

2024 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 2024 Colorado Department of Human Services (CDHS) Child Fatality Review Team's (CFRT) Annual Report focuses on data gathered from fatal, near fatal, and egregious incidents of child maltreatment that occurred in, and/or were reviewed by, the CFRT in calendar year (CY) 2024. The purpose of this annual report is to provide insight and context around the contributing factors associated with the reviewed incidents of abuse or neglect. This annual report also highlights related recommendations for improvements to the systems responsible for providing services and supports to Colorado's children and families, with the intent of mitigating future incidents of fatal, near fatal, and egregious child abuse and neglect.

A contributing factor is a variable that helps to cause an incident, influences the outcome of an incident, or combines with other factors to increase the likelihood of an incident. In this report, the contributing factors are also categorized into themes. The most frequently occurring themes identified by the CFRT during the incident reviews, along with some of their related recommendations, are:

Caregiver relationships (present in 74.4% of the incidents reviewed): This theme centered around the identified contributing factors related to domestic violence, custody issues, new caregiver relationships, complex family structures, single parents, relationship discord and conflict, and/or isolation related to domestic violence.

- **Related Recommendation:** The CFRT recommended having a dedicated domestic violence subject matter expert housed within the Colorado Department of Human Services' Domestic Violence Program who could support casework practice for families experiencing domestic violence and child welfare involvement.

Child characteristics (present in 60.5% of the incidents reviewed): This theme centered around the identified contributing factors related to the child's vulnerable age, the child's developmental, mental health, medical condition/diagnosis, the child's exposure to substances, and/or the child's premature birth or low birth weight.

- **Related Recommendation:** The CFRT recommended expanding access to community-based home visiting programs for all families after the birth of any

child, and in assisting young parents in understanding their baby's needs and providing resources that are focused on both the young parents and the baby.

Substance abuse (present in 58.1% of the incidents reviewed): This theme centered around the identified contributing factors of substance use, intergenerational substance use, prescription drug use, Fentanyl ingestion or overdose, and/or addiction issues.

- Related Recommendation: The CFRT recommended the need to create more universal support plans for parents who have substance addictions, thus treating the substance addiction as a physical illness, just like one would treat and create a care plan for someone with asthma.

Financial stress (present in 51.2% of the incidents reviewed): This theme centered around the identified contributing factors of housing instability, lack of concrete supports, poverty, lack of affordable/quality child care, financial stress itself, and/or unemployment.

- Related Recommendation: The CFRT recommended increasing the number of drop-in child care centers available throughout Colorado communities, which would help to make child care more accessible for families who need the support and assistance.

Caregiver mental health (51.2%): This theme centered around the contributing factors of mental health issues, caregiver's history of sexual assault or abuse, the caregiver's own trauma history, anger management issues, and/or a family experiencing grief.

- Related Recommendation: 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.

Additional information about the top five contributing factor themes, and their related CFRT recommendations, can be found on pages 13-24 of this report.

While any death due to child maltreatment is too many, it is important to understand these tragic incidents of fatal, near fatal, and egregious maltreatment are infrequent among all allegations of child abuse and neglect. In CY 2024, there were a total of 9,524 substantiated findings involving 7,299 unique children who were involved in

4,844 assessments in Colorado's child welfare system. Of those 4,844 assessments, there were 83 substantiated incidents (0.02%) involving 102 children (0.01%) at the fatal, near fatal, or egregious severity levels. Of the 83 substantiated incidents, 55 of them involved families who had current and/or prior Colorado child welfare involvement within the statutorily defined time frame of three years prior to the incident, thus necessitating a review by the CFRT.

The CFRT reviews focus on system level changes, based on the Systems Model approach to case reviews. This model creates a space to have vulnerable conversations with county child welfare departments about their practices and lessons learned from these tragedies, while keeping the children and families at the center of the review.

The CFRT also operates from a socio-ecological perspective. The socio-ecological model (SEM) provides a comprehensive framework for understanding the complex factors that contribute to child maltreatment by considering influences across multiple levels: individual, interpersonal, community, institutional, and societal/cultural. This model creates a more complete, contextual understanding of the impacts on caregiver protective capacity within and across these incidents. Working from this framework, the CFRT recognizes that preventing child abuse and neglect requires coordinated efforts across all levels to increase caregiver protective capacities to decrease the risk of harm to children.

Through the years of reviewing incidents of fatal, near fatal, and egregious child maltreatment from these perspectives, the CFRT has established that mitigating child maltreatment is a community responsibility. All systems and communities have a responsibility to help make families healthier and more resilient. Therefore, it is important to share learnings and data from such tragedies with the community and other service providers.

Together, we can continue to implement strategies and impact change to help prevent future incidents of child maltreatment for all of Colorado's children.

Glossary and Acronyms

Acronyms:

ARD: Administrative Review Division
 CDHS: Colorado Department of Human Services
 CDPHE: Colorado Department of Public Health and Environment
 CFPS: Child Fatality Prevention System
 CFRT: Child Fatality Review Team
 CY: Calendar Year
 FFY: Federal Fiscal Year
 SEM: Socio-Ecological Model

Definitions from Colorado Revised Statute (C.R.S.): C.R.S. 26-1-139:

Egregious: (2)(a) “‘Incident of egregious abuse or neglect’ means an incident of suspected abuse or neglect involving significant violence, torture, use of cruel restraints, or other similar, aggravated circumstances that may be further defined in rules promulgated by the state department pursuant to this section.”

Fatal: (2)(d) “‘Suspicious fatality or near fatality’ means a fatality or near fatality that is more likely than not to have been caused by abuse or neglect.”

Near Fatal: (2)(b) “‘Near fatality’ means a case in which a physician determines that a child is in serious, critical, or life-threatening condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment.”

Definitions from Volume 7: 7.000.2 (A):

Domestic Violence/Intimate Partner Violence: “‘Domestic violence’ means the commission or threatened commission of violence, including coercion, control, punishment, intimidation or revenge upon a person by a person with whom there is or was an intimate relationship.”

Inconclusive: “‘Inconclusive’ means that the abuse and/or neglect assessment established that there was some likelihood that an incident(s) of abuse and/or neglect occurred but assessment could not obtain the evidence necessary to make a founded finding.”

Substantiated/Founded: “‘Founded’ means that the abuse and/or neglect assessment established by a preponderance of the evidence that an incident(s) of abuse and/or neglect occurred. ‘Founded’ can also be utilized in a referral when there is a law enforcement fatality investigation with no surviving child sibling, or a law enforcement investigation of a third-party incident of abuse and/or neglect. ‘Founded’ and ‘confirmed,’ as used in sections 19-3-308 - 308.5, C.R.S., are interchangeable in these rules.”

Unsubstantiated/Unfounded: “‘Unfounded’ means that the abuse and/or neglect assessment established that there is clear evidence that no incident of abuse and/or neglect occurred.”

Vulnerable Child: “‘Child’s Vulnerability’ refers to circumstances that place a child at a greater risk for abuse and/or neglect such as being six years of age or younger or having limited capacity to self-protect or provide self-care due to physical, emotional, and/or cognitive limitations.”

Other Common Words/Phrases:

Contributing Factor: A variable that helps to cause an incident, influences the outcome of an incident, or combines with other factors to increase the likelihood of an incident.

Incident: Child maltreatment that occurred at the fatal, near fatal, and/or egregious severity level that was assessed by a county child welfare department.

Mental Health: How one copes with life’s challenges; one’s emotional, psychological, social, and overall mental well-being.

Out-of-Home: The child was in the temporary legal custody of a county child welfare department.

Reviewed Incidents: Those incidents of child maltreatment at the fatal, near fatal, and/or egregious severity level that were substantiated and the family had current and/or prior child welfare history in Colorado in the three years prior to the incident.

Risk Factor: A variable that increases the risk of an incident happening, but is not the direct cause of the incident.

Socio-Ecological Model (SEM): A framework that illuminates how different factors, related to individual, interpersonal, community, institutional, and societal/cultural levels, come together in a layered fashion to create a unique set of circumstances for

each individual child and family. The SEM was initially developed by Urie Bronfenbrenner in his Ecological Systems Theory.

Substance Use: From the Centers for Disease Control model: Illicit drugs, alcohol, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body with possible dependence and other detrimental effects.

Substantiated Incidents: Those assessed incidents of child maltreatment at the fatal, near fatal, and/or egregious severity levels that were determined to be caused by or related to child maltreatment by a preponderance of the evidence.

