Child Maltreatment Fatality Report 2007

Report Prepared by the CDHS Administrative Review Division
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1. Executive Summary

Colorado is one of 13 states with a state-supervised and county-administered system. In its most concrete definition, county administration is statewide social services programs at the local level. State supervision is indirect management as exercised through program development, practice standard development, workload standard development, model office design, rule promulgates, technical assistance, monitoring, program evaluation and performance improvement plans.

In response to the increase in child maltreatment fatalities where the victim and families were previously known to Child Protective Services (CPS) agencies, the Executive Director of the Colorado Department of Human Services ordered a review of child maltreatment fatalities focused on identifying any commonalities and making recommendations for improvements in the system based upon those findings. This review specifically examined 13-recent child maltreatment fatalities that occurred in Colorado where CPS had prior involvement in the last five years. In order to determine systemic issues, information from these 13 reviews was then combined with data regarding all child maltreatment fatalities occurring in Colorado over the past five years, as well as data at a national level and from research conducted within the child welfare field. Findings were categorized across four major areas and are summarized here by each category.

1. **Child Characteristics**

   The majority of child maltreatment fatality victims in Colorado over the past five years tend to be Caucasian (ranging from 34% to 51%), with a large percentage claiming Hispanic ethnicity (ranging from 27% to 39%). While not significantly different, slightly more than half the victims were female. Lastly, approximately 40% of child maltreatment victims in Colorado were infants, with approximately 90% of the victims being under the age of 5.

2. **Parent Characteristics**

   Parents of victims tend to have their own history of prior involvement with CPS. They also tend to be younger. For example, most parents were in their early 20's at the time of birth and death of the victim.

3. **Environmental/Situational Characteristics**

   Overall, almost 70% of the families in this fatality review had some history of identified Domestic Violence, while 54% had experienced Substance Abuse issues.

   Birth order appeared to be associated with fatalities. For example, over the past five years a range from 43% to 51% of child maltreatment fatality victims were only children. Of those with siblings, it ranged from 59% to 93% of the time the victim was the youngest child in the family. Related to this, the number of children and adults in the household tended to be associated. For example, neglect (both fatal and non-fatal) tends to occur in families with more children, while abuse (again, fatal and non-fatal) may be more likely to occur in families with fewer children. Also, high family mobility is often associated with child maltreatment fatalities both nationally, and in Colorado. As Colorado is a county administered system, this means that every time a family moves to a new county, a new agency becomes responsible for service provision and safety management. Family compositional characteristics were also identified. Specifically, 30% of the 13 cases reviewed had children involved in referrals that occurred while they were living with different families or family members, 38.5% had multigenerational involvement with CPS, and 46.2% were single female head of household. Finally, additional family stressors were found to be involved in a substantial portion of the 13 fatalities reviewed, including Substance Abuse issues (53.8%), Domestic Violence (69.2%), and Child's Medical Issues (38.5%).

4. Systemic Characteristics

Data integrity within the Statewide Automated Child Welfare Information System, known as Trails, as well as Colorado's process for tracking child fatalities were found to be inconsistent. For example, the ACCESS database of child maltreatment fatalities kept by the Division of Child Welfare did not match the Trails system. In addition, over the past five years, an average of 37.5% of victims did not have a date of death recorded in Trails. Also, for those victims listed as fatalities both in Trails, and on the ACCESS database, over the last five years the dates did not match approximately 30% of the time.

Over the past decade, two Agency Letters – CW02-215I dated May 30, 2002 and CW00-25A dated May 11, 2000 – summarized findings from two previous child fatality reviews. Lack of communication between agencies was the systemic factor. This includes communication between county agencies when families move and responsibility for service provision and safety management shift to a new county, and communication on new rules, policies, and oversight from the Division of Child Welfare to the county agencies.

Workers' characteristics were also examined for those workers involved in the 13 fatalities, and for the most part found to be in compliance. Most workers, by self-report, had the requisite level of education, background checks, and training as required by Volume VII. At a more general level, however, there is a need for increased funding for both CORE training as well as training for the safety assessment. Despite the training being full for all of 2008, training providers reported a much greater demand. This was mostly related to high turnover requiring new workers to complete the required training. The state does not have a continuing education model designed especially for supervisory needs. Also, while an estimated 839 child welfare professionals have been trained in the new safety model, there are still many professional who have not been trained. The Department is unable to give an exact number because there is not a centralized automated method for tracking.

Child welfare professionals interviewed as part of this process indicated that many of the gaps and issues identified were driven primarily by overburdened staff. However, due to the lack of any rigorous workload studies, it is difficult to determine what the current workload level is on average, and impossible to use it as a method for assigning cases.

A number of Volume VII regulations were found to be incomplete, inconsistent with other policies, or simply lacking definitions of key concepts. In addition, numerous areas of practice were identified where Volume VII regulations were not being applied accurately or consistently across county departments.

5. Recommendations

This report concludes with a list of recommendations intended to address many of the issues identified. Specifically, the list is broken into short-term recommendations to be implemented within 90 days of the publication of this report, and long-term recommendations that will require more time to study and craft solutions and/or implement statutory changes, budget requests, and rules and regulations.

2. Background

Approximately four children are fatally abused or neglected in the United States each day.[2] Overall, child maltreatment is the second leading cause of death for children under the age of five.[3] During Federal Fiscal Year (FFY) 2005 (October 2004 – September 2005), 1,460 children died nationwide due to abuse or neglect.[4] In fact, during FFY 2005 there were approximately 3.3 million referrals made nationwide alleging maltreatment towards roughly 6 million children.[4] Overall, this corresponds to a rate of 43.9 referrals for every 1,000 children in the United States during FFY 2005.[4] Perhaps even more alarming is the fact that this represents an increase of about 87% from the number of children reported to Child Protective Services (CPS) in the United States during FFY 1997.

In order to understand what these numbers mean for children, and the impact on CPS agencies, one must know what happens with these referrals. Overall, about 62% of the referrals received in FFY 2005 were accepted for an assessment, meaning that an estimated 3.6 million children were the subject of an investigation, equating to a rate of 48.3 investigations per 1,000 children nationally.[4] As a result of these investigations, the allegations were determined to be true for at least one child 25% of the time, for a rate of victimization equal to 12.1 per 1,000 children nationally.[2] Finally, the rate of child fatalities increased from 1.62 per every 100,000 children in 1994 to 1.96 per every 100,000 children in 2005.[4]

In many ways, as will be shown throughout this report, Colorado's experience with maltreatment referrals and fatalities mirror those seen nationally. While child welfare professionals within Colorado had been examining patterns with the state's referral and assessment data through an action research process focused around a White Paper created by the State's Administrative Review Division titled "Protecting Colorado's Children: An Analysis of Available Data on Referral and Assessment Trends", the recent increase in the number of child fatalities during the last quarter of calendar year 2007 increased concern among both child welfare professionals and the general public. As a direct result of these fatalities, the Executive Director of the Colorado Department of Human Services requested a study that included a thorough assessment of recent child fatalities where the families had prior involvement with a county department as well as an examination of other available data related to child fatalities. This report summarizes the findings of this focused time-limited preliminary study.

