 2022, less than half (41.2%) of all victims were three or younger. In CY 2023, the majority of victims of egregious incidents returned to those victims who were three years old or younger, at 57.8% (37/64).

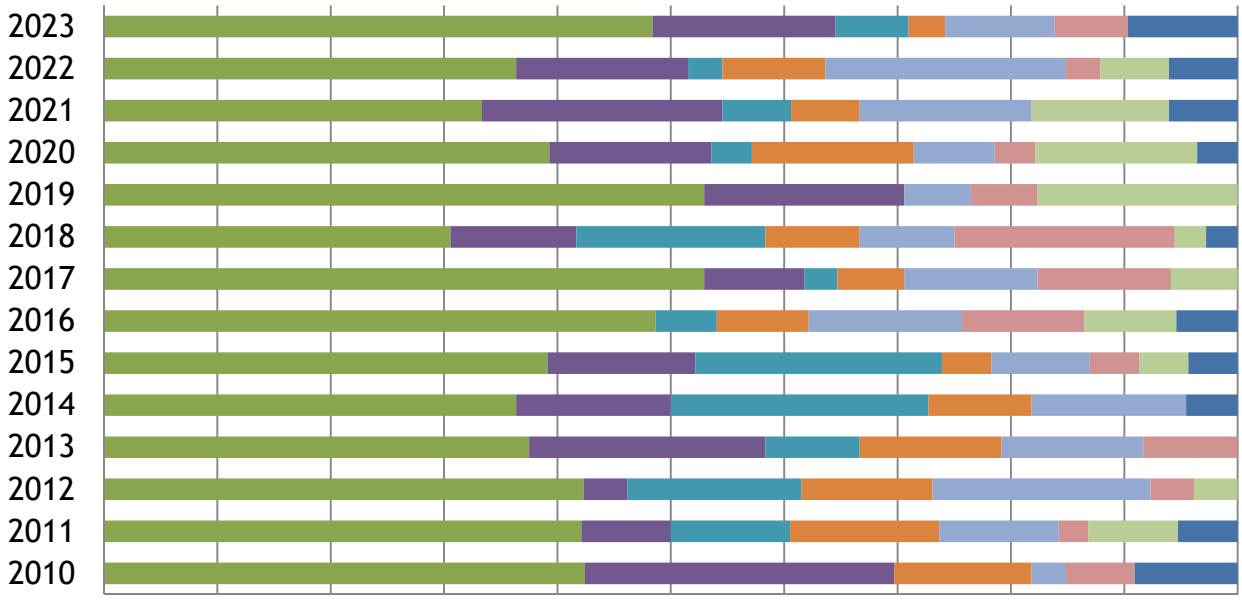
Chart 5: Age of 136 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2023



	Fatality	Near Fatality	Egregious
<1	15	20	33
1	5	11	1
2	2	0	1
3	1	3	2
4	0	2	1
5	2	2	1
6	1	0	3
7	1	0	1
8	0	0	3
9	1	0	2
10	0	0	0
11	0	2	2
12	0	1	1
13	0	0	1
14	1	0	4
15	1	0	3
16	1	0	2
17	0	0	3

Chart 6 displays the trends in ages of victims in child maltreatment fatalities over the past fourteen calendar years. The data further depicts that children under the age of one year are the most frequent victims of fatal child maltreatment. Furthermore, when looking at victims ages 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 6: Age of Substantiated Victims in Child Maltreatment Fatalities in Colorado over the Past Fourteen Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
<1	14	16	11	9	8	9	18	18	11	9	11	11	12	15
1	9	3	1	5	3	3	0	3	4	3	4	7	5	5
2	0	4	4	2	5	5	2	1	6	0	1	2	1	2
3	4	5	3	3	2	1	3	2	3	0	4	2	3	1
4-6	1	4	5	3	3	2	5	4	3	1	2	5	7	3
7-9	2	1	1	2	0	1	4	4	7	1	1	0	1	2
10-12	0	3	1	0	0	1	3	2	1	3	4	4	2	0
13+	3	2	0	0	1	1	2	0	1	0	1	2	2	3

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 2022, it was noted that 81.8% of fatal incidents of child maltreatment involved one or both parents, sometimes acting alone and sometimes involving another person. For CY 2023, in Colorado, there were eight 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. Unknown, and 8. Other.

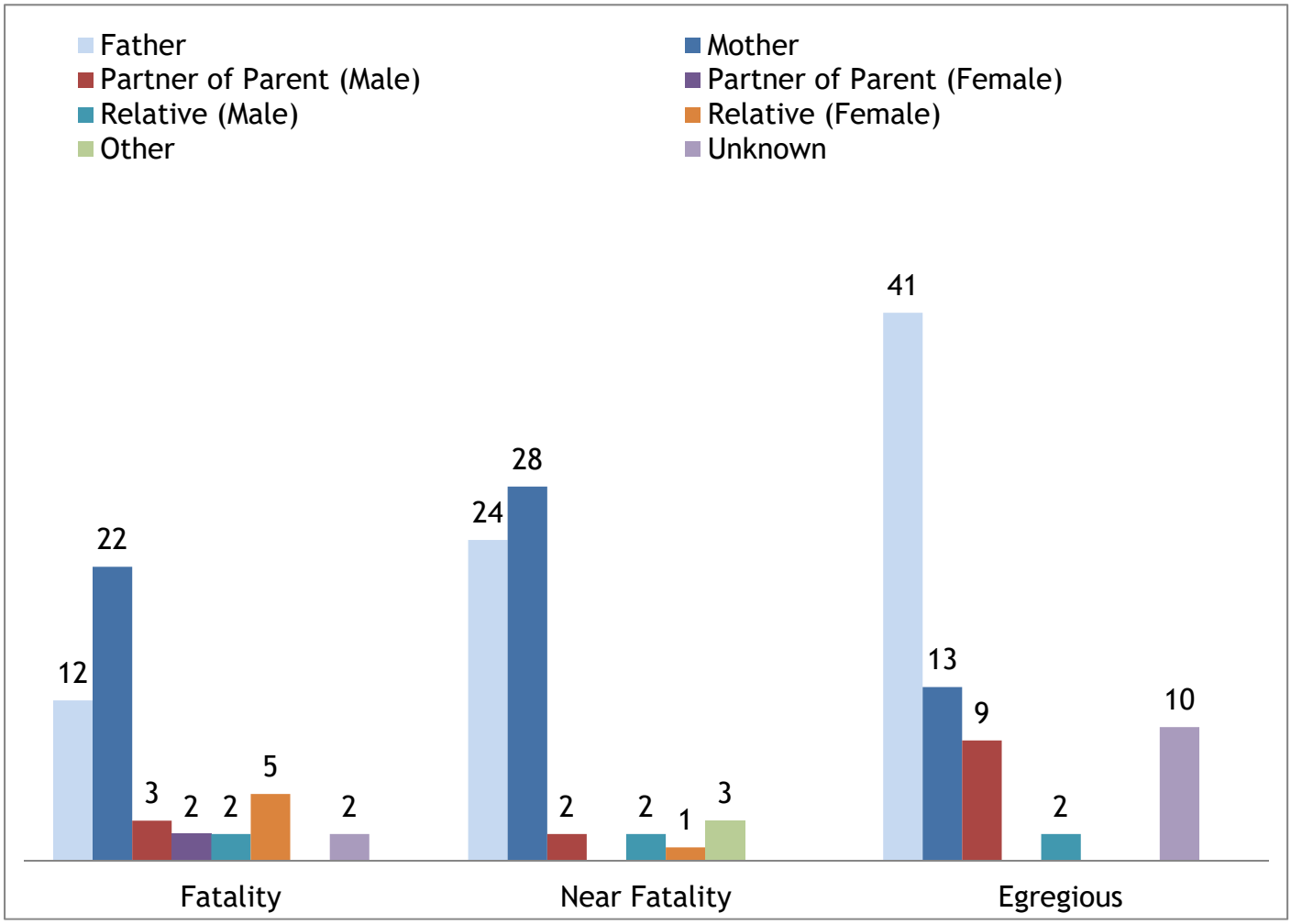
In Colorado for CY 2023, for fatal and near fatal incidents of child maltreatment, mothers were the most common perpetrator at 45.8% (22/48) and 46.6% (28/60) respectively. Fathers

were identified as the second most common perpetrator for fatal and near fatal incidents of child maltreatment at 25% (12/48) and 40% (24/60) respectively. Regarding egregious incidents of child maltreatment, fathers were the most common perpetrator at 54.6% (41/75), with mothers as the second most common at 17.3% (13/75).