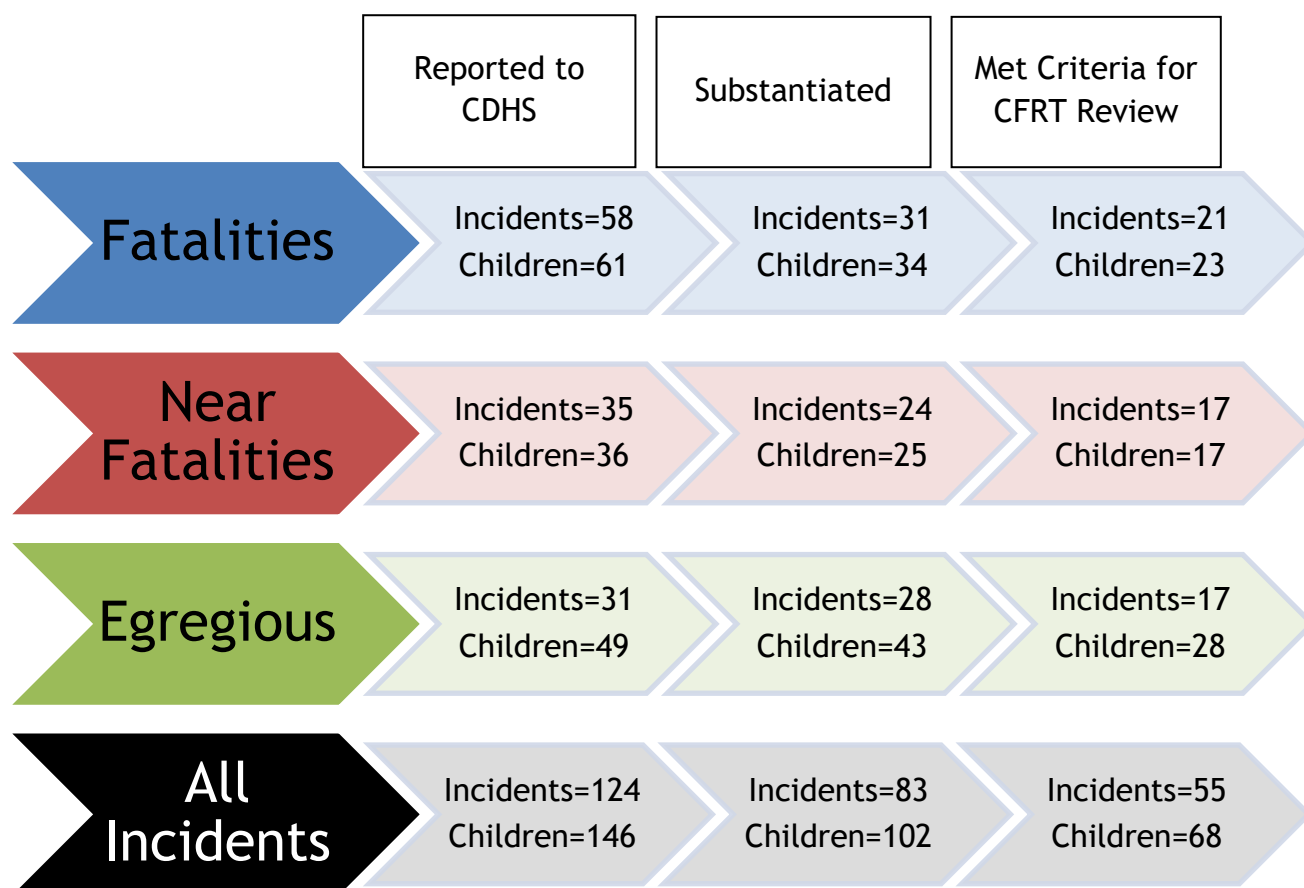
Systems Model: A model for case reviews that creates space to have vulnerable conversations with county child welfare departments about their practices and lessons learned from these tragic incidents, while keeping the children and families at the center of the review.

Overview of 2024 Incidents

Context for Substantiated Incidents and Child-Welfare-Involved Families

In calendar year (CY) 2024, there were 83 substantiated incidents involving 102 unique children at the fatal, near fatal, or egregious severity level. Figure 1 depicts the number of reports received, substantiated, and that met criteria for review in 2024, by severity level. Data on prior years can be found in Appendices B, C, and D.

Figure 1: Children Involved in Suspected and Substantiated Incidents of Fatal, Near Fatal, and Egregious Child Maltreatment in CY 2024



Of the 83 substantiated incidents, 55 (66%) of them involved families who had current and/or prior child welfare involvement within the three years prior to the incident and qualified for review through the full CFRT process. It should be noted that in just slightly over one third (34%) of the incidents, the families had no prior or current involvement with Colorado's child welfare system.

Table 1 provides information related to the percentage of incidents with no prior or current involvement at the time of incident for the years 2020 through 2024. As shown in Table 1, CY 2024, with 34% of the incidents having no prior or current involvement, is consistent with most years, when no prior or current involvement has ranged from approximately 30% to 38%.

Table 1: Percent of Incidents with No Prior or Current Involvement at Time of Incident				
2020	2021	2022	2023	2024
38%	30%	32%	35%	34%

Additionally, in 69 (83%) of the incidents, there was no current involvement with the child welfare system at the time of the incident (Table 2). This is again consistent with trends from previous years.

Table 2 provides information related to the percentage of incidents with no current involvement at the time of incident for the years 2020 through 2024. The data shows that the percentage of incidents with no current involvement at the time of the incident has ranged between 83% to 86%.

Table 2: Percent of Incidents with No Current Involvement at Time of Incident				
2020	2021	2022	2023	2024
86%	86%	84%	86%	83%

This data tells us that Colorado's child welfare system is not the singular system responsible for preventing fatal, near fatal, and egregious child maltreatment. This data further supports using a socio-ecological framework for identifying contributing factors and recommendations intended to prevent future incidents. While the child welfare system should continue to explore changes designed to improve outcomes for families involved in the system, the best opportunities to prevent fatal, near fatal, and egregious child maltreatment will come through recommendations focused on enhancing other systems with the potential to improve protective factors within and around families.

Contributing Factors

This section of the annual report focuses on the information gathered from the 43 incidents reviewed by the CFRT in CY24, including summarizing the information about the top five contributing factor themes and sharing the related CFRT recommendations. It should be noted that, while there were 55 incidents in CY24, incidents are not always reviewed in the year they occur. The 43 incidents reviewed by the multidisciplinary team in CY24 occurred between CYs 2020 and 2024.

Colorado's CFRT operates from a socio-ecological perspective. The socio-ecological model (SEM) provides a framework for understanding the complex factors that contribute to child maltreatment, by considering influences from across multiple levels.

- Individual level: a child's age, disabilities, or behavioral challenges may increase vulnerability. Parental factors such as mental health issues, substance abuse, or a history of being abused can increase risk.
- Interpersonal level: patterns of family conflict, intimate partner violence (domestic violence), or lack of positive parent-child bonding may contribute to harmful environments.
- Community level: neighborhood poverty, limited access to quality childcare, and weak social support networks can create stressful conditions that increase risk of child maltreatment.
- Institutional level: the role that organizations and systems such as schools, healthcare institutions, local law enforcement, and childcare centers can play in preventing child abuse and neglect.
- Societal/cultural level: policies that support economic disparities, limit access to healthcare, or create insufficient child welfare systems also increase the risk of child maltreatment.

Reviewing incidents from this perspective has enabled the CFRT to recognize that preventing fatal, near fatal, and egregious incidents of child abuse and neglect requires coordinated efforts across all these levels to increase caregiver protective capacities to decrease the risk of harm to children. Appendix A provides a more comprehensive description of the SEM.

During the qualitative case reviews conducted by the CFRT, the multidisciplinary team, along with the county child welfare departments involved with each incident, identify many factors that consistently contribute to fatal, near fatal, and egregious

incidents of child maltreatment. As each incident is unique, the contributing factors identified will be driven by the case specific dynamics of each child and family.

The CFRT also makes related recommendations intended to mitigate future incidents of fatal, near fatal, and egregious abuse and neglect.

Table 3 provides information related to the contributing factor themes identified in the incidents reviewed in CY 2024. Eleven themes are shown in the table.

The contributing factor themes most frequently identified by the CFRT included caregiver relationships (74.4%), child characteristics (60.5%), substance abuse (58.1%), financial stress (51.2%), and caregiver mental health issues (51.2%) (Table 3). Many incidents involved more than one of these contributing factor themes. Additional information on the co-occurrence of contributing factors can be found on page 24 of this report.

Contributing Factor Themes	Number of Reviews Identified	Percent of Reviews Identified
Caregiver Relationships	32	74.4%
Child Characteristics	26	60.5%
Substance Abuse	25	58.1%
Financial Stress	22	51.2%
Caregiver Mental Health	22	51.2%
Caregiver Criminal History	11	25.6%
Home Safety	10	23.3%
Caregiver Skills/Practice	9	20.9%
Caregiver Physical Health	5	11.6%
System Avoidant	5	11.6%
Family Culture	4	9.3%

Contributing Factor #1: Caregiver Relationships

The CFRT identified several contributing factors related to caregiver relationships, including domestic violence, which was identified in 62.8% of the incidents reviewed. Additional contributing factors included custody issues (9.3%), length of caregiver relationships (7%), and complex family structures (7%). Overall, caregiver relationships were considered a contributing factor in 32 out of 43 (74.4%) of the incidents reviewed. Table 4 provides information related to the specific factors that were identified within the Caregiver Relationships contributing factor theme in incidents reviewed in CY 2024.

Table 4: Specific Caregiver Relationship Contributing Factors Identified in Incidents Reviewed in CY 2024		
Caregiver Relationships	Number of Reviews Identified	Percent of Reviews Identified
Domestic violence	27	62.8%
Custody issues	4	9.3%
Parent or caregiver in a new relationship/Length of caregiver relationship	3	7.0%
Complex family structure	3	7.0%
Single parent	2	4.7%
Relationship problems not related to domestic violence	2	4.7%
Interfamilial conflict	2	4.7%
Marital problems	1	2.3%
Isolation related to domestic violence	1	2.3%

Related Recommendations: Domestic Violence

- The CFRT recommended exploring existing domestic violence task groups that are looking at the broader, more systemic recommendations related to data collection, moving from risk to safety concerns, and the thresholds for lethality assessments. The aggregated data collected can help to discern historical and systemic domestic violence related trends in domestic relations, criminal, and child welfare cases.

- The CFRT recommended having a dedicated domestic violence subject matter expert housed within the Colorado Department of Human Services' Domestic Violence Program who could support casework practice for families experiencing domestic violence and child welfare involvement.
- The CFRT recommended a thorough examination of current laws surrounding domestic violence, with a focus on how to hold perpetrators accountable for their action in order to help advocate for victims of domestic violence.
- The CFRT recommended the review of 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.
- The CFRT recommended 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 be seen as acts of domestic violence.

