INVESTIGATION MANUAL

Division for Developmental Disabilities
October 2006

ACKNOWLEDGEMENTS

The Division for Developmental Disabilities extends its appreciation to the following individuals for their time and contribution to the development of this manual:

Leslie Brossman, Imagine!

Shana Leeper, The Resource Exchange

Howard Levett, North Metro Community Services

Brenda Schrimsher, Mountain Valley Developmental Services

Shari Repinski, Division for Developmental Disabilities

Gina Finelli-Valdez, WheatRidge Regional Center

Kay Wells, Envision, Creative Support for People with Developmental Disabilities

Beverly Winters, Developmental Disabilities Resource Center

Table of Contents

Definitions and Abbreviations

APS: Adult Protection Services

CCB: Community Centered Board

CDPHE: Colorado Department of Public Health and Environment

CES: Children Extensive Support Services

Conflict of interest: Person has a vested interest in the outcome of the investigation.

DD: Developmental Disability

DDD: Division for Developmental Disabilities

Exploitation: An illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

HRC: Human Rights Committee

ICFMR: Intermediate Care Facility for Mentally Retarded

IDT: Interdisciplinary Team

Investigation: A systematic collection of information to describe and explain an event or series of events and to answer an investigative question.

IP: Individualized Plan

Labor Relations Alternatives: An organization who provides training and consultation in the process of conducting serious incident investigations. The training curriculum and manual are referenced throughout this document.

LRA: Labor Relations Alternatives, Inc.

MANE: Mistreatment, Abuse, Neglect, and Exploitation

MAR: Medication Administration Record

Mental or psychological abuse: Any verbal or nonverbal act which creates, is intended to create, reasonably could be expected to create mental anguish for a person. This includes, but is not limited to, such actions as discriminatory remarks, belittlement, derogatory name calling, teasing, and unreasonable exclusion from conversations or activities.

Mistreatment: An act or omission which threatens the health, safety, or welfare of a person.

Neglect: An act or failure to act by a person who is responsible for another's well being so that inadequate food, clothing, shelter, psychological care, physical care, medical care, or supervision is provided. This may include, but is not limited to, denial of meals, medication, habilitation, or other treatment necessities and which is not otherwise within the scope of Section 27-10.5, C.R.S., or these rules and regulations.

PASA: Program Approved Service Agency

Physical abuse: The infliction of physical pain, injury, or the imposition of unreasonable confinement or restraint on a person. This includes directing a person to physically abuse another person receiving services.

Preponderence (of the evidence): Superiority in weight, importance, or strength.

Probability: Likely to be or become true or real.

RC: Regional Center

Sexual abuse: Subjecting a person to nonconsensual sexual conduct or contact classified as a crime under the "Colorado Criminal Code", Title 18, C.R.S. This may include, but is not limited to, such actions as sexual assault, rape, fondling, or sexual exploitation. Additionally, any sexual interaction between employees or contractors and persons receiving services shall constitute sexual abuse.

Substantiated: The allegation is verified by proof or competent evidence.

SLS: Supported Living Services

Target: An employee, contractor, or volunteer identified as the one alleged to have performed the act of mistreatment, abuse, neglect, or exploitation against the person receiving services.

Unsubstantiated: The allegation is not verified due to a lack of evidence or contrary fact.

Victim: A person receiving any DD service who allegedly was the recipient of mistreatment, abuse, neglect, or exploitation.

Section 1

Introduction

The health and safety of persons with developmental disabilities receiving services is of priority importance as one of the core values of the developmental disabilities service system. The Division for Developmental Disabilities (DDD) has included a requirement that investigations be conducted for all allegations of mistreatment, abuse, neglect, and exploitation (MANE) that occur within the service delivery system in accordance with C.R.S. 27-10.5-102(17). DDD believes the investigation process is a key systematic element to the prevention of MANE.

DDD expects that the investigation process not only be thorough and complete, but will follow an approved process. Labor Relations Alternatives, Inc. (LRA) is an organization that has provided training to individuals in the proper techniques for conducting an investigation. DDD has strongly supported this agency's curriculum as a model for the proper procedures to be utilized to determine if MANE has occurred as alleged. While this training addresses how to conduct a thorough investigation, it does not address issues that are unique to the DD system in Colorado or the broader systemic issues that should be addressed through the investigation process, e.g., staff training needs, safety/supervision issues, IDT processes, etc.

The purpose of this paper is to outline issues and practices that should be incorporated into the investigation process in addition to the utilization of the approved investigation techniques taught by LRA. This paper does not replace the manual entitled *"Conducting Serious Incident Investigations"* rev. *2003* written by LRA. Although specific investigation techniques are referenced in this document, a full explanation of processes for collecting evidence, securing the scene, interviewing witnesses, collecting witness statements, and weighing evidence are included in the LRA manual and should only be utilized after receiving that training.

The target audience for this document is trained investigators in the DD system and will outline best practices for conducting investigations. The responsibility for conducting investigations is placed on the Community Centered Board (CCB) and Regional Centers (RC) in accordance with

Rule 16.580D. Rules do not prohibit the delegation of the investigation function to the Program Approved Service Agency (PASA). The policies and procedures of each CCB regarding who conducts investigations vary greatly and should be referenced to determine which agency is responsible to implement these practices.

Section 2

What is an investigation?

An investigation is a systematic collection of information to describe and explain an event or series of events and to answer an investigative question. As required in Rule 16.580, an investigation must be conducted for all allegations of Mistreatment, Abuse, Neglect, and Exploitation (MANE) to uncover the facts leading up to an incident and to provide an examination of the systemic issues and errors that occurred to contribute to the incident. Thorough investigation processes will accomplish the following:

- Protect victims who have developmental disabilities through the agency's policies and procedures by ensuring immediate medical treatment and safe environments when an allegation is reported.

- Ensure the use of adult protection or child protection, law enforcement and the criminal justice system when a crime has been committed against a person with a developmental disability.

- Uncover facts and descriptions of incidents of alleged MANE.

- Determine, based on these facts, whether or not an incident of MANE occurred.

- Use these facts and descriptions to identify and implement corrective actions specific to the incident e.g., disciplinary actions, retraining of staff, medical follow up.

- Implement process or systemic changes that will reduce the likelihood of a similar incident occurring.

- Contribute to an incident trend analysis system that will be utilized to detect and decrease the incidence of MANE.

- Create and maintain a permanent record of the investigation including all evidence, conclusions, recommendations, and actions taken by the agency in response to the incident.

CRIMINAL AND CIVIL INVESTIGATIONS

It is important to understand the difference between criminal and civil investigations. The investigations described in this document refer to the civil investigation process conducted by civilian investigators (CCB/RC staff). Many allegations of MANE are also possible crimes and must be reported to law enforcement agencies as appropriate. If pursued, the law enforcement agency will conduct a criminal investigation which takes precedence over the DD/civil investigation process. These two processes are entirely different. Some key differences are:

Civil Investigation Process	Criminal Investigation Process
Investigations by CCBs, PASAs, RCs, DDD, APS, attorneys, and others	Investigations by law enforcement
Wrongs against an individual	Wrongs against society
Victim takes action (e.g., lawsuit) ("Smith vs. Jones")	Government presses charges ("people vs. Jones")
No Miranda rights (e.g., right to remain silent, right to attorney, etc.)	Miranda rights apply to person charged with crime.
Retribution to the victim	Retribution (paid) to society, not the victim
No written, predetermined penalties	Penalties determined in statutes
Acts of abuse may be both civil and criminal in nature. The criminal process ALWAYS takes precedence over the civil investigation.	

- The civil investigation relies on the preponderance of the evidence to determine conclusions; the criminal investigation relies on proof beyond a reasonable doubt.

- The alleged perpetrator or "target" of the investigation may have additional protections in the criminal system that he/she may not have in the civil process. For example there are no Miranda rights ("You have the right to remain silent") when conducting the civil investigation. The target does not have the right to "plead the fifth" when being interviewed by a civilian/agency investigator. If the target is an employee or contractor of the involved DD agency, he/she must cooperate with the investigation process.

- For the target, there is no "right to face his/her accuser" in the civil investigation. If the target in an investigation makes such a request, it should not be honored. This can further intimidate the alleged victim or witness and influence him/her to recant or to minimize the

report. In fact, in this process, it is appropriate to withhold the identity of reporting parties.

- Although an agency can honor a request for an attorney to be present during an interview (something that is a legal right in a criminal investigation), it is not required. If the target of the investigation refuses to participate in the interview without an attorney, the investigator should refer to the agency's own policies and procedures for further direction. It is generally expected that employees and contractors of an agency fully cooperate with the investigation process. The agency's policies and procedures should state this. If a staff person is a member of a union, he/she may be entitled to representation if requested. It is important for the investigator to be knowledgeable of the union entitlements and the agency's policies and procedures regarding offering or allowing an attorney or other representative to be present.

In both types of investigations, the investigator gathers evidence to support or prove a theory, allegation, or charge. The investigator does not ever support that an allegation is false or that a person/target is "innocent". In civil investigations, a conclusion drawn that an allegation is not substantiated does not indicate that the allegation is false, only that there was not enough evidence to support the allegation. In the same way, in a criminal trial, a person is found guilty (proven beyond a reasonable doubt) or not guilty (not proven beyond a reasonable doubt). There is never a verdict of "innocent".

Section 3

When to initiate an investigation

Pursuant to DDD Rules and Regulations 16.580, all allegations of mistreatment, abuse, neglect and exploitation (MANE) must be thoroughly investigated. All of the applicable rules must be referenced and followed when investigating any allegation that fits within the definitions described below.

Definitions of MANE (Rule 16.120) include:

A. Physical abuse, which means the infliction of physical pain, injury, or the imposition of unreasonable confinement or restraint on a person. This includes directing a person to physically abuse another person receiving services.

B. Sexual abuse, which means subjecting a person to nonconsensual sexual conduct or contact classified as a crime under the "Colorado Criminal Code", Title 18, C.R.S. This may include, but is not limited to, such actions as sexual assault, rape, fondling, or sexual exploitation. Additionally, any sexual interaction between employees or contractors and persons receiving services shall constitute sexual abuse.

C. Mental or psychological abuse, which means any verbal or nonverbal act which creates, is intended to create, reasonably could be expected to create mental anguish for a person. This includes, but is not limited to, such actions as discriminatory remarks, belittlement, derogatory name-calling, teasing, and unreasonable exclusion from conversations or activities.

D. Exploitation, means an illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

E. Mistreatment, means an act or omission which threatens the health, safety, or welfare of a person.

F. Neglect, means an act or failure to act by a person who is responsible for another's well being so that inadequate food, clothing, shelter, psychological care, physical care, medical care, or supervision

is provided. This may include, but is not limited to, denial of meals, medication, habilitation, or other treatment necessities and which is not otherwise within the scope of Section 27-10.5, C.R.S., or these rules and regulations.

Caution: The definition of neglect can be extremely vague and the application to specific circumstances can be confusing since the definition covers a broad scope or scenarios. It is sometimes difficult to determine if an incident fits in this definition because potentially, any mistake made by a staff or provider can ultimately threaten the safety of an individual since persons with developmental disabilities are at such high risk. The following are some guidelines in determining whether or not an incident fits within the definition of neglect:

- The failure to follow an established procedure or provide an identified service is not automatically considered neglect. For example, failing to assist an individual to brush his teeth or implement physical therapy exercises may not automatically fit within an allegation of neglect.

- When the failure to follow an established procedure or provide an identified service leads to a substantial <u>probability</u> of an adverse medical or health/safety outcome and fits within the definition of neglect, then identification as an allegation of neglect may be appropriate. In the same example, if the provider failed to assist an individual to brush his teeth and when examined by a dentist, it was determined that his teeth were irreparable and needed to be extracted, then an allegation of neglect may be appropriate. If the provider did not complete physical therapy exercises on a regular basis, and upon examination from the therapist, it is determined that his motor functioning has regressed significantly, then the allegation of neglect may be appropriate.

- In general, if the action or failed action leads to an adverse health/safety or medical outcome or has a <u>probability</u> (not simply a possibility) of leading to an adverse health/safety or medical outcome, then an allegation is appropriate.

The definitions of MANE include only those incidents that involve a staff person, contractor, or volunteer as the alleged perpetrator. There may be incidents that are similar but involve a family member, another individual receiving services, or other unpaid person (except agency volunteer) as the alleged perpetrator. Please refer to page 31 and the section entitled "Other Professionals and Agencies Involved. Although these incidents require follow up, the process of an investigation per DD Rule 16.580 is not necessarily required, but a referral to the appropriate investigating agency might be necessary.

> *Example #1*: Susan (a person receiving services) reports that her boyfriend (not a person receiving services) hit her and caused a black eye. The agency must provide follow up to this incident by determining if law enforcement should be contacted, medical care needs to be provided, or if specific services and supports such as counseling for the victim, etc., are necessary, but an investigation by the CCB/service agency is not required.
>
> *Example #2*: Tom reports that he went grocery shopping with a "friend" he met at the bus stop and the "friend" took all of his groceries. The agency would be expected to complete follow up in order to protect the person from further incidents; however, this incident would not necessarily fit within the DDD definition of exploitation since the alleged perpetrator is not a staff person, contractor or volunteer.

It is important to note that the process followed in an investigation, in part or in full, might be important in order to determine facts necessary to provide appropriate follow up, when necessary. It would not, however be required by DDD rules and regulations that a complete investigation be conducted to address incidents that do not meet the definitions of MANE. Thorough and complete follow up must occur for these incidents.

LEVELS OF FOLLOW UP

DDD believes that a solid follow up process to incident reporting is as important as the investigation process in detecting and preventing critical incidents including MANE. It is necessary to make the distinction between the levels of follow up and appropriate processes to determine which is most appropriate. The level of follow up should be determined by the reviewer of the incident report or agency administrator and should not be determined by how the incident report is identified or labeled by the reporter. Levels of follow up include:

Level 1: Incident report follow up:
This includes the processes involved in following up and implementing necessary corrective actions to an incident of any type, except an allegation of MANE. An incident such as unexplained injury, consumer to consumer incident, theft, personnel problem(s), and death most often fit within this category but might also be included in the other levels depending on the circumstances (Rule 16. 560).

Level 2: Incident report follow up with higher level of review:
Some agencies call this a "partial investigation", "preliminary investigation", or "administrative review". This includes allegations of MANE that after the collection of some preliminary information, do not require further investigation to be completed. The most practical guideline for determining how much investigation is necessary is to identify when the investigative question can be answered. When enough information is collected, and there have not been additional investigative questions identified, then the investigation can be concluded at this level. This process should not include taking short cuts in order to answer the question, but following a thorough process that might lead the investigator to answer the question before all information has been gathered. ***Caution***-this is still considered an investigation per Rule 16.580 and all requirements apply.

> *For example: A person (John) reports that a staff person yelled profanities at him and made derogatory remarks. The investigative question is identified as Did staff verbally abuse John? Before initiating all interviews, the staff person admits to yelling profanities and calling John a derogatory name. Because of this, the staff person is interviewed before other witnesses and his confession is confirmed. The investigative question is answered and additional evidence does not need to be collected (i.e., interviewing other witnesses, etc.)*

For incidents requiring this level of review, documentation of the reasons why a complete investigation was not completed must be maintained as part of the record.

Level 3: Investigation requiring complete process:
This level includes all other allegations that require the full process (as described in section 6) to be implemented as required in Rule 16.580 such as interviewing all witnesses, document review, physical evidence, etc.

The following chart represents examples of the process of determining which level of follow up is required. These are examples only and similar incidents with different facts should be handled based on those specific circumstances.

Allegation/Incident	Preliminary Investigative Question	Information	Level of follow up
Jane has a suspicious bruise on her arm.	What is the cause of the injury?	Jane and staff described an accident that explains the injury.	**Level 1** Incident follow up is completed.
Tom reports that staff hurt him during a restraint.	Were proper techniques followed?	Evidence suggests injury and unreasonable use.	**Level 3** New investigative question is identified. "Complete" investigation is initiated.
Janet reports that staff person "kissed" her.	Did sexual abuse occur?	Janet recants her report and there is no other preliminary evidence to contradict her testimony. Intimidation has been ruled out.	**Level 2** "Partial" investigation is complete.
Day Program reports that inadequate lunch has been sent with person.	Does this fit within the definition of neglect?	Review indicates that sandwich, chips, fruit, and drink were sent. Person reported they were still hungry.	**Level 1** No neglect. Incident report follow up includes corrective actions, as necessary.
House Manager discovers staff person asleep while on shift. One person is missing.	Did neglect occur?	Person requires line of sight supervision due to dangerous behavior, has eloped and has not returned.	**Level 3** "Complete" investigation is initiated to address the alleged neglect.

Regardless of the level of follow up, documentation of the steps taken to follow up to the incident and to record the outcome of the review is required either as part of an incident report follow up process or as part of an investigation. Follow up actions should clearly be documented.

OTHER CRITICAL INCIDENTS REQUIRING REVIEW

In addition to allegations of MANE, there are incidents that are potentially as serious that should receive the agency's attention and follow up. It is expected that agencies take follow up actions in response to all incidents, however, critical incidents such as deaths and serious injuries should prompt a higher level of follow up from the agency. An investigation is often an appropriate action to take in order to discover key facts of the incident and to identify corrective actions.

Example: It is discovered that during a physical transfer of Mary, a person with a significant physical disability, into her wheelchair, her femur is broken. An investigation into the cause of this injury is warranted in order to determine whether or not proper lifting and transferring techniques were utilized and to determine if unknown medical conditions exists (e.g., demineralization of the bones) that would indicate the need for additional services.

1. When the target is a person receiving services (i.e., consumer to consumer)

   Occasionally, persons receiving services will experience incidents as a result of the actions of another person receiving services. Persons receiving services are often served in group settings for living and for day program. (**Note:** For incidents involving persons living in a group home, the agency must follow the Occurrence reporting requirements set forth by CDPHE-see page 34). In addition, persons often socialize and interact with other persons receiving services either in romantic relationships or in friendships. When incidents occur that involve two persons receiving services, the agency must decide how the follow up to the incident should be handled. Since the DDD definitions of MANE do not specifically include incidents that involve a person receiving services as the alleged perpetrator some guidelines should be used to determine appropriate follow up actions.

   a. What type of incident is it?

      An incident involving an allegation that a person receiving services sexually assaulted another person receiving services

should be handled much differently than an incident involving a person who has impulsive behavior and scratches another individual in a crowded van. If a crime may have been committed, law enforcement must be contacted. The agency should immediately evaluate the seriousness of the incident and provide follow up to adequately address the incident.

b. What injuries have occurred?
An incident that creates significant injury for one or both persons should receive a higher level of review.

c. What actions were taken by the agency?
In all cases, the agency involved has the obligation to take actions to protect persons from such incidents. In incidents in which a person has become aggressive and has targeted other persons receiving services, a review of the agency actions to protect those persons should be conducted and corrective actions should be implemented if problematic practices were identified.

d. Were there any elements of neglect?
When completing follow up on incidents between persons receiving services, it is important to review preliminary information to determine if there is any breakdown in supervision, or if there are programmatic issues that have not been addressed. An investigation should occur if any allegation of MANE is identified during this follow up and recommendations should always be made to address any system breakdowns.

Incident	Question	Information	Outcome
Julie and Mary begin to argue in the van. Julie hits Mary lightly in the face.	Not MANE, or a reportable crime.	No injury, persons were separated and conflict resolved.	Incident report follow up completed with corrective actions.
Margaret reports that Robert forced her to have sex.	Is this a reportable crime?	There are signs of force (i.e., injuries).	Reported to law enforcement for investigation. Extensive incident report follow up completed to identify system breakdowns.

2. Death of a person receiving services

An incident of MANE can result in death of a person receiving services. These incidents are rare, however, if such an incident should occur, the agency should be prepared to initiate an investigation involving other agencies, as appropriate.