For all substantiated incidents in 2023, 10 perpetrators were unknown in egregious incidents of child maltreatment and 2 were unknown in fatal incidents of child maltreatment, which means through the assessment and investigation it was determined that abuse or neglect had occurred and a perpetrator of the incident was unable to be determined. Three perpetrators of near fatal incidents were listed as other. Chart 7 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 7: Perpetrator Relationship to 136 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2023

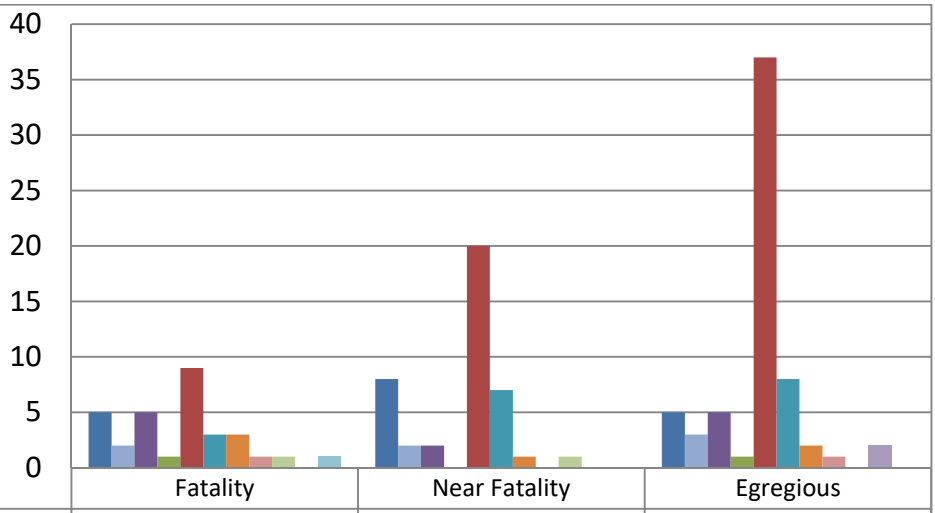
**More than one perpetrator exists for several children.*



Family Structure

In 2023, 48.5% (66/136) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents (see Chart 8). For fatal and near fatal incidents, the second most common type of family structure was one parent at 16.1% (5/31) and 19.5% (8/41), respectively. The second most common type of family structure across egregious incidents was two parents and relatives at 12.5% (8/64).

Chart 8: Family Structure of 136 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2023



	Fatality	Near Fatality	Egregious
One parent	5	8	5
One parent and one related caregiver	2	2	3
One parent and one unrelated caregiver	5	2	5
One unrelated caregiver	1	0	1
Two parents	9	20	37
Two parents and relatives	3	7	8
One parent and relatives	3	1	2
One related caregiver	1	0	1
One related caregiver and one unrelated caregiver	1	1	0
One legal caregiver with relatives and one unrelated caregiver	0	0	2
Two related caregivers	1	0	0

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 include data from fatal, near fatal, and egregious incidents reviewed by the CFRT in 2023 (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, are 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 80 unique caregivers involved in the 42 fatal, near fatal, and egregious incidents of child maltreatment reviewed by the CFRT in 2023; income information was only known for 11/80 of these individuals (13.7%). Of those caregivers with known income information, the average known income was $24,160 in fatal incidents and $9,900 for egregious incidents. There was only one known individual income for near fatal incidents, which was $100,000.

Educational level was known for 48.7% (39/80) of the legal caregivers involved in fatal, near fatal, and/or egregious incidents of child maltreatment reviewed by the CFRT in 2023. 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 56.4% (22/39) of the legal caregivers with a known educational attainment level.

Supplemental Public Benefits

In CY 2023, 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 (21/42; 50%). In 15 of the 42 incidents reviewed (35.7%), families were receiving Supplemental Nutrition Assistance Program (SNAP) benefits. Other types of benefits received included Supplemental Security Disability Income (SSDI),

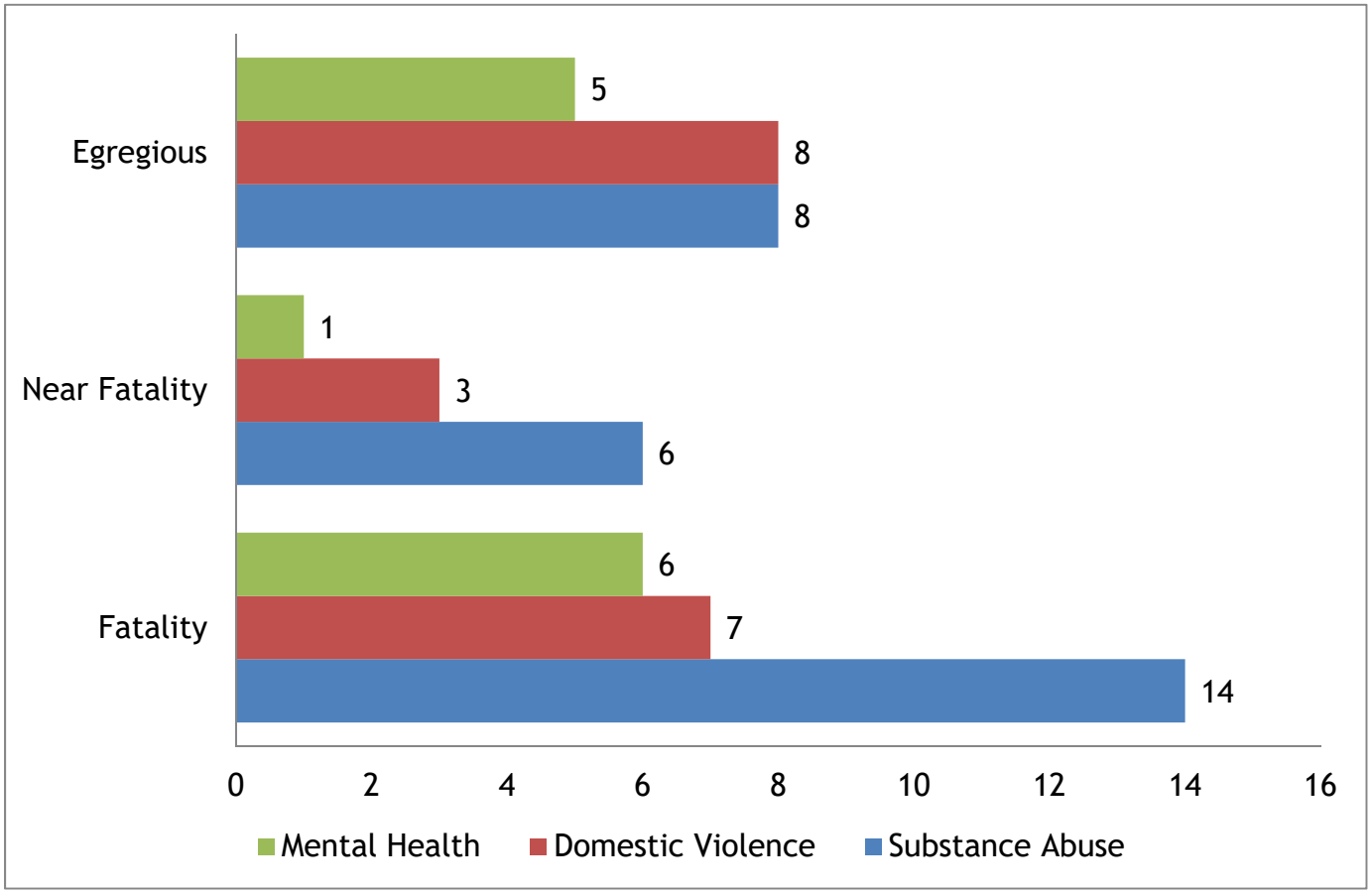
Temporary Assistance for Needy Families (TANF), Special Supplemental Nutrition Program-Women, Infants, Children (WIC), Housing Assistance, and Child Care Assistance Program (CCAP). Of the 42 incidents reviewed, 4 families (9.5%) were not receiving any supplemental public benefits, and in 14 incidents (33%), the information about supplemental benefits was unknown.