Related Recommendations: Custody

- The CFRT recommended for domestic relations court cases to look at the totality of a family's history, including child welfare allegations, criminal charges that are either dropped or dismissed, and criminal convictions before making custody decisions, in order to better understand the relationship dynamics and the impact those decisions will have on the children and caregivers.
- The CFRT recommended reviewing 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.
- 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.

Contributing Factor #2: Child Characteristics

The CFRT identified several contributing factors related to child characteristics, including vulnerable child, which was identified in 46.5% of the incidents reviewed. Additional contributing factors included the child's developmental, medical, or mental health condition (14%), and substance exposed newborn (11.6%). Overall, child characteristics were considered a contributing factor in 26 out of 43 (60.5%) of the incidents reviewed. Table 5 provides information related to the specific factors that were identified within the Child Characteristics contributing factor theme in incidents reviewed in CY 2024.

Table 5: Specific Child Characteristic Contributing Factors Identified in Incidents Reviewed in CY 2024		
Child Characteristics	Number of Reviews Identified	Percent of Reviews Identified
Vulnerable child	20	46.5%
Victim child/youths developmental, medical or mental health condition	6	14.0%
Substance exposed newborn	5	11.6%
Child/youth has significant medical condition/diagnosis	3	7.0%
Premature baby/Low birth weight	2	4.7%

Related Recommendations: Vulnerable Child

- The CFRT made six similar recommendations related to home visiting programs in Colorado, including one joint recommendation with the Colorado Department of Public Health and Environment's (CDPHE) Child Fatality Prevention System (CFPS). While the six recommendations were similar in nature, some had unique aspects to them, such as:
 - The CFRT and CFPS Joint Recommendation: supporting policies that expand access to community-based home visiting programs for all families with infants and young children
 - Utilizing providers with the competency to address families from a culturally literate standpoint
 - Assisting young parents in understanding their baby's needs and providing resources that are focused on both the youth and the baby at that time

- Providing universal home visiting nurse to all families with newborns, not just first-time parents (slight variations of this recommendation were in three different incidents)
- The CFRT 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 CFRT recommended looking into the development of a statewide standard to provide equity for families who experience infant loss due to unsafe sleep environments.

Contributing Factor #3: Substance Abuse

Contributing factors related to substance abuse were identified by the CFRT in 58.1% (25 out of 43) of the incidents reviewed in CY 2024. Table 6 provides information related to the specific factors that were identified when substance abuse was determined to be a contributing factor. Of those, substance abuse itself was identified as the contributing factor in 55.8% incidents.

Table 6: Specific Substance Abuse Contributing Factors Identified in Incidents Reviewed in CY 2024		
Substance Abuse	Number of Reviews Identified	Percent of Reviews Identified
Substance abuse	24	55.8%
Intergenerational substance use/abuse	2	4.7%
Prescription drug abuse	2	4.7%
Fentanyl overdose/ingestion	2	4.7%
Addiction issues	1	2.3%

Table 7 shows the frequency of known substances used by caregivers associated with fatal, near fatal, or egregious incidents in 2024, when a factor related to substance abuse was documented. More than one substance could be identified per caregiver and/or per incident reviewed.

Table 7: Frequency of Known Substances in Reviewed Incidents in CY 2024 when Substance Abuse was Identified as a Contributing Factor		
Substance	Number of Incidents	Percent of Incidents
Marijuana	11	44%
Fentanyl	8	32%
Alcohol	7	28%
Methamphetamine	6	24%
Cocaine	5	20%
Prescription Drugs	1	4%
Other	1	4%
Opiates (other than heroin)	1	4%
Heroin	1	4%

Child Maltreatment Fentanyl Crisis: 2020 through 2024

Starting in 2020, the CFRT noted a significant increase in Fentanyl exposure/ingestion as the factor immediately leading to the fatal or near fatal injury. Table 8 shows the prevalence of Fentanyl in fatal and near fatal incidents since that time. Due to its potency, a Fentanyl related incident is always at the fatal or near fatal severity level. As such, the percentages calculated in Table 8 are based only on those two severity levels and cannot be directly compared to the percentages in Table 7.

Table 8: Prevalence of Fentanyl in Fatal and Near Fatal Incidents

Year	Fatal: Fentanyl Related	Fatal: Total Incidents	Fatal: Percent Fentanyl Related	Near Fatal: Fentanyl Related	Near Fatal: Total Incidents	Near Fatal: Percent Fentanyl Related	Total Fentanyl Related	Total Incidents	Percent Fentanyl Related
2020	1	28	3.60%	2	28	7.10%	3	56	5.40%
2021	6	32	18.80%	6	17	35.30%	12	49	24.50%
2022	8	33	24.20%	6	26	23.10%	14	59	23.70%
2023	3	30	10.00%	18	39	46.20%	21	69	30.40%
2024	4	31	12.90%	3	24	12.50%	7	55	12.70%

In CY 2023, the relative number of fatal incidents decreased, while the near fatal incidents increased. The CFRT has attributed the decrease in fatalities and the increase in near fatalities to the Colorado-wide efforts of making Naloxone (Narcan) more readily available to first responders, hospital staff, caseworkers, and the general public.

CY 2024 saw a decline in total substantiated Fentanyl related incidents (12.7%) for the year. The CFRT has attributed the changes seen in CY 2024 to additional education, resources, and awareness of the dangers and lethality of Fentanyl, along with the continued efforts of making Narcan more readily available to everyone to help reduce and/or prevent Fentanyl overdoses throughout Colorado.

Related Recommendations: Substance Abuse

- The CFRT and CFPS Joint Recommendation: Provide information to parents and communities in their preferred language about the risks associated with substance misuse and overdose and evidence-informed strategies to reduce these risks, including:
 - How to access and use naloxone and fentanyl test strips;
 - How to respond to a suspected drug overdose, including information on Colorado's Good Samaritan Law;
 - How to safely store and dispose of both prescription and illegal drugs;
 - How to avoid accidental ingestion of drugs by young children; and
 - How to have conversations with children about overdose and poisoning prevention in age-appropriate ways.
- The CFRT recommended the need to create more universal support plans for parents who have substance addictions, thus treating the substance addiction as a physical illness, just like one would treat and create a care plan for someone with asthma.
- The CFRT recommended 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.
- The CFRT recommended that a training be developed regarding how to assess a caregiver's lawful use of a substance and their parenting capacity in light of that use. The training should be specific to: methadone use, its contraindications with other medications/substances, what methadone abuse looks like, how methadone use/abuse can impact parenting capacity, and how caseworkers can create partnerships with methadone treatment providers.

Contributing Factor #4: Financial Stress

The CFRT also identified several contributing factors related to financial stress, including housing instability, which was identified in 20.9% of the incidents reviewed. Additional contributing factors included lack of concrete supports (14%) and poverty (9.3%). Overall, financial stress was considered a contributing factor in 22 out of 43 (51.2%) of the incidents reviewed. Table 9 provides information related to the specific factors that were identified within the Financial Stress contributing factor theme in incidents reviewed in CY 2024.

Table 9: Specific Financial Stress Contributing Factors Identified in Incidents Reviewed in CY 2024

Financial Stress	Number of Reviews Identified	Percent of Reviews Identified
Housing instability	9	20.9%
Lack of concrete supports	6	14.0%
Poverty	4	9.3%
Lack of affordable/quality child care	3	7.0%
Financial stress	3	7.0%
Unemployment	2	4.7%

Related Recommendations: Financial Stress

- The CFRT recommended to have more drop-in child care centers available throughout Colorado communities, which would help to make child care more accessible for families who need the support and assistance.

Contributing Factor #5: Caregiver Mental Health

Contributing factors related to caregiver mental health were identified by the CFRT in 51.2% (22 out of 43) of the incidents reviewed in 2024. Table 10 provides information related to the specific factors that were identified within the Mental Health contributing factor theme in incidents reviewed in CY 2024. Of those, mental health itself was identified as a contributing factor in 41.9% incidents. A caregiver's history of sexual assault/abuse was a factor in 14% of the incidents, while the caregiver's trauma history was identified in 11.6% of the incidents.

Table 10: Specific Mental Health Contributing Factors Identified in Incidents Reviewed in CY 2024

Caregiver Mental Health	Number of Reviews Identified	Percent of Reviews Identified
Mental health	18	41.9%
Caregiver history of sexual assault/abuse	6	14.0%
Trauma history - parent of child/caregiver	5	11.6%
Parent or caregiver with anger management problems	2	4.7%
Family experiencing grief	1	2.3%

Related Recommendations: Mental Health

- 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.

Cross Cutting Recommendations

The CFRT also makes recommendations that, rather than focusing on a singular contributing factor, have potential to reduce incidents of fatal, near fatal, or egregious child maltreatment by crossing many factors and/or many systems.

- The CFRT recommended for more services and supports to be made available in rural communities, including more law enforcement officers, child care programs, and other necessary services to ensure the community's safety and access to supports.
- The CFRT recommended to ensure that the Memorandums of Understanding (MOUs) between county departments and law enforcement highlight the laws and requirements around making a report of concern to child welfare whenever there is a crime of child abuse.
- The CFRT and CFPS Joint Recommendation: Support evidence-based firearm safety practices by reducing access to firearms through safe storage and increasing access to affordable gun safety resources.
- The CFRT recommended exploring a multi-disciplinary, coordinated response when working with families who have dynamic and complex issues. The CFRT noted that it would be beneficial to have coordinated, strategic partnerships between law enforcement, mental health, domestic violence advocates, trauma-informed specialists, and departments of human services who could focus on specialized interventions and the needs of each individual family when responding and working together.
- The CFRT and CFPS Joint Recommendation: Support policies that ensure access to stable, quality, and affordable child care, especially for infants and young children.
- 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.

Joint Recommendations: Colorado's 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. Statute requires, as a result of that collaboration, the two child fatality review teams make joint recommendations.