3.1 Objectives

- Identify commonalities among fatalities, as well as systemic issues within Colorado's child protection system, that might play a role in fatalities.
- Based on the findings of the review, make recommendations for changes within the system to improve Colorado's ability to protect children and keep them safe.

3.2 Assumptions

- Continuous Quality Improvement initiatives must be informed by a sound baseline of information.
- This study should not be interpreted as blaming or exonerating any one particular person, county department, or policy; but rather should be used to understand the interactions between numerous dynamics occurring within Colorado's child welfare system that may combine to play a role in child fatalities.
- Due to the complexity involved with research and analysis in child welfare, and the limited time available for this review, this report will provide recommendations for change, but cannot possibly address all concerns.

3.3 Demographic Overview of the Thirteen Maltreatment Fatality Victims

While discussed later in depth, Table 1 provides a quick overview of the demographic characteristics of the thirteen 2007 child maltreatment fatalities reviewed specifically for this report.

Table 1: Summary of Demographic Information of all 13 Child Maltreatment Fatalities Reviewed in March 2007

Characteristic	Detail	N	%	Mean	Median	Mode
Race/Ethnicity	Caucasian	5	38.5			
	Black or African American	1	7.7			
	More than one race identified	1	7.7			
	Hispanic	6	46.2			
Gender	Female	7	53.8			
	Male	6	46.2			
Family Structure	Single Female	6	46.2			
	Married Couple	3	23.1			
	Unmarried Couple	2	15.4			
	Foster Care	1	7.7			
	Multi-Generational/Extended Family	1	7.7			
Age of Child at Death	<1 year	5	38.5	3.00	3.5	<1 year
	2 years	1	7.7			
	3 years	1	7.7			
	4 years	1	7.7			
	5 years	1	7.7			
	7 years	3	23.1			
	11 years	1	7.7			
Birth Order	Only Child	4	30.8			
	Youngest	4	30.8			
	Middle Child	3	23.1			
	Oldest	1	15.4			
Common Issues Identified During Review Process	Substance Abuse Issues Identified	7	53.8			
	Domestic Violence Issues Identified	9	69.2			
	Child's Medical Issued Identified	5	38.5			
Age of Mother at Child's Birth				22	22	20
Aged of Mother at Child's Death				25	25	20
Age of Father at Child's Birth				23	24	18
Age of Father at Child's Death				28	24	22

3. Findings

3.1 Introduction

Prior to discussing the key findings in depth, it is critical to understand the definition of a child fatality. Volume VII, at 7.202.75 (see inset) sets forth parameters under which county departments are required to conduct a child fatality review. Upon the conclusion of an investigation, the county departments then enter both a severity level (e.g., minor, severe, fatal) and a disposition (e.g., unfounded, inconclusive, founded) into Trails. In Colorado, the State Department's Division of Child Welfare defines a child fatality as "any death that the county department has confirmed at the fatal level, including intra-familial, third party, or institutional abuse/neglect".

Volume VII Citations

7.202.75 Investigation, Reporting, and Review of Child Fatalities [Rev. eff. 3/1/02]

Parameters:

The county department shall investigate child fatalities in Intrafamilial and institutional settings in those cases in which:

A. There is reason to know or suspect that abuse/or neglect caused or contributed to the child's death.
B. The death is not explained or cause of death is unknown at the time of the child's death.
C. The history given about the child's death is at variance with the degree or type of injury and subsequent death.

7.202.8 FATALITY REVIEWS [Rev. eff. 3/1/02]

When a child fatality occurs, the county shall submit reports for review by the State Department in accordance with Sections 7.202.7 and 7.202.78 of this staff manual, and cooperate with the State Department's review. The State Department shall conduct a review of cases where the county was involved prior to the child's death.

The Division of Child Welfare is also required by Volume VII (7.202.8; see inset above) to conduct an additional review of cases where the county was involved prior to the child's death. Further defining this requirement, however, the Division of Child Welfare initiates a review on all child deaths that are/or involve:

- Suspicious in nature
- Deaths in which the cause is not immediately known and there may have been foul play
- Prior county child welfare services within the past five years, excluding:
    - Non-child protection services, such as parental conflict with an adolescent
    - Services when the parent was a teenager or younger and not yet parenting his or her own children
    - Prior involvement with a sibling AND a different constellation of family members AND the prior services had no bearing on the current alleged person responsible for abuse/neglect behavior

3.2 Key Findings

Within the field of child welfare, studies have indicated a number of factors related to maltreatment. These factors, along with a systemic factor intended to capture aspects of the child welfare system itself, will be used as a framework for organizing the findings of this study. These factors include: 1) child characteristics, 2) parent characteristics, and 3) environmental/situational characteristics.[5] Before proceeding however, it is important to caution that while fatalities may share certain characteristics that can be used as indicators or risk factors, there is no one profile that will allow child protection workers to identify either perpetrators or children who will become victims. Because it is impossible to accurately predict fatalities, and the causes of child maltreatment and fatalities are so complex, it is impossible to

guarantee that child fatalities will not occur in the future. However, through processes such as this, it is hoped that findings can be used to improve the system so that the chances of successful intervention are increased.

Before proceeding through the child characteristics, it should be noted that aggregate numbers presented for all child fatalities in Colorado over the past five years are based on a combined list of fatalities. This list was made by combining a list of fatalities maintained by the Division of Child Welfare with one pulled from Trails. Specific reasons for and potential issues caused by the differences between these two lists will be described under the Systemic Characteristics, but it is important to note the population of children described here. In the following Tables the number of valid responses fluctuates as not all data fields in Trails were entered for each child fatality case.

3.2.1 Child Characteristics

The Child Maltreatment 2005 publication (published annually by the United States Department of Health and Human Services' Administration for Children and Families), provides aggregate information on key demographic characteristics of the children reported to the National Child Abuse and Neglect Data System (NCANDS) whose death was "caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor." It should be noted, however, that the determination of when abuse or neglect is considered a contributing factor is left to each individual state, so determining actual child fatality numbers is difficult at best. However, comparing demographics of the children reported nationally to those of fatalities occurring in Colorado might indicate similarities or differences from national trends.