Most times, when a person in services dies, it is due to natural causes such as heart failure, or pneumonia. Sometimes an individual will die during the night with the absence of signs or symptoms of illness. The explanation of "death by 'natural causes'" should not be misinterpreted to mean that the incident was unavoidable. All unexpected deaths, even those without suspicious circumstances should receive a more intense level of follow up from the agency. At minimum, a review of the immediate circumstances, (i.e., what happened just prior to the death, response of the staff/provider to the medical emergency, etc.) should be reviewed in addition to reviewing the individual's file to identify any signs or symptoms of illness or other unusual circumstances that may have contributed to the person's death. If there are no concerns that warrant a complete investigation, documentation should include the follow up that was completed and an explanation as to why an investigation was deemed not necessary. When an investigation is conducted because the outcome of this preliminary review identifies alleged abuse and/or neglect, the procedures outlined in this manual should be followed.

Example: Mike dies unexpectedly during the night and a staff person discovers this when trying to wake him in the morning. It appears as though Mike may have had a violent seizure because his body is lying in an awkward position on the bed. Once the staff person makes the discovery, he follows all of the proper emergency procedures such as assessing the need for CPR, calling 911, etc. The coroner later determines that Mike died of "natural causes", most likely from a seizure. It appears that this incident was unavoidable. However, because the agency insisted on a preliminary review, documents and brief interviews indicate that Mike has been refusing to take his seizure medication consistently and the staff had not reported this. It was also determined that the staff person is required to check on every individual in the house every 30 minutes because of their fragile medical status, and a physical check of Mike was not completed at any time that night. It was beneficial for the agency to conduct this review as it

identified the need for further investigation to outline corrective actions.

If a death is anticipated or otherwise not "unexpected", (e.g., person has been in hospice with terminal illness or in the hospital receiving medical treatment) the agency may need to conduct a review of the circumstances to identify any problem areas.

3. Unexplained injuries
   Incidents of unexplained injuries are always difficult to investigate because of the fact that they are "unexplained" and without many clues and facts. For some unexplained injuries, it is appropriate to complete a thorough incident report follow up process to uncover possible causes and to initiate corrective actions. For these incidents, a complete investigation may not be necessary. For other incidents, a higher level of review is necessary due to any of the following factors:
   - The injury is reccurring.
   - The injury is serious or potentially serious (i.e., head injury, ruptured spleen, fractures, etc.).
   - The injury is suspicious in nature (bruise in the shape of a handprint or other object).
   - The location of the injury causes concern (e.g., bruises in the groin area).

   When these injuries occur, an investigation should be considered to determine if physical abuse, sexual abuse or neglect is occurring.

4. Incidents involving family and/or community members
   When an alleged incident of MANE occurs while the individual is living or supervised by a family member either through Supported Living Services (SLS) or during a home visit, a referral should be made to Adult Protective Services (APS) or the local law enforcement agency as appropriate. For children receiving services through Children's Extensive Services (CES), Early Intervention (EI), or Family Support Services (FSSP) a referral to the local Child Protective Services should be made (Refer to page 34).

5. Trend analysis
   Each PASA, CCB, and RC is required by Rule 16.560F to analyze incident reports to identify trends and problematic practices that may be occurring and to take appropriate corrective action to address the problematic practices identified. During this process, a pattern of incidents may reveal concerns that should be

investigated. For example, this analysis might identify that a specific staff person is involved in a high number of physical injuries as compared with other staff. An allegation of physical abuse might be identified at this point and an investigation should be initiated.

6. Individuals who frequently report allegations of MANE
   Occasionally, the investigator may receive frequent reports of alleged MANE from a person receiving services. As these allegations are investigated, they consistently result in an unsubstantiated conclusion. While some may quickly determine that the person has a history of making "false allegations", in general, DDD does not support the use of this label. The outcome of the investigation process is never to prove an allegation to be false, only to identify if enough evidence exists to substantiate the allegation. Persons who are labeled as "false reporters" are at an increased risk of being victims of MANE and of having their allegations being inappropriately dismissed as "false".

   It has been identified that there are individuals who are more likely to make reports that are not true as a result of a mental illness, past history of abuse, or lack of problem solving skills. It is important for the IDT to identify, through assessments, what supports in this area are needed. Supports should be provided in a way that do not negate the legitimacy of a report. In other words, the person should not be told or made to feel as though he/she is lying. The unintended result of this may be to discourage the person from reporting a legitimate allegation in the future. Supports and services should be provided to assist the person with the reasons and/or motivation for the frequent reporting (e.g., the anxiety, depression, lack of problem solving, etc.)

   When allegations are received from individuals who make frequent reports, the investigator should determine what follow up is necessary. Since all allegations must be investigated, however, it may be appropriate for the investigator to determine the level of investigation necessary as discussed beginning on page 12. In some situations, it may be appropriate to develop a protocol for the investigator and/or agency staff to follow when a report is received from an individual who makes frequent reports. A protocol should only be used in very rare circumstances when it is the best way to address the frequent reports and all other approaches have been exhausted. A protocol could be used to identify the level of follow up necessary based on the

circumstances of the report and the needs of the individual, however, every report should receive the appropriate level of follow up necessary to address the allegation.

> *For example*: For a report from a person with Borderline Personality Disorder who demonstrates an established pattern of frequent reports of alleged abuse only to later recant the allegation, may not require a complete investigation to be initiated. A protocol might state the screening procedure to be completed (e.g., observe for injuries, interview individual, review circumstances) to evaluate the validity of the report and then determine the level of follow up appropriate.

Section 4

The Investigator

An investigator has an important role beyond investigating allegations of MANE. There are numerous responsibilities that an investigator must carry out when investigating an allegation.

OBJECTIVE PARTY

The investigator must ensure that he/she is as objective and free from bias as is possible.

- A bias creates a personal and sometimes unreasoned judgment.
- All evidence must be weighed without bias as to behaviors, relationships and previous incidents (Note: previous incidents should be reviewed in the investigation process for information purposes but should not create a "bias" for the investigator).
- A person who has a conflict of interest or a perceived conflict of interest, meaning there is a vested interested in the outcome of the investigation, should not be assigned or have any involvement in the investigation process.

The investigator must continuously be aware of these following issues:

Personal Bias	
Possible causes of bias	**Mitigating personal bias**
• Biases exist with all persons although they may not be aware of them. • Experiences that may create a bias include religion, values, beliefs about sexual orientation, race, gender, disability, etc. • Events can also create a bias e.g., victimization, etc.	• Recognize when these biases exist. • Recognize when and how these relationships might influence the investigation process. • If bias does exist, and might influence the investigation process, the investigator should not conduct the investigation whenever possible.

Relationship Bias	
Possible causes of bias	**Mitigating relationship bias**
• It is typical for an investigator to develop personal relationships with other staff and with persons receiving services. • Opinion of a person might develop. • Knowledge of the person and personal information occurs. • Emotional connections/opinions are likely to develop.	• Recognize when these relationships exist. • Recognize when and how these relationships might influence the investigation process. • If bias does exist and might influence the process, the investigator should not conduct the investigation whenever possible.

Professional Bias	
Possible causes of bias	**Mitigating professional bias**
• Depending on the agency, investigators are sometimes involved in service delivery (e.g., Residential supervisor, etc.). • Professional knowledge of co-workers, supervisors, and agency administrators exist within any agency (e.g., knowledge of personnel actions, etc.)	• A direct supervisor of the service in which an alleged incident occurs should never conduct the investigation. • An investigator from another program area or agency should conduct the investigation. • A Case Manager should not investigate an alleged incident that involves someone on his/her caseload. • The supervisor of the target of the investigation should never conduct the investigation.

Investigation practices of the agency should eliminate as much bias as possible in order to ensure an objective process that is free from conflict of interest. Two primary factors can be used to weigh the level of bias in order to determine the best investigation process including who is assigned to conduct the investigation.

1. Conflict of interest or perceived conflict of interest: This occurs when a person has a vested interest (or interest that is perceived by others) in the outcome of the investigation and has some level of involvement in the investigation process. If there is a potential for the agency to experience negative results when an allegation is substantiated, then there is a greater risk for the conflict of interest to influence the overall outcome of the investigation. For example, an agency concern about exposure of agency practices due to a risk of civil litigation, legal implications, financial sanctions, or a

desire to protect staff/board members, etc., there is a higher risk that the conflict of interest will influence the outcome.

2. Severity of the incident: While all allegations of MANE are serious, there are varying degrees of severity. For example, a verbal abuse allegation is considered less serious than a sexual assault resulting in injuries.

For alleged incidents that are less severe and have a lesser conflict of interest factor, the practices to eliminate bias are not as critical. It might be appropriate in these situations for the CCB to allow a PASA to conduct an internal investigation (see more below) or could be appropriately assigned to any CCB/RC investigator. For alleged incidents of greater severity and a higher level of conflict of interest, the CCB/RC should be more careful and thoughtful to eliminate bias to ensure a thorough and objective investigation. The following chart represents a continuum of issues that might be present in any allegation and might assist an agency in determining the amount of potential bias present.

The following chart identifies extreme examples only and should only be used to help evaluate where an incident might fit on the continuum based on individual circumstances.

SEVERITY OF INCIDENT	CONFLICT OF INTEREST: LOW	CONFLICT OF INTEREST: HIGH
LOW	Examples: No injuries Exploitation less than $50 Minor verbal abuse Minor neglect Minor psychological abuse No administrative involvement Several non-agency witnesses	Examples: No injuries Exploitation less than $50 Minor verbal abuse Minor neglect Involves agency administrator Guardian complaint Possible police involvement Attorney inquiry Frequent unexplained incidents
HIGH	Examples: Serious injuries Sexual assault Exploitation greater than $200 Neglect w/adverse effect on health No administrative involvement Several non-agency witnesses No public scrutiny	Examples: Serious injuries Sexual assault Exploitation greater than $200 Neglect w/adverse effect on health Involves agency administrator Guardian complaint Police involvement Attorney inquiry Frequent incidents Risk of financial penalties Involvement of Board of Directors

Incidents falling in the first section of the grid (low severity, low conflict of interest) might be appropriately investigated by a PASA or by any CCB/RC investigator. However, incidents falling in the shaded area (high severity and high conflict of interest) are at extreme risk for bias and should be handled carefully. In these situations, it would not be appropriate for a PASA to conduct the investigation. When the conflict of interest is high for a CCB/RC, the agency should contact and request involvement from their county APS (see page 37) and should assign a CCB/RC investigator as removed from the actual incident and involved persons as possible. The level of involvement from the agency administrators should be limited as much as possible. In situations in which the conflict of interest is extremely high for a CCB/RC, e.g., the executive staff from the CCB/RC is involved, in addition to requesting the involvement of APS, the CCB/RC should consider another CCB/RC to conduct the investigation or should seek assistance from DDD.

As required in DD Rule 16.580 and through contract with DDD and Health Care Policy and Finance (HCPF), the CCB/RC is responsible for the investigation of all incidents of MANE. A CCB/RC may choose to allow someone other than a CCB/RC employee (a contractor, PASA, etc.) to complete the investigation. DDD expects that:

- The CCB/RC will have a policy and procedure outlining when someone other than a CCB/RC employee will be allowed to conduct an investigation,

- How the investigation will be supervised by the CCB/RC, and;

- How the final results of the investigation including the investigation report will be reviewed and approved by the CCB/RC.

In addition, the CCB/RC should consider such issues as:

- The history of the contractor/PASA in conducting investigations,

- The overall performance of the contractor/PASA,

- The use of trained investigators only, and;

- The level of conflict of interest (low severity, low conflict of interest) prior to allowing a contractor/PASA to conduct the investigation.

DDD will use its discretion based on the seriousness of the incident and the level of conflict of interest in deciding the level of DDD's involvement in a critical incident and/or an investigation. DDD may request ongoing verbal updates from a CCB/RC during the course of an investigation, may request a copy of the investigation report and supporting documentation, arrange for an independent investigation, or conduct an investigation utilizing DDD staff.

LIAISON WITH OTHER AGENCIES

The investigator should be the primary contact for all communication regarding the case being investigated. This is for several reasons. First, the decision to release or withhold information regarding the incident and investigation is a serious one. The investigator is in the best position to know what information is factual and what is hearsay or speculation. Other agencies, i.e., law enforcement and APS must have accurate information in order to respond accordingly. Second, the investigator may have developed a professional relationship with law enforcement and APS therefore understanding their processes and being able to advocate for the proper actions to be taken.

TRAINED INVESTIGATOR

The investigator should have received the proper training in investigative practices.

- DDD recommends the training be conducted by Labor Relations Alternatives, Inc. The training should include all aspects of conducting an investigation including gathering and weighing evidence and report writing. Training provided by other entities can also be considered, such as law enforcement training, social services investigation training, etc. Any agency wanting to utilize a trainer other than LRA to train investigators should notify DDD for review and prior approval.

- An investigator should not conduct any investigation without having proper training.

PROCEDURAL SUPERVISOR

The investigator has the responsibility to oversee the procedures taken by the agency during the investigation process. The investigator should ensure that:

- evidence is secured,

- all proper contacts have been made (guardian, APS, law enforcement, etc.),

- the victim receives proper medical attention and victim supports,
- coordination with law enforcement occurs, and;
- handling of the report and file at the agency occurs as required.

FILE MANAGER

The investigator has the responsibility to ensure that the investigation file has been properly secured and contains information relevant during the process of the investigation. The investigation file should include:

- the investigation report,
- all supporting information in addition to those documents required by DDD rules (see page 35),
- a written account of all evidence, findings, and conclusions.

Agencies/individuals who should have access to the investigation report and file include the Human Rights Committee, as required, and The Legal Center, local department of social services (Adult Protection), and law enforcement, upon request. Distribution within the CCB/agency (e.g., agency administrators) should be minimal but is to the discretion of the agency and should be handled per agency procedures. If a CCB conducts an investigation, it is generally expected that the complete investigation report (not the entire file) be submitted to the PASA involved in the investigation. In unique situations, when exceptions are made, the investigation file should document the reasons for not releasing the report. If the investigation involves more than one PASA, the investigator should use judgment in deciding what information is not relevant or appropriate to share with the other PASA and submit only the relevant information to each PASA. When a PASA conducts an investigation under the oversight of the CCB, the full investigation report must be submitted for the CCB file and the entire agency investigation file must be made available to the CCB upon request.

Release of information regarding the investigation should be handled according to agency policies and procedures. The investigation process is an administrative process and thus different from an "individual" process. Persons who have access to an individual's record, e.g., guardian, authorized representative, attorneys, etc., do not automatically have access to the investigative file and/or report. A "Release of Information" signed by the individual receiving services involved in the

investigation does not apply to administrative records. It is appropriate to release the outcome and/or the recommendations of the investigation to guardians and authorized representatives, without releasing the report and file in its entirety. When the target of the investigation requests a copy of the investigation report, the agency must refer to its policies and procedures; however, it is not advisable to release the entire report to the target. The target should receive some information regarding the outcome of the investigation as deemed appropriate by the investigating agency.

Section 5

Planning for the Investigation

TIMELINES OF AN INVESTIGATION

DDD requires completion of a thorough investigation of allegations of MANE in a timely manner. There are many factors that effect the actual time it will take to complete the investigation and it is impossible to define exactly how long an investigation should take. It is expected that the following process be completed as it relates to the timeliness of investigations.

An investigation should be initiated immediately upon receiving either a verbal or written report of an allegation of MANE. This should include at a minimum:

- Ensuring the person is protected and receiving treatment for any injuries, if necessary.

- Receipt and review of the incident report and preliminary information such as victim, witnesses, description of incident, and actions taken to protect the victim.

- Securing evidence as appropriate including confirming with the agency that witnesses have been separated as much as possible and instructed not to discuss the details of the alleged incident.

- Starting an investigation record.

- Organizing the initial investigation process including setting up interviews and reviewing pertinent documents.

Efforts to reduce the potential for contamination of information should occur for all investigations regardless of an existing delay. The investigator should prioritize the collection of evidence that is most at risk of contamination. In some cases, securing physical evidence will be necessary and should be initiated first. In most cases (because of the lack of physical evidence), interviews should be identified as the highest priority for the investigator and should be completed as soon as possible.

Securing relevant documentation should also be a high priority and should be completed as soon as possible. The investigator must ensure that the evidence is maintained in his/her custody and supervision throughout the investigation and should keep records of any review or access to the evidence by someone other than the investigator.

Investigations should take as much time as required to ensure a thorough and complete process but should not contain lapses of time (days or weeks) in which there is little or no activity. There should always be progress toward completing the investigation. Agency's policies and procedures should outline the expectations for the timliness of investigations. Labor Relations Alternatives recommends a timeline of 10 days from the first interview to the last interview. There may be factors that will contribute to a reasonable delay of an investigation. For example,

- The victim is in the hospital and receiving emergency medical care.
- Law enforcement/APS have been contacted and are involved.
- These processes may be slower and may impact what investigation processes can be initiated (see page 34-38).
- Witnesses are not available immediately due to physical absence (e.g., staff out of town, etc.).
- The incident is complex and requires a review of many documents and interviews with many witnesses.
- An outside investigator needs to be assigned due to bias or other factors that would hinder an objective process.
- Especially in rural communities, it may be necessary for an investigator to travel a great distance to respond to the incident.
- Due to error, the incident may not be reported timely delaying the initiation of an investigation.

There are delays that may occur which would not be reasonable. DDD expects that all PASAs, CCBs and RCs and staff cooperate with an investigation to the fullest extent necessary. Delays due to staff scheduling difficulties are not reasonable and should be minimized.

Any significant delay in the investigation, or any timeline that does not meet the agency's expectation should be carefully documented in the investigation report. The reasons for the delay should be described. In addition, testimonial evidence collected after a significant amount of time after an alleged incident should be carefully weighed against all evidence with the question to the integrity and reliability of that information in question.

INCIDENT REPORTING

An incident report must be completed in accordance with DDD Rule 16.560. CCB/RC policies and procedures should be sure to include:

- Allegations of MANE must be reported to the agency administrator and to the CCB within 24 hours but should be done as soon as possible.

- CCB's, PASA's and RCs must have policies and procedures that ensure the timely reporting of incidents and should outline the expectations for the timelines for completing an incident report.

- For allegations of MANE, it is expected that the incident report should be completed at the first available moment following the incident in order to capture key details of the incident.

- The incident report should describe what is known about the incident including the name of the victim, any witnesses involved, the alleged target (if known), the details of the incident as observed or reported, and the actions taken to address the immediate issues of the incident.

- When other persons receiving services are involved in the incident, identifying information (e.g., first and last name, date of birth, social security number, etc.) should not be included in the incident report in order to comply with confidentiality rules. The use of initials is also not appropriate when it may be considered identifying information (e.g., in smaller settings).

- A separate incident report must be written for each individual involved.

When an investigator is assigned, a priority task would involve the identification of witnesses or other involved persons. Through contacts with the reporting party or agency representative, these persons should

be identified without causing a significant delay to the investigation process.

PROTECTING THE VICTIM

1. Emergency room/physician visit
   It is important to understand the protocol local law enforcement agency use for determining when an emergency room visit should occur for the purpose of gathering evidence. Some law enforcement agencies request to be contacted first, before a decision is made to seek a medical examination. Other law enforcement agencies request that this medical examination be the immediate step in order to preserve evidence. Regardless of which step comes first, the victim should always be taken to an emergency room after an alleged sexual assault or physical assault to evaluate any injuries and in order to identify and collect physical evidence. Additionally, the physician will complete a physical exam to assess any injuries and provide emergency medical treatment. The physician can also identify injuries that may not be observed by a non-medical person.

   The agency should have written procedures in place for handling the medical care of the potential victim. If ever there is a question regarding possible injuries, it is always best to see a physician. If the agency has a nurse available, there should be written procedures about when that nurse is contacted and the assessment that will be provided in response to allegations of physical or sexual abuse.