Previous joint recommendations made by the CFRT and CFPS (and already referenced in this report) include:

- Support policies that ensure access to stable, quality, and affordable child care, especially for infants and young children.
- Support policies that expand access to community-based home visiting programs for all families with infants and young children.
- Provide information to parents and communities in their preferred language about the risks associated with substance misuse and overdose and evidence-informed strategies to reduce these risks, including:
 - How to access and use naloxone and fentanyl test strips;
 - How to respond to a suspected drug overdose, including information on Colorado's Good Samaritan Law;
 - How to safely store and dispose of both prescription and illegal drugs;
 - How to avoid accidental ingestion of drugs by young children; and
 - How to have conversations with children about overdose and poisoning prevention in age-appropriate ways.
- Support evidence-based firearm safety practices by reducing access to firearms through safe storage and increasing access to affordable gun safety resources.

This year's joint recommendation with CFPS is:

- Improve outcomes for childbearing parents and enhance family well-being across Colorado by ensuring equitable access to evidence-based services and providing new parent resource kits that will deliver essential resources and culturally relevant support and education to caregivers.

Recently Completed Recommendations

Staff from the CFRT and the Colorado Department of Human Service's Division of Child Welfare (DCW) meet regularly to discuss the progress made on all of the recommendations made during the CFRT incident reviews. The following recommendations have recently been marked completed:

- The CFRT 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.
 - CDHS reviewed the current mandatory training provided through the CO4Kids website, which offers a comprehensive explanation of injuries and how to identify them.
- The CFRT recommended for the team to draft a letter to law enforcement explaining the benefits of reviewing fatal, near fatal, and egregious incidents more timely in an effort for the law enforcement records to be released to the counties more timely for the purpose of reviewing the incident.
 - CDHS wrote the recommended letter and distributed it to the county child welfare departments throughout the state.
- The CFRT recommended 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.
 - CDHS has partnered with a national non-profit organization to provide additional recruitment and support to foster parents, focusing on the foster and adoptive families who serve, or are open to serving, children and youth who identify as LGBTQIA2S+.
- 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.
 - CDHS reviewed the National Training and Development Curriculum (NTDC), which provides trainings from a trauma-informed lens. Their trainings are part of the annual training requirements for foster and adoptive parents in Colorado.

Conclusion

The 2024 CFRT Annual Report contextualized the information learned through the 43 fatal, near fatal, and egregious incidents of child maltreatment that were reviewed by the multidisciplinary team in CY 2024. By analyzing the data through the lens of the Socio-Ecological Model, clusters of contributing factors that impacted children and families throughout Colorado were identified.

Themes of caregiver relationships, child characteristics, substance abuse, financial stress, and caregiver mental health were identified most frequently through the 43 incidents reviewed. The theme for caregiver relationships was identified individually and in conjunction with each of the remaining contributing factor themes, while financial stress was never identified as the sole contributing factor theme related to fatal, near fatal, or egregious child maltreatment. Of note, the majority of the incidents reviewed had at least two or more combinations of the contributing factor themes.

The recommendations made by the CFRT highlight the correlations between the identified contributing factor themes and the need for changes and improvements to communities, systems, and policies that regularly intersect with children and families. Overall, improving the lives and protective capacities of Colorado's children and families will assist in mitigating future incidents of fatal, near fatal, and egregious child maltreatment.

Together, we can make a difference.

Appendices

Appendix A: The Socio-Ecological Model (SEM)

There are many factors that help create the circumstances under which child maltreatment occurs, including personal histories of abuse, family dynamics, and access to social services. The socio-ecological model (SEM) is a framework that illuminates how these different factors come together in a layered fashion to create a unique set of circumstances for each individual child and family. It is important to understand how interactions among these different factors can lead to child maltreatment, including those at the fatal, near-fatal, and egregious severity levels.

The ultimate goal is to prevent these incidents of maltreatment before they occur, and the SEM framework is a useful tool for helping policy makers and practitioners identify points of intervention. The U.S. Department of Health and Human Services uses a five-level SEM framework to understand the complex interactions between multiple layers of factors that influence an individual's degree of risk of experiencing or perpetrating violence. The key to identifying points of intervention is understanding that any intervention must act across multiple layers to be effective and sustainable.

- **Individual:** Individual factors such as age, education, income, substance use, or history of abuse may influence one's risk of experiencing or perpetrating violence. For example, children under one year of age are most at-risk of becoming victims of violence. A caregiver who regularly attends a parenting support group may be less likely to inflict violence. Therefore, individual-level prevention strategies may include approaches that promote attitudes, beliefs, and behaviors that prevent violence.
- **Interpersonal:** Interactions with family members, peers, and others may also influence one's risk of experiencing or perpetrating violence. For example, a caregiver's interactions, or lack thereof, with other caregivers in their child's peer group may affect their behavior toward a child in their care. Interpersonal-level prevention strategies may include educational or mentoring programming designed to strengthen coping and problem-solving skills to promote healthy relationships.

- **Community:** The community settings in which social interactions occur (such as schools, workplaces, and neighborhoods) and the joint effects of these settings may influence one's risk of experiencing or perpetrating violence. For example, children who attend formal childcare may have different interactions with their caregivers at home because of the interactions both they and their caregivers have with childcare staff. Community-level prevention strategies may include improving physical and social settings to promote safety and by addressing other local conditions that give rise to violence (e.g., neighborhood poverty, residential segregation and housing instability).
- **Institutional:** At the institutional level, institutions such as schools, childcare centers, law enforcement agencies, healthcare facilities, and social service agencies play a critical role in preventing or contributing to child maltreatment. These organizations create environments in which children and families interact and play a role in identifying and responding to child maltreatment. As such, their policies, practices, and culture can significantly impact child safety and well-being. For example, a lack of proper staff training on recognizing and reporting signs of abuse, high staff turnover, and inadequate collaboration across systems can increase risk. While stronger safety protocols, collaboration and trauma informed care can serve to create systems of protection around children.
- **Societal/Cultural:** Formal and informal social systems in which individuals and communities are embedded help define a climate in which violence is encouraged or inhibited. These systems include health and entitlement services, transportation systems, educational policy, and social networks whose norms help define acceptable ways to resolve conflicts, which may or may not include violence. Societal-level prevention strategies may include formal policies that increase access to parenting classes and support or mental health treatment and informal approaches such as promoting norms of positive parenting.

The layered SEM framework illustrates that no single factor influences individuals and families in isolation from other factors. Therefore, we expect that policies and initiatives that address multiple layers will have the most impact on preventing child maltreatment. Many of the CFRT recommendations attempt to address the complex interactions that occur within these multiple layers of influence.

Appendix B: Statewide Incidents Reported Over Time

Appendix B includes Table B1, which shows the number of fatal, near fatal, and egregious incidents occurring from CYs 2020-2024, regardless of whether the incident was substantiated or met criteria for CFRT review.

Table B1: Fatal, Near Fatal, and Egregious Incidents Reported in CYs 2020-2024				
Calendar Year	Fatal Incidents	Near Fatal Incidents	Egregious Incidents	Total Incidents
2020	60	35	31	126*
2021	77	27	29	133**
2022	59	31	26	116***
2023	61	42	58	161
2024	58	35	31	124

*There was one egregious incident and one fatal incident 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.

Appendix C: Total Statewide Substantiated Incidents

Appendix C includes Table C1, which shows the number of substantiated fatal, near fatal, and egregious incidents occurring from CYs 2020-2024, regardless of whether the incident met criteria for CFRT review.

Table C1: Fatal, Near Fatal, and Egregious Substantiated Incidents in CYs 2020-2024				
Calendar Year	Fatal Incidents	Near Fatal Incidents	Egregious Incidents	Total Incidents
2020	29	28	29	86
2021	33	17	27	77 [^]
2022	35	25	22	82 ^{^^}
2023	30	39	48	117
2024	31	24	28	83

[^]The number of substantiated incidents for 2021 is different from what was published in previous annual reports, as there were two fatalities and one egregious incident that were reported after the finalization of the 2021 Annual Report.

^{^^}The number of substantiated incidents for 2022 is different from what was published in previous annual reports, as there were two fatalities, involving three children, that were reported after the finalization of the 2022 Annual Report.

Appendix D: Incidents Meeting Statutory Criteria to be Reviewed by CFRT Over Time

Appendix D includes Table D1, which shows the number of substantiated fatal, near fatal, and egregious incidents occurring from CYs 2020-2024 that met the criteria for review by the CFRT.

Table D1: Fatal, Near Fatal, and Egregious Incidents that Met Criteria for CFRT Review in CYs 2020-2024				
Calendar Year	Fatal Incidents	Near Fatal Incidents	Egregious Incidents	Total Incidents
2020	22	14	18	54
2021	21	13	19	53 [^]
2022	27	17	11	55 ^{^^}
2023	20	30	26	76
2024	21	17	17	55

[^]The fatal incidents, egregious incidents, and total incident numbers for 2021 are different from what was published in the previous annual 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 annual reports, as one fatal incident involving two children was reported, substantiated, and reviewed after the finalization of the 2022 Annual Report.

Appendix E: Age of Victims in CY 2024

Appendix E includes Table E1, which shows age at the time of the incident of the 102 victims in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in CY 2024. Most of the victims in substantiated child maltreatment fatalities, near fatalities, and egregious were less than one year old.