3.2.1.1 Race/Ethnicity

Table 2: Race/Ethnicity of 13 Child Maltreatment Fatalities Reviewed

Characteristic	Detail	n	%
Race/Ethnicity	Caucasian	5	38.5
	Black or African American	1	7.7
	More than one Race Identified	1	7.7
	Hispanic	6	46.2

Nationally, 49.7% of child fatalities are Caucasian, 23.1% African American, and 17.4% are Hispanic[4]. Table 2 displays the race/ethnicity for the 13-child maltreatment fatalities investigated as part of this study. For these fatalities, the most frequent race/ethnicity was Hispanic (46.2%) followed by Caucasian (38.5%). However, given that 13 fatalities occurring within such a short time span may not be a good representation of all fatalities in Colorado, Table 3 shows the race/ethnicity of all child maltreatment fatalities in Colorado over the past five years. As can be seen, for calendar years 2003 through 2006, Colorado's numbers matched national trends in that the largest percent were Caucasian. However, in CY 2007 this trend changed in that Hispanics, for the first time, were the largest percentage of fatalities in Colorado. In addition, unlike the national numbers, Hispanics have consistently been the second highest percentage of fatalities, with Black or African American being third highest. It should be noted that these numbers do not represent rates of abuse within the given race/ethnicity, but just race/ethnicity as a percentage of all fatalities reported in the given calendar year.

Table 3: Race/Ethnicity of All Child Maltreatment Fatalities in Colorado Over the Past Five Calendar Years

	2003		2004		2005		2006		2007	
	Count	%	Count	%	Count	%	Count	%	Count	%
Caucasian	20	51.3	12	40.0	12	48.0	10	40.0	14	34.1
Asian	0	0.0	0	0.0	0	0.0	1	4.0	0	0.0
Black or African American	3	7.7	7	23.3	4	16.0	4	16.0	5	12.2
Native Hawaiian/Other Pacific Islander	1	2.6	0	0.0	0	0.0	0	0.0	0	0.0
More than one Race Identified	1	2.6	0	0.0	1	4.0	1	4.0	1	2.4
Hispanic	14	35.9	8	26.7	8	32.0	9	36.0	16	39.0
Missing	0	0.0	3	10.0	0	0.0	0	0.0	5	12.2
Total	39	100.0	30	100.0	25	100.0	25	100.0	41	100.0

Data from the State Demographers Office indicate that, based upon projected race and ethnicity data for 2006 in Colorado, 88% of Colorado's population is Caucasian and 4.7% is African American. Approximately 27% of the population indicates being of Hispanic or Latino origin. Given that Colorado has a higher percentage of individuals claiming Hispanic origin than African American heritage, it is perhaps not as surprising that Hispanics consistently rank second in child maltreatment fatalities. The finding that they were the highest in 2007 deserves to be followed into the future. Should Hispanic's remain the highest percent of fatality into the next few years, this may indicate a critical shift deserving future research into the causes of their over-representation in child maltreatment fatalities.

3.2.1.2 Gender

Research on child fatalities shows that there are generally no significant differences across gender[5], and the numbers from Child Maltreatment 2005 reflect this nationally, with gender split about equal (50.7% reported females, and 47.3% reported males). Overall, Colorado mirrors national numbers in regard to gender of child fatalities. As can be seen in Tables 4 and 5, slightly more than half of the child maltreatment fatality victims reviewed for this study, and in all fatalities over the past five years, involved females as the victim. The lone exception to this occurred in 2004, where this was reversed.

Table 4: Gender of Victims in 13 Child Maltreatment Fatalities Reviewed

	Gender	Count	%
Gender	Female	7	53.8
	Male	6	46.2

Table 5: Gender of Victims in All Child Maltreatment Fatalities in Colorado over the Past Five Calendar Years

	2003		2004		2005		2006		2007	
	Count	%	Count	%	Count	%	Count	%	Count	%
Female	20	51.3%	14	46.7%	14	56.0%	14	56.0%	21	51.2%
Male	19	48.7%	16	53.3%	11	44.0%	11	44.0%	20	48.8%
Total	39	100.0%	30	100.0%	25	100.0%	25	100.0%	41	100.0%

3.2.1.3 Age at time of fatality

Research has shown that victims of fatal child maltreatment tend to be younger, with approximately 90% of the child fatalities experienced by children age five or younger, and 41% being infants. Once again, Colorado's numbers appear to be representative of the national trends. For example, as displayed in Table 6, almost 39% of the fatalities involved infants, slightly more than half (53.8%) were three or younger, and the vast majority (92.3%) were seven or younger.

Table 6: Age of Victims in 13 Child Maltreatment Fatalities Reviewed

Age	Count	Percent	Cumulative Percent
<1	5	38.5	38.5
2	1	7.7	46.2
3	1	7.7	53.8
4	1	7.7	61.5
5	1	7.7	84.6
7	3	23.1	92.3
11	1	7.7	53.8

In addition, looking at the trends over the past five years, displayed in Table 7 (Page 8), shows that the key demographic of age has historically been a factor associated with child maltreatment fatalities. For example, for every year since 2003, the highest number of fatalities has involved infants as victims, ranging from 34% to 44% of all child maltreatment fatalities in any given year. In addition, the range of fatalities for victims 5 and younger is almost always right around 90% as indicated in some child welfare literature[5]. Compared to the national numbers reported in Child Maltreatment 2005, it appears that Colorado may have a higher percentage of fatalities occurring with younger victims. For example, Child Maltreatment 2005 reported that 54.5% of maltreatment related fatalities involved victims age 7 and younger. In Colorado, this same age group represented approximately 90% of all fatalities. Overall, this would seem to indicate that abuse and neglect related fatalities occur almost exclusively in younger children in Colorado. Based on these findings, it might be critical to

educate both professionals and the public to the increased risk of maltreatment related fatalities, when combined with the other risk factors discussed here, for younger children.

Table 7: Age of Victims in All Fatalities in Colorado over the Past Five Calendar Years

	2003		2004		2005		2006		2007		Total	
Age	Count	Cumulative %	Count	Cumulative %	Count	Cumulative %	Count	Cumulative %	Count	Cumulative %	Count	Cumulative %
0	13	34.2%	12	41.4%	10	40.0%	10	40.0%	18	43.9%	63	39.9%
1	7	52.6%	7	65.5%	5	60.0%	4	56.0%	6	58.5%	29	58.2%
2	4	63.2%	4	79.3%	5	80.0%	3	68.0%	2	63.4%	18	69.6%
3	1	65.8%	2	86.2%	1	84.0%	2	76.0%	4	73.2%	10	75.9%
4	7	84.2%	0	86.2%	1	88.0%	2	84.0%	1	75.6%	11	82.9%
5	1	86.8%	0	86.2%	0	88.0%	2	92.0%	1	78.0%	4	85.4%
6	2	92.1%	2	93.1%	0	88.0%	0	92.0%	2	82.9%	6	89.2%
7	1	94.7%	1	96.6%	0	88.0%	0	92.0%	3	90.2%	5	92.4%
8	1	97.4%	0	96.6%	0	88.0%	0	92.0%	1	92.7%	2	93.7%
9	0	97.4%	0	96.6%	1	92.0%	0	92.0%	0	92.7%	1	94.3%
10	0	97.4%	0	96.6%	0	92.0%	0	92.0%	1	95.1%	1	94.9%
11	1	100.0%	1	100.0%	0	92.0%	0	92.0%	1	97.6%	3	96.8%
12	0	100.0%	0	100.0%	1	96.0%	0	92.0%	0	97.6%	1	97.5%
13	0	100.0%	0	100.0%	1	100.0%	0	92.0%	0	97.6%	1	98.1%
15	0	100.0%	0	100.0%	0	100.0%	2	100.0%	1	100.0%	3	100.0%
Total	38	100.0%	29	100.0%	25	100.0%	25	100.0%	41	100.0%	158	100.0%

*For additional information, see Table 13 on page 13.