2. Victim Protection/Assistance Services (VPS)
   Many law enforcement agencies have a victim's assistance/protection unit to assist victims of crime. It is important that investigators become familiar with victim protection statutes specifically C.R.S. 24-4.1-302.5 (see appendices) which define the rights available to victims of crime. The investigator should become knowledgeable about when a victim qualifies for assistance and what resources are available to the victim through VPS.

   A person who has had a crime committed against him/her qualifies for special protections under this Colorado law. These include the right to be informed of all critical stages of the criminal justice process, the right to be heard by the court, a process to submit written statements called "victim impact statement", and referrals to special counseling facilities and community service agencies.

Sometimes, financial assistance is available for these counseling services. In addition, some districts have employees available to be a liaison between the victim and the law enforcement agency and the court. This is very helpful throughout the various stages of the investigation process and the trial process.

3. Personnel/respite
   Each CCB, PASA, and RC must have a policy and procedure on ensuring a person's safety when an allegation of MANE is reported. These procedures should ensure that the least amount of disruption occurs for persons receiving services while the agency is taking steps to ensure the safety of the individual (s). The policy must specify how the agency will handle the staff person/contractor who is the target during the period of the investigation and ensure that there is no contact between the target and the victim or other persons receiving services and any witnesses. There are some different approaches that may be taken by the agency in ensuring the person receiving services is protected from any likelihood of continuing MANE. Agencies should seek the advice of legal counsel when developing these policies and procedures and in unique individual situations to ensure that employment laws are being followed. Regardless of which action the agency decides to take, it is imperative that the target staff person/ contractor not be informed of the specific allegations that have been reported or by whom they have been reported. Informing the staff person/contractor of the specific allegations will taint the evidence gathering process and therefore compromise the investigation. These are all possible scenarios and may or may not be appropriate given specific circumstances including the severity of the incident.

4. Staffed settings:
   a. Suspension-Agencies often suspend the staff person who is the target of the investigation. When the investigator has reached some conclusions about the staff person's involvement then the agency should make decisions regarding further disciplinary action, if any. The agency should be cautious about simply reassigning a staff person to another setting during the investigation. If there is any possibility that the person committed MANE, it is best that he/she does not work with any person with disabilities until the investigation is complete.

b. Alternative duties- The agency can arrange for the staff person to perform duties that do not involve unsupervised contact with persons receiving services. These can include duties such as office work, housecleaning, etc.

Caution: It has been noted that on some occasions, a staff person has been terminated immediately based on the initial facts of the incident. While the agency might have sufficient reason for taking this action, it might create problems during the investigation process. Once the staff person is no longer employed by the agency, the agency has no authority to require the person's cooperation with the process. This will most likely leave the investigative findings incomplete.

It has also been noted that in some situations in a staffed setting (not a host home), that the person receiving services has been placed in an alternative residential setting instead of the staff person being removed from the setting. This should not be considered an option. It is inappropriate to move someone from his/her home because of actions for which a staff person may be responsible. In addition, it does not eliminate the potential risk to the other persons in the home.

5. Host Home Provider:
   Temporary placement-The best option when an allegation occurs may be for the person to move into another setting. Since the host home model provides services in the home of a contractor, it is not possible to take the same actions as when an allegation occurs in a staffed setting. When permanently removing someone from a host home due to an allegation of MANE, the agency must follow Rule 16.232 which outlines the due process requirements.

6. Increased monitoring:
   Depending on the circumstances, it may be appropriate to increase monitoring of the residential or day program setting during the course of the investigation or as an action in response to the investigation. This action should occur especially in situations of alleged abuse and/or neglect of unknown origin (when a target has not been identified). This could include unannounced site visits, staff/manager presence in the home, agency and CCB increasing the frequency of visits, etc.

OTHER AGENCIES AND PROFESSIONALS INVOLVED

1. Law enforcement

The appropriate law enforcement agency, i.e., city law enforcement department, sheriffs department, must be contacted any time it is suspected that a crime has occurred. Agency policies and procedures must identify the agency or the person responsible for notifying the law enforcement agency. The investigator should verify that a report has been made when applicable. The investigator must be familiar with the specific crime definitions in Colorado Criminal Codes (C.R.S. Title 18- Appendix C). Having this knowledge will help the investigator and agency know when an allegation should be reported to law enforcement. The report should be made to the law enforcement agency in the jurisdiction where the alleged incident occurred. For example, if a person lives in Arvada, and the alleged incident occurs in the home, the Arvada Police Department should be contacted. But if the same person lives in Arvada and attends day program in Denver and the alleged incident occurs in Denver, the Denver Police Department should be contacted.

When an incident is reported to the law enforcement agency the following should be considered:

- Information released to the law enforcement agency at the time of the initial report should be factual information pertaining to the preliminary details only. The person filing the report should refrain from speculation, opinion, or bias when making the report. The person making the initial report must cooperate with the officer.

- After involving the law enforcement agency, the process can take a much longer period of time than is expected. This depends on factors outside of the investigator or agency's control such as the seriousness of the crime, the number of cases an officer/detective has assigned, etc. It is important to practice patience with the law enforcement agency yet practice diligence by staying in contact with the officer/detective and ask for progress updates frequently.

- The responding officer will most typically come to the location of the alleged incident to take an initial report. If the incident occurs in a host home and the provider is the target, notify the

person taking your call of this information. They will determine the way in which this should be handled.

- The responding officer will typically leave a business card or other contact information. The investigator or agency staff should contact the officer within 24 hour of the report in order to determine the disposition of the case.

- If the law enforcement agency decides that an investigation should be conducted, a detective or investigating officer will be assigned. It is important for the investigator to contact the detective and identify him/herself as the primary contact. The investigator should let the detective know that he/she will help to coordinate interviews and help whenever possible and if allowed. Often, an explanation of the investigator's role is necessary in order for the detective to understand the purpose behind the inquiries.

- The officers and detectives usually have little previous contact with DD agencies. It is important to provide them with information so that they understand important aspects of the case and the DD system i.e., roles of host home providers, case managers, day programs, etc. It is important to answer any questions that he/she has in order to assist.

- Since officers and detectives may have little experience with persons with developmental disabilities, offer to provide them with information or assistance in preparing or conducting the interview with the person with DD.

- The involvement of the law enforcement agency does not mean that the CCB/RC investigator must cease all investigation processes. The criminal investigation does take precedence over the CCB/RC investigation and the requests of the law enforcement should be respected. All steps necessary to eliminate interference with the law enforcement process should be taken. The investigator should make it known to the law enforcement investigator that there is a need for the CCB/RC investigation to be completed as soon as it is allowable to do so. Request the law enforcement investigator to notify you as soon as it is allowable to interview the victim and witnesses. In many cases the law enforcement investigator will allow for interviews from the CCB/RC investigator to be conducted once the law

enforcement interviews have been completed. This is a decision that must be left up to the law enforcement investigator. In the meantime, the CCB/RC investigator should progress in the investigation by reviewing information that is not relevant or will not interfere with the criminal process such as reviewing agency practices and documentation. For example, the investigator could review hiring and training practices, supervision breakdowns, medical follow up, and any other processes or practices that are involved but do not relate directly to the crime that is under investigation by law enforcement.

- Whether the case is closed by law enforcement or the prosecution process is initiated, the CCB/RC has an obligation to complete an investigation to the degree possible. While the actual determination of a MANE incident may not be possible after several months, it is important to complete the process as much as possible in order to meet the other purposes of an investigation.

2. District Attorney

Once the detective investigates the case, he/she will present the case to the district attorney. At this stage, the district attorney will decide the following:

- Either there is enough evidence to prosecute a target and the process will continue, or;

- There is not enough evidence to prosecute a target, and the case will be dropped.

If the district attorney decides that the case should be prosecuted, the agency and the investigator should utilize the same strategies outlined above.

Some larger district attorney's offices contain special investigation units to handle the investigation of specific cases. In Denver County, for example, the D.A. has an investigation unit that handles economic crimes, i.e., theft and fraud. It is important for the investigator to know which crimes should be reported directly to the D.A. instead of filing a report with the law enforcement/sheriff.

3. Adult Protection Services (APS)

This agency operates out of the county's Department of Social Services. Just as each law enforcement agency operates

differently from another, so does the county's APS system. It is important for the agency investigator to become familiar with how each county operates its APS.

The CCB, RC and local APS are encouraged to develop a protocol for the handling of investigations of MANE. This protocol is discussed in the document entitled "Protocol for Addressing the Mistreatment of At-risk Adults with Developmental Disabilities dated April 2005 and should be referenced when developing processes that involve both agencies.

APS concerns itself with the incidents of abuse and neglect that involve persons who are elderly and/or disabled. Any allegation of abuse or neglect that fits within the APS reportable incidents (Appendix H) and that occurs within the DD system should be reported to the local APS agency. That agency will then make a determination as to whether or not to investigate the case.

4. Child Protection Services (Children Extensive Supports, Family Support Services, Early Intervention (EI) or child of an adult person receiving services who is victimized by parent). Colorado statute requires that staff who work at a PASA or CCB/RC are mandated to report child abuse/neglect. Child protection statutes (C.R.S. 19-10-103) should be followed for any incident involving a person under the age of 18 when that person has been abused/assaulted or neglected. (Appendix G)

5. Colorado Department of Public Health and Environment (CDPHE)

   For a residential setting that is operated as a Group Home and therefore licensed by the Colorado Department of Public Health and Environment (CDPHE), the occurrence reporting requirements of CDPHE must be implemented in accordance with C.R.S. 25-1-124, 25-3-109 and Chapter 11 and 3.2 of CDPHE Rules (Appendix E). It is necessary to file a report per those procedures and verify if an investigation by CDPHE will be completed. As with a law enforcement investigation or an APS investigation, the CCB/RC investigator should coordinate the investigation process with the CDPHE investigator.

6. Other Service Agencies

When individuals are served by more than one service agency (a residential agency and a day program agency), both agencies are sometimes involved in an allegation and a subsequent investigation. For example, an individual might report to a day program staff that his host home provider hit him. Both the day program and the residential agency should be involved in the follow up. Some basic guidelines apply in these situations:

- The agency receiving or identifying the allegation is responsible for completing an incident report. This should be made available to the other involved agency in addition to submitting the report to the CCB per their procedures.

- If immediate medical attention is necessary, the agency receiving or identifying the allegation should assist the person to the extent necessary or contact the other agency immediately for assistance.

- The circumstances of the incident will dictate the agency responsible for follow up/investigation. Regardless of who received/identified the allegation, the place of the alleged incident and staff/contractors involved will determine which agency provides the follow up. In the example above, the residential agency would be required to complete the follow up (in coordination with the CCB) or to ensure the follow up has been completed, and to maintain the records.

- It is expected that the service agencies will communicate and coordinate either directly or through the case manager/CCB. The reporting agency should receive some basic information on the outcome of the follow up to include in the records.

- The reporting agency (if not also the agency responsible to ensure follow up) is not required to maintain a complete administrative record of the investigation but should maintain the incident report and a record of general follow up that was completed, e.g., CCB conducted investigation, contacted residential agency, etc.

7. The Legal Center

The Legal Center for Persons with Disabilities and Older Persons is designated in Colorado as the Protection and Advocacy agency in Colorado. They are charged by Federal Statutes to investigate

allegations of abuse and neglect. The Legal Center may choose to investigate an allegation of abuse and neglect, or may choose to review the investigation conducted by the CCB/PASA. The CCB and PASA involved is required to cooperate with the investigator from The Legal Center and must release information as requested by The Legal Center.

8. County Coroner's Office
   C.R.S. 30-10-606 (Appendix I) mandates the report of specific deaths to the County Coroner's office. These reportable deaths include deaths as a result of a violent crime or of a suspicious nature, or an unexpected death of an otherwise healthy person. Typically, emergency personnel make a determination as to whether or not the coroner needs to be notified. However, the CCB or PASA is responsible for notifying the County Coroner of a reportable death if not done by another entity.

THE INVESTIGATION FILE

Once a decision has been made to investigate an incident and after the investigator has ensured that the agency has taken action to protect the victim, the investigation file should be started. It is very important for the investigator to have a standard filing system for each investigation.

Although there is not one specific way to organize a file, there are some suggestions:

- ✓ For overall organization, the file must be kept in a secure location such as a locked filing cabinet. The access to these files should be restricted to only authorized personnel given the sensitive information that is contained in the reports and files.

- ✓ To allow for ease in retrieval of files, the filing system should include a coding system, alphabetical system, or numerical system (i.e., monthly/yearly). Investigation files are requested very frequently by other authorized agency staff, DDD, law enforcement, Human Rights Committees, and Attorneys. The investigator should have a system that allows for quick access to files giving only limited information such as only a name or a date.

- ✓ A record of requests for the file or for specific information should be kept in the file. If a copy of any part of the record is requested, it

should be logged with the specific document(s), date, by whom it was requested and for what purpose.

- ✓ Specific investigation documents, e.g., the investigative report, investigator's contact notes, evidence not contained anywhere else should be kept only in the investigation record and not be maintained in any other filing system. The investigation report should not be kept in the client record or in any staff person's personnel/contract file.

- ✓ A preliminary report of the investigation findings must be maintained in the file. This is most often an incident report although some agencies have developed an additional way to capture the preliminary findings of the investigation. Regardless, the incident report is a key piece of documentary evidence and should be included in the investigation file. The incident report is also a part of the person's record and should be maintained there. If an agency has a policy that the incident report of an allegation should not be maintained in the person's record due to the sensitivity of the information, there must be a replacement report/document referencing the incident report and where it can be located.

- ✓ The investigator should keep contact information and investigation activities logged in the file. Any key activities such as conversations with the agency or law enforcement, document reviews, contacts with the guardian, confirmation of physician visits, etc., should be logged. This should include date/time, specific activity, and a brief note on the content of that activity. Any specific actions to be taken as a result of that activity should also be documented at that time.

- ✓ All evidence considered in the investigation should be organized and maintained in the file. This includes notes of the interviews, witness statements, documentary evidence, and demonstrative evidence, e.g., pictures. It is best to number or code each piece of evidence in order to reference a specific document quickly. This is more critical for investigations in which numerous forms of evidence are gathered.

Other documents are required to be maintained in the administrative record of the investigation. These documents include:

- ✓ Preliminary results of an investigation (typically the incident report as discussed above).

- ✓ Summary of investigative procedures used: These procedures are generally summarized in the final report, e.g., who was interviewed, in what order, documents reviewed, physical evidence, etc.

- ✓ The investigative findings: These include the factual findings and conclusions drawn and need to be completely and thoroughly summarized in the investigation report.

- ✓ Actions taken based on the findings: Appropriate actions should have been taken and documented. All recommendations made as the result of an investigation should be implemented or an explanation given as to why not.

- ✓ HRC review of the report/actions taken and actions taken based on their recommendation. The HRC review of the investigation should be conducted as soon as possible after its completion. The record must document that this review occurred and the HRC's specific recommendation(s). Records need to reflect that recommendations were implemented or if not, the reasons why.

Section 6

Investigation Process

The techniques involved in conducting a thorough and complete investigation are included in the training provided by Labor Relations Alternatives, Inc. and are not detailed in these materials. Only the areas that need further explanation and clarification relating to systemic issues will be discussed here. The investigator must reference the LRA training and materials in addition to this manual.

IDENTIFYING THE INVESTIGATIVE QUESTION

The process of identifying the investigation question is also outlined in Chapter 2 of the LRA investigations manual. This section of the DDD investigations manual must take into consideration the information outlined by LRA.

The investigative question is the backbone of all the steps that will follow in the investigation process. Identifying the question to be answered is one of the most important steps to conducting a thorough and focused investigation. Although it is important to identify this question before you start any investigation process, it is also important to remember that there may be more than one question and additional secondary questions might be raised at any time throughout the investigation process.

The investigator must rely on the accurate definitions of abuse, neglect, mistreatment, and exploitation as defined in DDD rules and regulations 16.120 and the policies and procedures of the CCB, PASA, and RC in identifying the investigation question. For alleged incidents that do not fit within these definitions and result in an investigation, the investigative question should be clearly defined, e.g., "what were the circumstances that preceded the injury?"

There is always at least one primary question. This question will most directly answer the allegation as reported. As a simple example, if an allegation is reported that staff person (Steve) hit individual (John), then the investigation question is "Did Steve hit John?" In addition to the

primary question, a definitional question should be asked. This will involve the definitions of abuse, neglect, mistreatment, and exploitation. For example “Did physical abuse occur?” There may be a secondary question or questions that need to be answered. These should be considered when there are procedural or other systemic errors that may have contributed to the incident of alleged abuse, neglect, mistreatment, and exploitation. For example, there may be a question of "what were the circumstances that led up to the incident?"; or "What is the agency's process for providing training for staff/providers?" The investigator should rely heavily on the defined questions in collecting evidence and drawing conclusions that will answer all applicable questions.

The investigative question should be simply stated. The question should be based on what the investigator already knows and what the investigator is trying to determine through the investigation. All evidence collected should contribute towards answering the identified question(s). Here are some examples:

Example #1
John is a person living in a group home. After becoming physically aggressive toward his peers, the staff person implemented a physical restraint. After the restraint, a black eye slowly develops on John’s right eye. When asked about how this occurred, John states that the staff person punched him in the eye.

Investigative questions to consider:

1) Did the staff person punch John in the eye? (primary question)

2) Did the staff person physically abuse John during the restraint or at any other time during the intervention? (definitional question)

3) If the staff person did not punch John in the eye, how did the injury occur? (secondary question)

4) Did the staff person use the appropriate approved technique in order to implement a restraint on John? (secondary question)

5) If the appropriate restraint technique was not used, what training did the staff person receive? (secondary question)

Example #2
Dorothy is a person living in a host home. She becomes severely ill with symptoms of a severe cold. When she is taken to the doctor, she is

diagnosed with pneumonia and is transferred to ICU at the hospital. It is discovered that she has lost 40 pounds in the last five months and now weighs 95 pounds. An examination also reveals a serious decubitus (bed sore) that has not been treated. The doctor expressed concern to the Residential Manager of the quality of care Dorothy was receiving in the host home.

Investigative questions to consider:

1) Did the host home provider fail to attend to her health and safety needs? (primary question)

2) Did the host home provider's actions fit within the definition of neglect? (definitional question)

3) If not, what are the circumstances contributing the health issues identified by the physicians? (secondary question)

4) Did the agency provide adequate monitoring of the host home in order to identify and rectify Dorothy's health concerns? (secondary question)

5) If not, what agency systems are in place to ensure that health issues are identified, communicated, and rectified? (secondary question)

GATHERING EVIDENCE

Physical evidence should be collected and/or preserved as early in the investigation as possible. The investigator must make a preliminary assessment about whether potential physical evidence is available and if so, should take steps to collect evidence to evaluate injuries, locations where injuries occurred, and various substances and objects.[1]

Testimonial evidence (the interview) is the most common type of evidence that will be available and important to the investigator. The investigator must be familiar with proper techniques for conducting the interview according to the Labor Relations Alternatives Investigation Manual [2]

[1]Aboud, Antone (2003). Investigations Manual. Labor Relations Alternatives, Inc. *Chapter 3 Physical and Demonstrative Evidence* (pp.14-18).
[2] Aboud, Antone (2003). Investigations Manual. Labor Relations Alternatives, Inc. *Chapter 4-5 Testimonial Evidence, Slicing the Bologna* (pp. 20-45).

Interviewing a person with a developmental disability:

The investigator in the DD system is sometimes faced with a difficult challenge of interviewing individuals who have DD including individuals who are limited in verbal ability or have no verbal skills. Some guidelines for conducting an interview with an individual with DD can be applied to the interview process.

1. Assess the person's communication abilities.
   - Ask someone who knows the person well how the person best communicates.
   - Know the language and terms that the victim will use.
   - Ask for a neutral person (e.g., case manager) to be present, if necessary.