Table E1: Age of Victims in Substantiated Fatal, Near Fatal, and Egregious Incidents in CY 2024						
Age	Fatal	% of Fatal	Near Fatal	% of Near Fatal	Egregious	% of Egregious
Less than one	15	44.1%	7	28.0%	16	37.2%
One	4	11.8%	3	12.0%	4	9.3%
Two	2	5.9%	5	20.0%	2	4.7%
Three	4	11.8%	2	8.0%	2	4.7%
Four	0	0.0%	2	8.0%	3	7.0%
Five	1	2.9%	2	8.0%	3	7.0%
Six	0	0.0%	0	0.0%	0	0.0%
Seven	3	8.8%	1	4.0%	4	9.3%
Eight	0	0.0%	1	4.0%	2	4.7%
Nine	3	8.8%	1	4.0%	3	7.0%
Ten	1	2.9%	0	0.0%	1	2.3%
Eleven	0	0.0%	0	0.0%	0	0.0%
Twelve	1	2.9%	1	4.0%	0	0.0%
Thirteen	0	0.0%	0	0.0%	1	2.3%
Fourteen	0	0.0%	0	0.0%	1	2.3%
Fifteen	0	0.0%	0	0.0%	1	2.3%
Sixteen	0	0.0%	0	0.0%	0	0.0%
Seventeen	0	0.0%	0	0.0%	0	0.0%

Appendix F: Age of Victims through Time

Appendix F shows the age of substantiated victims in child maltreatment fatal (Table F1), near fatal (Table F2) and egregious (Table F3) incidents in Colorado over the past five CYs 2020-2024.

Table F1 provides information related to the age of victims in substantiated fatal incidents between CYs 2020-2024. The information shows that during this 5-year period, most of the victims were less than one year old.

Table F1: Age of Victims in Substantiated Fatal Incidents Through Time					
Age	2020	2021	2022	2023	2024
Less than 1 year	11 (37.9%)	13 (36.1%)	12 (33.3%)	15 (48.4%)	15 (44.1%)
1	4 (13.8%)	8 (22.2%)	5 (13.9%)	5 (16.1%)	4 (11.8%)
2	1 (3.4%)	2 (5.6%)	1 (2.8%)	2 (6.5%)	2 (5.9%)
3	4 (13.8%)	2 (5.6%)	3 (8.3%)	1 (3.2%)	4 (11.8%)
4-6	2 (6.9%)	5 (13.9%)	8 (22.2%)	3 (9.7%)	1 (2.9%)
7-9	2 (6.9%)	0 (0%)	2 (5.6%)	2 (6.5%)	6 (17.6%)
10-12	4 (13.8%)	4 (11.1%)	2 (5.6%)	0 (0.0%)	2 (5.9%)
13 years or older	1 (3.4%)	2 (5.6%)	3 (8.3%)	3 (9.7%)	0 (0%)

Table F2 provides information related to the age of victims in substantiated near fatal incidents between CYs 2020-2024. The information shows that during this 5-year period, most of the victims were less than one year old.

Table F2: Age of Victims in Substantiated Near Fatal Incidents Through Time					
Age	2020	2021	2022	2023	2024
Less than 1 year	20 (69%)	11 (57.9%)	12 (48%)	20 (48.8%)	7 (28%)
1	3 (10.3%)	5 (26.3%)	2 (8%)	11 (26.8%)	3 (12%)
2	1 (3.4%)	0 (0%)	5 (20%)	0 (0%)	5 (20%)
3	1 (3.4%)	1 (5.3%)	0 (0%)	3 (7.3%)	2 (8%)
4-6	2 (6.9%)	1 (5.3%)	4 (16%)	4 (9.8%)	4 (16%)
7-9	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (12%)
10-12	0 (0%)	0 (0%)	2 (8%)	3 (7.3%)	1 (4%)
13 years or older	2 (6.9%)	1 (5.3%)	0 (0%)	0 (0%)	0 (0%)

Table F3 provides information related to the age of victims in substantiated egregious incidents between CYs 2020-2024. The information shows that during this 5-year period, most of the victims were less than one year old.

Table F3: Age of Victims in Substantiated Egregious Incidents Through Time					
Age	2020	2021	2022	2023	2024
Less than 1 year	18 (42.9%)	9 (25%)	9 (26.5%)	33 (51.6%)	16 (37.2%)
1	2 (4.8%)	4 (11.1%)	2 (5.9%)	1 (1.6%)	4 (9.3%)
2	3 (7.1%)	4 (11.1%)	3 (8.8%)	1 (1.6%)	2 (4.7%)
3	0 (0%)	1 (2.8%)	0 (0%)	2 (3.1%)	2 (4.7%)
4-6	3 (7.1%)	5 (13.9%)	6 (17.6%)	5 (7.8%)	6 (14%)
7-9	5 (11.9%)	6 (16.7%)	5 (14.7%)	6 (9.4%)	9 (20.9%)
10-12	6 (14.3%)	3 (8.3%)	6 (17.6%)	3 (4.7%)	1 (2.3%)
13 years or older	5 (11.9%)	4 (11.1%)	3 (8.8%)	13 (20.3%)	3 (7%)

Appendix G: Race/Ethnicity of Victims in CY 2024

Appendix G includes Table G1, which shows the race/ethnicity of the 102 victims in all substantiated fatal, near fatal, and egregious incidents of child maltreatment in Colorado for CY 2024. 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.

Table G1 shows that the most frequent race/ethnicity identified was Hispanic for fatal incidents (47.1%) followed by White (38.2%). The most frequent race/ethnicity identified for near fatal incidents was Hispanic (56%) followed by White (28%). The most frequent race/ethnicity for egregious incidents was White (37.2%) followed by Hispanic (37.2%).

Race/Ethnicity	Fatal	% of Fatal	Near Fatal	% of Near Fatal	Egregious	% of Egregious
Hispanic	16	47.1%	14	56.0%	14	32.6%
White	13	38.2%	7	28.0%	16	37.2%
Black or African American	2	5.9%	3	12.0%	10	23.3%
Missing/Unknown	2	5.9%	0	0.0%	0	0.0%
Asian	1	2.9%	0	0.0%	0	0.0%
Native American	0	0.00%	0	0.00%	0	0.00%
Native Hawaiian/Other Pacific Islander	0	0.0%	0	0.0%	2	4.7%
Multiracial	0	0.0%	1	4.0%	1	2.3%

Appendix H: Race/Ethnicity of Victims through Time

Appendix H shows the race/ethnicity of victims in all substantiated child maltreatment fatal (Table H1), near fatal (Table H2), and egregious (Table H3) incidents in Colorado over the past five CYs 2020-2024. 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.

Table H1 shows the race/ethnicity of victims in all substantiated child maltreatment fatal incidents in Colorado over the past five calendar years (2020-2024). The most frequent race/ethnicity identified for CYs 2020-2023 was White. This changed in CY 2024 when the most frequent race/ethnicity for fatal incidents was Hispanic (47.1%) followed by White (38.2%).

Table H1: Race/Ethnicity of Victims in Substantiated Fatal Incidents Through Time					
Year	2020	2021	2022	2023	2024
White	15 (51.7%)	13 (36.1%)	12 (33.3%)	17 (54.8%)	13 (38.2%)
Asian	0 (0%)	1 (2.8%)	0 (0%)	0 (0%)	1 (2.9%)
Black or African American	4 (13.8%)	3 (8.3%)	7 (19.4%)	2 (6.5%)	2 (5.9%)
Native Hawaiian/Other Pacific Islander	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
American Indian or Alaska	0 (0%)	0 (0%)	1 (2.8%)	0 (0%)	0 (0%)
Multiracial	3 (10.3%)	5 (13.9%)	3 (8.3%)	1 (3.2%)	0 (0%)
Hispanic	7 (24.1%)	8 (22.2%)	10 (27.8%)	9 (29%)	16 (47.1%)
Missing or Unknown	0 (0%)	6 (16.7%)	3 (8.3%)	2 (6.5%)	2 (5.9%)

Table H2 shows the race/ethnicity of victims in all substantiated child maltreatment near fatal incidents in Colorado over the past five CYs 2020-2024. Between CYs 2020-2021, White was the most frequent race/ethnicity for victims in near fatal incidents. Since 2022, the trends show Hispanic and White as the most frequent ethnicity for victims in near fatal incidents.

Table H2: Race/Ethnicity of Victims in Substantiated Near Fatal Incidents Through Time					
Year	2020	2021	2022	2023	2024
White	14 (48.3%)	9 (47.4%)	7 (28%)	8 (19.5%)	7 (28%)
Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Black or African American	4 (13.8%)	1 (5.3%)	5 (20%)	7 (17.1%)	3 (12%)
Native Hawaiian/Other Pacific Islander	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
American Indian or Alaska	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Multiracial	6 (20.7%)	1 (5.3%)	2 (8.0%)	4 (9.8%)	1 (4%)
Hispanic	5 (17.2%)	6 (31.6%)	10 (40%)	20 (48.8%)	14 (56%)
Missing or Unknown	0 (0%)	2 (10.5%)	1 (4%)	2 (4.9%)	0 (0%)

Table H3 shows the race/ethnicity of victims in all substantiated egregious child maltreatment incidents in Colorado over the past five CYs 2020-2024. During this time frame, the most frequent race/ethnicity for victims in all substantiated egregious child maltreatment was White, with the exception of 2022, when the most frequent race/ethnicity for victims in all substantiated egregious incidents was Hispanic.