3.2.2 Parent Characteristics

Several characteristics related to family dynamics appear to be generally associated with maltreatment fatalities. Each of these is discussed below.

3.2.2.1 Age of Parents

Age appears to be inversely correlated to fatality rates. The younger the parent at the time of birth, the higher the rate of child maltreatment fatalities. More specifically, it has been found that parents of abuse/neglect fatality victims tend to be in their late teens or early 20's, with a large percentage becoming parents around the age of 20, regardless of whether or not they are the perpetrator.[5] According to data from the Colorado Department of Public Health and Environment, in 2004 Colorado ranked 24th for babies born to women under the age of 20. Specifically, approximately 10% of all births in Colorado in 2004 were to women under the age of 20. In 2006, around 10% of births were to mothers less than 19 years old, indicating a trend towards a greater number of younger mothers in Colorado.

Table 8 (Page 9) shows descriptive statistics for the age of mothers and fathers, at the time of birth and death of the victim. Only 5 of the victims had fathers actively participating in the family, while 12 had mothers that were part of the family during the CPS agency's intervention. With only 13 cases, the mean can be overly influenced by one high or low number and, as such, it is perhaps more useful to consider the mode (the most frequently occurring number). The most frequent age at birth was 18 and 20 for fathers and mothers respectively. At the time of death of the victim, the mode age was 22 and 20, again for fathers and mothers respectively. Thus, for the 13 fatalities reviewed, parents of the victims tended to be younger, similar to the national numbers and research literature.

Table 8: Age of Mother and Father at Time of Victim's Birth and Death for 13 Fatalities Reviewed

	Age of Father at Child's Birth	Age of Father at Child's Death	Age of Mother at Child's Birth	Age of Mother at Child's Death
N	5	5	12	12
Mean	23	28.2	21.7	25.4
Median	24	24	21.5	25
Mode	18	22	20	20
Std. Deviation	4.5	7.2	4.1	5.7
Variance	20.5	51.7	16.4	32.6
Minimum	18	22	16	16
Maximum	29	37	31	34

Tables 9 and 10 show descriptive statistics for the age of mothers and fathers at both time of birth and death of the victim for all maltreatment fatalities over the past five years. The average age of mothers at the birth of the victim ranged from 22 to 25, with the mode ranging from 17 to 23. Average age at time of the victim's death ranged from 25 to 28 for mothers, while the mode ranged from 18 to 31. It should be noted that the mode of 31 in CY 2006 was as aberration, as it usually falls in the lower 20's in Colorado.

Table 9: Age of Mother at Time of Victim's Birth and Death for Maltreatment Fatalities occurring Over the Past Five Years

	2003		2004		2005		2006		2007	
	Age of Mother at Child's Birth	Age of Mother at Child's Death	Age of Mother at Child's Birth	Age of Mother at Child's Death	Age of Mother at Child's Birth	Age of Mother at Child's Death	Age of Mother at Child's Birth	Age of Mother at Child's Death	Age of Mother at Child's Birth	Age of Mother at Child's Death
N	36	35	27	26	17	17	26	26	37	37
Mean	23.1	26.0	22.6	25.1	24.0	26.1	25.2	28.3	24.5	27.3
Median	23	25	21	23	22	23	25	28	23	27
Mode	23	23	21	22	17	18	19	31	23	23
Std. Deviation	4.3	5.2	5.5	6.5	7.0	7.8	8.5	9.4	5.9	6.2
Minimum	16	19	15	18	17	18	15	16	16	16
Maximum	33	36	36	48	37	41	39	55	38	41

Table 10: Age of Father at Time of Victim's Birth and Death for Maltreatment Fatalities occurring Over the Past Five Years

	2003		2004		2005		2006		2007	
	Age of Father at Child's Birth	Age of Father at Child's Death	Age of Father at Child's Birth	Age of Father at Child's Death	Age of Father at Child's Birth	Age of Father at Child's Death	Age of Father at Child's Birth	Age of Father at Child's Death	Age of Father at Child's Birth	Age of Father at Child's Death
N	26	25	14	12	10	10	17	17	20	20
Mean	26.2	29.4	25.6	28.0	27.2	28.7	28.9	31.2	27.2	30.1
Median	23	27	24	28.5	24.5	26.5	26	30	27.5	29.5
Mode	23	23	21	23	24	33	21	25	25	24
Std. Deviation	7.6	8.3	5.5	5.6	6.4	6.1	8.8	9.0	6.5	6.8
Minimum	17	19	17	19	20	21	17	19	16	17
Maximum	44	50	36	37	38	39	43	44	42	45

For fathers, the average age at the time of the birth of the victim has ranged from 26 to 30, while the mode ranged from 21 to 25. At the time of the victim's death, the average age of fathers ranged from 28 to 31, while the mode ranged from 23 to 33. Again, the mode of 33 in CY 2006 was unusual in that the mode tended to fall in the early to mid twenties for fathers.

Overall, the age of parents in Colorado, both at the time of birth and death, closely resembles what has been found in the literature in that they became parents at a young age (early twenties) and were young when the fatality occurred.

As such, public health initiatives such as parenting classes specifically targeted for younger parents may be an important component to positively impacting child maltreatment rates in general, and fatalities specifically.

3.2.2.2 Prior Involvement

Studies in the literature indicated that anywhere from 21% to 29% of families who experienced a maltreatment fatality had prior contact with CPS agencies.[2] One study conducted in 1998 indicated that 28.6% of families included in the study had an open case at the time of the fatality.[6] The National Center of Child Abuse Prevention Research's Fifty State Survey also found that, between 1998 and 2000, approximately 36% of abuse/neglect fatalities took place in families that had at least one prior contact with CPS agencies.[7] Research presented at the National Conference on Child Abuse and Neglect examined fatalities between 1999 and 2002 and found that 64% of the families were known to CPS agencies, with approximately 41% of them having at least two prior reports.[8] Lastly, one other publication found that anywhere from 30% to 50% of victim's families had been reported to a CPS agency prior to the fatal incident.[3] While these numbers provide a relatively large range (e.g., anywhere from 30% to 60%) of prior involvement, it is apparent that a significant portion of maltreatment victims were know to CPS agencies prior to their fatality. This should only serve to underscore the difficulty in both predicting victims and perpetrators as well as intervening in such a multidimensional issue as child maltreatment.