2. Establish rapport.
   - Meet in a place the victim chooses e.g., home, work, case manager's office, etc.
   - Ask questions about familiar things e.g., work, movies, favorite things.
   - Assure the person that he/she is not in trouble.
   - State to the person that he/she is helping <u>you</u> solve a problem.
   - Assure the person that it is safe to talk to you and that you want to help.

3. Simplify language.
   - Limit compound sentences and those that contain more than one idea or concept.
   - Avoid tag phrases like "You came home after work, right?"
   - Use concrete terms as opposed to abstract concepts.
   - Be prepared for longer response times from the witness/victim with DD.
   - Check the understanding of victim's use of complex words like "sex".
   - Be cautious of relational concepts, e.g., yesterday, last week, etc.

4. Use LRA-trained interviewing techniques first.
   - Allow the person the opportunity to answer open ended questions.
   - Avoid "why" questions as they impose judgment.

- Use "reflective listening" techniques to acknowledge the explanation given.
- Go with the witness/victim's pace. It may take a long time to answer the question.

5. Move to more direct closed ended questions.
   - Only use when open-ended questions are not effective or when clarification is needed.
   - Check the accuracy of the answer throughout the interview. For example, if the person begins to answer "yes" to every question, ask a question that requires a "no" answer to see if they are accurate.
   - Ask the question several times in different ways.
   - Check person's definitions of terms used, e.g., black vs. white, hit vs. touch, yell vs. firm tone of voice, etc.
   - Be aware of your non-verbal behavior which will provide witness/victim with DD "clues" about how to respond.
   - Evaluate the answers carefully when assigning weight to the testimonial evidence.

6. Be creative.
   - Creative techniques can further enhance testimony given or check accuracy.
   - Use pictures of specific people and specific places.
   - Ask the person to "act out" what happened.
   - Have the victim play the role of the target and show you ("the victim") how the incident happened.
   - Have the witness/victim demonstrate what "hit" or a "push" looks like.
   - Ask the witness/victim to draw a picture.
   - Evaluate carefully when assigning the weight to this evidence. Some information may not be sound evidence but might lead the investigator to look at other information/evidence.

7. Observe witness/victim's behaviors.
   - Take note of the behaviors observed.
   - Don't interpret behaviors or draw conclusions based only on behaviors.
   - Review records and ask persons who know the witness/victim.

When interviewing a person who has a profound level of disability, the investigator may obtain very little information. This unfortunately, limits the

amount and quality of the evidence that is available. When information is obtained from any person with a developmental disability, the investigator must carefully weigh the evidence as this might differ from other testimony. Some issues to consider are:

- How much time lapsed from the incident to the interview? This may directly effect the reliability of the person's testimony. In situations when the interview was delayed significantly, the investigator might have to assign a lesser weight factor to that testimony.

- Did the person with DD discuss the incident with anyone? This should be evaluated closely during the interview process. Individuals with DD are likely to be influenced by others, even unintentionally. If conversations occurred with the individual, it is essential to explore this during the interview process. The amount of discussion that occurred should affect the weight that the evidence carries in the evaluation phase.

- Did the person with DD (especially if the person is the alleged victim) have any contact with the target before the interview? Again, persons with DD can be easily influenced and the target could potentially have a significant influence on the person's testimony.

Documentary evidence is means by which testimonial evidence is preserved and also includes other agency and client records.[3] This section will not discuss how to record testimonial evidence since the LRA Investigations Manual discusses this in great detail. There are numerous forms of other documentation that can assist in the investigation process. This section will focus on the information that may be available in addition to the preservation of this information.

Throughout the initial process of the investigation, the investigator should make note of any documentation that should be reviewed. This information should be considered in order to answer the investigative question(s) and because it has some relationship to the incident being reviewed and/or to other systemic issues that may have contributed to the incident. There are many forms of documentary evidence that should be considered and/or included in the investigative process.

[3] Aboud, Antone (2003). Investigations Manual. Labor Relations Alternatives, Inc. *Chapter 6. Documentary Evidence/Taking Statements* (pp. 46-53).

Critical documents from agency records and client records should be secured immediately by the investigator to prevent tampering or the suspicion of tampering. This may mean that records are removed from their usual location and should be photocopied immediately. Some (but not all) of the records that the investigator should consider in the investigation process are as follows:

Individualized Plan**:** This document should always be reviewed in the investigation process. If another person receiving services is involved in the alleged incident, his/her IP should also be reviewed. A review of the previous IPs should be considered when a broader history would be helpful. The IP will outline what the person's strengths and needs are and will include the specific services that are to be provided to the person. Depending on the type of incident being investigated, the IP can provide a general overview or can provide very specific information i.e., when a doctor's appointment should be scheduled.

Incident report: An incident report must always be written to record the allegation or incident that is being investigated. This can be used as a record of preliminary report of the allegation and can be the basis for initiating the investigation process. This should help in identifying preliminary facts and witnesses in the incident.

Incident report history**:** A review of the past incident reports should be completed to identify a history or pattern of incidents.

HRC record: This record will include all of the presentations to HRC including safety control procedures, previous allegations, use of psychotropic medication, rights suspensions, and restrictive procedures as applicable.

Contact/Progress Notes: If the agency regularly documents in the form of contact notes, these should be reviewed. This information can reveal daily routines, interactions, and any changes in the person's behavior or medical condition. If the agency's management staff maintains separate contact/progress notes, these should also be reviewed.

Doctor contacts/ Physician's orders**:** A review of documents such as recent visits to doctors or other medical professionals should be reviewed when researching a person's physical or mental health.

This history can be helpful when the person's medical, physical, or mental status is an element being addressed by the investigation.

Safety Control Procedures**:** For incidents involving restraints or other behavioral interventions, this document can describe the restraint technique to be used.

Safety Plan**:** This document should describe the person's ability to respond to an emergency situation and detail the assistance that is required. It should also specify the amount of supervision the person requires and under what circumstances it is required. This should be reviewed when there is an alleged incident involving an area covered in the safety plan (i.e., response to fire, medical emergency, etc.).

Medication Administration Record (MAR): These documents can help to answer whether a person received the proper medication if this is a factor in an investigation. This should be reviewed any time someone is hospitalized for a condition treated through prescribed medication e.g., seizures, diabetes, blood pressure, etc. If the agency maintains a medication count record, or a record of when a bottle or bubble pack is started, this should be reviewed to determine if it matches the MAR.

Timesheets/Schedules**:** The agency's employee timesheets and/or schedules can be used to identify when each employee worked with the individual. This can be helpful when investigating unexplained injuries or other incidents that may have occurred over a period of time.

Previous investigations**:** Any previous investigations involving the consumer should be reviewed to determine if a pattern exists. This can be especially helpful when investigating unexplained injuries. The recommendations from previous investigations should be reviewed to determine if follow up has been completed by the agency. If the staff person involved has been involved in a previous investigation, this should also be reviewed by the investigator.

Personnel record(s): The target's personnel record should be accessed to review any history of disciplinary actions.

Training records**:** The agency's training records for staff should be reviewed to determine if proper training was provided in an

appropriate timeframe. This can help in determining if the staff/provider acted outside of a reasonable standard of care. For example, if a staff person employs an improper physical restraint that subsequently causes injury, training records should be reviewed to determine if proper training was conducted. If the staff person was properly trained, he/she may have acted outside of a reasonable standard of care.

Other agency records

Since one of the purposes in conducting an investigation is to identify systemic issues in order to reduce the likelihood that a similar incident will occur, it is important to complete a review of all other relevant information. Looking at why an incident occurred is critical in identifying necessary systemic changes. Here are some general guidelines on how to identify problematic areas. Keep in mind that some of these may not apply or there may be additional applicable areas depending on the specifics of the incident.

***Ask**-How could this have been prevented?*

A question such as this should be formulated throughout the investigation process in order to prompt a "look behind" approach. Because problematic practices are often identified much more clearly in "hindsight", this look behind approach will assist the investigator to identify these problematic or potentially problematic practices.

***Ask**-What could be in place to prevent future occurances?*

Once the problematic practices have been identified, corrective actions must be considered in order to reduce the likelihood of a similar incident. Consider actions of management and agency, reporting lines, actions taken, behavioral/medical issues etc. to identify these future changes. The corrective actions might be specific to the individual, or might be generalized to address all individuals through an agency process.

The following are areas that should be considered for review:

Policies and Procedures: Review agency policies and procedures- were they followed?

The agency's policies and procedures should be written to address not only the steps to take to respond to an incident but also other

processes that contributed to the incident. For example, in the first example on page 44, it would be important to review the policies and procedures on the use of restraints. In the second example on page 44, it would be important to review the agency's policies and procedures on nursing and monitoring. If the agency does not have policies and procedures to address the key processes identified in the investigation, a recommendation for development should be made. Other policies and procedures that should be reviewed if applicable are:

- Abuse/Neglect
- Incident reporting
- Restraints/Safety Control Procedures
- Training of direct service providers
- Monitoring
- Emergency procedures
- Other applicable policies and procedures

Rules and Regulations: In most cases, the rules and regulations were developed and adopted by DDD to ensure that persons receive quality services and emphasize the importance of ensuring safety and rights of persons with DD. When an incident occurs, it is important to review the processes that were involved in the incident to evaluate whether these processes conform to DDD requirements. For example, if an injury occurs to a person receiving services during a physical restraint, were the requirements for safety control procedures and physical restraint followed? For another example, if a person is receiving medical treatment for smoke inhalation from a fire in their home when the provider was not present, were proper assessments completed to determine the person's ability to evacuate in an emergency without supervision? Does the safety plan outline the specific steps the person will take to evacuate without supervision?

Other Information:

- Incident reporting breakdown
- Trends in incidents not addressed (changes in behavior/health)
- Person specific training
- Training provided on medical and behavioral practices
- Physical environments adequate (including medical supplies)
- Medical procedures followed (including emergency care, weight monitoring)
- Adequate behavioral supports
- Appropriate action taken in emergencies (safety plans)

- Hiring processes and standards
- Monitoring systems of the agency

Any documentary evidence that is used during the investigation should be maintained in the investigation file. If numerous documents are gathered and maintained in the file, a labeling or numbering system can be utilized for a quick reference in the investigation report. All documents used as evidence should be listed or otherwise identified in the investigation report. Note: it is not necessary to list in the investigation report those documents that were reviewed as part of the investigation but not maintained as evidence (unless it fits within the "lack of evidence" definition). A record of the information (a list, within notes, etc.) reviewed but determined irrelevant should be maintained in the investigation file in order to document all information considered (the actual documents do not need to be maintained).

EVALUATING EVIDENCE

The Investigation Manual by Labor Relations Alternatives discusses the process for evaluating the evidence that has been obtained throughout the investigation.[4] In addition to utilizing this process of evaluation, the following guidelines should be used:

The investigator should continuously review the investigative questions in order to identify the facts that are relevant to answering the question(s). Occasionally, facts collected may result in the identification of additional investigative questions. When this happens, the newly identified question should be added to the process, or if appropriate, a new investigation should be initiated.

A list of findings should be made by the investigator only after all evidence has been collected. Determining facts prior to the consideration of all evidence can lead to serious errors in the process. The following considerations should be made in listing findings based on evidence:

- Findings should not simply be a re-statement of the evidence, e.g., "Susan stated that it was 8:00PM", but only if this information can be confirmed, e.g., "four witnesses confirmed that the incident occurred at 8:00PM" or more simply, "the incident occurred at 8:00PM".

[4] Aboud, Antone (2003). Investigations Manual. Labor Relations Alternatives, Inc. *Chapter 7. Drawing Conclusions and Reporting Investigative Findings.* (pp. 54-59).

- For specific investigative questions in which there is no evidence in order to answer the question(s), this should be stated, e.g., "there is no evidence available to determine how many pills were left in the medication container".

- The list of findings should be reviewed to ensure relevancy to the investigative questions. Findings that are irrelevant to the investigative question or to the overall investigation should be eliminated.

- Consider the specific elements of the definitions of MANE to ensure that all applicable elements have been considered in the collection of evidence.

DRAWING CONCLUSIONS

Critical to the investigation process is the determination of a conclusion(s). The investigator must formulate this conclusion in response to the allegations of MANE, as applicable. The importance of these determinations should not be minimized as these conclusions will represent the entire outcome of the investigation and may be disclosed at any time. The following considerations should be taken when drawing conclusions:

- The investigator should not draw conclusions based on evidence which is not collected as part of the investigation.

- An investigation may result in the conclusion that a determination cannot be made due to lack of evidence or contrary evidence.[5]

- Conclusions must only be based on fact, and not emotion or opinion.

The following steps should be utilized when determining conclusions of the investigation:

Step 1: Review the investigative question(s) identified in the initial stages of the investigation.

Step 2: Review the evidence to determine each finding/fact.

[5] Aboud, Antone (2003). Investigations Manual. Labor Relations Alternatives, Inc. *Chapter 7. Drawing Conclusions and Reporting Investigative Findings.* (pp. 58).

Step 3: List the findings/facts that have been identified that relate to the specific question.

Step 4: Review the **primary** question and determine if the allegation is substantiated or unsubstantiated based on the following definitions:

- **Substantiated**: The allegation is verified by proof or preponderance of the evidence.
  Preponderance-superiority in weight, importance, or strength.
- **Unsubstantiated**: The allegation is not verified due to a lack of evidence or contrary fact.

Step 5: Review the definitions of MANE as applicable to the incident being investigated. Review the definitional question.

Step 6: To answer the **definitional** question(s), determine if the allegation is substantiated or unsubstantiated based on the definitions.

Step 7: To answer the **secondary** question, evaluate the other evidence to answer the question(s).

In order to demonstrate these steps, the previous examples for identifying the investigative question (Page 44) will be used here.

Step 1. Investigation Questions	Example #1 Step 2. Evidence	Step 3-Findings
1. Did the staff person punch John during the restraint?	• John stated that the staff person hit him in the eye. • Witness #1 stated that he was assisting the target and did not observe staff hit John during the restraint. • Target stated that he restrained John appropriately and did not hit him in the eye. • Witness #2 stated that 30 minutes before the restraint, John reported that he fell and hit his head on the desk in his room.	There is inconsistent information and no evidence that the staff punched John in the eye.
2. If the staff person did not punch John in the eye, how did the injury occur?	• John's roommate reported that he and John got into a fight and John fell and hit his head on the desk. • Witness #2 stated that 30 minutes before the restraint, John reported that he fell and hit his head on the desk in his room. • Witness #3 stated that he heard John and his roommate fighting from the bedroom next to John's.	John and his roommate got into a fight approximately 30 minutes before the restraint. John fell and hit his head on the desk in his room.

Continued		
Step 1: Investigation Questions	Step 2: Evidence	Step 3: Findings
3. Did the staff person use the appropriate approved technique in order to implement a restraint on John?	• Witness #1 stated that he was assisting the target and that he used a one-person take-down restraint and John was restrained on his side. • John stated that the target was sitting on him while on the floor. • The target reported that he did a "take-down" with John on the floor because he was highly combative and couldn't be restrained any other way. • John's safety control procedures states that because of a previous back injury, John should only be restrained with two staff in a standing position. • A review of medical records indicate a back injury that receives regular treatment and Physical Therapy.	John's safety control procedure was not followed by the target. John was restrained with an unsafe technique due to a previous back injury.
4. If the appropriate restraint technique was not used, what training did the staff person receive?	• Training records documented that the target received training in crisis prevention techniques 6 months previous to the incident. • Target stated that he did receive general training but had never seen or been trained on the safety control procedure for John. • Witness #1 stated that he had never seen or been trained on the safety control procedure for John. • The group home manager stated that she reviewed the safety control procedure for John at a house meeting. • Documentation of the house meeting was not available	There is no verification of training on John's safety control procedure provided to the target and other staff.

Determining conclusions for Example #1:
Step 4: Review the **primary question**: "Did the staff person punch John in the eye? Determine if the allegation substantiated or unsubstantiated.

The target stated that he did not hit John in the eye (*Because he is the target of the investigation, there is lesser weight tied to his self-report/evidence).* There was a direct witness to the incident who stated that the target did not hit John in the eye. There is other circumstantial evidence that indicates the injuries may have occurred previous to the restraint. There is no additional evidence, other than John's testimony that there was "infliction of pain, injury, or the imposition of unreasonable

confinement of restraint on a person." Therefore, **the allegation that the staff person punched John is unsubstantiated.**

Step 5: Review the definitions of MANE as applicable to the incident being investigated.

Physical abuse, which means the infliction of physical pain, injury, or the imposition of unreasonable confinement of restraint on a person. This includes directing a person to physically abuse another person receiving services.

Step 6: To answer the **definitional** question, determine if the allegation is substantiated or unsubstantiated.

Since the allegation that the staff person punched John is unsubstantiated and there is no other evidence of actions fitting within the definition of physical abuse, then the **allegation of physical abuse is unsubstantiated.**

Step 7: To answer the **secondary** question, evaluate the other evidence to answer the question(s).

If the staff person did not punch John in the eye, how did the injury occur?

One direct witness reported that John fell and hit his head on the desk in the bedroom. Another witness reported that John told her that he fell and hit his head and although this is hearsay evidence, it should be carry some weight. Finally, a witness confirmed that there was a fight between John and his roommate giving additional weight to the roommate's report. Given this information and the fact that no contrary evidence was identified, it can reasonably be concluded due to the preponderance of the evidence that **John injured his eye during a fall in his bedroom.**

Did the staff person use the appropriate approved technique in order to implement a restraint on John?

One direct witness, in addition to John and the target reported that John was restrained while lying on the floor. Although the proper technique for this type of restraint was utilized, John had a specific safety control procedure that stated he was only to be restrained by two staff in a standing position because of a pre-existing back injury. Based on this information, it is reasonable to conclude that **the target did not utilize proper restraint techniques in restraining John.**

If the appropriate restraint technique was not used, what training did the staff person receive?

In addition to the target's report, documentation indicates that he did receive general training in utilizing restraint techniques. Because John had an individualized safety control procedure due to a pre-existing back injury, it would be expected that training occur with staff on this specialized procedure. Although the Manager reported that she conducted this training during a house meeting, her testimony carries less weight than the other information because she has the direct responsibility in providing the training (therefore self-interest in the outcome of the review). All other evidence suggests that the training of staff on the individualized safety control procedure did not occur. Therefore, it is reasonable to conclude that **the target received inadequate training on how to restrain John properly and safely**.

ACTIONS TO BE TAKEN/RECOMMENDATIONS

DDD Rule 16.580 D2d requires that that agency document the actions taken in response to findings of an investigation and that this documentation be maintained in an investigative record. The CCB/RC must have identified procedures that ensure that actions taken are documented. Typically, this occurs when an investigator makes specific recommendations in response to the findings and conclusions of an investigation. In some agencies, however, the investigator does not formulate the recommendations but only the conclusions. The actions to be taken are developed by another person(s) who has more direct control over the correction process. Regardless of how that occurs, some general guidelines should be considered in this process:

- The LRA Investigation manual states that the investigator should not make recommendations about what should be done to someone who is apparently guilty of misconduct.[6] DDD agrees with this, however, DDD believes it is appropriate to recommend that an agency follow its policies and procedures in addressing the outcome of the investigation with the identified employee, or contractor. Rule 16.580 B4 states that policies and procedures must "ensure that appropriate disciplinary actions up to and including termination and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation".

[6] Aboud, Antone (2003). Investigations Manual. Labor Relations Alternatives, Inc. *Chapter 7. Drawing Conclusions and Reporting Investigative Findings.* (pp. 58).

- Actions taken/Recommendations should address each issue identified in the conclusion as problematic. In the example above, the conclusion "the target received inadequate training on how to restrain John properly and safely", should be met with an action/recommendation to ensure the proper training is provided to all staff working with John.