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 2023; 20 fatal incidents, 10 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, 30% (6/20) had a history of identified mental health issues, and 35% (7/20) were identified to have had some history of domestic violence.

Nationally, in FFY 2022, 5.1% of child fatalities were associated with a caregiver known to abuse alcohol, while 20.8% 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, 70% (14/20) of the incidents reviewed had some identified caregiver history of substance abuse issues. Chart 9 further identifies stressors identified/associated with caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2023.

Chart 9: Other Stressors in Families of the Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents Reviewed by the CFRT in 2023



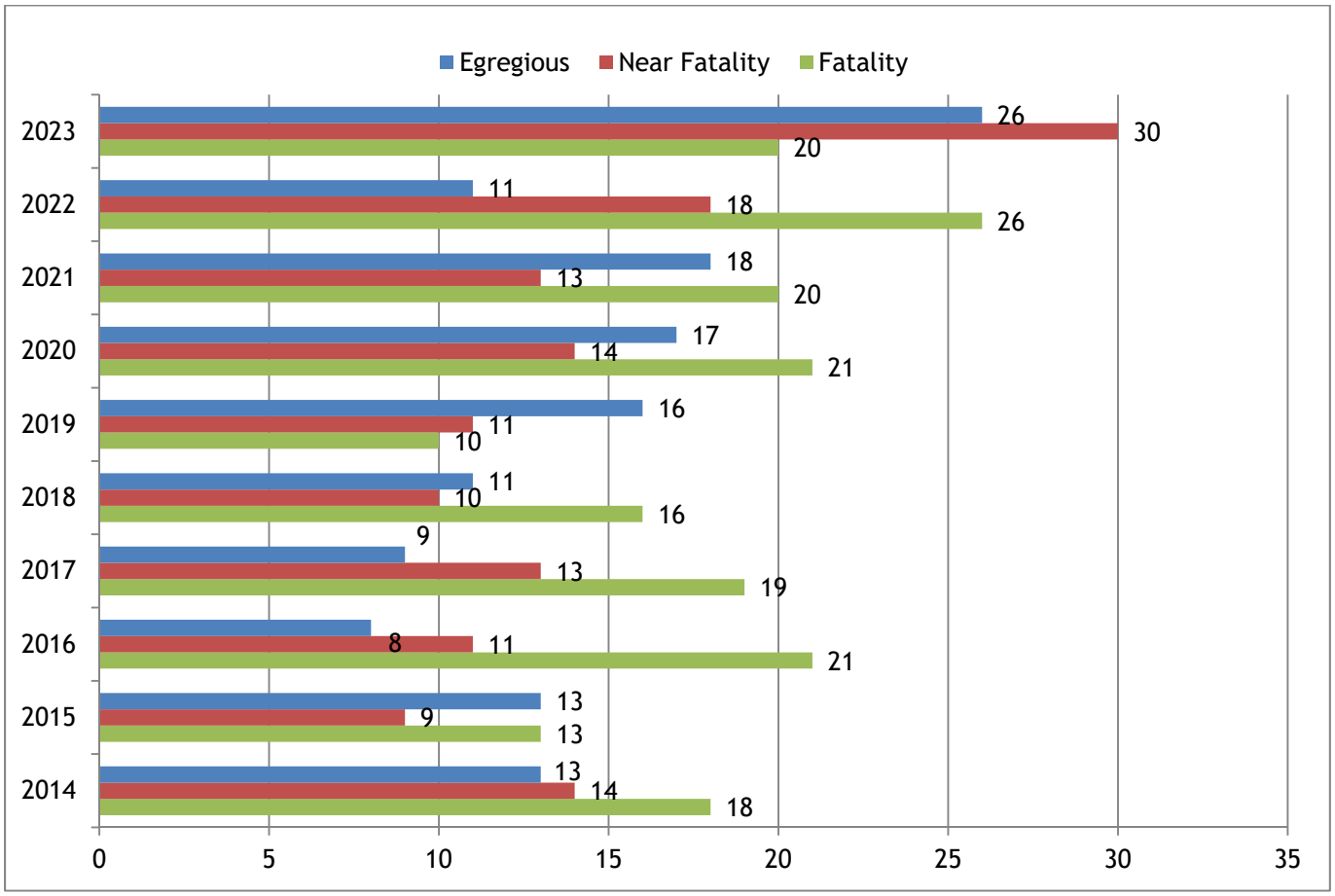
Prior Involvement

In CYs 2014 - 2023 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 2023, 66.6% of substantiated fatal child maltreatment incidents, the child, child's family, and/or alleged perpetrator had prior involvement with the child welfare system. This is a decrease from 2022, when 78.8% 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 2023 was a prior and/or current assessment, also mirroring 2020, 2021, and 2022 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 2022, and increased to 76.9% in 2023. 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 54.1% in 2023. Chart 10 details the trends in incidents with prior and/or current involvement for the past ten calendar years.

Chart 10: Prior and/or Current CPS Involvement of Families in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado from 2014-2023



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 ten years is illustrated in Charts 11 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 2023, for those families with prior involvement, 50% (10/20) 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, 2021, and 2022. In 2023, for those families with prior involvement, 25% (5/20) of

families involved with a fatal incident of child maltreatment had a prior and/or current case(s).

Near fatal incidents in 2023 fell in line with trends seen in 2014, 2017, 2018, 2019, 2021, and 2022 with assessments as the most common level of prior and/or current involvement with the child welfare system (20/30; 66.6%). The second most common level of prior involvement in 2023 for near fatal incidents was a current and/or prior case (7/30; 23.3%).

In 2023, 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 (14/26; 53.8%) which followed 2015, 2016, 2018, 2019, 2020, 2021, and 2022 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 11 a: Detail of Prior Involvement of Families in Fatal Incidents of Child Maltreatment