One of the criteria for selecting the fatalities reviewed as part of this study was that they had prior CPS involvement in the past five years, so it would not be helpful to consider them for purposes of this factor. Table 11 shows the number and percent of fatalities over the past five years that had prior CPS involvement. Overall, Colorado's numbers tend to match those indicated in the literature. That is, approximately 30% to 46% of maltreatment victims had some level of involvement with CPS prior to the fatality. The exception to this appeared in 2005, where only 12% had prior involvement. This appears to be a data anomaly and will require further research.

Table 11: Prior History of Victims in All Child Maltreatment Fatalities in Colorado over the Past Five Calendar Years

	2003		2004		2005		2006		2007		Total 5 years	
Not Identified on Trails Report	0	0.0%	0	0.0%	1	4.0%	2	8.0%	1	2.4%	4	2.5%
No Prior History Documented In Trails	28	71.8%	20	66.7%	21	84.0%	13	52.0%	21	51.2%	103	64.4%
Prior History Documented in Trails	11	28.2%	10	33.3%	3	12.0%	10	40.0%	19	46.3%	53	33.1%
Total	39		30		25		25		41		160	

3.2.3 Environmental/Situational Characteristics

Child maltreatment is a complex and increasing problem in the United States today. In fact, fatalities due to maltreatment is the second leading cause of death for children under the age of five.[3] As such, child fatalities are as much a public health concern as they are a child welfare issue. Some examples of this were discussed under Parental Characteristics (e.g., becoming a parent at an early age), others will be discussed here. The fact that many of these characteristics can fit under multiple categories only underscores the multidimensional nature of child fatalities.

3.2.3.1 Birth Order

Some research indicates that birth order may be associated with child maltreatment fatalities. For example, one study has shown that, for families with multiple children involved in *non-fatal* maltreatment, the victim was the oldest child 44% of the time[5]. On the other hand, in *fatal* maltreatments, the victim was the youngest child 58% of the time[5].

Similarly, of the 13 cases reviewed:

- 31% of the victims were only children.
- 43% in 2003 and 51% in 2007 were only children.
- Of those with siblings, 44% of the time the victim was the youngest child in the family.
- Of those with siblings, 59% in 2003 and 93% in 2005 of the time the victim was the youngest child.

3.2.3.2 Number of Children and Adults in Household

Studies have shown that families founded for neglect tend to have approximately three children while those founded for abuse tend to have, on average, just under two.[10] There also tends to be a significant difference in the number of children in the household for fatalities occurring due to abuse versus neglect. For example, fatal neglect was found to rarely occur in single child families (only 6% of the families studied), while fatal abuse involved single child families in almost half (46%) of the families studied.[10] Also, another study indicated that families involved in fatalities tended to have, on average, one more child and adult living in the house than did the families with non-fatal maltreatment.[5] As such, it would appear that the number of children living in the house may not only be related to an increased chance of a fatality, but also to the type of maltreatment involved (e.g., abuse or neglect) and who is more likely to experience each type of maltreatment.

The child welfare professionals interviewed as part of this fatality review indicated a belief that relatives living in the household of the victim were seen as a positive safety factor. However, when the cases were examined, some relatives were not included in the services provided, nor were their own child welfare histories thoroughly reviewed. It was also indicated that there were often other children living in the home or being cared for at least part time by the alleged perpetrator. In some cases, because these children were not the children of the parent being assessed, these additional children were not addressed, despite the safety concerns in the household where they spent significant time.

Thus, in situations where the research suggests that additional children and adults in the home may be a risk factor associated with an increased chance of fatal neglect, the system was not taking this into consideration by specifically assessing children spending time in the household of the alleged perpetrator nor appropriately involving the extra relative in the household (i.e., including them in the Family Services Plan and Safety Planning for the child). Doing these extra steps might mitigate the risk factor suggested in the literature through a process that actively assesses and involves all pertinent parties, thereby making them aware of the issues and involving them in creating the solutions.

3.2.3.3 Mobility

Another factor that may be associated with fatalities is frequent moves. In one study, 40% of families had lived in the area they were living in at the time of the fatality for less than one year, with 26% having lived there for less than six months at the time of the fatality.[6] Indeed, three of the families involved in the fatalities reviewed had referrals made in several different counties. One family had resided in and received referrals in five different counties and one other state. Moreover, 4 of those referrals were received within 4 months of each other, with the family having a total of 11 referrals made in the span of 19 months. Another family had referrals in three different counties, all within four months of each other. The last family had referrals in two different counties within a year. Due to the mobility of the families served, and its association to fatalities, increased use of Trails through quality data entry, as well as diligent research of past histories appears to be a critical component to conducing thorough assessments and interventions.

3.2.3.4 Family Composition

There is some data that suggests that frequent and/or recent changes in family composition may be a significant characteristic of fatality cases. For example, one study documented that approximately two-thirds of the families with a maltreatment fatality had also had a recent change in the family composition.[6] Also, the number of changes in composition were higher in the families experiencing a fatality than for those with non-fatal maltreatment.[5]

Related to this factor, four of the reviews (30.7%) indicated that children were involved in multiple families (boyfriend/live-in, stepparent, birth families) and that individuals often moved in and out of the households. Also, five of the families reviewed (38.5%) were found to have multigenerational histories of involvement with county department. Examples of this included grandparents living in the home, while other times it manifested as grandparents' involvement with the children fluctuating. For example, grandparents may have had concerns regarding child safety and so periodically took care of the child(ren), only to return them to the risk filled situation without child welfare involvement.

There is also a national movement within the child welfare field to use extended family more often as placement options, informally known as kin-care. In 1980, the Adoption Assistance and Child Welfare Act (P.L. 96-272) was enacted in response to concerns about children remaining in long-term foster care. This required states to make

reasonable efforts to keep families together by preventing the need for placement into foster care and reuniting children already in foster care with their families, and established funding towards achieving these goals.

To keep families together, grandparents, adult siblings, aunts, uncles, etc. are often involved. In practice, the involvement of these relatives may occur with minimal consideration of their prior child welfare histories. Prior histories may be minimized due to a philosophical shift towards a preference for keeping children within their families. While this practice philosophy reflects a basic value of child welfare, the use of relatives as a safety net for children remaining in the home should not occur without thorough assessment, consideration, and planning for significant risk factors such as prior child welfare experience of adult caregivers and their stability within the family composition.

In fact, in three of the fatalities reviewed relatives in the home were viewed as a possible safety net. As such, CPS workers should conduct a more thorough assessment and monitoring of other adults in the household (regardless of relationship to the child) to better monitor their influence on the safety of the child. While Colorado embraces the practice of keeping families together and increases the utilization of Family Group Decision Making and Family-to-Family initiatives, we must also find a way to evaluate kinship care situations, while providing support services and the necessary oversight.