- Actions taken/Recommendations should address other regulatory issues that were not followed in the incident being investigated. For example, if an incident report was not written according to established agency policies, an appropriate action/recommendation would include ensuring that the incident reporting process is followed and that training is provided, if appropriate.

- When allegations are unsubstantiated, or when such a lack of evidence exists to identify a target or provide an explanation, actions taken/recommendations should still be identified, as appropriate. These can include how to monitor the situation, to ensure the safety of the individual, and to address other problematic practices identified in the investigation.

- If the investigator makes recommendations based on the conclusions of the investigation, DDD expects the agency to address the recommendation; however, there may be reasons why recommendations cannot be implemented. When an agency determines that a recommendation cannot be implemented as written, an explanation from the agency should be documented.

- Documentation of the outcomes of the recommendations and/or actions taken must be included in the administrative record of the investigation.

WRITING THE REPORT

The final product of the investigator's work must be recorded and included in the administrative file. This critical part of the investigation process should not be minimized since it will display the evidence, findings, and conclusions of the investigation. A thorough investigation report will do the following:

- Record the activities of the investigator.
- Record the activities of the agency, e.g., how the victim was protected.

- Identify the investigative question.
- Disclose all evidence and findings pertaining to the question.
- Will explain or justify the conclusions drawn by the investigator.
- Will identify corrective actions to correct problematic practices.

The following are guidelines for the content of the report that are recommended. Some elements are required and these will be marked by an asterisk (*).

Titles**:**

✓ Type of allegation (e.g., "physical abuse", "neglect")
This information will be useful to the agency for data collection purposes.

✓ Person involved (e.g., the victim, or person effected by the incident)

✓ The name and title of person completing the investigation

✓ Date of incident

✓ Date the investigation was completed

Introduction**:**

✓ A general description of the alleged incident
This description should be a general, but factual description based on the incident report information.

✓ How the incident was reported
This description should include the reporting of the incident to the agency administrator, or designee according to agency procedures. Notifications to guardians, police, Adult Protection, and other persons, should be included in this section.

✓ When the investigation was assigned and initiated
A statement including the date that the investigator initiated the investigation will assist the agency in evaluating the timeliness and efficiency of the investigation process.

✓ Identification of the investigative question(s)
All investigative questions should be stated clearly in order to specify the questions that will be addressed by the investigation.

- ✓ The process for securing the evidence
  The steps that were taken to secure evidence should be described. Any errors in this process should be explained in this section.

- ✓ The process for protecting the victim
  Actions to protect the victim, e.g., taking the victim to the physician, moving the person to an alternate setting, etc., should be described in this section.

- ✓ Other investigative procedures should be described
  The documentation of all investigative procedures gives validity to the conclusions drawn.

Evidence**:**

- ✓ A list of physical evidence by type and date secured

- ✓ A list of testimonial evidence by full name of person, title (if applicable) and interview date.

- ✓ A list of documentary evidence by record and applicable dates
  Documentary evidence that is maintained in the administrative record should be identified in this list with a numbering or coding system so that information in the file can be accessed quickly and easily.

Summary of Evidence**:**

There are several ways to organize the summary of evidence. The investigator should evaluate the best way to organize the information so that it is understandable and the chain of events is easy to follow. For example, in many cases, a summary of each piece of evidence including testimony, will give the reader the information in an understandable format. In other cases, when the chronology of events is the most critical to answering an investigative question, the information can be summarized in a chronological format.

Some considerations are as follows:

- ✓ Testimonial evidence should be arranged so that the information gives a factual account of sequential events as if the investigator is "telling a story" based on the information received. In other words, the arrangement of information should not jump back and forth between periods of time/events or should not simply follow in the order that the interviews were conducted. In some cases,

particularly cases with a lot of discrepancies, this may be the easiest and cleanest way to summarize the evidence.

- ✓ The investigator should screen through each person's testimony to eliminate information that has been determined irrelevant to the investigative question. Only relevant testimony pertaining to the investigative question(s) should be included.

- ✓ The investigator should be extremely cautious in summarizing a person's testimony and should ensure that the information contained in the summary can be validated by the person through a statement or other confirmation.

- ✓ In a chronology of events format, each period of time highlighted in the report might contain several pieces of evidence (testimonial, documentary) that describes what occurred. For example:
  Friday 10/29/05 3:00 PM:
  Staff #1: stated that John (consumer) arrived home from day program.
  Staff #2: stated that John (consumer) arrived home from day program.
  John: reported that he came home so that he could watch Dr. Phil on T.V.
  Staff Log: Documentation in the log indicated that John came home from day program and immediately began to watch the beginning of Dr. Phil.

- ✓ Since the absence of evidence is evidence in itself, any critical absence should be included in this section if it is relevant to answering (or not being able to answer) an investigative question(s).

Findings**:**
A list of all findings relevant to the investigative question(s) should be included in this section. Only verified facts should be included and should not simply be a restatement of evidence. If relevant, any fact that cannot be determined by the evidence should be stated in this section.

For example, in the description of evidence described in the previous paragraph, two staff witnesses reported that John arrived home at 3:00. John's testimony and documentary evidence stated that he came home and watched Dr Phil. The investigator researched the time of Dr Phil and determined that it starts at 3:00PM. Given this

evidence, a finding should state: "*John arrived home from day program at 3:00"*.

Conclusions**:**
The investigator should describe the conclusions drawn by the evidence and subsequent findings. A restatement of the investigative question(s) should be included here. **A statement that either the allegation is substantiated or unsubstantiated must be included in this section**.

Recommendations/Actions taken**:**
If, according to agency procedures, the investigator formulates recommendations to the agency, this section should contain those recommendations. If the investigator does not formulate recommendations, the agency must document the actions taken and maintain in the administrative record. The actions taken must directly relate to the conclusions made by the investigator.

AGENCY REVIEW OF THE REPORT

As part of the agency process for finalizing the report, an internal review process might occur. It is important that if an agency has such a review process that it is followed consistently for each investigation and report generated. The purpose of this review process should be to ensure the investigation report is readable and the content is understandable. Minor edits for spelling and grammar can be included in this review. This process also might identify additional gaps that need follow up before the investigation can be closed. The purpose of this review should never be to monitor or change the content of the report in any way. In other words, the facts/findings that are identified should remain and the conclusions drawn as a result of those findings should never be altered during this review process.

HUMAN RIGHTS COMMITTEE REVIEW

C.R.S. 27-10.5-102(17) states that it is the responsibility of the HRC to either provide or ensure the investigations of allegations of abuse or neglect are conducted. All CCB policies and procedures regarding the conduct of investigations and subsequent review by the HRC should be reviewed and approved by the HRC.

C.R.S. 27-10.5-115(10) requires that all incidents of MANE are reviewed by the HRC. When reviewing an investigation, there are several key issues that should receive attention from the HRC. The following are guidelines for what the HRC should review.

HRC review should, at minimum, include:

- ✓ Actions taken to ensure the safety of the individual during the investigation were adequate;
- ✓ Investigation process was timely, thorough and complete;
- ✓ Conclusions were reasonable based on evidence collected;
- ✓ Actions taken were appropriate and complete; and,
- ✓ Investigation was free from bias and conflict of interest.

Since statute requires that all allegations of MANE are required to receive HRC review, the CCB should discuss with the HRC how this process should occur. Since some **level 2** investigations *(refer to page 13)* do not result in a complete investigation and report, the HRC must be involved in determining how these allegations should be reviewed by the committee. At minimum, the HRC should be aware of allegations that require only this "preliminary review" to ensure that all processes (as stated above) have been completed.

Appendices

Appendix A:	DD Statutes 27-10.5
Appendix B:	DDD Rules 2 CCR503-1 16.000
Appendix C:	Criminal Statutes
Appendix D:	DDD Critical Incident Criteria
Appendix E:	CDPHE Occurrence Reporting Quick Reference
Appendix F:	Victim Rights Statutes
Appendix G:	Children's Code/Child Protection Statutes
Appendix H:	Adult Protection Statutes
Appendix I:	Coroner Reporting Statutes

Appendix A
Applicable DDD Statutes (C.R.S. 27-10.5)

27-10.5-102 Definitions

(17) "Human rights committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavior development programs in which persons with developmental disabilities are involved, monitoring the use of psychotropic medication by persons with developmental disabilities, and at the committee's option, either providing or ensuring the investigation of allegations of abuse or neglect of persons with developmental disabilities who are receiving services or supports under this article.

27-10.5-115. Right to humane care and treatment.

(1) Corporal punishment of persons with a developmental disability shall not be permitted.

(2) All service agencies shall prohibit mistreatment, exploitation, neglect, or abuse in any form of any person receiving services.

(3) Service agencies shall provide every person receiving services with a humane physical environment.

(4) Each person receiving services shall be attended to by qualified staff in numbers sufficient to provide appropriate services and supports.

(5) Seclusion, defined as the placement of a person receiving services alone in a closed room for the purpose of punishment, is prohibited.

(6) "Time out" procedures, defined as separation from other persons receiving services and group activities, may be employed under close and direct professional supervision, as defined by the department, and only as a technique in behavior-shaping programs. Behavior-shaping programs utilizing a "time out" procedure shall be implemented only when it incorporates a positive approach designed to result in the acquisition of adaptive behaviors. Such behavior programs shall only be implemented following the completion of a comprehensive functional analysis, when alternative nonrestrictive procedures have been proven to be ineffective, and only with the informed consent of the individual, parents, or legal guardian. Such behavior programs shall be implemented only following the review and approval process defined in rules and regulations. Behavior development programs shall be developed in conjunction with the interdisciplinary team and implemented only following review by the human rights committee. Behavior development programs involving the use of the procedure in a "time out room" are prohibited.

(7) Behavior development programs involving the use of aversive or noxious stimuli are prohibited.

(8) Physical restraint, defined as the use of manual methods intended to restrict the movement or normal functioning of a portion of an individual's body through direct contact by staff, shall be employed only when necessary to protect the person receiving services from injury to self or others. Physical restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports. Physical guidance or prompting techniques of short duration such as those employed in training techniques are not considered physical restraint. Physical restraint shall be applied only if alternative techniques have failed and only if such restraint imposed the least possible restriction consistent with its purpose. If physical restraint is used in an emergency or on a continuing basis its use shall be reviewed by the interdisciplinary team and the human rights committee in accordance with the rules and regulations of the department.

(9) The use of a mechanical restraint, defined as the use of mechanical devices intended to restrict the movement or normal functioning of a portion of an individual's body, is subject to special review and oversight, as defined in rules and regulations. Use of mechanical restraints shall be applied only in an emergency if alternative techniques have failed and in conjunction with a behavior development program. Mechanical restraints shall be designed and used so as not to cause physical injury to the person receiving services and so as to cause the least possible discomfort. The use of mechanical restraints shall be reviewed by the human rights committee. The use of posey vests, straight jackets, ankle and wrist restraints, and other devices defined in rules and regulations is prohibited.

(10) A record shall be maintained of all physical injuries to any person receiving services, all incidents of mistreatment, exploitation, neglect, or abuse, and all uses of physical or mechanical restraint. All records shall be subject to review by the human rights committee.

(11) Behavior development programs shall be supervised by a developmental disabilities professional having specific knowledge and skills to develop and implement positive behavioral intervention strategies.

Source: L. 75: Entire article added, p. 914, § 1, effective July 1. **L. 85:** (2) and (8) amended, p. 1002, § 17, effective July 1. **L. 92:** Entire section R&RE, p. 1377, § 16, effective July 1.

Appendix B
Applicable DDD Rules
2 CCR 503-1 16.120
2 CCR 503-1 16.500

16.120 DEFINITIONS

As used in these rules and regulations, unless the context requires otherwise:

Abuse includes, but is not limited to:

A. Physical abuse, which means the infliction of physical pain, injury, or the imposition of unreasonable confinement or restraint on a person. This includes directing a person to physically abuse another person receiving services.

B. Sexual abuse, which means subjecting a person to nonconsensual sexual conduct or contact classified as a crime under the "Colorado Criminal Code", Title 18, C.R.S. This may include, but is not limited to, such actions as sexual assault, rape, fondling, or sexual exploitation. Additionally, any sexual interaction between employees or contractors and persons receiving services shall constitute sexual abuse.

C. Mental or psychological abuse, which means any verbal or nonverbal act which creates, is intended to create, or reasonably could be expected to create mental anguish for a person. This includes, but is not limited to, such actions as discriminatory remarks, belittlement, derogatory name calling, teasing, and unreasonable exclusion from conversations or activities.

Mistreatment means an act or omission which threatens the health, safety, or welfare of a person.

Neglect means an act or failure to act by a person who is responsible for another's well being so that inadequate food, clothing, shelter, psychological care, physical care, medical care, or supervision is provided. This may include, but is not limited to, denial of meals, medication, habilitation, or other treatment necessities and which is not otherwise within the scope of Section 27-10.5, C.R.S., or these rules and regulations.

16.550 HUMAN RIGHTS COMMITTEES (HRC)

A. Each community centered board and regional center shall establish at least one Human Rights Committee (HRC) as a third party mechanism to safeguard the rights of persons receiving services. The Human Rights Committee is an advisory and review body to the administration of the community centered board or regional center.

B. Such committee shall~~,~~ be constituted as required by Section 27-10.5-105, C.R.S.

C. If a consultant to the community centered board, regional center, or service agency serves on the Human Rights Committee, procedures shall be developed by the community centered board or regional center and the Human Rights Committee related to potential conflicts of interest.

D. The community centered board and regional center shall orient members regarding the duties and responsibilities of the Human Rights Committee.

E. The community centered board and regional center shall provide the Human Rights Committee with the necessary staff support to facilitate its functions.

F. Each program approved service agency shall make referrals as required in rules and regulations for review by the Human Rights Committee(s) in the manner required by the community centered board or regional center.

G. The recommendations of the Human Rights Committee shall become a part of the community centered board's, service agency's or regional center record as well as a part of the individual's master record.

H. The Human Rights Committee shall develop operating procedures which include, but are not limited to, Human Rights Committee responsibilities for the committee's organization, the review process, and provisions for recording dissenting opinions of committee members in the committee's recommendations.

I. The Human Rights Committee shall establish and implement operating and review procedures to determine that the practices of the community centered board, service agencies and regional centers are in compliance with Section 27-10.5, C.R.S., are consistent with the mission, goals and policies of the Department, and community centered board or regional center, and ensure that:

1. Informed consent is obtained when required from the person receiving services, the parent of a minor, or the guardian as appropriate;

2. Suspension of rights of persons receiving services occurs only within procedural safeguards as stipulated in Section 16.312 and that continued suspension of such rights is reviewed by the interdisciplinary team at a frequency decided by the team, but not less than every six months;

3. Emergency control procedures, safety control procedures and Individual Service and Support Plans with restrictive procedures are used in accordance with the requirements of these rules;

4. The use of psychotropic medications and other medications used for the purpose of modifying a person's behavior by persons receiving comprehensive services and supports are used in accordance with the requirements of Section 16.623, D, 7 & 8, and are monitored by the Human Rights Committee on a regular basis; and,

5. Allegations of mistreatment, abuse, neglect and exploitation are investigated and the investigation report reviewed.

16.560 INCIDENT REPORTING

A. Community centered boards, service agencies and regional centers shall have a written policy and procedure for the

timely reporting, recording and reviewing of incidents which shall include, but not be limited to:

1. Injury to a person receiving services;

2. Lost or missing persons receiving services;

3. Medical emergencies involving persons receiving services;

4. Hospitalization of persons receiving services;

5. Death of person receiving services;

6. Errors in medication administration;

7. Incidents or reports of actions by persons receiving services that are unusual and require review;

8. Allegations of abuse, mistreatment, neglect, or exploitation;

9. Use of safety control procedures;

10. Use of emergency control procedures; and,

11. Stolen personal property belonging to a person receiving services.

B. Reports of incidents shall include, but not be limited to:

1. Name of the person reporting;

2. Name of the person receiving services who was involved in the incident;

3. Name of persons involved or witnessing the incident;

4. Type of incident;
5. Description of the incident;

6. Date and place of occurrence;

7. Duration of the incident;

8. Description of the action taken;

9. Whether the incident was observed directly or reported to the agency;

10. Names of persons notified;

11. Follow-up action taken or where to find documentation of further follow-up; and,

12. Name of the person responsible for follow-up.

C. Allegations of abuse, mistreatment neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the agency administrator or designee, and to the community centered board within 24 hours.

D. Reports of incidents shall be–placed in the record of the person.

E. Records of incidents shall be made available to the community centered board, and the Department upon request.

F. Community centered boards, program approved service agencies and regional centers shall review and analyze information from incident reports to identify trends and problematic practices which may be occurring in specific services and shall take appropriate corrective action to address problematic practices identified.

16.580 ABUSE, MISTREATMENT, NEGLECT, AND EXPLOITATION

A. Pursuant to Section 27-10.5-115, C.R.S., all community centered boards, service agencies and regional centers shall prohibit abuse, mistreatment, neglect, or exploitation of any person receiving services.

B. Community centered boards, program approved service agencies and regional centers shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any person receiving services. These policies and procedures must be consistent with state law and:

1. Definitions of abuse, mistreatment, neglect, or exploitation must be consistent with state law and these rules;

2. Provide a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation. Monitoring is to include, at a minimum, the review of:

   a. Incident reports;

   b. Verbal and written reports of unusual or dramatic changes in behavior(s) of persons receiving services; and,

   c. Verbal and written reports from persons receiving services, advocates, families, guardians, and friends of persons receiving services.

3. Provide procedures for reporting, reviewing, and investigating all allegations of abuse, mistreatment, neglect, or exploitation;

4. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation;

5. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to abuse, mistreatment, neglect or exploitation;

6. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;

7. Require reporting of allegations within 24 hours to the parent of a minor, guardian, authorized representative, and community centered board or regional center;

8. Ensure prompt action to protect the safety of the person receiving services. Such action may include any action that would protect the person(s) receiving services if determined necessary and appropriate by the service agency or community centered board pending the outcome of the investigation. Actions may include, but are not limited to, removing the person from his/her residential and/or day services setting and removing or replacing staff;

9. Provide necessary victim supports;

10. Require prompt reporting of the allegation to appropriate authorities in accordance with statutory requirements pursuant to Section 16.580, C, of these rules;

11. Ensure Human Rights Committee review of all allegations; and,

12. Ensure that no individual is coerced, intimidated, threatened or retaliated against because the individual, in good faith, makes a report of suspected abuse, mistreatment, neglect or exploitation or assists or participates in any manner in an investigation of such allegations in accordance with Section 16.580, D.

B. Any and all actual or suspected incidents of abuse, mistreatment, neglect, or exploitation shall be reported immediately to the agency administrator or designee. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, Section 19-10-103, C.R.S., (Colorado Children's Code), Section 18-8-115, C.R.S., (Colorado Criminal Code - Duty To Report A Crime),

and Section 26-3.1-101, C.R.S., (Social Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

D. All alleged incidents of abuse, mistreatment, neglect, or exploitation by agency employees or contractors shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to Section C, herein.

1. Within twenty-four hours of becoming aware of the incident, a written incident report shall be made available o the agency administrator or designee and the community centered board or regional center.

2. The agency shall maintain a written administrative record of all such investigations including:

a. The incident report and preliminary results of the investigation;

b. A summary of the investigative procedures utilized;

c. The full investigative finding(s);

d. The actions taken; and,

e. Human Rights Committee review of the investigative report and the action taken on recommendations made by the committee.

3. The agency shall ensure that appropriate actions are taken when an allegation against an employee or contractor is substantiated, and that the results of the investigation are recorded, with the employee's or contractor's knowledge, in the employee's personnel or contractor's file.

18-3-202. Assault in the first degree.