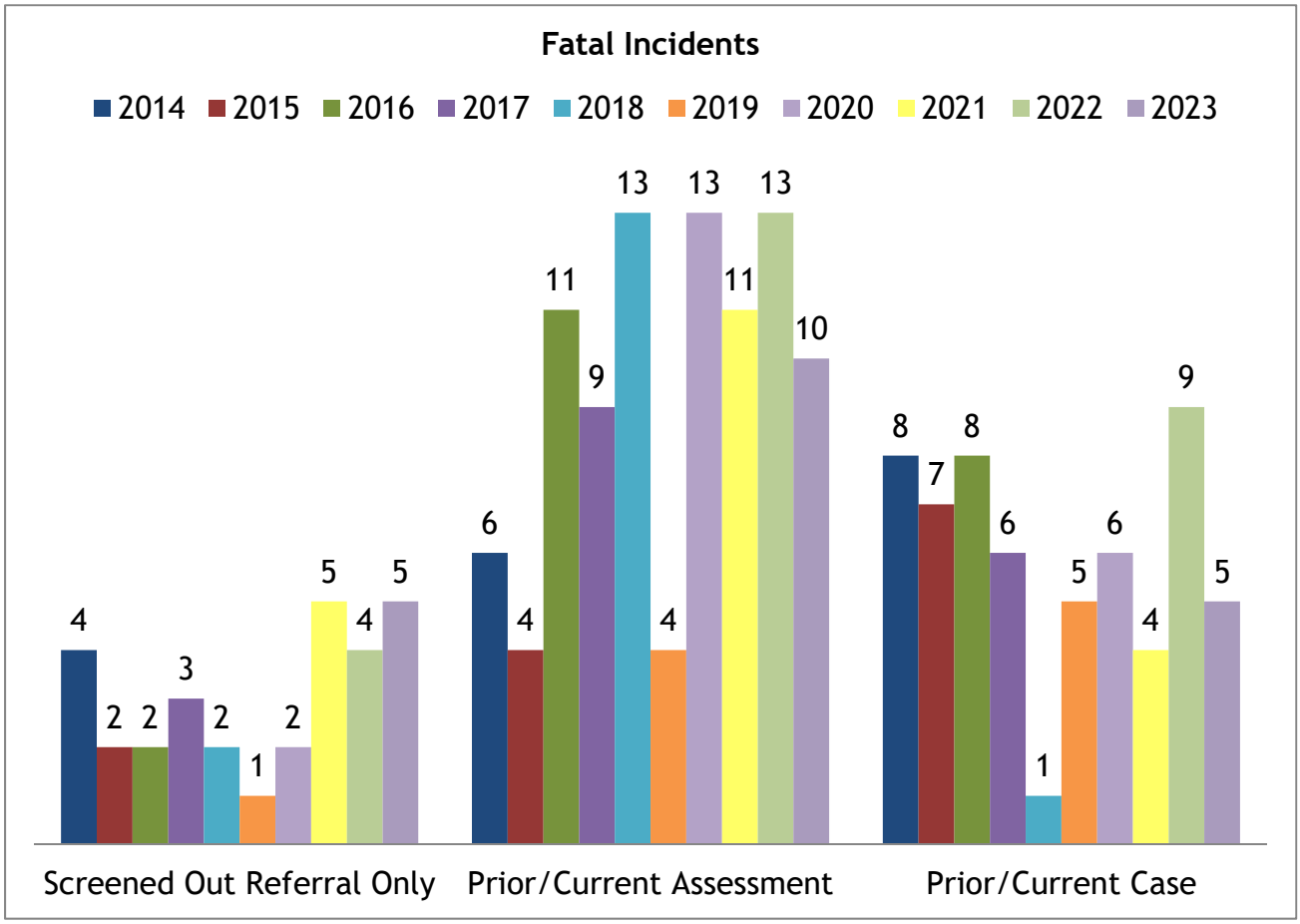


Chart 11 b: Detail of Prior Involvement of Families in Near Fatal Incidents of Child Maltreatment

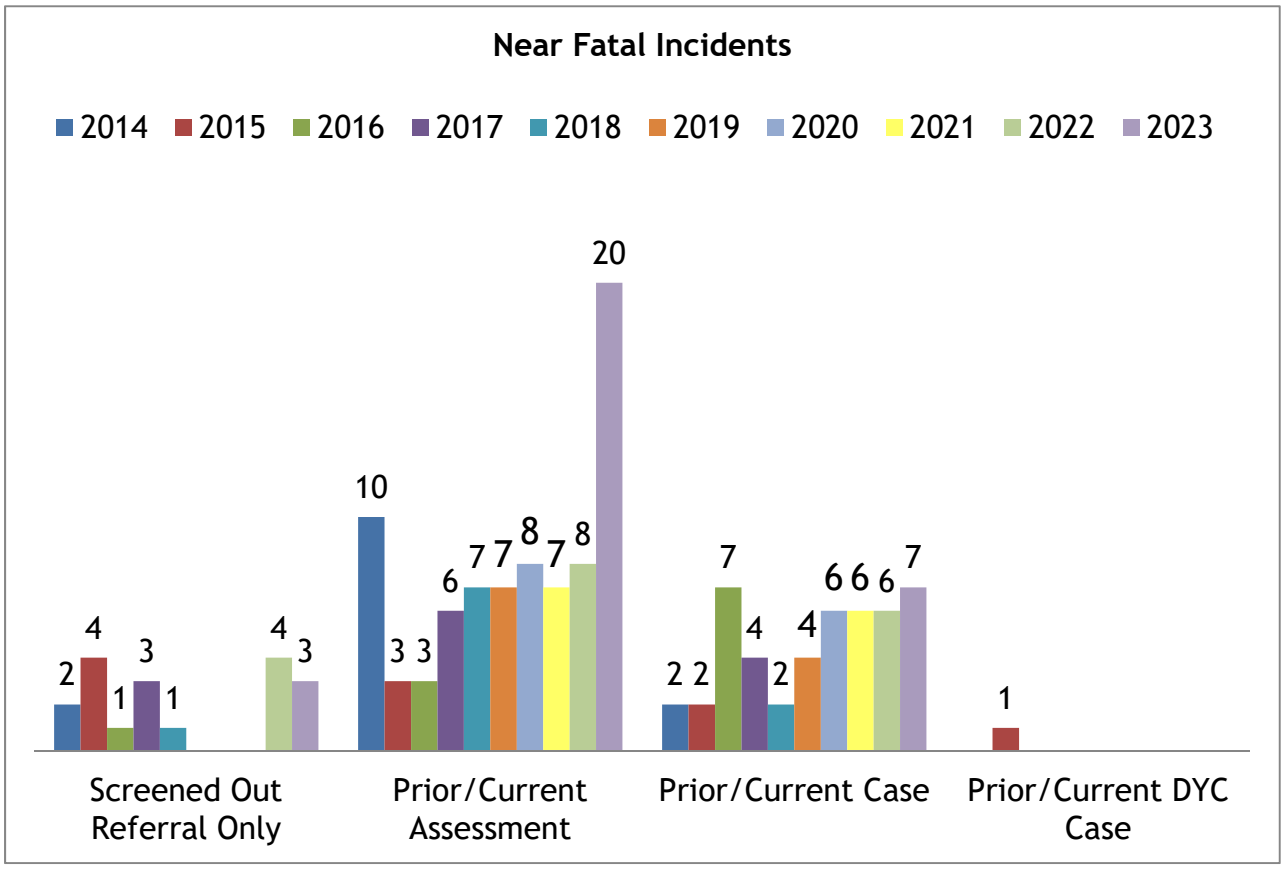
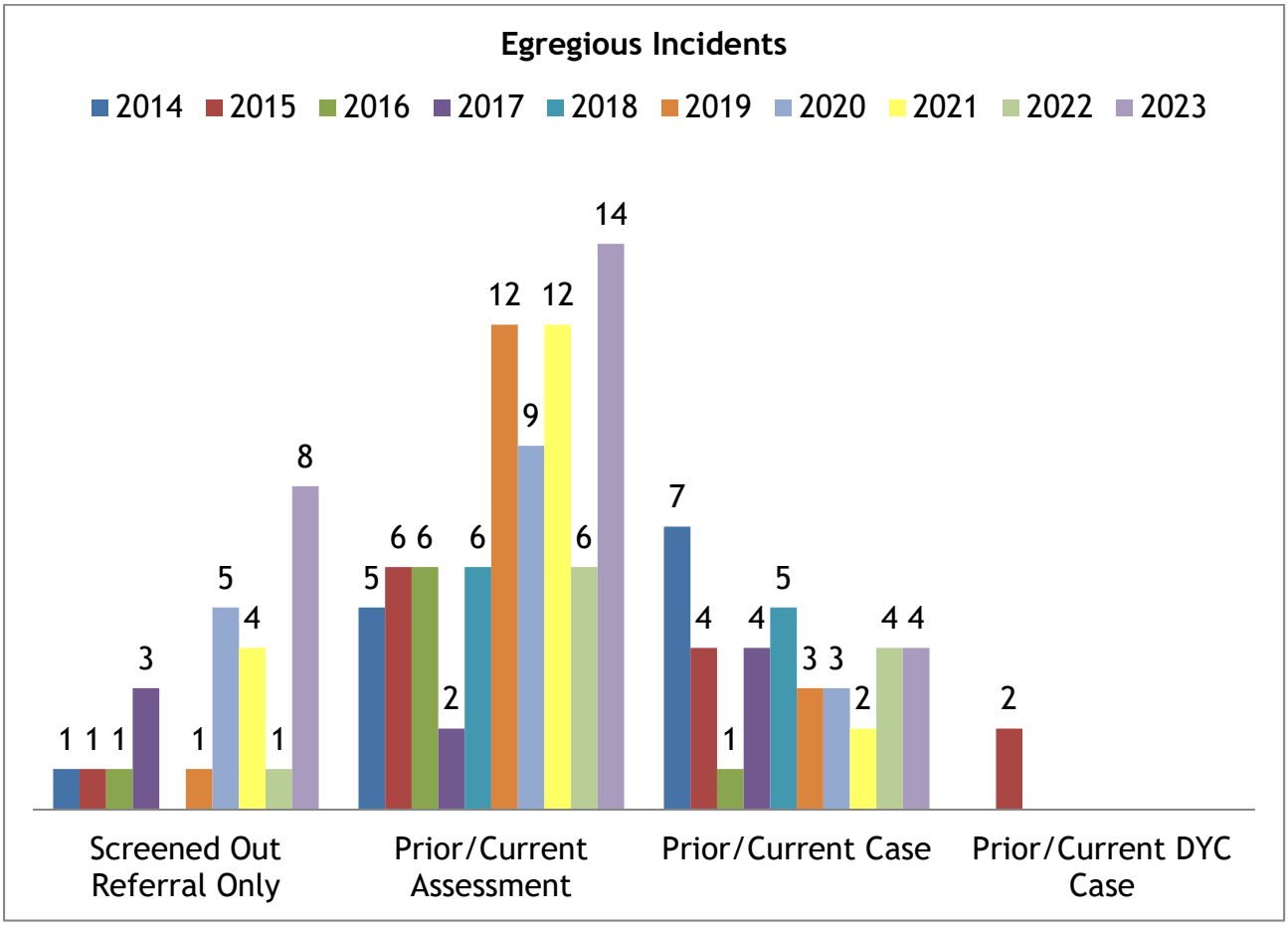