Another factor related to family composition is the parenting structure. Of the 13 fatalities reviewed in this process, 6 of them (46.2%) were living in a single female head of household at the time of the fatality, 3 (23.1%) were residing in a two parent family, 2 children (15.4%) were living in a household with an unmarried couple, 1 (7.7%) child was residing in foster care, and 1 (7.7%) child was living in a multi-generational living arrangement.

3.2.3.5 Additional Family Stressors

Table 12 identifies additional elements that were tracked in an effort to determine commonalities among the 13 fatalities reviewed. Overall, almost 70% of the families in this fatality review had some history of identified Domestic Violence, while 54% had experienced Substance Abuse issues. Additionally, in 39% of the fatalities reviewed the child had a history of medical issues. While these three areas obviously impact the work that the CPS system does, and child welfare professionals attempt to mitigate these issues as part of ensuring a child's safety, they all involve systems other than the county department CPS (e.g., mental health, substance abuse, health systems, etc.). As such, this provides an excellent example of the broader public health focus that should be included as part of any attempt to reduce maltreatment referrals/investigations, cases, and fatalities.

Table 12: Additional Family Stressors in 13 Child Maltreatment Fatalities Reviewed

	Substance Abuse		Domstic Violence		Child's Medical Issues	
	N	%	N	%	N	%
Yes	7	53.8%	9	69.2%	5	38.5%
No	4	30.8%	3	23.1%	4	30.8%
Unknown	2	15.4%	1	7.7%	4	30.8%
Total	13	100.0%	13	100.0%	13	100.0%

3.2.4 Systemic Characteristics

One of the main objectives of this review was to identify commonalities and systemic issues that existed across the 13 child maltreatment fatalities and that may also play a larger role in child safety in general. This section will highlight these issues and, where possible, supplement the findings with any additional data available.

3.2.4.1 Data Integrity

The Division of Child Welfare maintains an ACCESS database of child fatalities each year. The Division also uses Trails to report child fatality numbers to the National Child Abuse and Neglect Data System (NCANDS). However, using Trails data extracted March 18, 2008 and following the definition of a child fatality provided by the Division of Child Welfare (any allegation founded at the fatal level), the numbers of child fatalities contained on the ACCESS database maintained by the Division did not match the number of child fatalities found in Trails. Table 13 provides the

numbers of child fatalities for CY 2003 – CY 2007, using the ACCESS database provided by the Division compared to the number of children in Trails with a confirmed report of child abuse/neglect with a severity level of fatal.

Table 13: Number of Victims in All Child Maltreatment Fatalities in Colorado over the Past Five Calendar Years

Year	Child Fatalities Recorded by the DCW	Child Fatalities Recorded in Trails	Child Fatalities Showing on At Least One System
2003	35	38	39
2004	27	29	30
2005	16	24	25
2006	19	25	25
2007	38	28	41
Total	135	144	160

When reconciling the differences between the numbers of child maltreatment fatalities observed each year in Colorado, a number of data integrity issues were found. Specifically:

- The capacity of the Division of Child Welfare to track the data is complicated by limitations in the Trails system; specifically, the fatality data report is inadequate and missing key elements.
- The county departments are not entering the date of death on fatality assessments consistently, nor do they always assure that a disposition is entered timely. Sometimes child fatalities are not always reported in a timely manner to the Division of Child Welfare. As a result, it is difficult for CDHS to determine whether to include the fatal incident in a count of fatal child maltreatment.
- The Division of Child Welfare are not consistently tracking the data and assuring that it is up-to-date and accessible. The Division of Child Welfare needs to standardize a process to review the county's data entry and assure that the counties are up-to-date on all fatality entries. The Division of Child Welfare provides the NCANDS data, and yet must have updated fatality data available more frequently than required by the federal government, and needs to develop a process to coordinate the evolution of the data as additional entries occur following NCANDS pull.

For specific examples:

- For CY 2003 through CY 2007 there were between 5 and 8 children each year with a confirmed abuse/neglect allegation identified as fatal documented in Trails, however the children were not included on the ACCESS database maintained by the Division of Child Welfare.
- For CY 2003 through CY 2005, each year there was one child identified on the Division Child Welfare ACCESS database as a child fatality; however, there was no finding documented in the Trails database. As of March 18, 2008, there were 10 child fatalities that occurred during CY 2007 documented on the Division of Child Welfare ACCESS database with no finding entered into Trails.
- For CY 2003 through CY 2007, on average 37.5% of the children identified as a child fatality, whether on the ACCESS database maintained by the Division of Child Welfare or documented in Trails, did not have a date of death recorded in Trails. Further, for CY 2007 child fatality victims, 43.9% did not have a date of death recorded.
- For CY 2003 through 2007, for those children who had a date of death recorded in Trails and a date of death on the ACCESS database maintained by the Division of Child Welfare, an average of 30% of the dates recorded did not agree between the two data sources.

3.2.4.2 Communication

Throughout the former administration, interagency communication has been consistently identified as a top issue related to fatalities and CPS services in general. For example, an agency letter in 2002 (CW-02-15-I) releasing the results of the 2002 State/County Fatality Review indicated, "communication between county agencies continues to be an issue requiring further improvement." It further clarified that this included prior counties sending information in a more timely and thorough manner as well as receiving counties making a more concerted effort to inquire about past

histories and request detailed information from counties with past involvement with families. The 2002 agency letter also correctly stated that this is a critical issue, as it allows subsequent counties to make more informed decisions based upon a more complete understanding of the history and dynamics of the family. Given that family mobility was discussed earlier as an important factor associated with fatalities, this issue becomes even more important.

During this review, communication between counties was once again found to be an issue associated across several fatalities. There is no Volume VII cite that requires counties to communicate specific information when reporting allegations to another county department. In addition, in one case where a prior county had thoroughly documented the family's' history and had flagged the family as a high risk case, the subsequent county failed to thoroughly read this documentation and understand the history of the family's involvement and lack of cooperation with previous agencies.

It should also be noted that, during reviews of cases conducted by the Colorado Department of Humans Services' Administrative Review Division (Colorado's independent, third party review system), similar patterns of lack of communication have been identified as a systemic issue. In addition, there is often a lack of communication between service providers, such as mental health, and county departments. This often leaves the county departments with less information regarding the progress of families and increases the difficulties in making critical decisions with the families. Given the lack of improvement in this area over the past 10 years, Volume VII should be updated to require that counties have a formal process for notifying one another of families that move across counties. This might even include a change to the Trails system that would allow counties to create an alert that scrolls across the top of the screen indicating high-risk families.

Lastly, there also seems to be a lack of communication channels for distribution of information from the State Division of Child Welfare to the various levels of child welfare professionals working in the counties. For example, while agency letters are often drafted with the intent of informing caseworkers about new Volume VII rules and/or practice standards, it has been reported that these letters do not always make it down to that level. Also, information regarding state/county workgroups that involve state staff and county workers does not always seem to be provided back up to the level of county administrators and directors, meaning that new policies may often be crafted without their vital input.