Table H3: Race/Ethnicity of Victims in Substantiated Egregious Incidents Through Time					
Year	2020	2021	2022	2023	2024
White	17 (40.5%)	10 (27.8%)	7 (20.6%)	28 (43.8%)	16 (37.2%)
Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Black or African American	7 (16.7%)	7 (19.4%)	3 (8.8%)	5 (7.8%)	10 (23.3%)
Native Hawaiian/Other Pacific Islander	1 (2.4%)	0 (0%)	0 (0%)	0 (0%)	2 (4.7%)
American Indian or Alaska	0 (0%)	0 (0%)	0 (0%)	1 (1.6%)	0 (0%)
Multiracial	4 (9.5%)	7 (19.4%)	3 (8.8%)	3 (4.7%)	1 (2.3%)
Hispanic	12 (28.6%)	7 (19.4%)	18 (52.9%)	23 (35.9%)	14 (32.6%)
Missing or Unknown	1 (2.4%)	5 (13.9%)	3 (8.8%)	4 (6.3%)	0 (0%)

Appendix I: Sex of Victims in CY 2024

Appendix I includes Table I1 which shows the sex of the 102 victims in substantiated fatal, near fatal, and egregious child maltreatment incidents in Colorado for CY 2024. During CY 2024, victims were identified as male at a higher rate than females in all types of incidents: Fatal (55.9%), Near Fatal (60%), and Egregious (53.5%).

Table I1: Sex of Substantiated Victims of Fatal, Near Fatal, and Egregious Incidents in CY 2024						
Sex	Fatal	% of Fatal	Near Fatal	% of Near Fatal	Egregious	% of Egregious
Male	19	55.9%	15	60.0%	23	53.5%
Female	15	44.1%	10	40.0%	20	46.5%

Appendix J: Sex of Victims through Time

Appendix J shows the sex of victims in all substantiated fatal (Table J1), near fatal (Table J2) and egregious (Table J3) child maltreatment incidents in Colorado over the past five CYs 2020-2024.

Table J1 provides information about the sex of victims in substantiated fatal incidents for CYs 2020-2024. There were more male victims during four of the five years. There were more female victims in CY 2022.

Table J1: Sex of Victims in Substantiated Fatal Incidents Through Time					
Year	2020	2021	2022	2023	2024
Female	9 (31%)	16 (44.4%)	19 (52.8%)	9 (29%)	15 (44.1%)
Male	20 (69%)	20 (55.6%)	17 (47.2%)	22 (71.0%)	19 (55.9%)
Total	29	36	36	31	34

Table J2 provides information about the sex of victims in substantiated near fatal incidents for CYs 2020-2024. There is no consistent trend regarding the sex of victims for this period. There were more male victims for CYs 2021, 2022, and 2024, while there were more female victims for CYs 2020 and 2023.

Table J2: Sex of Victims in Substantiated Near Fatal Incidents Through Time					
Year	2020	2021	2022	2023	2024
Female	18 (62.1%)	4 (21.1%)	10 (40%)	24 (58.5%)	10 (40%)
Male	11 (37.9%)	15 (78.9%)	15 (60%)	17 (41.5%)	15 (60%)
Total	29	19	25	41	25

Table J3 provides information about the sex of victims in substantiated egregious incidents for CYs 2020-2024. There were more male victims for the CYs 2020, 2021, and 2024, while there were more female victims in 2022. In 2023, there was no difference in the sex of victims.

Table J3: Sex of Victims in Substantiated Egregious Incidents Through Time					
Year	2020	2021	2022	2023	2024
Female	20 (47.6%)	15 (41.7%)	19 (55.9%)	32 (50%)	20 (46.5%)
Male	22 (52.4%)	21 (58.3%)	15 (44.1%)	32 (50%)	23 (53.5%)
Total	42	36	34	64	43

Appendix K: Income and Education Level of Legal Caregivers in CY 2024

The income and education level of legal caregivers, 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. In CY 2024, there were 75 unique legal caregivers involved in the 43 reviewed incidents of fatal, near fatal, and egregious child maltreatment.

Income and education level information about the legal caregivers continues to prove difficult to collect and report on, as it is not always part of the available documentation from county child welfare departments.

Income information was only known for 6 out of the 75 (8%) legal caregivers. Of those caregivers with known income information, the average known income was:

- \$0.00 for fatal incidents
- No known income for near fatal incidents
- \$13,775 for egregious incidents

Educational level was known for 29 out of the 75 (38.6%) legal caregivers. Of the known education levels, the most common education level was:

- Associates/Vocational Degree (3 out of 25 legal caregivers) for fatal incidents
- Less than a High School Diploma or (General Educational Development) GED (3 out of 22 legal caregivers) for near fatal incidents
- High School Diploma or GED (8 out of 28 legal caregivers) for egregious incidents

Appendix L: Family Structures in CY 2024

Appendix L includes Table L1, which shows the family structure of the 102 victims of substantiated fatal, near fatal, and egregious child maltreatment incidents in CY 2024.

Table L1 shows that the most frequent family structure for victims of fatal incidents was one parent (38.2%), followed by two parents (32.4%). The most frequent family structure for victims of near fatal incidents was two parents (44%), followed by one parent (20%). The most frequent family structure for victims of egregious incidents was two parents (53.5%), followed by one parent (16.3%).

Table L1: Family Structure of Substantiated Victims in Fatal, Near Fatal, and Egregious Incidents in CY 2024						
Family Structure	Fatal	% of Fatal	Near Fatal	% of Near Fatal	Egregious	% of Egregious
One parent	13	38.2%	5	20.0%	7	16.3%
Two parents	11	32.4%	11	44.0%	23	53.5%
Two parents and relatives	5	14.7%	0	0.0%	4	9.3%
One parent and one related caregiver	2	5.9%	0	0.0%	1	2.3%
One parent and one unrelated caregiver	1	2.9%	3	12.0%	4	9.3%
Two related caregivers	1	2.9%	0	0.0%	2	4.7%
One parent and relatives	1	2.9%	4	16.0%	2	4.7%
One related caregiver	0	0.0%	1	4.0%	0	0.0%
One unrelated caregiver	0	0.0%	0	0.0%	0	0.0%
One legal caregiver with relatives and one unrelated caregiver	0	0.0%	0	0.0%	0	0.0%
One related caregiver and one unrelated caregiver	0	0.0%	0	0.0%	0	0.0%
Foster Care	0	0.0%	1	4.0%	0	0.0%

Appendix M: Perpetrator Relationships in CY 2024

Appendix M includes Table M1, which provides information about the perpetrators' relationships to the 102 victims of substantiated fatal, near fatal, and egregious child maltreatment incidents in CY 2024.

Table M1 shows that fathers and mothers were identified most often as the perpetrator for victims of fatal, near fatal, and egregious incidents, with fathers identified in 61.8% of fatal incidents and mothers identified in 52.9% of fatal incidents, mothers identified in 60% of near fatal incidents and fathers identified in 44% of near fatal incidents, and fathers identified in 62.8% of egregious incidents and mothers identified in 51.2% of egregious incidents.

Note: More than one perpetrator may exist for each child.

Table M1: Perpetrator Relationship of Substantiated Victims in Fatal, Near Fatal, and Egregious Incidents in CY 2024						
Perpetrator Relationship	Fatal	% of Fatal	Near Fatal	% of Near Fatal	Egregious	% of Egregious
Father	21	61.8%	11	44.0%	27	62.8%
Mother	18	52.9%	15	60.0%	22	51.2%
Partner of Parent (Female)	2	5.9%	0	0.0%	0	0.0%
Relative (Female)	2	5.9%	2	8.0%	4	9.3%
Relative (Male)	1	2.9%	0	0.0%	0	0.0%
Sibling (Male)	1	2.9%	0	0.0%	0	0.0%
Unknown	1	2.9%	2	8.0%	1	2.3%
Partner of Parent (Male)	0	0.0%	1	4.0%	6	14.0%
Legal Guardian (Female)	0	0.0%	1	4.0%	0	0.0%
Foster Parent (Non-Relative)	0	0.0%	1	4.0%	0	0.0%

Appendix N: Prior Child Welfare Involvement of Families through Time

Appendix N includes details of prior child welfare involvement of families in fatal (Table N1), near fatal (Table N2), and egregious (Table N3) incidents of child maltreatment in Colorado over the past five CYs 2020-2024.

Table N1 shows the prior child welfare involvement of families in fatal incidents in Colorado over CYs 2020-2024.

Table N1: Prior Child Welfare Involvement in Substantiated Fatal Incidents Through Time					
Year	2020	2021	2022	2023	2024
No prior history	7 (24.1%)	12 (36.4%)	8 (22.9%)	10 (33.3%)	10 (32.3%)
Screened Out Referral Only	2 (6.9%)	6 (18.2%)	5 (14.3%)	5 (16.7%)	6 (19.4%)
Prior/Current Assessment	13 (44.8%)	11 (33.3%)	13 (37.1%)	10 (33.3%)	7 (22.6%)
Prior/Current Case	7 (24.1%)	4 (12.1%)	9 (25.7%)	5 (16.7%)	8 (25.8%)
Prior/Current DYC Case	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	29	33	35	30	31

Table N2 shows the prior child welfare involvement of families in near fatal incidents in Colorado over CYs 2020-2024.

Table N2: Prior Child Welfare Involvement in Substantiated Near Fatal Incidents Through Time					
Year	2020	2021	2022	2023	2024
No prior history	14 (50%)	4 (23.5%)	8 (32%)	9 (23.1%)	7 (29.2%)
Screened Out Referral Only	0 (0%)	0 (0%)	4 (16%)	3 (7.7%)	3 (12.5%)
Prior/Current Assessment	8 (28.6%)	7 (41.2%)	7 (28%)	20 (51.3%)	10 (41.7%)
Prior/Current Case	6 (21.4%)	6 (35.3%)	6 (24%)	7 (17.9%)	4 (16.7%)
Prior/Current DYC Case	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	28	17	25	39	24

Table N3 shows the prior child welfare involvement of families in egregious incidents in Colorado over CYs 2020-2024.