Chart 11 c: Detail of Prior Involvement of Families in Egregious Incidents of Child Maltreatment



Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 35 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 35 reports completed and/or posted to the CDHS public notification website after the cut-off date for inclusion in the 2022 CFRT Annual Report (4/1/2023) and prior to and including the cut-off date for inclusion in this year's report (3/31/2024). Each of the 35 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 35 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 35 reports. It should be noted that two reports did not have systemic strengths identified during the review of the incident. Then, the section provides an overview of systemic gaps and deficiencies, as well as any corresponding recommendations and progress.

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

Across the 35 fatal, near fatal, or egregious incidents of child maltreatment reviewed by the Child Fatality Review Team and posted to the public notification website between the dates of April 1, 2023 and March 31, 2024, the team noted 63 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) Family and Friends.

Collaboration

The CFRT uses multi-disciplinary expertise to examine coordination and collaboration between various agencies as reflected in documents from multiple sources. The CFRT identified that collaboration between county offices and other professional entities was a systemic strength on 18 occasions across 16 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, family and friends of child(ren), law enforcement, 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 assessments. Additionally, there were several strengths noted around county departments of human/social services working together on various fatal, near fatal, and egregious assessments, which allowed for better engagement with the families during such difficult times.

Engagement of Family and Friends

Engagement of family members and friends and/or foster parents during the assessments was noted as a strength seven times across seven reports. County departments of human/social services were often recognized for engaging friends and family members, or other natural familial supports, 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. Additionally, one strength noted the foster parents' support of the parents and encouragement of reunification efforts.

Case Practice

The CFRT identified caseworkers who excelled in case practice 22 different times across 19 reports. Some examples of case practices that were identified as strengths included: connecting families to appropriate services and supports in a timely manner, thoughtful placement planning for children and siblings to minimize any additional, unexpected moves, working with law enforcement to establish a complete timeline of events leading up to the incident, and the benefits of having experienced caseworkers complete the assessments for fatal, near fatal, and egregious incidents.

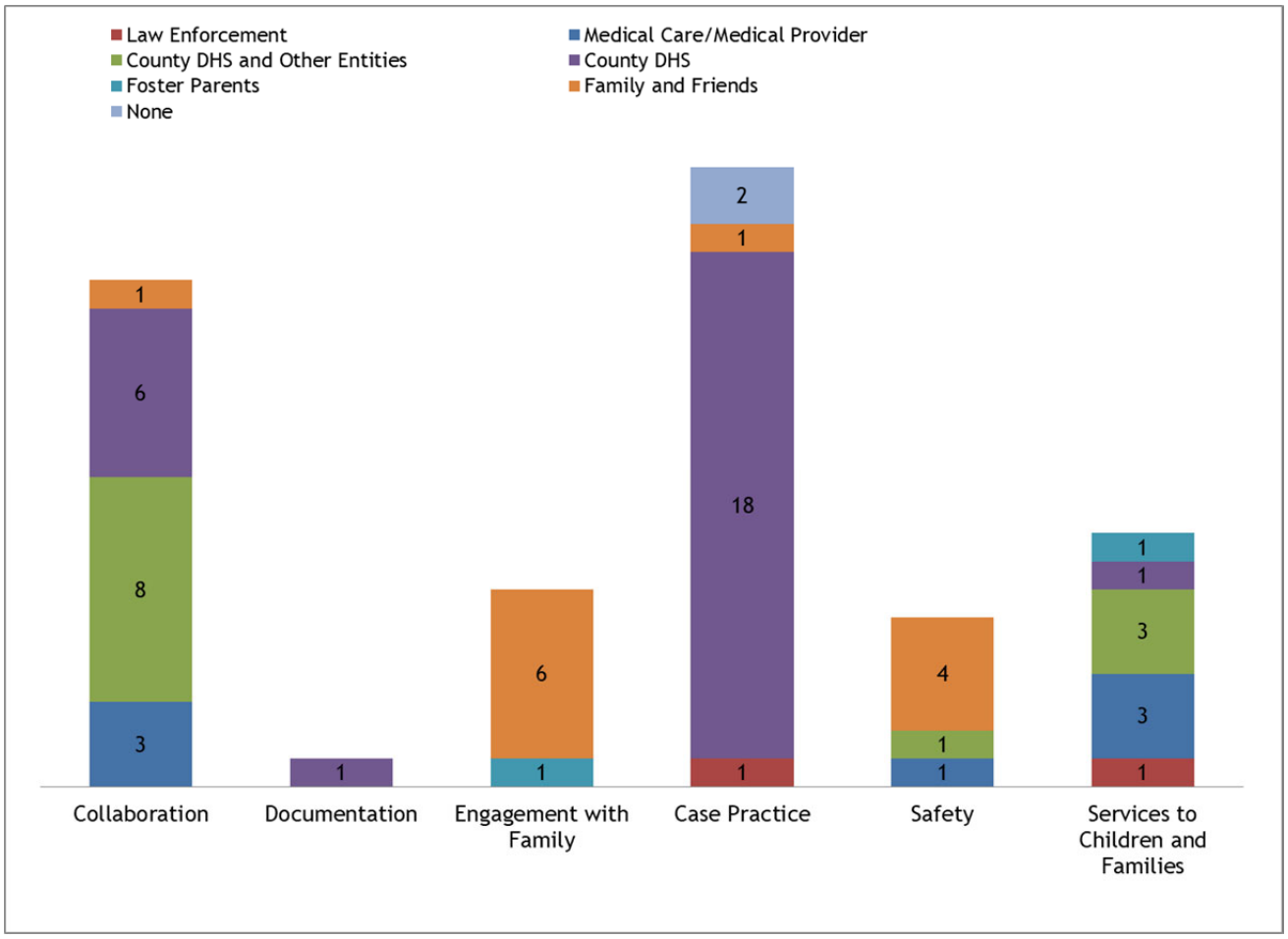
Safety

The CFRT identified six instances across five reports where systems surrounding children and families promoted child safety. Oftentimes, the strengths were related to the parents or extended family members' efforts to ensure safety and stability for the children and siblings during the prior child welfare involvement or after an incident of fatal, near fatal, or egregious harm. Other strengths noted were related to parents' engagement in services and supports in order to maintain their sobriety and access resources for the children and siblings, such as supervised visitation and routine medical appointments.

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 nine times across nine 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. Several strengths highlighted the services and supports the children and families received from partnering agencies, such as law enforcement, hospitals, treatment providers for substance use and domestic violence, and foster and kinship placement providers.