After over ten years of being identified as a critical issue associated with child maltreatment fatalities, it is extremely important that Colorado's child welfare professionals act on this critical area through both more formalized requirements and improved practice.

3.2.4.3 Worker Characteristics

In Sections3.2.4.3.1 though 3.2.4.3.9, the Department requested that a survey be completed by the county employee. The purpose of the survey was to gather the experience and performance of the employee, educational background, completed Colorado Bureau of Investigation background check, training, and caseload. The Department had some counties refusing to provide some information on the survey, and one county refused to provide any information citing that the State-administered county merit system was repealed. By allowing the State access to this information, it was in violation of employee confidentiality. Therefore, the information below is not complete.

As part of the fatality review process, workers who had been part of the county department CPS's prior involvement with the family were interviewed and asked to complete a survey capturing some key characteristics of the workers. The following section presents the information collected in aggregate form. Surveys were filled out by various levels of professionals, from County Administrators to Intake Screeners. Overall, a total of 56 surveys were aggregated. It should be noted that, due to the small number of individuals included in this analysis, the results have limited generalization to Colorado's entire population of child welfare professionals. The only way to increase this would be to conduct a more rigorous, research based study of workers across the state. This analysis can, however, provide insight into some of the characteristics of those involved with the 13 fatalities reviewed for this study.

3.2.4.3.1 Current Position

For the purposes of this review, as shown in Table 14, child welfare professionals at various levels were surveyed about the agency's involvement with the children and families. The majority of the surveys were completed by Caseworkers (44.6%) and Supervisors (35.7%). As these are the individuals most directly responsible for decision making regarding these cases. Additionally, there were several Managers (8.9%) and a few Screeners (5.4%) who completed the survey.

Table 14: Number of Surveys Completed by Position Type

Position Title	Count	Percent
Caseworker	25	44.6%
Supervisor	20	35.7%
Manager	5	8.9%
Screener	3	5.4%
Case Aide	1	1.8%
Misc	1	1.8%
TANF	1	1.8%
Total	56	100.0%

3.2.4.3.2 Length of Time in Position

Also tracked was the length of time each individual had held his or her current position. On average, the 56 respondents included in this analysis had held their position for 5 years. Within this, Caseworkers averaged 5 years in their position while Supervisors averaged 5.2 years in theirs. It should again be pointed out that, due to the small number of respondents overall, these numbers should not be generalized over to all child welfare professionals across the state.

Table 15: Average Years in Current Position-by-Position Type

Position Title	Average Years in Position	Number of Respondents
Misc	8.0	1
Case Aide	7.0	1
Supervisor	5.2	20
Caseworker	5.0	25
Manager	4.2	5
Screener	3.3	3
TANF	3.0	1
Total	5.0	56

3.2.4.3.3 Education

Table 16 (on the following page) displays the highest educational level attained within each position. Seven percent of respondents did not include an educational level on their surveys. Due to the critical nature of their work, and the fact that they represent the majority of the survey respondents, Caseworkers and Supervisors bear further examination. Overall, 60% of Caseworkers had earned a Bachelor's degree in a social science related field (e.g., Social Work, Human Development, Counseling) while 36% had earned a Master's degree. Supervisors, on average, tended to have a higher level of education; with 60% having earned a Master's degree and 35% earning a Bachelors degree. Although they represent a small percentage of the surveys collected, Screeners are critical as they are the individuals who receive referrals from the community and are responsible for attempting to gather as much information as possible regarding the maltreatment allegation. In addition, they often assign the first response timeframe to the referral, with a supervisor then reviewing the referral information and either approving or changing the response time. For the three Screeners who completed the survey, one did not report an educational level, one had a high school degree, and one had a Masters degree.

The Department does not have an educational requirement for screeners. All of the other respondents to the survey appeared to meet the minimum Volume VII requirements.

Volume VII Citations

7.000.6 COUNTY RESPONSIBILITIES [Rev.eff. 1/1/04]

Q. The county department shall ensure that all personnel who supervise or provide professional services in child welfare and adult protection services possess the following minimum qualifications:

1. Professional Entry (Training) Level Position
   A bachelor's degree with a major in a human behavioral sciences field

2. Professional Journey Level Position
   This position has obtained the skills, knowledge, and abilities to perform duties at the full independent working level through experience and education
   a. A bachelor's degree with a major in a human behavioral science field and one year of professional caseworker experience acquired after the degree in a public or private social services agency; or,
   b. A master's degree in social work or human behavioral sciences field

Table 16: Highest Level of Education by Position Type

Position Title	Not Reported	High School	Bachelors	Masters	Position Total
Misc	0.0%	0.0%	0.0%	100.0%	1
TANF	100.0%	0.0%	0.0%	0.0%	1
Screener	33.3%	33.3%	0.0%	33.3%	3
Case Aide	0.0%	0.0%	100.0%	0.0%	1
Caseworker	4.0%	0.0%	60.0%	36.0%	25
Manager	0.0%	0.0%	60.0%	40.0%	5
Supervisor	5.0%	0.0%	35.0%	60.0%	20
Total	7.1%	1.8%	46.4%	44.6%	56

3.2.4.3.4 Colorado Bureau of Investigation Background Check

Prior to hiring anyone who will have direct contact with children, Volume VII (7.000.6 S) requires that the county conduct a background check on the applicant, whose employment is conditional upon satisfactorily passing the background check. As such, the survey asked whether or not, prior to hire, individuals were required to pass a background investigation through the Colorado Bureau of Investigation. The majority of individuals, 83.9%, had been required to pass a background check. Specifically, 88% of Caseworkers and 60% of Managers had been required to go through a background check. (See Table 17 on the following page.)

Volume VII Citations

7.000.6 COUNTY RESPONSIBILITIES [Rev.eff. 1/1/04]

S. All current and prospective employees of the county department, who in their position have direct contact with any child in the process of being placed or who has been placed in out of home care, shall submit a complete set of fingerprints to the Colorado Bureau of Investigation (CBI) that were taken by a qualified law enforcement agency to obtain any criminal record held by the CBI.

Table 17: CBI Background Check Prior to Hiring By Position Type

Position Title	Percent of Position With CBI Check	Percent of Position Without CBI Check	Total
Case Aide	0.0%	100.0%	1
Caseworker	88.0%	12.0%	25
Manager	60.0%	40.0%	5
Misc	0.0%	100.0%	1
Screener	100.0%	0.0%	3
Supervisor	90.0%	10.0%	20
TANF	100.0%	0.0%	1
Total	83.9%	16.1%	56

3.2.4.3.5 Core Training

In Colorado, individuals working in public child welfare agencies are required to attend a comprehensive competency based training series called CORE Training. All new child welfare workers are required to attend four CORE trainings within 12 months of hire. The first of the four courses is required within 90 days of hire. As shown in Table 18 the majority of individuals, 83.9%, reported attending the required Core training. Specifically, 96% of Caseworkers and 80% of Managers and Supervisors reported attending the required CORE Training. Of the individuals completing the survey, the screeners reported the lowest rate of CORE training attendance, with 66.7% reporting attendance at CORE training.