Table N3: Prior Child Welfare Involvement in Substantiated Egregious Incidents Through Time					
Year	2020	2021	2022	2023	2024
No prior history	11 (37.9%)	9 (32.1%)	11 (50%)	22 (45.8%)	11 (39.3%)
Screened Out Referral Only	5 (17.2%)	4 (14.3%)	1 (4.5%)	8 (16.7%)	5 (17.9%)
Prior/Current Assessment	9 (31%)	13 (46.4%)	6 (27.3%)	14 (29.2%)	10 (35.7%)
Prior/Current Case	4 (13.8%)	2 (7.1%)	4 (18.2%)	4 (8.3%)	2 (7.1%)
Prior/Current DYC Case	0 (0%)	0	0 (0%)	0 (0.0%)	0 (0.0%)
Total	29	28	22	48	28

Appendix O: Systemic Strengths

Table O1 provides information about the systemic strengths and collaborative partners identified during the 43 incidents reviewed in CY 2024. The most frequent strength identified was case practice of county departments of human services staff. This strength was identified in 28 (65%) of the incidents reviewed.

Table O1: The Systemic Strengths and Collaborative Partners Identified During the 43 Incidents Reviewed in CY 2024								
Strength	Law Enforcement	Medical Care/Medical Provider	County DHS and Other Entities	County DHS	Family and Friends	CDHS-DCW	School System	DYS Client Manager
Collaboration	2	2	15	1	0	0	0	0
Documentation	0	0	0	1	0	0	0	0
Engagement with Family	0	1	1	1	2	0	0	0
Case Practice	0	0	3	28	3	2	0	1
Safety	1	3		2	5	0	0	0
Services to Children and Families	1	2	2	3	5	0	2	0

Appendix P: 2024 CFRT Attendance

Table O1 provides information about the Child Fatality Review Team members and their attendance throughout CY 2024.

2024 CFRT Membership Attendance												
CFRT Member and Role	1/8 2024	2/5 2024	3/4 2024	4/1 2024	5/6 2024	6/3 2024	7/1 2024	8/5 2024	9/9 2024	10/8 2024	11/4 2024	12/2 2024
Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.												
Cheryl Hyink Administrative Review Division, CFRT Manager CDHS Appointee (1 of 3): 26-1-139 6(a)	NA	NA	Yes	Yes	Yes	NA	Yes	Yes	Yes	---	Yes	Yes
→Backup: Marc Mackert, Administrative Review Division, Director	Yes	Yes	Yes	---	Yes	NA	Yes	Yes	Yes	Yes	Yes	---
April Jenkins CDHS, Child Protection and Prevention Services Unit Manager CDHS Appointee (1 of 3): 26-1-139 6(a)	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	No	---	Yes

2024 CFRT Membership Attendance

[illegible]

2024 CFRT Membership Attendance

CFRT Member and Role	1/8 2024	2/5 2024	3/4 2024	4/1 2024	5/6 2024	6/3 2024	7/1 2024	8/5 2024	9/9 2024	10/8 2024	11/4 2024	12/2 2024
Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.												
Josefina Raphael-Milliner Executive Director of Advocates for Children CASA - Child Advocacy Team Appointee (1 of 8): 26-1-139 6(d)	No	Yes	Yes	No	No	NA	Yes	No	No	No	No	Yes
Heather Porter School Social Worker, Sheridan School District - Education Team Appointee (1 of 8): 26-1-139 6(d)	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes
Nicole Adams Douglas County Department of Human Services - Child Protection Team Appointee (1 of 8): 26-1-139 6(d)	No	Yes	Yes	Yes	Yes	NA	Yes	No	Yes	No	Yes	Yes
→Backup: Ruby Richards	---	---	---	---	---	---	---	---	---	---	---	---
→Backup: Molly Stegink	---	---	---	---	---	---	---	---	---	---	Yes	---
Michael Stumph Fremont County Department of Human Services - Child Protection CDHSDA Appointee (1 of 2): 26-1-139 6(d)	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	No	Yes	No

2024 CFRT Membership Attendance												
CFRT Member and Role	1/8 2024	2/5 2024	3/4 2024	4/1 2024	5/6 2024	6/3 2024	7/1 2024	8/5 2024	9/9 2024	10/8 2024	11/4 2024	12/2 2024
Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.												
Alysse Nemecek Jefferson County Department of Human Services - Child Protection CDHSDA Appointee (1 of 2): 26-1-139 6(d)	Yes	---	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes
→Backup: Erin Dowler	---	Yes	---	---	---	---	---	---	---	---	---	---
Cheryl Hyink Administrative Review Division CFRT Staff	Yes	Yes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Angela Myers Administrative Review Division CFRT Staff	Yes	No	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes
Nada Pavlovich Administrative Review Division CFRT Staff	No	No	No	Yes	No	NA	Yes	No	Yes	Yes	Yes	Yes
Priscilla Gonzales Administrative Review Division CFRT Staff	NA	NA	NA	NA	NA	NA	NA	NA	Yes	Yes	Yes	Yes

2024 CFRT Membership Attendance												
CFRT Member and Role	1/8 2024	2/5 2024	3/4 2024	4/1 2024	5/6 2024	6/3 2024	7/1 2024	8/5 2024	9/9 2024	10/8 2024	11/4 2024	12/2 2024
Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.												
Niki Rust Attorney General's Office	Yes	---	Yes	---	Yes	NA	Yes	---	Yes	Yes	---	Yes
Nicole Chaney Attorney General's Office	---	Yes	---	Yes	---	NA	---	Yes	---	---	Yes	---

*Did not attend the meeting but sent in notes.

**Member and their Backup split the meeting.

All 2024 Meetings were held virtually.

Appendix Q: 2020-2024 Incidents Qualified for CFRT Review by County and Type

Table Q1 provides information about the number of fatal incidents that qualified for CFRT Review, by county, in CYs 2020-CY 2024. Fatal incidents are rare, with higher numbers generally occurring in counties with larger populations.

Table Q1: Fatal Incidents that Qualified for CFRT Review, by County, CYs 2020-2024					
County*	2020	2021	2022	2023	2024
Adams	1	4	4	6	3
Arapahoe	0	3	2	1	3
Archuleta	0	0	0	0	0
Broomfield	0	0	0	0	0
Boulder	0	0	0	1	2
Chaffee	0	0	0	0	0
Crowley	0	2	0	0	0
Delta	0	0	0	0	1
Denver	5	3	4	3	3
Dolores	0	0	0	0	1
Douglas	0	0	1	1	1
Eagle	0	0	0	0	0
Elbert	0	0	1	0	0
El Paso	7	3	8	3	1
Fremont	0	0	0	1	0
Garfield	0	1	0	0	0
Huerfano	0	0	0	0	0
Jefferson	5	0	1	1	3
Kit Carson	0	0	0	0	1
La Plata	0	0	0	0	0
Larimer	0	1	5	1	0
Las Animas	0	0	0	0	0

Table Q1: Fatal Incidents that Qualified for CFRT Review, by County, CYs 2020-2024					
County*	2020	2021	2022	2023	2024
Mesa	0	1	0	0	1
Moffat	0	1	0	0	0
Montezuma	0	0	0	0	0
Montrose	0	0	0	0	0
Morgan	1	1	0	0	0
Otero	0	0	0	0	1
Park	0	0	0	0	0
Pueblo	2	0	0	1	0
Saguache	1	0	0	0	0
San Miguel	0	0	0	0	0
Teller	0	0	0	1	0
Weld	0	1	1	0	0
Total	22	21	27	20	21

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

Table Q2 provides information about the number of near fatal incidents that qualified for CFRT review, by county, in CYs 2020-2024. Near fatal incidents are rare, with higher numbers generally occurring in counties with larger populations. No county experienced 10 or more near fatal incidents within a year.

Table Q2: Near Fatal Incidents that Qualified for CFRT Review, by County, CYs 2020-2024					
County*	2020	2021	2022	2023	2024
Adams	0	0	2	3	3
Alamosa	0	0	0	1	0
Arapahoe	2	1	2	0	1
Broomfield	0	0	0	0	0
Boulder	0	0	0	2	0
Denver	2	6	2	9	3
Douglas	0	0	0	0	0
El Paso	4	2	4	5	4
Fremont	0	1	1	0	0
Jefferson	3	0	1	2	2
La Plata	0	0	0	0	0
Larimer	0	1	0	1	0
Mesa	0	0	1	2	2
Moffat	0	0	0	0	0
Montezuma	0	0	1	0	0
Montrose	0	0	0	1	0
Morgan	0	0	0	0	0
Park	0	0	0	2	0
Prowers	1	0	0	0	0
Pueblo	0	1	1	1	2
Rio Blanco	0	1	0	1	0
Routt	0	0	0	0	0
Teller	0	0	0	0	0
Weld	2	0	2	0	0
Total	14	13	17	30	17

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

Table Q3 provides information about the number of egregious incidents that qualified for CFRT review, by county, in CYs 2020-2024. Egregious incidents are rare, with many counties reporting 0 or 1 incident per year. Higher numbers of incidents occurred in counties with larger populations.

Table Q3: Egregious Incidents that Qualified for CFRT Review, by County, CYs 2020-2024					
County*	2020	2021	2022	2023	2024
Adams	1	0	2	3	5
Arapahoe	1	1	1	1	0
Boulder	0	0	0	0	2
Delta	0	0	0	0	1
Denver	5	3	1	4	0
Douglas	0	2	0	0	1
Elbert	1	0	0	0	0
El Paso	6	9	3	9	7
Fremont	1	0	0	1	0
Garfield	0	0	1	0	0
Jefferson	2	0	2	1	1
La Plata	0	0	0	0	0
Larimer	0	0	0	3	0
Lincoln	0	0	0	0	0
Mesa	1	2	0	2	0
Morgan	0	0	0	1	0
Otero	0	1	0	0	0
Pueblo	0	0	0	1	0
Routt	0	0	0	0	0
Weld	0	1	1	0	0
Total	18	19	11	26	17

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

Table Q4 provides information about the total incidents that qualified for CFRT review, by county, in CYs 2020-2024. Fatal, near fatal, and egregious incidents are rare. Higher numbers of incidents occurred in counties with larger populations.