Chart 12: Systemic Strengths



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

In the 35 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, 2023 and March 31, 2024, the CFRT identified seven gaps and deficiencies in the delivery of services to children and families for which eight corresponding recommendations were made. Systemic gaps and deficiencies were organized into the following categories: 1) Practice; 2) Prevention; and 3) Services. When possible, the CFRT makes recommendations corresponding with the gaps and deficiencies to address the

identified concern. Appendix C contains the recommendations resulting from these 35 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. 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.

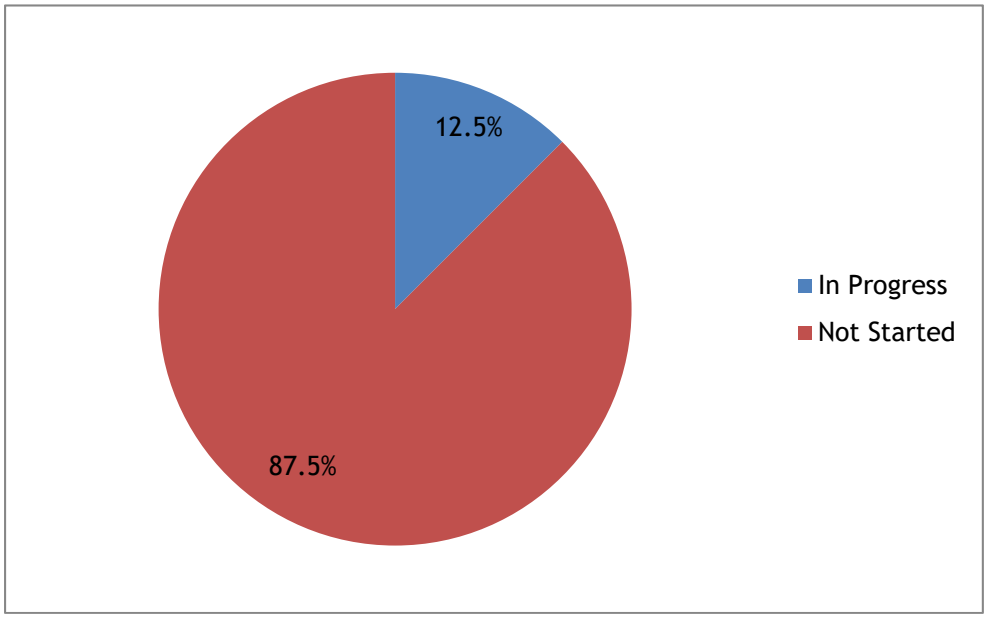
Each policy finding represents an instance when caseworkers and/or county departments did not meet the specific requirements of statute or rule. However, there are limitations to interpreting policy findings in the aggregate across the varied history and circumstances of multiple incidents. For example, 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 8 recommendations were made across the 35 reports posted between 4/1/2023 and 3/31/2024.

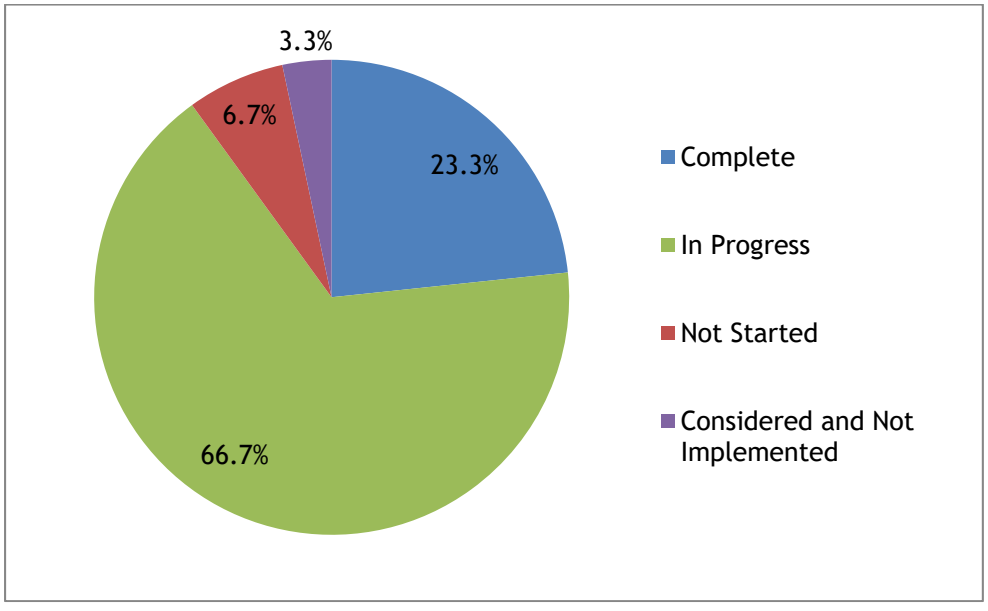
The full text of all 8 recommendations are contained in Appendix C. Adding recommendations to the tracking spreadsheet is an ongoing process, therefore, a number of recommendations will not be started at the time of each year’s annual report if the reports were just finalized and the recommendations were recently added to the tracking spreadsheet. The status of the recommendations is illustrated in Chart 13.

Chart 13: Status of Recommendations (n=8) for Reports Posted Between 4/1/2023 and 3/31/2024



An update on the implementation status of 33 recommendations previously presented in the 2022 CFRT Annual Report that were not completed at that time is presented in full detail in Appendix D, as well as summarized in Chart 14 below.

Chart 14: Status of Recommendations (n=33) Not Previously Completed From Reports Posted Prior to 4/1/2023



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, near fatal, and egregious child maltreatment. 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 five different CDHS offices as well as three 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 Civil and Forensic Mental Health, the Administrative Review Division, the Colorado Department 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 as timely as possible.

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 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

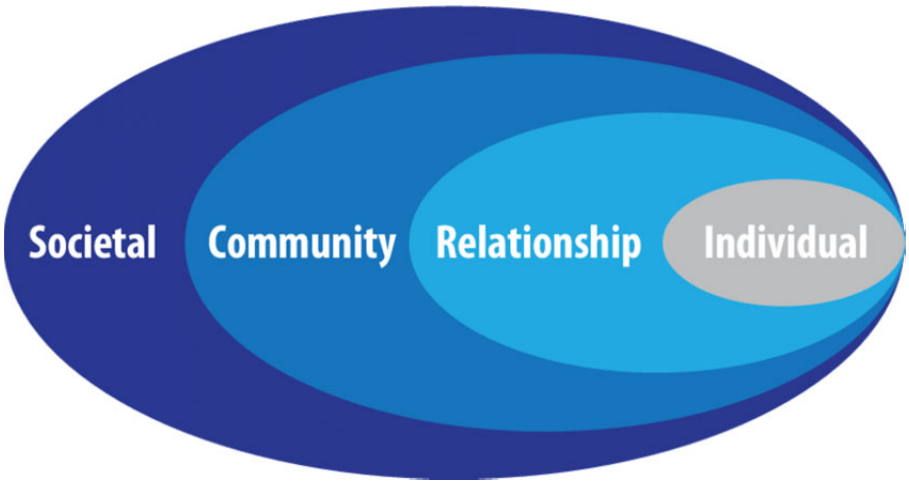
The CFRT operates under relevant criteria for excellence in child death reviews, as published by the National Center for Fatality Review and Prevention in 2018. Recent understandings have emerged on a national level that reviews should focus on system level changes and the CFRT has also come to understand 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 is important to evaluate our work, it is equally important to understand the complex nature of human behavior, and look at families through a larger system lens (i.e., public health approach).

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, 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 focus on improving the physical and social environment in these settings (e.g., by creating safe places where people live, learn, work, and play) and by addressing other conditions that give rise to violence in communities (e.g., neighborhood poverty, residential segregation, and instability, high density of alcohol outlets).

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.

CDPHE and CDHS Joint Recommendation to Prevent Child Maltreatment

Gun Violence Prevention and Firearm Safety: Support evidence-based firearm safety practices by reducing access to firearms through safe storage and increasing access to affordable gun safety resources.