(1) A person commits the crime of assault in the first degree if:

(a) With intent to cause serious bodily injury to another person, he causes serious bodily injury to any person by means of a deadly weapon; or

(b) With intent to disfigure another person seriously and permanently, or to destroy, amputate, or disable permanently a member or organ of his body, he causes such an injury to any person; or

(c) Under circumstances manifesting extreme indifference to the value of human life, he knowingly engages in conduct which creates a grave risk of death to another person, and thereby causes serious bodily injury to any person; or

(d) Repealed.

(e) With intent to cause serious bodily injury upon the person of a peace officer or firefighter, he or she threatens with a deadly weapon a peace officer or firefighter engaged in the performance of his or her duties, and the offender knows or reasonably should know that the victim is a peace officer or firefighter acting in the performance of his or her duties; or

(e.5) With intent to cause serious bodily injury upon the person of a judge of a court of competent jurisdiction or an officer of said court, he threatens with a deadly weapon a judge of a court of competent jurisdiction or an officer of said court, and the offender knows or reasonably should know that the victim is a judge of a court of competent jurisdiction or an officer of said court; or

(f) While lawfully confined or in custody as a result of being charged with or convicted of a crime or as a result of being charged as a delinquent child or adjudicated as a delinquent child and with intent to cause serious bodily injury to a person employed by or under contract with a detention facility, as defined in section 18-8-203 (3), or to a person employed by the division in the department of human services responsible for youth services and who is a youth services counselor or is in the youth services worker classification series, he or she threatens with a deadly weapon such a person engaged in the performance of his or her duties and the offender knows or reasonably should know that the victim is such a person engaged in the performance of his or her duties while employed by or under contract with a detention facility or while employed by the division in the department of human services responsible for youth services. A sentence imposed pursuant to this paragraph (f) shall be served in the

department of corrections and shall run consecutively with any sentences being served by the offender. A person who participates in a work release program, a furlough, or any other similar authorized supervised or unsupervised absence from a detention facility, as defined in section 18-8-203 (3), and who is required to report back to the detention facility at a specified time shall be deemed to be in custody.

(2) (a) If assault in the first degree is committed under circumstances where the act causing the injury is performed upon a sudden heat of passion, caused by a serious and highly provoking act of the intended victim, affecting the person causing the injury sufficiently to excite an irresistible passion in a reasonable person, and without an interval between the provocation and the injury sufficient for the voice of reason and humanity to be heard, it is a class 5 felony.

(b) If assault in the first degree is committed without the circumstances provided in paragraph (a) of this subsection (2), it is a class 3 felony.

(c) If a defendant is convicted of assault in the first degree pursuant to subsection (1) of this section, the court shall sentence the defendant in accordance with the provisions of section 18-1.3-406.

(d) Repealed.

Source: L. 71: R&RE, p. 420, § 1. **C.R.S. 1963:** § 40-3-202. **L. 75:** (1)(d) amended, p. 632, § 6, effective July 1; (1)(a) amended, p. 618, § 7, effective July 21. **L. 76, Ex. Sess.:** (1)(f) added, p. 8, § 1, effective September 18. **L. 77:** (1)(c) amended, p. 961, § 9, effective July 1. **L. 79:** (2) R&RE, p. 732, § 1, effective May 18. **L. 81:** (1)(d) R&RE, p. 973, § 6, effective July 1. **L. 86:** (1)(d) amended, p. 770, § 5, effective July 1; (1)(f) amended, p. 789, § 1, effective July 1; (2)(c) and (2)(d) added, p. 776, § 2, effective July 1. **L. 90:** (1)(f) amended, p. 991, § 1, effective April 5; (1)(e.5) added and (2)(c) amended, p. 986, §§ 7, 8, effective April 24. **L. 94:** (1)(f) amended, p. 2655, § 137, effective July 1. **L. 95:** (1)(d) and (2)(d) repealed, p. 1250, § 6, effective July 1. **L. 97:** (2)(a) amended, p. 1544, § 13, effective July 1; (1)(e) amended, p. 1011, § 15, effective August 6. **L. 98:** (2)(c) amended, p. 1441, § 25, effective July 1. **L. 2002:** (2)(c) amended, p. 1512, § 186, effective October 1. **L. 2003:** (1)(f) amended, p. 1430, § 16, effective April 29.

Cross references: For the legislative declaration contained in the 1994 act amending subsection (1)(f), see section 1 of chapter 345, Session Laws of Colorado 1994. For the legislative declaration contained in the 2002 act amending subsection (2)(c), see section 1 of chapter 318, Session Laws of Colorado 2002.

18-3-203. Assault in the second degree.

(1) A person commits the crime of assault in the second degree if:

(a) Repealed.

(b) With intent to cause bodily injury to another person, he or she causes such injury to any person by means of a deadly weapon; or

(c) With intent to prevent one whom he or she knows, or should know, to be a peace officer or firefighter from performing a lawful duty, he or she intentionally causes bodily injury to any person; or

(d) He recklessly causes serious bodily injury to another person by means of a deadly weapon; or

(e) For a purpose other than lawful medical or therapeutic treatment, he intentionally causes stupor, unconsciousness, or other physical or mental impairment or injury to another person by administering to him, without his consent, a drug, substance, or preparation capable of producing the intended harm; or

(f) While lawfully confined or in custody, he or she knowingly and violently applies physical force against the person of a peace officer or firefighter engaged in the performance of his or her duties, or a judge of a court of competent jurisdiction, or an officer of said court, or, while lawfully confined or in custody as a result of being charged with or convicted of a crime or as a result of being charged as a delinquent child or adjudicated as a delinquent child, he or she knowingly and violently applies physical force against a person engaged in the performance of his or her duties while employed by or under contract with a detention facility, as defined in section 18-8-203 (3), or while employed by the division in the department of human services responsible for youth services and who is a youth services counselor or is in the youth services worker classification series, and the person committing the offense knows or reasonably should know that the victim is a peace officer or firefighter engaged in the performance of his or her duties, or a judge of a court of competent jurisdiction, or an officer of said court, or a person engaged in the performance of his or her duties while employed by or under contract with a detention facility or while employed by the division in the department of human services responsible for youth services. A sentence imposed pursuant to this paragraph (f) shall be served in the department of corrections and shall run consecutively with any sentences being served by the offender; except that, if the offense is committed against a person employed by the division in the department of human services responsible for youth services, the court may grant probation or a suspended sentence in whole

or in part, and such sentence may run concurrently or consecutively with any sentences being served. A person who participates in a work release program, a furlough, or any other similar authorized supervised or unsupervised absence from a detention facility, as defined in section 18-8-203 (3), and who is required to report back to the detention facility at a specified time shall be deemed to be in custody.

(f.5) (I) While lawfully confined in a detention facility within this state, a person with intent to infect, injure, harm, harass, annoy, threaten, or alarm a person in a detention facility whom the actor knows or reasonably should know to be an employee of a detention facility, causes such employee to come into contact with blood, seminal fluid, urine, feces, saliva, mucus, vomit, or any toxic, caustic, or hazardous material by any means, including but not limited to throwing, tossing, or expelling such fluid or material.

(II) (A) Any **adult** or juvenile who is bound over for trial for the offense described in subparagraph (I) of this paragraph (f.5) subsequent to a preliminary hearing or after having waived the right to a preliminary hearing, any person who is indicted for or is convicted of any such offense, or any person who is determined to have provided blood, seminal fluid, urine, feces, saliva, mucus, or vomit to a person bound over for trial for, indicted for, or convicted of such an offense shall be ordered by the court to submit to a medical test for communicable diseases and to supply blood, feces, urine, saliva, or other bodily fluid required for the test. The results of such test shall be reported to the court or the court's designee, who shall then disclose the results to any victim of the offense who requests such disclosure. Review and disclosure of medical test results by the court shall be closed and confidential, and any transaction records relating thereto shall also be closed and confidential. If a person subject to a medical test for communicable diseases pursuant this sub-subparagraph (A) voluntarily submits to a medical test for communicable diseases, the fact of such person's voluntary submission shall be admissible in mitigation of sentence if the person is convicted of the charged offense.

(B) In addition to any other penalty provided by law, the court may order any person who is convicted of the offense described in subparagraph (I) of this paragraph (f.5) to meet all or any portion of the financial obligations of medical tests performed on and treatment prescribed for the victim or victims of the offense.

(C) At the time of sentencing, the court may order that an offender described in sub-subparagraph (B) of this subparagraph (II) be put on a period of probation for the purpose of paying the testing and treatment costs of the victim or victims; except that the period of probation, when added to any time served, shall not exceed the maximum sentence that can be imposed for the offense.

(III) (A) As used in this paragraph (f.5), "detention facility" means any building, structure, enclosure, vehicle, institution, or place, whether permanent or temporary, fixed or mobile, where persons are or may be lawfully held in custody or confinement under the authority of the state of Colorado or any political subdivision of the state of Colorado.

(B) As used in this paragraph (f.5), "employee of a detention facility" includes employees of the department of corrections, employees of any agency or person operating a detention facility, law enforcement personnel, and any other persons who are present in or in the vicinity of a detention facility and are performing services for a detention facility. "Employee of a detention facility" does not include a person lawfully confined in a detention facility.

(g) With intent to cause bodily injury to another person, he causes serious bodily injury to that person or another.

(2) (a) If assault in the second degree is committed under circumstances where the act causing the injury is performed upon a sudden heat of passion, caused by a serious and highly provoking act of the intended victim, affecting the person causing the injury sufficiently to excite an irresistible passion in a reasonable person, and without an interval between the provocation and the injury sufficient for the voice of reason and humanity to be heard, it is a class 6 felony.

(b) If assault in the second degree is committed without the circumstances provided in paragraph (a) of this subsection (2), it is a class 4 felony.

(b.5) Assault in the second degree by any person under subsection (1) of this section without the circumstances provided in paragraph (a) of this subsection (2) is a class 3 felony if the person who is assaulted, other than a participant in the crime, suffered serious bodily injury during the commission or attempted commission of or flight from the commission or attempted commission of murder, robbery, arson, burglary, escape, kidnapping in the first degree, sexual assault, sexual assault in the first or second degree as such offenses existed prior to July 1, 2000, or class 3 felony sexual assault on a child.

(c) If a defendant is convicted of assault in the second degree pursuant to paragraph (b), (c), (d), or (g) of subsection (1) of this section or paragraph (b.5) of this subsection (2), except with respect to sexual assault or sexual assault in the first degree as it existed prior to July 1, 2000, the court shall sentence the defendant in accordance with the provisions of section 18-1.3-406. A defendant convicted of assault in the second degree pursuant to paragraph (b.5) of this subsection (2) with respect to sexual assault or sexual assault in the first degree

as it existed prior to July 1, 2000, shall be sentenced in accordance with section 18-1.3-401 (8) (e) or (8) (e.5).

Source: L. 71: R&RE, p. 420, § 1. **C.R.S. 1963:** § 40-3-203. **L. 76, Ex. Sess.:** (1)(f) amended, p. 8, § 2, effective September 18. **L. 79:** (2) R&RE, p. 732, § 2, effective May 18. **L. 81:** (1)(f) amended and (1)(g) added, p. 973, § 7, effective July 1. **L. 86:** (1)(f) amended, p. 789, § 2, effective July 1; (2)(c) added, p. 777, § 3, effective July 1. **L. 88:** (2)(c) amended, p. 717, § 4, effective July 1. **L. 90:** (1)(f) amended, p. 992, § 2, effective April 5; (1)(f) amended, p. 986, § 9, effective April 24. **L. 91:** (2)(a) and (2)(c) amended, p. 405, § 9, effective June 6. **L. 94:** (1)(a) repealed, p. 1717, § 8, effective July 1; (1)(f) amended, p. 2655, § 138, effective July 1. **L. 95:** (1)(b) and (2)(c) amended and (2)(b.5) added, p. 1250, § 7, effective July 1. **L. 97:** (1)(f.5) added, p. 1591, § 1, effective July 1; (2)(a) amended, p. 1544, § 14, effective July 1; (1)(c) and (1)(f) amended, p. 1011, § 16, effective August 6. **L. 98:** (2)(c) amended, p. 1441, § 26, effective July 1. **L. 2000:** (1)(f) amended, p. 693, § 3, effective July 1. **L. 2002:** (2)(b.5) and (2)(c) amended, p. 757, § 2, effective July 1; (2)(c) amended, p. 1512, § 187, effective October 1. **L. 2003:** (1)(f) amended, p. 1430, § 17, effective April 29.

Editor's note: Amendments to subsection (1)(f) in Senate Bill 90-58 and House Bill 90-1255 were harmonized. Amendments to subsection (2)(c) in House Bill 02-1046 and House Bill 02-1225 were harmonized.

Cross references: For the legislative declaration contained in the 1994 act amending subsection (1)(f), see section 1 of chapter 345, Session Laws of Colorado 1994. For the legislative declaration contained in the 2002 act amending subsection (2)(c), see section 1 of chapter 318, Session Laws of Colorado 2002.

18-3-204. Assault in the third degree.

A person commits the crime of assault in the third degree if the person knowingly or recklessly causes bodily injury to another person or with criminal negligence the person causes bodily injury to another person by means of a deadly weapon. Assault in the third degree is a class 1 misdemeanor and is an extraordinary risk crime that is subject to the modified sentencing range specified in section 18-1.3-501 (3).

Source: L. 71: R&RE, p. 421, § 1. **C.R.S. 1963:** § 40-3-204. **L. 77:** Entire section amended, p. 961, § 10, effective July 1. **L. 2004:** Entire section amended, p. 635, § 4, effective August 4.

18-3-206. Menacing.

(1) A person commits the crime of menacing if, by any threat or physical action, he or she knowingly places or attempts to place another person in fear of imminent serious bodily injury. Menacing is a class 3 misdemeanor, but, it is a class 5 felony if committed:

(a) By the use of a deadly weapon or any article used or fashioned in a manner to cause a person to reasonably believe that the article is a deadly weapon; or

(b) By the person representing verbally or otherwise that he or she is armed with a deadly weapon.

Source: L. 71: R&RE, p. 421, § 1. **C.R.S. 1963:** § 40-3-206. **L. 77:** Entire section amended, p. 961, § 12, effective July 1. **L. 2000:** Entire section amended, p. 694, § 5, effective July 1.

18-3-402. Sexual assault.

(1) Any actor who knowingly inflicts sexual intrusion or sexual penetration on a victim commits sexual assault if:

(a) The actor causes submission of the victim by means of sufficient consequence reasonably calculated to cause submission against the victim's will; or

(b) The actor knows that the victim is incapable of appraising the nature of the victim's conduct; or

(c) The actor knows that the victim submits erroneously, believing the actor to be the victim's spouse; or

(d) At the time of the commission of the act, the victim is less than fifteen years of age and the actor is at least four years older than the victim and is not the spouse of the victim; or

(e) At the time of the commission of the act, the victim is at least fifteen years of age but less than seventeen years of age and the actor is at least ten years older than the victim and is not the spouse of the victim; or

(f) The victim is in custody of law or detained in a hospital or other institution and the actor has supervisory or disciplinary authority over the victim and uses this position of authority to coerce the victim to submit, unless the act is incident to a lawful search; or

(g) The actor, while purporting to offer a medical service, engages in treatment or examination of a victim for other than a bona fide medical purpose or in a manner substantially inconsistent with reasonable medical practices; or

(h) The victim is physically helpless and the actor knows the victim is physically helpless and the victim has not consented.

(2) Sexual assault is a class 4 felony, except as provided in subsections (3), (3.5), (4), and (5) of this section.

(3) If committed under the circumstances of paragraph (e) of subsection (1) of this section, sexual assault is a class 1 misdemeanor and is an extraordinary risk crime that is subject to the modified sentencing range specified in section 18-1.3-501 (3).

(3.5) Sexual assault is a class 3 felony if committed under the circumstances described in paragraph (h) of subsection (1) of this section.

(4) Sexual assault is a class 3 felony if it is attended by any one or more of the following circumstances:

(a) The actor causes submission of the victim through the actual application of physical force or physical violence; or

(b) The actor causes submission of the victim by threat of imminent death, serious bodily injury, extreme pain, or kidnapping, to be inflicted on anyone, and the victim believes that the actor has the present ability to execute these threats; or

(c) The actor causes submission of the victim by threatening to retaliate in the future against the victim, or any other person, and the victim reasonably believes that the actor will execute this threat. As used in this paragraph (c), "to retaliate" includes threats of kidnapping, death, serious bodily injury, or extreme pain; or

(d) The actor has substantially impaired the victim's power to appraise or control the victim's conduct by employing, without the victim's consent, any drug, intoxicant, or other means for the purpose of causing submission.

(e) (Deleted by amendment, L. 2002, p. 1578, § 2, effective July 1, 2002.)

(5) (a) Sexual assault is a class 2 felony if any one or more of the following circumstances exist:

(I) In the commission of the sexual assault, the actor is physically aided or abetted by one or more other persons; or

(II) The victim suffers serious bodily injury; or

(III) The actor is armed with a deadly weapon or an article used or fashioned in a manner to cause a person to reasonably believe that the article is a deadly weapon or represents verbally or otherwise that the actor is armed with a deadly weapon and uses the deadly weapon, article, or representation to cause submission of the victim.

(b) (I) If a defendant is convicted of sexual assault pursuant to this subsection (5), the court shall sentence the defendant in accordance with section 18-1.3-401 (8) (e). A person convicted solely of sexual assault pursuant to this subsection (5) shall not be sentenced under the crime of violence provisions of section 18-1.3-406 (2). Any sentence for a conviction under this subsection (5) shall be consecutive to any sentence for a conviction for a crime of violence under section 18-1.3-406.

(II) The provisions of this paragraph (b) shall apply to offenses committed prior to November 1, 1998.

(6) Any person convicted of felony sexual assault committed on or after November 1, 1998, under any of the circumstances described in this section shall be sentenced in accordance with the provisions of part 10 of article 1.3 of this title.

Source: L. 75: Entire part R&RE, p. 628, § 1, effective July 1. **L. 77:** (1) amended, p. 962, § 15, effective July 1. **L. 83:** IP(1) amended, p. 698, § 1, effective July 1. **L. 85:** (2) R&RE and (3) and (4) amended, pp. 666, 667, §§ 1, 2, effective July 1. **L. 95:** (4) amended, p. 1252, § 9, effective July 1. **L. 98:** (4) amended, p. 1293, § 13, effective November 1. **L. 2000:** Entire section R&RE, p. 698, § 18, effective July 1. **L. 2002:** (1)(g), (2), and (4)(e) amended and (1)(h) and (3.5) added, p. 1578, §§ 1, 2, effective July 1; (5)(b)(I) and (6) amended, p. 1512, § 189, effective October 1. **L. 2004:** (3) and (6) amended, p. 635, § 5, effective August 4.

Editor's note: This section was contained in a part that was repealed and reenacted in 1975. Provisions of this section, as it existed in 1975, are similar to those contained in 18-3-401 as said section existed in 1974, the year prior to the repeal and reenactment of this part.

Cross references: For the legislative declaration contained in the 2002 act amending subsections (5)(b)(I) and (6), see section 1 of chapter 318, Session Laws of Colorado 2002.

18-3-404. Unlawful sexual contact.

(1) Any actor who knowingly subjects a victim to any sexual contact commits unlawful sexual contact if:

(a) The actor knows that the victim does not consent; or

(b) The actor knows that the victim is incapable of appraising the nature of the victim's conduct; or

(c) The victim is physically helpless and the actor knows that the victim is physically helpless and the victim has not consented; or

(d) The actor has substantially impaired the victim's power to appraise or control the victim's conduct by employing, without the victim's consent, any drug, intoxicant, or other means for the purpose of causing submission; or

(e) Repealed.

(f) The victim is in custody of law or detained in a hospital or other institution and the actor has supervisory or disciplinary authority over the victim and uses this position of authority, unless incident to a lawful search, to coerce the victim to submit; or

(g) The actor engages in treatment or examination of a victim for other than bona fide medical purposes or in a manner substantially inconsistent with reasonable medical practices.