Table Q4: Total Incidents that Qualified for CFRT Review, by County, CYs 2020-2024					
County*	2020	2021	2022	2023	2024
Adams	2	4	8	12	11
Alamosa	0	0	0	1	0
Arapahoe	3	5	5	2	4
Archuleta	0	0	0	0	0
Broomfield	0	0	0	0	0
Boulder	0	0	0	3	4
Chaffee	0	0	0	0	0
Crowley	0	2	0	0	0
Delta	0	0	0	0	2
Denver	12	12	7	16	6
Dolores	0	0	0	0	1
Douglas	0	2	1	1	2
Eagle	0	0	0	0	0
Elbert	1	0	1	0	0
El Paso	17	14	15	17	12
Fremont	1	1	1	2	0
Garfield	0	1	1	0	0
Jefferson	10	0	4	4	6
Kit Carson	0	0	0	0	1
La Plata	0	0	0	0	0
Larimer	0	2	5	5	0
Las Animas	0	0	0	0	0
Lincoln	0	0	0	0	0
Mesa	1	3	1	4	3
Moffat	0	1	0	0	0
Montezuma	0	0	1	0	0
Montrose	0	0	0	1	0
Morgan	1	1	0	1	0
Otero	0	1	0	0	1

Table Q4: Total Incidents that Qualified for CFRT Review, by County, CYs 2020-2024					
County*	2020	2021	2022	2023	2024
Park	0	0	0	2	0
Prowers	1	0	0	0	0
Pueblo	2	1	1	3	2
Rio Blanco	0	1	0	1	0
Routt	0	0	0	0	0
Saguache	1	0	0	0	0
San Miguel	0	0	0	0	0
Teller	0	0	0	1	0
Weld	2	2	4	0	0
Total	54	53	55	76	55

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

Appendix R: Recommendations from 2024 Posted Reports

Appendix R contains Table R1, which provides information about the CFRT recommendations and status updates from reports posted in CY 2024. Of the seven recommendations, one has a status of complete, while the others remain in progress.

Table R1: CFRT Recommendations and Status Updates from Reports Posted in CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
24-007	CFRT	The CFRT made a formal recommendation for domestic relations court cases to look at the totality of a family's history, including child welfare allegations, criminal charges that are either dropped or dismissed, and criminal convictions before making custody decisions, in order to better understand the relationship dynamics and the impact those decisions will have on the children and caregivers.	In Progress
24-007	CFRT	The CFRT made a formal recommendation to explore existing domestic violence task groups that are looking at the broader, more systemic recommendations related to data collection, moving from risk to safety concerns, and the thresholds for lethality assessments. The aggregated data collected can help to discern historical and systemic domestic violence related trends in domestic relations, criminal, and child welfare cases.	In Progress
24-011	CFRT	The CFRT made a recommendation to have more drop-in daycare centers available throughout Colorado communities, which would help to make daycare more accessible for families who need the support and assistance.	In Progress
23-054	CFRT	The team recommended a thorough examination of current laws surrounding domestic violence, with a focus on how to hold perpetrators accountable for their action in order to help advocate for victims of domestic violence.	In Progress

Table R1: CFRT Recommendations and Status Updates from Reports Posted in CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
23-100	CFRT	<p>The team discussed that counties often find that they are limited by the 60 day assessment closure timeframe set out in 7.104.131 (A), “High Risk Assessments (HRA) or Traditional Response Assessment shall be approved by a certified supervisor and closed within sixty (60) calendar days of the date the referral was received.”</p> <p>County partners noted that in general the law enforcement investigation takes longer than 60 days and that if the assessment is closed timely, there may a wealth of information missing from the assessment. The team recommends continued support for a prior recommendation to allow more time for assessments at the fatal/near fatal/egregious severity levels to ensure that thorough assessments are being completed on these incidents.</p>	In Progress
21-131	CFRT	<p>The CFRT recommended for the team to draft a letter to law enforcement explaining the benefits of reviewing fatal, near fatal, and egregious incidents more timely in an effort for the law enforcement records to be released to the counties more timely for the purpose of reviewing the incident.</p>	Complete
18-042	CFRT	<p>The CFRT recommended that a training be developed regarding how to assess a caregiver’s lawful use of a substance and their parenting capacity in light of that use. The training should be specific to: methadone use, its contraindications with other medications/substances, what methadone abuse looks like, how methadone use/abuse can impact parenting capacity, and how caseworkers can create partnerships with methadone treatment providers.</p>	In Progress

Appendix S: Status Update for Recommendations from Previously Posted Reports

Table S1 provides information about the CFRT recommendations and status updates from reports posted prior to CY 2024. Six of the recommendations have been completed since the last annual report.

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
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.	In Progress
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.	In Progress
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.	In Progress
22-115	CFRT	The CFRT made a formal recommendation to review empirically supported domestic violence risk and lethality assessment tools to determine	In Progress

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
		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.	
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.	In Progress
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.	Considered and not implemented
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	In Progress

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
		options even more accessible and universal for Colorado's rural and frontier communities.	
21-022	CFRT	The CFRT recommended the continuation of a previous recommendation to support 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
21-058	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.	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

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
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.	Considered and not implemented
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
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

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
19-058	CFRT	The CFRT made a systemic recommendation that families have access to universal home visiting programs for families with newborn 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 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
18-070	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	In Progress

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024

CFRT ID	Recommendation Type	Recommendation	Status
		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.	
18-104	CFRT	The CFRT formally recommended for legislative changes to be made that would enhance and streamline the cooperation between county departments of human/social services and law enforcement in order to make those professional relationships more consistent and reciprocal across the state. The CFRT recommended exploring the possibility of creating a more defined legislative statement regarding the relationship between county departments of human/social services and law enforcement, which would also provide further guidance on what information could be shared between them to assist with their respective assessments and investigations.	In Progress
17-006	CFRT	It is recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	In Progress
17-039	CFRT	The CFRT recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information	In Progress

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
		sharing and collaboration regarding joint investigations/assessments.	
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	In Progress

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024

CFRT ID	Recommendation Type	Recommendation	Status
		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.	
15-006	CFRT	It is recommended that the Colorado Trails system be changed to alert caseworkers when a county staff member adds a client into demographics on a referral and/or assessment if that client is open in another Colorado Trails case/assessment/referral.	In Progress
15-006	Policy Finding	The Policy Finding related to not interviewing others who may have information regarding the alleged maltreatment during the assessment phase does reflect a systemic practice issue for Arapahoe County DHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of December 28, 2014 to June 28, 2015, showed that Arapahoe County DHS interviewed all required parties 60% of the time. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure improvement.	Complete
15-006	Policy Finding	The Policy Finding related to the assessment containing the required content does reflect a systemic practice issue for Arapahoe County DHS. As part of a routine quality assurance	Complete

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
		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.	
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

Table S1: Recommendations and Status Updates from Reports Posted Prior to CY 2024			
CFRT ID	Recommendation Type	Recommendation	Status
14-087	Policy Finding	The policy finding related to the timeliness of notification of the egregious incident reflects a systemic practice issue for JCDCYF. From January 1, 2015 to June 11, 2015, JCDCYF provided timely notification to CDHS for 75% (3/4) of incidents. It is recommended that: a. The JCDCYF create a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
14-089	CFRT	It is recommended that DCW work with Trails to develop a way for DHS staff to research foster families and gain a complete and accurate picture, ensuring educated decisions can be made around the placement for children.	Complete
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

Appendix T: Occurrence and Co-Occurrence of the Top Five Contributing Factor Themes

Appendix T includes Table T1 which reports the count of occurrence and co-occurrence of the top five contributing factor themes that were depicted in Figure 2.

Table T1: Occurrence and Co-Occurrence of the Top Five Contributing Factor Themes Depicted in Figure 2			
Occurrence/Co-Occurrence	Number of Themes	Count of Incidents	Percent of Incidents
Did not have a top 5	0	1	2.30%
Caregiver Mental Health	1	1	2.30%
Caregiver Relationships	1	3	7%
Caregiver Relationships, Financial Stress	2	3	7%
Caregiver Relationships, Substance Abuse, Caregiver Mental Health	3	3	7%
Caregiver Relationships, Substance Abuse, Financial Stress	3	2	4.70%
Caregiver Relationships, Child Characteristics, Caregiver Mental Health	3	3	7%
Caregiver Relationships, Child Characteristics, Financial Stress, Caregiver Mental Health	4	4	9.30%
Caregiver Relationships, Child Characteristics, Substance Abuse	3	3	7%
Caregiver Relationships, Child Characteristics, Substance Abuse, Caregiver Mental Health	4	1	2.30%
Caregiver Relationships, Child Characteristics, Substance Abuse, Financial Stress	4	1	2.30%
Caregiver Relationships, Child Characteristics, Substance Abuse, Financial Stress, Caregiver Mental Health	5	7	16.30%
Caregiver Relationships, Substance Abuse	2	1	2.30%
Caregiver Relationships, Substance Abuse, Financial Stress, Caregiver Mental Health	4	1	2.30%
Child Characteristics	1	2	4.70%

Table T1: Occurrence and Co-Occurrence of the Top Five Contributing Factor Themes Depicted in Figure 2			
Occurrence/Co-Occurrence	Number of Themes	Count of Incidents	Percent of Incidents
Child Characteristics, Substance Abuse	2	2	4.70%
Child Characteristics, Substance Abuse, Financial Stress	3	2	4.70%
Child Characteristics, Substance Abuse, Financial Stress, Caregiver Mental Health	4	1	2.30%
Financial Stress, Caregiver Mental Health	2	1	2.30%
Substance Abuse	1	1	2.30%