CFPS reviews deaths of children involving firearms in Colorado, regardless of whether the death was determined to be an accident, a suicide death, or a homicide. From 2017-2021, 224 children and youth ages 0-17 died as a result of firearm injuries. The number of yearly firearm deaths for the time period ranged from a low of 40 deaths in 2017 to a high of 54 deaths in 2020, averaging 44.8 deaths per year. For deaths reviewed by CFPS, most firearm deaths were by suicide (52.7%, n=118); however, the proportion of homicides by firearm (43.3%, n=97) has increased in recent years. Unintentional firearm-related injuries accounted for 2.7% of firearm deaths (n=6). Notably, firearms were used in 90.5% (n=76) of child homicides in which the perpetrator was not a caregiver.

Regardless of the cause of death or specific circumstances, it is clear that too many young people in Colorado are dying by firearms. These deaths can be prevented by reducing access to firearms, both for young people themselves and also for adults who may use firearms to injure or kill young people, and by increasing education for young people and their families about firearm safety, including storage.

Reduce access to firearms through safe storage

In 2021, the Healthy Kids Colorado Survey asked students about perceived access to firearms; 16.8% of students said it was “sort of easy” or “very easy” to access a handgun, with higher prevalence among male and older-aged youth and with differences between racial and/or ethnicity groups. Schools in rural areas were more likely to report perceived easy access. Students who had felt sad or hopeless, attempted suicide, or been in a fight were more likely to say they had access to a handgun. At the same time, CFPS data highlight that firearms used in fatal incidents were most frequently stored unlocked and known to belong to the child or youth’s caregiver. Given that children are likely to have easy access to firearms in their own homes, it is critical that families know how to take action to reduce access to firearms, especially if there are concerns about young people harming themselves or others.

Firearm-owning households should adopt best practices for safe and secure storage, especially when children and youth live in or visit the home. State law requires firearms to be safely stored when they are not in use to prevent access by unsupervised youth and other unauthorized users. This may include changing the locks on guns or safes, making sure the keys or combinations are secure, and locking up ammunition separately from firearms, among others. Best evidence shows that keyed or combination-code trigger locks are the preferred mechanism to prevent the trigger from being pulled and the firearm discharging. Making trigger locks and locked storage, such as safes, more accessible and affordable can encourage responsible storage practices and prevent unauthorized access to firearms. In addition to securing firearms in homes where young people live, families can consider storing firearms outside of the home during a time of crisis. This safe storage interactive map includes a list of places in Colorado where someone can temporarily store their gun out of the home. These

measures can prevent not only child fatality and injury, but suicidality, retaliatory firearm involvement, substance-involved firearm access and usage, or despair-driven firearm use.

In the case of imminent threat, extreme risk protection orders allow family members, law enforcement, or other concerned parties to petition a court to temporarily remove firearms from an adult who may pose a risk to their family or others during periods of crisis. Law enforcement and public health systems should provide education to families and communities on Colorado's gun safety laws, including understanding steps that can be taken prior to requesting a protection order, as well as the process to obtain an extreme risk protection order, when warranted.

Increase access to affordable gun safety resources

Gun owners can help prevent firearm-related deaths and keep loved ones and others safe. Promoting and providing affordable firearm safety training can help educate gun owners and their household members about safe handling, storage, and responsible use of firearms. This is especially important when there are children and youth in the home. Firearm safety training should be made broadly available to gun owners through hunter safety courses, firearms dealers, shooting ranges, groups that advocate for gun rights, and other organizations that support the sale and use of guns.

Several initiatives in Colorado currently address gun safety among gun owners. The Colorado Firearm Safety Coalition is a group of gun shop owners, firearm safety instructors, and public health professionals with a shared goal of educating firearm retailers, range employees, and the general public about suicide prevention and firearm safety. Engaging these organizations can help to promote responsible gun ownership and limit child and youth access to guns. Similarly, CDPHE's Office of Suicide Prevention funds the Gun Shop Project, a suicide prevention program that empowers local firearm ranges, retailers, and others, to share critical suicide prevention messaging with firearm owners.

Colorado has dedicated resources to understanding and preventing firearm deaths. The Office of Gun Violence Prevention is leading the state in these efforts and CPFS will continue to partner with the office to ensure the safety of Colorado's children and youth.

Content source: Child Fatality Prevention System: 2023 Annual Legislative Report

Appendix A: 2023 CFRT Attendance

Membership Role	CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	1.9.23	2.6.23	3.6.23	4.3.23	5.1.23	6.5.23	7.10.23	8.7.23	9.11.23	10.3.23	11.6.23	12.4.23
CDHS Appointees (3): 26-1-139 6(a)	**Allison Gonzales** *Administrative Review Division, Manager*	---	Yes	Yes	Yes	Yes**	Yes	Yes					
	→**Backup:** Marc Mackert, *Administrative Review Division, Director*	Yes	---	---	---	Yes**	---	---	Yes	Yes	Yes	Yes	Yes
	Lisa Mayer *CDHS, Ongoing Child Protection Manager*	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	---	---	---	---
	→**Backup: April Jenkins** *CDHS, Child Protection and Prevention Services Unit Manager*									Yes	Yes	Yes	Yes
	Beth Collins *CDHS, Domestic Violence Program Director*	---	---	---	Yes	Yes	Yes	Yes	---	---	Yes	---	Yes
	→**Backup: Shelley Reader** *CDHS, Domestic Violence Program Specialist*	Yes	Yes	Yes	---	---	---	---	Yes	Yes	---	Yes	---
CDPHE Appointees (2): 26-1-139 6(b)	**Kate Jankovsky** *CDPHE, Childhood Adversity Prevention Manager*	Yes	---	No	No	No	Yes	No	Yes	No	Yes	Yes	No
	→**Backup:** Mandy Bakulski	---	Yes	---	---	---	---	---	---	---	---	---	---
	Vacant *(CDPHE)*												
CCI Appointees (3): 26-1-	**Angela Sneddon** *Morgan County Human Services*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.	1.9.23	2.6.23	3.6.23	4.3.23	5.1.23	6.5.23	7.10.23	8.7.23	9.11.23	10.3.23	11.6.23	12.4.23
139 6(c)	**Ray Douglas** *Park County Commissioner*	Yes											
	Vacant *(County Commissioner)*												
	Liz Smith *Gunnison County Commissioner*	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Senate Appointee (1): 26-1-139 6(f)	**Vacant (Legislative)**												
House Appointee (1): 26-1-139 6(f)	**Representative Stephanie Luck** *House of Representatives Minority Leader appointment*	No	No	No	No	No	Yes	Yes	No	Yes	No	No	No
Team Appointees (8): 26-1-139 6(d)	**Claire Hooker** *Office of Colorado's Child Protection Ombudsman*	Yes	Yes	Yes	Yes	No	Yes	Yes	---	Yes	Yes	No	Yes
	→**Backup:** Amanda Pennington	---	---	---	---	---	---	---	Yes	---	---	---	---
	Sgt. Brian Cotter *Denver Police Department*	Yes	No	No	Yes	Yes	No	No	Yes	No	Yes	Yes	No
	→**Backup:** Sgt. Eric Denke	---	---	---	---	---	---	---	---	---			
	→**Backup:** Sgt. Carlos Castillo										---	---	---

	CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.	1.9.23	2.6.23	3.6.23	4.3.23	5.1.23	6.5.23	7.10.23	8.7.23	9.11.23	10.3.23	11.6.23	12.4.23
	Dr. Andrew Sirotnak *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	No	Yes	Yes	Yes	No	Yes	Yes	Yes				
	→**Backup:** Dr. Antonia Chiesa	---	---	---	---	---	---	---	---				
	Dr. Nichole Wallace *Associate Professor of Clinical Pediatrics, The Kempe Center; Children's Hospital Colorado in Colorado Springs*									Yes	Yes	Yes	---
	→**Backup:** Dr. Andrew Sirotnak									Yes	---	---	No*
	Shelby Fyles *Senior Lead Deputy District Attorney, 17th Judicial District*	No	No	No	No	No	No	No	No	No	No	No	No
	Mara Kailin, PsyD *Mental Health*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
	→**Backup:** Kathy Snell	---	---	---	---	---	---	---	---	---	---	---	---
	Jenny Bender, *Executive Director of Colorado CASA - Child Advocacy*	---	No	No	No	No							
	→**Backup:** Josefina Milliner	Yes	---	---	---	---							
	Josefina Raphael-Milliner, *Executive Director of Advocates for Children CASA - Child Advocacy*						Yes	No	Yes	No	Yes	No	Yes

	CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.	1.9.23	2.6.23	3.6.23	4.3.23	5.1.23	6.5.23	7.10.23	8.7.23	9.11.23	10.3.23	11.6.23	12.4.23
	Lea Bernstein-Holmes *Mental Health Coordinator, Sheridan School District - Education*	Yes**	---	---	---								
	→**Backup:** Heather Porter	Yes**	Yes	Yes	Yes								
	Heather Porter *School Social Worker, Sheridan School District - Education*					Yes	Yes	**No**	**No**	Yes	Yes	Yes	Yes
	Nicole Adams *Douglas County Department of Human Services - Child Protection*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	→**Backup:** Ruby Richards	---	---	---	---	---	---	---	---	---	---	---	---
Team/CDHS DA Appointees (2): 26-1-139 6(d)	**Michael Stumph** *Fremont County Department of Human Services - Child Protection*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Alysse Nemecek *Jefferson County Department of Human Services - Child Protection*	---	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes
	→**Backup:** Erin Dowler	Yes	---	---	---	---	---	---	---	---	---	---	---
CFRT Staff	**Cheryl Hyink** *Administrative Review Division Staff*	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
	Nada Pavlovich *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	**No**	**No**	Yes	Yes	Yes	Yes	Yes	Yes

	CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	**1.9.23**	**2.6.23**	**3.6.23**	**4.3.23**	**5.1.23**	**6.5.23**	**7.10.23**	**8.7.23**	**9.11.23**	**10.3.23**	**11.6.23**	**12.4.23**
Attorney General Representatives	**Sarah Richelson** *Attorney General's Office*	Yes	Yes	---	Yes	Yes	Yes**				Yes		
	Niki Rust *Attorney General's Office*	Yes	---	Yes	---	---	Yes**	Yes	---	Yes	---	---	---
	Nicole Chaney *Attorney General's Office*						Yes**	---	Yes	---	---	Yes	Yes

*Did not attend the meeting but sent in notes.

**Member and their Backup split the meeting.

All 2023 Meetings were held virtually.

Appendix B: 2014-2023 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	2023 Total
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023										
Adams		2	1	2	2	1	1	4	4	6	1		3	1					2	3	2			1	1	2	1		2	3	3	2	4	4	3	3	2	4	8	12
Alamosa																				1																			1
Arapahoe	1	1	4	1	2	1		3	2	1		1		2		1	2	1	2			2	1	1	2	2	1	1	1	1	1	4	5	4	4	4	3	5	5	2
Archuleta					1																1										1				1					
Broomfield				1												1																		1		1				
Boulder	1					1				1		1	2			1				2						1	2				1	1	2		1	4				3
Chaffee				1																														1					
Crowley								2																													2		
Clear Creek	1																														1								
Denver	4	1	1		2	1	6	2	4	3	3	3	1	1	2	1	2	5	3	9	3	3	3	3	4	7	5	4	1	4	10	7	5	4	8	9	13	11	8	16
Douglas			1	1		1			1	1				1									1			1		1					2	2		2		1	1	1
Eagle		1																														1							
Elbert									1																		1										1		1	
El Paso	2		4	4	4	2	7	3	8	3	1	1	1	5	2	3	4	2	4	5	1	1	1	1	1	1	5	9	3	9	4	2	6	10	7	6	16	14	15	17
Fremont										1	1							1	1		2	1			1		1			1	3	1			1		1	1	2
Garfield		1				1		1																					1			1				1		1	1	
Huerfano	1																														1								
Jefferson	2	2	2	3			3		1	1	4		1	1	1	2	3		1	2	1	3					2		2	1	7	5	3	4	1	2	8		4	4
La Plata			1		1							1		1	1									1								1	1	2	2				
Larimer	1	1	1	3	1	1		1	4	1								1		1		2				1				3	1	3	1	3	1	2		2	4	5
Las Animas		1																														1							
Lincoln																						1										1							
Logan	1																														1								
Mesa	1	1	2		1	1		1				1			2	1			1	2							1	2		2	1	2	2		3	2	1	3	1	4
Moffat			1		1			1					1																			2		1			1		
Montezuma			1																1		1										1		1				1		
Montrose			1																	1													1						1
Morgan	1						1	1			1		1			1								1						1	2		1	1		1	1	1		1
Otero				1							1							1													1			1			1		
Park			1																	2													1						2
Phillips																																							
Prowers																	1																				1		
Pitkin																					1										1								
Pueblo	1				1		2			1	2	1	1					1	1	1	1			1						1	4	1	1	1	1		2	1	1	3
Rio Blanco															1			1		1																1			1
Routt	1													1									1								1		1	1					
Saguache							1																														1		
San Miguel				1																														1					
Teller										1					1			2																	1					1
Weld		1		1				1	1								2		2				1		1			1	1			1	1	1	1		2	2	4	
Total	**18**	**12**	**21**	**19**	**16**	**10**	**21**	**20**	**26**	**20**	**14**	**9**	**11**	**13**	**10**	**11**	**14**	**13**	**18**	**30**	**13**	**13**	**8**	**9**	**11**	**16**	**17**	**18**	**11**	**26**	**45**	**34**	**40**	**41**	**37**	**37**	**52**	**51**	**55**	**76**

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

Appendix C: Recommendations from 2023 Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
23-027	CFRT	The team recommended continued support for universal home visiting programs for parents with infants, especially utilizing providers with the competency to address families from a culturally literate standpoint.	Not Started
23-027	CFRT	The team noted that over time, the team has observed inconsistencies across the state in both law enforcement practices as well as child welfare practices when dealing with families when infant loss due to an unsafe sleep environment is the main concern in the case. The team recommended looking into the development of a statewide standard to provide equity for families who experience infant loss due to unsafe sleep environments.	Not Started
22-108	CFRT	The CFRT made a formal recommendation regarding the need for services and supports for young caregivers, such as offering home visiting nurse programs to assist young parents in understanding their baby's needs, and/or prevention referral programs for youth, who are expecting a baby, and providing resources that are focused on both the youth and the baby at that time.	Not Started
22-115	CFRT	The CFRT made a formal recommendation to review empirically supported domestic violence risk and lethality assessment tools to determine if they can be more widely available and utilized for all domestic violence incidents across the state, regardless of criminal charges or financial ability to access resources.	Not Started
22-115	CFRT	The CFRT made a formal recommendation to review how different court systems working concurrently with a family can intersect and collaborate together to systematically collect and share information and make recommendations for the involved families.	Not Started
22-115	CFRT	The CFRT made a formal recommendation regarding a need for a rule change in Volume 7 to be able to enter a founded finding in referral stage, based on the law enforcement records or coroner reports. The current process of having to complete an assessment, when there are fatalities with no surviving siblings and no surviving person responsible for the abuse/neglect, is not trauma informed for the family or the child welfare staff who have to complete the assessments.	Not Started

CFRT ID	Recommendation Type	Recommendation	Status
21-058	CFRT	The team recommended investigating whether the child welfare specific medical neglect training created for EPCDHS in conjunction CHC could be shared more widely with other counties and caseworkers.	Not Started
21-132	CFRT	The CFRT made a formal recommendation regarding the need for more system-wide trainings about domestic violence, especially when perpetrated in the presence of children, to be seen and recognized as child abuse. Additionally, the team was concerned about the dangers of stalking behaviors, that are often missed or overlooked, to also be seen as acts of domestic violence.	In Progress

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
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.	In Progress
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.	Complete
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

CFRT ID	Recommendation Type	Recommendation	Status
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	Closed, Reassigned
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.	Closed, Reassigned
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.	Complete
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	Closed, Reassigned

CFRT ID	Recommendation Type	Recommendation	Status
		care for all families.	
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

CFRT ID	Recommendation Type	Recommendation	Status
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	Complete

CFRT ID	Recommendation Type	Recommendation	Status
		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.	
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	In Progress

CFRT ID	Recommendation Type	Recommendation	Status
		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.	
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