(1.5) Any person who knowingly, with or without sexual contact, induces or coerces a child by any of the means set forth in section 18-3-402 to expose intimate parts or to engage in any sexual contact, intrusion, or penetration with another person, for the purpose of the actor's own sexual gratification, commits unlawful sexual contact. For the purposes of this subsection (1.5), the term "child" means any person under the age of eighteen years.

(1.7) Any person who knowingly observes or takes a photograph of another person's intimate parts without that person's consent, in a situation where the person observed has a reasonable expectation of privacy, for the purpose of the observer's own sexual gratification, commits unlawful sexual contact. For purposes of this subsection (1.7), "photograph" includes any photograph, motion

picture, videotape, print, negative, slide, or other mechanically, electronically, or chemically reproduced visual material.

(2) (a) Unlawful sexual contact is a class 1 misdemeanor and is an extraordinary risk crime that is subject to the modified sentencing range specified in section 18-1.3-501 (3).

(b) Notwithstanding the provisions of paragraph (a) of this subsection (2), unlawful sexual contact is a class 4 felony if the actor compels the victim to submit by use of such force, intimidation, or threat as specified in section 18-3-402 (4) (a), (4) (b), or (4) (c) or if the actor engages in the conduct described in paragraph (g) of subsection (1) of this section or subsection (1.5) of this section.

(3) If a defendant is convicted of the class 4 felony of unlawful sexual contact pursuant to paragraph (b) of subsection (2) of this section, the court shall sentence the defendant in accordance with the provisions of section 18-1.3-406; except that this subsection (3) shall not apply if the actor engages in the conduct described in paragraph (g) of subsection (1) of this section.

Source: L. 75: Entire part R&RE, p. 629, § 1, effective July 1. **L. 77:** IP(1) amended, p. 962, § 17, effective July 1. **L. 86:** (3) added, p. 777, § 6, effective July 1. **L. 89:** (1.5) added and (2) and (3) amended, p. 830, § 41, effective July 1. **L. 90:** (1)(e) repealed, p. 1033, § 25, effective July 1. **L. 91:** (3) amended, p. 1912, § 21, effective June 1. **L. 92:** (1.5) amended and (1.7) added, p. 404, § 15, effective June 3. **L. 94:** (1.5) and (1.7) amended, p. 1717, § 9, effective July 1. **L. 95:** (3) amended, p. 1252, § 10, effective July 1. **L. 96:** (1.7) amended, p. 1581, § 4, effective July 1. **L. 2000:** IP(1), (1.5), (1.7), (2), and (3) amended, p. 700, § 20, effective July 1. **L. 2002:** (3) amended, p. 1513, § 190, effective October 1. **L. 2004:** (2) and (3) amended, p. 635, § 6, effective August 4.

Editor's note: This section was contained in a part that was repealed and reenacted in 1975. Provisions of this section, as it existed in 1975, are similar to those contained in 18-3-403, 18-3-404, and 18-3-410 as said sections existed in 1974, the year prior to the repeal and reenactment of this part.

Cross references: For the legislative declaration contained in the 2002 act amending subsection (3), see section 1 of chapter 318, Session Laws of Colorado 2002.

18-3-405. Sexual assault on a child.

(1) Any actor who knowingly subjects another not his or her spouse to any sexual contact commits sexual assault on a child if the victim is less than fifteen years of age and the actor is at least four years older than the victim.

(2) Sexual assault on a child is a class 4 felony, but it is a class 3 felony if:

(a) The actor applies force against the victim in order to accomplish or facilitate sexual contact; or

(b) The actor, in order to accomplish or facilitate sexual contact, threatens imminent death, serious bodily injury, extreme pain, or kidnapping against the victim or another person, and the victim believes that the actor has the present ability to execute the threat; or

(c) The actor, in order to accomplish or facilitate sexual contact, threatens retaliation by causing in the future the death or serious bodily injury, extreme pain, or kidnapping against the victim or another person, and the victim believes that the actor will execute the threat; or

(d) The actor commits the offense as a part of a pattern of sexual abuse as described in subsection (1) of this section. No specific date or time must be alleged for the pattern of sexual abuse; except that the acts constituting the pattern of sexual abuse must have been committed within ten years prior to or at any time after the offense charged in the information or indictment. The offense charged in the information or indictment shall constitute one of the incidents of sexual contact involving a child necessary to form a pattern of sexual abuse as defined in section 18-3-401 (2.5).

(3) If a defendant is convicted of the class 3 felony of sexual assault on a child pursuant to paragraphs (a) to (d) of subsection (2) of this section, the court shall sentence the defendant in accordance with the provisions of section 18-1.3-406.

Source: L. 75: Entire part R&RE, p. 630, § 1, effective July 1. **L. 77:** (1) amended, p. 962, § 18, effective July 1. **L. 83:** (5) amended, p. 693, § 2, effective June 15. **L. 86:** (3) added, p. 777, § 7, effective July 1. **L. 89:** (2)(b) and (3) amended and (2)(c) added, p. 903, §§ 2, 3, effective June 1. **L. 90:** (2)(b) repealed, p. 1033, § 25, effective July 1. **L. 95:** (2) and (3) amended, p. 1252, § 11, effective July 1. **L. 2002:** (2)(d) amended, p. 1582, § 8, effective July 1; (3) amended, p. 1513, § 191, effective October 1.

Editor's note: This section was contained in a part that was repealed and reenacted in 1975. Provisions of this section, as it existed in 1975, are similar to those contained in 18-3-408 as said section existed in 1974, the year prior to the repeal and reenactment of this part.

Cross references: For the legislative declaration contained in the 2002 act amending subsection (3), see section 1 of chapter 318, Session Laws of Colorado 2002.

18-6.5-103. Crimes against at-risk adults and at-risk juveniles - classifications.

(1) Crimes against at-risk adults and at-risk juveniles shall be as prescribed in this section.

(2) Any person whose conduct amounts to criminal negligence, as defined in section 18-1-501 (3), commits:

(a) A class 4 felony if such negligence results in the death of an at-risk adult or an at-risk juvenile;

(b) A class 5 felony if such negligence results in serious bodily injury to an at-risk adult or an at-risk juvenile; and

(c) A class 6 felony if such negligence results in bodily injury to an at-risk adult or an at-risk juvenile.

(3) (a) Any person who commits a crime of assault in the first degree, as such crime is described in section 18-3-202, and the victim is an at-risk adult or an at-risk juvenile commits a class 4 felony if the circumstances described in section 18-3-202 (2) (a) are present and a class 2 felony if such circumstances are not present.

(b) Any person who commits a crime of assault in the second degree, as such crime is described in section 18-3-203, and the victim is an at-risk adult or an at-risk juvenile commits a class 5 felony if the circumstances described in section 18-3-203 (2) (a) are present and a class 3 felony if such circumstances are not present.

(c) Any person who commits a crime of assault in the third degree, as such crime is described in section 18-3-204, and the victim is an at-risk adult or an at-risk juvenile commits a class 6 felony.

(4) Any person who commits robbery, as such crime is described in section 18-4-301 (1), and the victim is an at-risk adult or an at-risk juvenile, commits a

class 3 felony. If the offender is convicted of robbery of an at-risk adult or an at-risk juvenile, the court shall sentence the defendant to the department of corrections for at least the presumptive sentence under section 18-1.3-401 (1).

(5) Any person who commits theft, and commits any element or portion of the offense in the presence of the victim, as such crime is described in section 18-4-401 (1), and the victim is an at-risk adult or an at-risk juvenile, commits a class 5 felony if the value of the thing involved is less than five hundred dollars or a class 3 felony if the value of the thing involved is five hundred dollars or more. Theft from the person of an at-risk adult or an at-risk juvenile by means other than the use of force, threat, or intimidation is a class 4 felony without regard to the value of the thing taken.

(6) Any person who knowingly neglects an at-risk adult or an at-risk juvenile or knowingly acts in a manner likely to be injurious to the physical or mental welfare of an at-risk adult or an at-risk juvenile commits a class 1 misdemeanor.

(7) (a) Any person who commits a crime of sexual assault, as such crime is described in section 18-3-402, sexual assault in the first degree, as such crime was described in section 18-3-402, as it existed prior to July 1, 2000, and the victim is an at-risk adult or an at-risk juvenile commits a class 2 felony.

(b) Any person who commits a crime of sexual assault in the second degree, as such crime was described in section 18-3-403, as it existed prior to July 1, 2000, and the victim is an at-risk adult or an at-risk juvenile, commits a class 3 felony.

(c) Any person who commits unlawful sexual contact, as such crime is described in section 18-3-404 or sexual assault in the third degree, as such crime was described in section 18-3-404, as it existed prior to July 1, 2000, and the victim is an at-risk adult or an at-risk juvenile, commits a class 6 felony; except that the person commits a class 3 felony if the person compels the victim to submit by use of such force, intimidation, or threat as specified in section 18-3-402 (4) (a), (4) (b), or (4) (c), or if the actor engages in the conduct described in section 18-3-404 (1) (g) or (1.5).

(d) Any person who commits sexual assault on a child, as such crime is described in section 18-3-405, and the victim is an at-risk juvenile, commits a class 3 felony; except that, if the circumstances described in section 18-3-405 (2) (a), (2) (b), (2) (c), or (2) (d) are present, the person commits a class 2 felony.

(e) Any person who commits sexual assault on a child by one in a position of trust, as such crime is described in section 18-3-405.3, and the victim is an at-risk juvenile, commits a class 2 felony if the victim is less than fifteen years of

age or a class 3 felony if the victim is fifteen years of age or older but less than eighteen years of age.

(f) Any person who commits sexual assault on a client by a psychotherapist, as such crime is described in section 18-3-405.5, and the victim is an at-risk adult or an at-risk juvenile, commits a class 3 felony if the circumstances described in section 18-3-405.5 (1) exist or a class 6 felony if such circumstances are not present.

(8) For purposes of subsections (3) to (7) of this section, commission of the offenses described in said subsections shall include the attempt, solicitation, or conspiracy to commit such offenses.

Source: L. 91: Entire article added, p. 1779, § 2, effective July 1. **L. 93:** Entire section amended, p. 1733, § 24, effective July 1. **L. 95:** (3) amended, p. 1254, § 14, effective July 1. **L. 97:** (7) added, p. 1539, § 2, effective July 1. **L. 98:** (5) amended and (8) added, pp. 1440, 1441, §§ 19, 24, effective July 1. **L. 99:** (6) amended, p. 799, § 20, effective July 1. **L. 2000:** (7)(a), (7)(b), and (7)(c) amended, p. 706, § 32, effective July 1. **L. 2002:** (4) amended, p. 1516, § 201, effective October 1. **L. 2003:** (4) amended, p. 1428, § 10, effective April 29.

Cross references: For the legislative declaration contained in the 2002 act amending subsection (4), see section 1 of chapter 318, Session Laws of Colorado 2002.

Appendix D
DDD Critical Incident Reporting Criteria

Division for Developmental Disabilities
Criteria for Reportable Critical Incidents
Revised October 1, 2006

Incidents to be reported by Community Centered Board (CCB) to DDD are as follows:

1. Allegations of mistreatment, abuse, neglect and exploitation committed by an agency staff, contractor, or volunteer, meeting the definition specified in Rule 16.120 *and* involve one of the following factors:

   ✓ Injury or death: *Examples* of injuries**:**
   - Welts, bruises, discoloration that may indicate abuse (i.e. bilaterally on upper arms indicating grabbing, shaking, bruises of different colors indicating repeated injuries, etc.)
   - Burns (i.e. cigarette burns, scalding, iron burn, -do not report minor sunburns)
   - Fractures of any bone.
   - Cuts, lacerations, puncture wounds, or other injuries**.**

   Injuries may or may not require emergency medical treatment, however, to be reported in this category the injury must be a fundamental element of the allegation.

   ✓ Adverse medical/health outcome**,** *Examples* of adverse medical/health outcomes;
   - Need for medical treatment as a result of the abuse or neglect due to the nature of the injury or concern resulting from the abuse or neglect
   - Death,
   - Seizures as a result of missed medication or ongoing medication errors due to neglect;
   - Malnutrition (e.g., significant weight loss not addressed by agency/provider) resulting from neglect;
   - Any of the serious medical crisis or occurrences listed below that involves neglect (e.g., failure to provide prescribed medications or treatments, and/or to seek medical attention for identifiable problems, etc.).

   ✓ When a crime against a person in service may have been committed by an employee, contractor or volunteer of an agency providing services and supports (i.e. alleged sexual abuse by a staff or contractor);

- ✓ Exploitation of a person in services that results in potential loss in excess of $300.00;
- ✓ When there is any police involved in an allegation of mistreatment, abuse, neglect or exploitation.
- ✓ When an incident does not otherwise meet the above criteria but is identified through trend analysis as an allegation of mistreatment, abuse, neglect, and exploitation due to a reoccurring pattern (e.g., frequency, type of injury, etc.) requiring further investigation.

Note: For licensed group homes, refer to the Colorado Department of Public Health and Environment (CDPHE) Occurrence Reporting Manual for reporting requirements including requirements for reporting to law enforcement**.**

2. Serious injuries or other medical crises or occurrences requiring immediate emergency medical treatment to preserve life and limb or resulting in an emergency admission to the hospital. Do not report minor injuries or illnesses that may have resulted in a trip to the emergency room, but where the person was essentially okay (e.g., the person complained of chest pain and was taken to the ER but no concerns were found, or received stitches for a small laceration on their leg, etc).

Generally serious injuries or medical emergencies would include, but not be limited to:

- Fractures of a major bone (i.e., hip, femur, humerous, shoulder, ribs);
- Dislocations of a major joint (i.e. hip, knee, shoulder, elbow, ankle or wrist);
- Spinal injuries with possible loss of sensation or function;
- Internal injuries;
- Head injuries with loss of consciousness;
- Lacerations associated with damage to nerves, tendons or organs, or serious blood loss;
- Third degree burns on any body part or second degree burns that involve blistering on sensitive body parts or over more than 10% of the body.
- Prolonged seizures;
- Bowel obstructions;
- Diabetic crises;
- Pneumonia;

- Medication emergency (e.g., overdose, toxicity, etc.)
- Near drowning;
- Attempted suicide;
- Emergency admittance into psychiatric facility necessary to protect the person receiving services or others.

3. Death of a person receiving services including unexpected deaths and those anticipated (i.e., in hospice, nursing home, hospital, etc.). Information for mortality data (i.e., cause of death from certificate, etc.) should be submitted through follow up actions in the data base**.**

4. Incidents when a person was a victim of a serious crime (e.g., rape or attempted rape, aggravated assault, etc.) by another person receiving services, someone in the community or guardian or family member**.**

5. Serious criminal offense by person receiving services. Examples include but are not limited to, sexual offense, serious assault or other criminal acts pursuant to statutes, violation of court order or probation, (do not report "minor" violations such as a person is on probation for shoplifting and violates probation by entering a store he/she is not permitted to). Such crimes must either involve a crime against a person or a crime that is likely to involve the incarceration of the person receiving services.

6. Likely media interest or involvement in a situation. *(And not fitting any of the above categories.)*

7. Missing persons (immediate location is not known) in which
   - The safety of the person is at serious risk (i.e. person has uncontrolled seizures, ongoing dissociative or mental health issues, non-verbal, high risk of victimization) or persons are more independent but absent for a period of time that causes concern for the person's safety.
   - The missing person may pose a risk to the general public (i.e. sex offense behavior, fire-starting behavior, assaultive or other dangerous behavior)
   - Other exacerbating circumstances exist that clearly increase the seriousness of the risk (i.e., severe weather, onset of a psychiatric episode, recent contact with other people who might exploit or victimize the person, etc.)

Cont.

- Location of person is unknown for eight (8) or more hours regardless of level of risk. Agencies should not report incidents in which the

person was considered missing and quickly found. Incidents in which a person leaves the site (i.e., elope or AWOL) but don't otherwise meet the above criteria should not be reported.

Please note that the requirements for occurrence reporting by group homes to the Department of Public Health and Environment (DPH&E) also continue to be in place and are not effected by reporting requirements to DDD or any changes in DDD reporting requirements.

Appendix E
CDPHE Occurrence Reporting Criteria

All healthcare facilities licensed by the department are required to report occurrences to the Health Facilities and Emergency Medical Services Division. Statutory citations for this can be found at 25-1-124 (CRS) and 25-3-109 (1),(3),(7),(8) and the regulations can be found in Chapter II, Licensing: 3.2 Reporting.

Reportable occurrences include unexplained deaths, brain injuries, spinal cord injuries, life-threatening complications of anesthesia, life-threatening transfusion errors/reactions, severe burns, missing persons, physical abuse, verbal abuse, sexual abuse, neglect, misappropriation of property, diverted drugs and malfunction/misuse of equipment.

Facilities must report these occurrences within one business day. The Health Facilities Division will investigate the occurrence and determine if appropriate facility action has been taken. The Health Facilities Division will then write a summary of the occurrence for public viewing. The summaries respect confidentiality and do not reflect the names of the persons involved.

If necessary, following the investigation of the occurrence, the Health Facilities Division will cite a deficiency if it finds that state or federal regulations have been violated. As well, Health Facilities Division staff review occurrence reports prior to conducting annual surveys in facilities and prior to reissuing a facility's license. Occurrence reports may also be reviewed as part of a complaint investigation.

CDPHE Occurrence Reporting
Quick Reference

Death	• Occurrence resulting in death • Reportable to coroner as unexplained or suspicious
Brain Injury	• Result of occurrence involving the head **and** • Change or loss of consciousness and/or loss of bodily function, **or** • Diagnostic test which shows brain injury
Spinal Cord Injury	• Result of an occurrence • Functional loss consistent with spinal injury • Permanent or Temporary
Burns	• 2nd or 3rd degree burns • 20% or more of body surface of an adult and 15% or a child
Missing persons	• At risk and missing after search conducted **or** • Missing after 8 hours regardless of risk
Physical abuse	• Intent • Bodily injury and/or serious bodily injury **and/or** • Unreasonable confinement or restraint ***Bodily injury****-physical pain, illness, or impairment of physical and/or mental condition***.** ***Serious bodily injury****-substantial risk of death, permanent disfigurement, or loss of function of body*
Sexual abuse	• Knowingly • Consent not given • Sexual intrusion or penetration, **or** touching intimate parts, **or** observes photographs, **or** physical force/threat.
Verbal abuse (menacing)	• Knowingly • Threat **or** • Physical action • Fear of imminent bodily injury
Neglect	• At-risk adult • Failure to provide any care or services (in definition) resulting in actual harm **or** • Staff has a history in the past 12 months **or** • Staff intentionally failed to follow standard of practice or policy
Misappropriation of property	• Deliberate misplacing, wrongful use of property **or** • Pattern of misplacing, wrongful use of property **and** • Consent not given
Diverted Drugs	• Deliberate

24-4.1-302.5. Rights afforded to victims.

(1) In order to preserve and protect a victim's rights to justice and due process, each victim of a crime shall have the following rights:

(a) The right to be treated with fairness, respect, and dignity, and to be free from intimidation, harassment, or abuse, throughout the criminal justice process;

(b) The right to be informed of and present for all critical stages of the criminal justice process as specified in section 24-4.1-302 (2);

(c) The right to be informed, upon request by the victim, when a person who is accused or convicted of a crime against the victim is released or discharged from custody, is paroled, escapes from a secure or nonsecure correctional facility or program, or absconds from probation or parole;

(d) The right to be heard at any court proceeding that involves a bond reduction or modification, the acceptance of a negotiated plea agreement, or the sentencing or any modification of sentence of any person accused or convicted of a crime against such victim;

(e) The right to consult with the prosecution after any crime against the victim has been charged, prior to any disposition of the case, or prior to any trial of the case, and the right to be informed of the final disposition of the case;

(f) The right to be informed by local law enforcement agencies, prior to the filing of charges with the court, or by the district attorney, after the filing of charges with the court, of the status of any case concerning a crime against the victim, and any scheduling changes or cancellations, if such changes or cancellations are known in advance;

(g) The right to be present at the sentencing hearing, including any hearing conducted pursuant to section 18-1.3-1201 or 18-1.4-102, C.R.S., for cases involving class 1 felonies, of any person convicted of a crime against such victim, and to inform the district attorney or the court, in writing, by a victim impact statement, or in person by an oral statement, of the harm that the victim has sustained as a result of the crime;

(h) The right to have the court determine the amount, if any, of restitution to be paid to a victim pursuant to article 18.5 of title 16, C.R.S., by any person convicted of a crime against such victim for the actual pecuniary damages that resulted from the commission of the crime;

(i) The right to be informed of the victim's right to pursue a civil judgment against any person convicted of a crime against the victim for any damages incurred by the victim as a result of the commission of the crime regardless of whether the court has ordered such person to make restitution to the victim;

(i.5) In a case of domestic violence, as that term is defined in section 18-6-800.3 (1), C.R.S., the right to be informed of the violation of any condition of probation and the right to receive copies of all probation reports submitted to the court and notice of probation revocation hearings;

(j) The right to be informed, upon written request from the victim, of any proceeding at which any postconviction release from confinement in a secure state correctional facility is being considered for any person convicted of a crime against the victim and the right to be heard at any such proceeding or to provide written information thereto. For purposes of this subsection (1), "proceeding" means reconsideration of sentence, a parole hearing, or commutation of sentence.

(j.5) The right to provide a written statement that will be included with any referral made by the department of corrections or a district court to place an offender in a community corrections facility or program;

(j.7) The right, at the discretion of the district attorney, to view all or a portion of the presentence report of the probation department;

(k) The right to promptly receive any property belonging to a victim which is being held by a prosecutorial or law enforcement agency unless there are evidentiary reasons for the retention of such property;

(l) The right to be informed of the availability of financial assistance and community services for victims, the immediate families of victims, and witnesses, which assistance and community services shall include, but shall not be limited to, crisis intervention services, victim compensation funds, victim assistance resources, legal resources, mental health services, social services, medical resources, rehabilitative services, and financial assistance services, and the right to be informed about the application process for such services;

(m) The right to be informed about what steps can be taken by a victim or a witness in case there is any intimidation or harassment by a person accused or convicted of a crime against the victim, or any other person acting on behalf of the accused or convicted person;

(n) The right to be provided with appropriate employer intercession services to encourage the victim's employer to cooperate with the criminal justice system in order to minimize the loss of employment, pay, or other benefits resulting from a victim's court appearances or other required meetings with criminal justice officials;

(o) The right to be assured that in any criminal proceeding the court, the prosecutor, and other law enforcement officials will take appropriate action to achieve a swift and fair resolution of the proceedings;

(p) The right to be provided, whenever practicable, with a secure waiting area during court proceedings that does not require a victim or a witness to be seen or to be in close proximity to the person accused or convicted of a crime against the victim or such person's family or friends;

(q) The right to be informed, upon written request by the victim, when a person convicted of a crime against the victim is placed in or transferred to a less secure public or private correctional facility or program;

(r) The right to be informed, upon written request by the victim, when a person who is or was charged with or convicted of a crime against the victim escapes or is permanently or conditionally transferred or released from any public hospital, private hospital, or state hospital;

(s) The right to be informed of any rights which the victim has pursuant to the constitution of the United States or the state of Colorado;

(t) The right to be informed of the process for enforcing compliance with this article pursuant to section 24-4.1-303 (17); and

(u) The right to be informed of the results of any HIV testing that is ordered and performed pursuant to section 18-3-415, C.R.S.

(2) Subsection (1) of this section shall not be construed to imply that any victim who is incarcerated by the department of corrections or any local law enforcement agency has a right to be released to attend any hearing or that the department of corrections or the local law enforcement agency has any duty to transport such incarcerated victim to any hearing.

(3) Municipalities and municipal courts shall be encouraged to adopt policies which afford the rights granted to crime victims pursuant to this section to crime victims at the municipal court level, to the extent the adoption of such policies is practicable in the particular municipality.

Source: L. 92: Entire section added, p. 418, § 3, effective January 14, 1993. **L. 94:** (1)(i.5) added, p. 2042, § 25, effective July 1. **L. 95:** (1)(b), (1)(c), (1)(e), (1)(h), (1)(i.5), (1)(j), and (1)(p) to (1)(r) amended and (1)(j.5) added, p. 1403, § 5, effective July 1. **L. 97:** (1)(g) amended, p. 47, § 1, effective March 21; (1)(r) and (1)(s) amended and (1)(t) added, p. 1561, § 6, effective July 1. **L. 2000:** (1)(d), (1)(q), and (1)(r) amended and (1)(j.7) and (1)(u) added, p. 241, § 5, effective March 29; (1)(h) amended, p. 1051, § 21, effective September 1. **L. 2002:** (1)(g) amended, p. 1530, § 240, effective October 1. **L. 2002, 3rd Ex. Sess.:** (1)(g) amended, p. 34, § 31, effective July 12 and (1)(g) amended, p. 34, § 32, effective October 1.

Cross references: (1) For the legislative declaration contained in the 2002 act amending subsection (1)(g), see section 1 of chapter 318, Session Laws of Colorado 2002.

(2) For the legislative declaration contained in the 2002 Third Extraordinary Session act amending subsection (1)(g), see section 16 of chapter 1, Session Laws of Colorado 2002, Third Extraordinary Session

19-3-304. Persons required to report child abuse or neglect.

(1) Except as otherwise provided by section 19-3-307 and sections 25-1-122 (4) (d) and 25-4-1404 (1) (d), C.R.S., any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately upon receiving such information report or cause a report to be made of such fact to the county department or local law enforcement agency.

(2) Persons required to report such abuse or neglect or circumstances or conditions shall include any:

(a) Physician or surgeon, including a physician in training;

(b) Child health associate;

(c) Medical examiner or coroner;

(d) Dentist;

(e) Osteopath;

(f) Optometrist;

(g) Chiropractor;

(h) Chiropodist or podiatrist;

(i) Registered nurse or licensed practical nurse;

(j) Hospital personnel engaged in the admission, care, or treatment of patients;

(k) Christian science practitioner;

(l) Public or private school official or employee;

(m) Social worker or worker in any facility or agency that is licensed or certified pursuant to part 1 of article 6 of title 26, C.R.S.;

(n) Mental health professional;

(o) Dental hygienist;

(p) Psychologist;

(q) Physical therapist;

(r) Veterinarian;

(s) Peace officer as described in section 16-2.5-101, C.R.S.;

(t) Pharmacist;

(u) Commercial film and photographic print processor as provided in subsection (2.5) of this section;

(v) Firefighter as defined in section 18-3-201 (1), C.R.S.;

(w) Victim's advocate, as defined in section 13-90-107 (1) (k) (II), C.R.S.;

(x) Licensed professional counselors;

(y) Licensed marriage and family therapists;

(z) Unlicensed psychotherapists;

(aa) (I) Clergy member.

(II) The provisions of this paragraph (aa) shall not apply to a person who acquires reasonable cause to know or suspect that a child has been subjected to abuse or neglect during a communication about which the person may not be examined as a witness pursuant to section 13-90-107 (1) (c), C.R.S., unless the person also acquires such reasonable cause from a source other than such a communication.

(III) For purposes of this paragraph (aa), unless the context otherwise requires, "clergy member" means a priest, rabbi, duly ordained, commissioned, or licensed minister of a church, member of a religious order, or recognized leader of any religious body.

(bb) Registered dietitian who holds a certificate through the commission on dietetic registration and who is otherwise prohibited by 7 CFR 246.26 from making a report absent a state law requiring the release of this information;

(cc) Worker in the state department of human services;

(dd) Juvenile parole and probation officers;

(ee) Child and family investigators, as described in section 14-10-116.5, C.R.S.;

(ff) Officers and agents of the state bureau of animal protection, and animal control officers.

(2.5) Any commercial film and photographic print processor who has knowledge of or observes, within the scope of his or her professional capacity or employment, any film, photograph, video tape, negative, or slide depicting a child engaged in an act of sexual conduct shall report such fact to a local law enforcement agency immediately or as soon as practically possible by telephone and shall prepare and send a written report of it with a copy of the film, photograph, video tape, negative, or slide attached within thirty-six hours of receiving the information concerning the incident.

(3) In addition to those persons specifically required by this section to report known or suspected child abuse or neglect and circumstances or conditions which might reasonably result in abuse or neglect, any other person may report known or suspected child abuse or neglect and circumstances or conditions which might reasonably result in child abuse or neglect to the local law enforcement agency or the county department.

(3.5) No person, including a person specified in subsection (1) of this section, shall knowingly make a false report of abuse or neglect to a county department or local law enforcement agency.

(4) Any person who willfully violates the provisions of subsection (1) of this section or who violates the provisions of subsection (3.5) of this section:

(a) Commits a class 3 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.;

(b) Shall be liable for damages proximately caused thereby.

Source: L. 87: Entire title R&RE, p. 764, § 1, effective October 1. **L. 90:** (2)(m) amended, P. 1394, § 2, effective May 24; (3.5) added and IP(4) amended, p. 1023, § 1, effective July 1. **L. 93:** (1) amended, p. 1609, § 1, effective June 6; (2) amended, p. 1735, § 29, effective July 1. **L. 95:** (2)(w) added, p. 949, § 5, effective July 1. **L. 96:** (2.5) amended, p. 83, § 8, effective March 20; (2)(m) amended, p. 265, § 16, effective July 1. **L. 97:** (2)(v) amended, p. 1013, § 19, effective August 6. **L. 2001:** (2)(x), (2)(y), and (2)(z) added, p. 160, § 1, effective July 1. **L. 2002:** (1) amended, p. 568, § 2, effective May 24; (2)(aa) added, p. 1145, § 1, effective June 3; (1) amended, p. 1592, § 30, effective July 1; (4)(a) amended, p. 1527, § 231, effective October 1. **L. 2003:** (2)(m) amended and (2)(cc) added, p. 660, § 1, effective March 20; (2)(bb) added, p. 666, § 1, effective March 20; (2)(s) amended, p. 1616, § 18, effective August 6. **L. 2005:** (2)(dd), (2)(ee), and (2)(ff) added, p. 357, § 1, effective April 22; (2)(ee) amended, p. 963, § 9, effective July 1.

26-3.1-102. Reporting requirements.

(1) (a) An immediate oral report of abuse should be made or caused to be made within twenty-four hours to the county department or during non-business hours to a local law enforcement agency responsible for investigating violations of state criminal laws protecting at-risk adults by any person specified in paragraph (b) of this subsection (1) who has observed the mistreatment or self-neglect of an at-risk adult or who has reasonable cause to believe that an at-risk adult has been mistreated or is self-neglected and is at imminent risk of mistreatment or self-neglect.

(b) The following persons are urged to make or initiate an initial oral report within twenty-four hours followed by a written report within forty-eight hours:

(I) Physicians, surgeons, physicians' assistants, or osteopaths, including physicians in training;

(II) Medical examiners or coroners;

(III) Registered nurses or licensed practical nurses;

(IV) Hospital and nursing home personnel engaged in the admission, care, or treatment of patients;

(V) Psychologists and other mental health professionals;

(VI) Social work practitioners;

(VII) Dentists;

(VIII) Law enforcement officials and personnel;

(IX) Court-appointed guardians and conservators;

(X) Fire protection personnel;

(XI) Pharmacists;

(XII) Community centered board staff;

(XIII) Personnel of banks, savings and loan associations, credit unions, and other lending or financial institutions;

(XIV) State and local long-term care ombudsmen;

(XV) Any caretaker, staff member, or employee of or volunteer or consultant for any licensed care facility, agency, home, or governing board.

(c) In addition to those persons urged by this subsection (1) to report known or suspected mistreatment or self-neglect of an at-risk adult and circumstances or conditions which might reasonably result in mistreatment or self-neglect, any other person may report such known or suspected mistreatment or self-neglect and circumstances or conditions which might reasonably result in mistreatment or self-neglect of an at-risk adult to the local law enforcement agency or the county department. Upon receipt of such report, the receiving agency shall prepare a written report within forty-eight hours.

(2) Pursuant to subsection (1) of this section, the report shall include: The name and address of the at-risk adult; the name and address of the at-risk adult's caretaker, if any; the age, if known, of such at-risk adult; the nature and extent of such at-risk adult's injury, if any; the nature and extent of the condition that will reasonably result in mistreatment or self-neglect; and any other pertinent information.

(3) A copy of the report prepared by the county department in accordance with subsections (1) and (2) of this section shall be forwarded within twenty-four hours to the district attorney's office and the local law enforcement agency. A report prepared by the local law enforcement agency shall be forwarded within twenty-four hours to the county department and to the district attorney's office.

(4) No person, including a person specified in subsection (1) of this section, shall knowingly make a false report of mistreatment or self-neglect to a county department or local law enforcement agency. Any person who willfully violates the provisions of this subsection (4) commits a class 3 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S., and liable for damages proximately caused thereby.

(5) Any person, except a perpetrator, complicitor, or coconspirator, who makes a report pursuant to this section shall be immune from any civil or criminal liability on account of such report, testimony, or participation in making such report, so long as such action was taken in good faith and not in reckless disregard of the truth or in violation of subsection (4) of this section.

(6) No person shall take any discriminatory, disciplinary, or retaliatory action against any person who, in good faith, makes a report of suspected mistreatment or neglect of an at-risk adult.

(7) (a) Except as provided in paragraph (b) of this subsection (7), reports of the mistreatment or self-neglect of an at-risk adult, including the name and address of any at-risk adult, member of said adult's family, or informant, or any

other identifying information contained in such reports, shall be confidential, and shall not be public information.

(b) Disclosure of the name and address of an at-risk adult or member of said adult's family and other identifying information contained in a report shall be permitted only when authorized by a court for good cause. Such disclosure shall not be prohibited when a criminal complaint, information, or indictment based on the report is filed or when there is a death of a suspected at-risk adult from mistreatment or self-neglect and a law enforcement agency files a formal charge or a grand jury issues an indictment in connection with the death.

(c) Any person who violates any provision of this subsection (7) is guilty of a class 2 petty offense and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars.

Source: L. 91**:** Entire article R&RE, p. 1774, § 1, effective July 1. L. 2004**:** (4) amended, p. 275, § 1, effective July 1.

Editor's note: This section was contained in a part that was repealed and reenacted in 1991. Provisions of this section, as it existed in 1991, are similar to those contained in 26-3.1-104 as said section existed in 1990, the year prior to the repeal and reenactment of this part.

30-10-606. Coroner - inquiry - grounds - postmortem - jury - certificate of death.

(1) The coroner shall immediately notify the district attorney, proceed to view the body, and make all proper inquiry respecting the cause and manner of death of any person in his jurisdiction who has died under any of the following circumstances:

(a) From external violence, unexplained cause, or under suspicious circumstances;

(b) Where no physician is in attendance or where, though in attendance, the physician is unable to certify the cause of death;

(c) From thermal, chemical, or radiation injury;

(d) From criminal abortion, including any situation where such abortion may have been self-induced;

(e) From a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;

(f) While in the custody of law enforcement officials or while incarcerated in a public institution;

(g) When the death was sudden and happened to a person who was in good health; or

(h) From an industrial accident.

(1.1) After consultation with the district attorney, the coroner may request that jurisdiction of any such death be transferred to the coroner of the county in which the event which resulted in the death of the person occurred, with the jurisdiction effective upon the acceptance by the receiving coroner. Such transfer shall be in writing, and a copy thereof shall be maintained in the offices of the transferring and receiving coroners.

(1.2) When a person dies as a result of circumstances specified in subsection (1) of this section or is found dead and the cause of death is unknown, the person who discovers the death shall report it immediately to law enforcement officials or the coroner, and the coroner shall take legal custody of the body. The body of any such person shall not be removed from the place of death except upon the authority of the coroner in consultation with the district attorney or local law enforcement agency, nor shall any article on or immediately surrounding

such body be disturbed until authorized by the coroner in consultation with the district attorney or local law enforcement agency.

(2) The coroner shall, if he or the district attorney deems it advisable, cause a post-mortem examination of the body of the deceased to be made by a licensed physician to determine the cause of death.

(3) When the coroner has knowledge that any person has died under any of the circumstances specified in subsection (1) of this section, he may summon forthwith six citizens of the county to appear at a place named to hold an inquest to hear testimony and to make such inquiries as he deems appropriate.

(4) (a) In all cases where the coroner has held an investigation or inquest, the certificate of death shall be issued by the coroner or the coroner's deputy.

(b) Any certificate of death issued by a coroner or a coroner's deputy shall be filed with the registrar and shall state their findings concerning the nature of the disease or the manner of death, and, if from external causes, the certificate shall state whether in their opinion death was accidental, suicidal, or felonious. In addition, the certificate shall include the information described in section 25-2-103 (3) (b), C.R.S., whenever the subject of the investigation or inquest is under one year of age.

(c) A copy of the certificate of death or affidavit of presumed death, including any related documents and statements of fact, shall be retained in the applicable county in a secure location in an appropriate county facility accessible only to the county coroner or the coroner's designee and in a manner that is consistent with the county's record retention policy and federal law.

(5) Nothing in this section shall be construed to require an investigation, autopsy, or inquest in any case where death occurred without medical attendance solely because the deceased was under treatment by prayer or spiritual means alone in accordance with the tenets and practices of a well-recognized church or religious denomination.

(6) (a) Notwithstanding the provisions of sections 12-43-218 and 13-90-107 (1) (d) or (1) (g), C.R.S., the coroner holding an inquest or investigation pursuant to this section has the authority to request and receive a copy of:

(I) Any autopsy report or medical information from any pathologist, physician, dentist, hospital, or health care provider or institution if such report or information is relevant to the inquest or investigation; and

(II) Any information, record, or report related to treatment, consultation, counseling, or therapy services from any licensed psychologist, professional counselor, marriage and family therapist, social worker, addiction counselor, or

unlicensed psychotherapist if such report, record, or information is relevant to the inquest or investigation.

(b) The coroner shall, at the request of the district attorney or attorney general, release to the district attorney or attorney general any autopsy report or medical information described in subparagraph (I) of paragraph (a) of this subsection (6) that the coroner obtains pursuant to paragraph (a) of this subsection (6).

(c) The coroner shall not release to any party any information, record, or report described in subparagraph (II) of paragraph (a) of this subsection (6) that the coroner obtains pursuant to paragraph (a) of this subsection (6).

(d) Any person who complies with a request from a coroner pursuant to paragraph (a) of this subsection (6) shall be immune from any civil or criminal liability that might otherwise be incurred or imposed with respect to the disclosure of confidential patient or client information.

Source: G.L. § 511. **G.S.** § 615. **L. 1887:** p. 233, § 1. **R.S. 08:** § 1300. **C.L.** § 8775. **CSA:** C. 45, § 122. **CRS 53:** § 35-6-6. **L. 57:** p. 311, § 1. **L. 73:** R&RE, p. 462, § 1. **C.R.S. 1963:** § 35-6-6. **L. 81:** (1)(c) to (1)(h) amended and (1.1), (1.2), and (6) added, pp. 1439, 1440, §§ 2, 3, effective June 4. **L. 89:** (6) amended, p. 1276, § 3, effective April 18. **L. 96:** (4) amended, p. 402, § 15, effective April 17. **L. 2000:** (6) amended, p. 157, § 1, effective August 2. **L. 2001:** (6) amended, p. 735, § 5, effective July 1. **L. 2002:** (6)(a)(II) amended, p. 1029, § 56, effective June 1. **L. 2004:** (4)(c) added, p. 626, § 3, effective August 4.

Cross references: For issuance of death certificate, see § 25-2-110; for postmortem examination by licensed physician, see § 12-36-133.