Volume VII Citations

7.000.6 COUNTY RESPONSIBILITIES [Rev.eff. 1/1/04]

M. The county department shall ensure that newly hired social caseworkers who work with children, youth and families complete all training required by the state department.

Table 18: CORE Training Requirement Met by Position Type

Position Title	No Response	Yes	No	Total
Case Aide	0.0%	0.0%	100.0%	1
Caseworker	0.0%	96.0%	4.0%	25
Manager	0.0%	80.0%	20.0%	5
Misc	0.0%	0.0%	100.0%	1
Screener	33.3%	66.7%	0.0%	3
Supervisor	0.0%	80.0%	20.0%	20
TANF	0.0%	100.0%	0.0%	1
Total	1.8%	83.9%	14.3%	56

In 2002-2003, Child Welfare Training experienced budget reductions resulting in waiting lists in new worker training. The State contracts with The Butler Institute for Families at the University of Denver, responsible for the CORE training, indicated that over the past several years they have only been able to conduct 10 trainings for each of the CORE series. For 2008, they will hold 12 sessions of CORE 1 and 2, and 10 sessions for CORE 3 and 4. By overbooking these trainings, the Department is maximizing space to accommodate for workers at the last minute being unable to attend resulting in full sessions. Even with this commitment, the Butler Institute indicated that they have booked all of the trainings throughout calendar year 2008 and still are

experiencing a waiting list of 1-5 workers per training. Due to the high rate of turnover for caseworkers (self reported by the counties), the largest demand is for CORE 1 and 2, as workers tend to leave the field prior to needing CORE 3 and 4. In order to address the training backlog for workers, increased funding is necessary to be able to meet the demand. One of the other issues the State faces, is that without a formal reporting structure from the counties, the State is unable to project the number of new workers that will require training in future years.

3.2.4.3.6 Six Hour Training

Following a continuing education model, Volume VII, at 7.000.6 P, requires that caseworkers complete at least 6 hours of in-service training each year. Table 19 (below) reflects that the majority of individuals, 91.1%, reported completing at least six hours of training. Specifically, 92% of caseworkers and 95% of Supervisors reported attending the required six hours of training. Managers, screeners, and the one TANF worker interviewed all self-reported attending six hours of training. Again, this information is not tracked by Trails.

Volume VII Citations

7.000.6 COUNTY RESPONSIBILITIES [Rev.eff. 1/1/04]

P. The county department shall ensure that all experienced social caseworkers who work with children, youth and families complete at least six (6) hours of ongoing in-service training per year.

Table 19: Completion of Six Hours of In-Service Training Per Year

Position Title	Missing Response	Yes	No	Responses Per Position
Case Aide	0.0%	0.0%	100.0%	1
Caseworker	8.0%	92.0%	0.0%	25
Manager	0.0%	100.0%	0.0%	5
Misc	0.0%	0.0%	100.0%	1
Screener	0.0%	100.0%	0.0%	3
Supervisor	0.0%	95.0%	5.0%	20
TANF	0.0%	100.0%	0.0%	1
Total	3.6%	91.1%	5.4%	56

3.2.4.3.7 Safety Model Training

As shown on Table 20 (on page 19)of all the individuals completing the survey, 71.4%, reported attending the new safety model training while 23.2% reported they did not attend; 5.4% of the respondents did not respond. Of the individuals surveyed, Managers reported 100% attendance and 85% of the Supervisors reporting they had completed the safety model training. Caseworkers reported lower attendance at the safety model training compared to the Managers and Supervisor, with 68% of Caseworkers attending. The screeners (33.3%) and the case aide (0%) had the lowest attendance rates for the safety model training. Given that the Safety Model has only been in policy for just over a year, ensuring that all supervisors and caseworkers across Colorado have been trained in the relevant concepts and their application is crucial to its valid implementation. Based on these results, then, the Division of Child Welfare may want to seek additional funding to allow for increased frequency and varied locations of additional training.

Table 20: Safety Model Training Completion by Position Type

Position Title	Missing Response	Yes	No	Responses Per Position
Case Aide	0.0%	0.0%	100.0%	1
Caseworker	4.0%	68.0%	28.0%	25
Manager	0.0%	100.0%	0.0%	5
Misc	0.0%	0.0%	100.0%	1
Screener	0.0%	33.3%	66.7%	3
Supervisor	5.0%	85.0%	10.0%	20
TANF	100.0%	0.0%	0.0%	1
Total	5.4%	71.4%	23.2%	56

Records from the Division of Child Welfare indicate that, statewide, a total of 849 child welfare professionals have attended the Safety Model training. Specifically, 530 attended one of 18 trainings conducted by ACTION for Child Protection between December 2006 and June 2007; while, 288 attended one of 9 trainings run by the Butler Institute for Families between June 2007 and January 2008; and an additional 31 were trained by the Division's Child Protection Intake Program Administrator.

3.2.4.3.8 Supervisory Training

The survey also captured whether individuals had completed the Supervisory training offered by the state. This information is self-reported and cannot be verified by the Department, as there is no tracking system. This question did not apply to the majority of respondents; however, 3 Administrators, 5 Managers, and 10 Supervisors answered it. Just as important as whether or not individuals had completed the training was when they last participated. Training for the Administrators and Managers tended to be less recent, with 9 of them completing the training prior to 1995, and one Manager completing training in 2006. In general, supervisors tended to have participated more recently, with half of them completing the training in 2006 and 2007. However, the other half last participated in the training in the late 90's and early 2000's. Looking at the surveys closer indicated that those supervisors who completed the training in 2006 and 2007 had recently been promoted into this new role, whereas those who had been supervisors for some time had not been retrained recently. As a result, those who had not attended recently were not as aware of new policy and practice models implemented recently. As it appears that the more experienced supervisors have not been through supervisor specific training recently, the Division of Child Welfare should consider creating more of a continuing education model requiring that supervisors complete part a specified amount of in-service training each year on supervisory specific topics.

Volume VII Citations

7.000.6 COUNTY RESPONSIBILITIES [Rev.eff. 1/1/04]

N. The county department shall ensure that newly hired or promoted social services supervisors, who have responsibility for supervising social caseworkers who work with children, youth and families, complete supervisory training which is required by the state department. This training must be completed within six (6) months of hire or promotion.

3.2.4.3.9 Average and Current Caseload

Effective January 1, 2001, statutory authority for State administered county merit systems was repealed. Each county was directed to provide for a merit system for the selection, retention, and promotion of employees of the county department of human/social services. Title 26-1-120 Merit System does not include a requirement for counties to report the number of caseworkers or workloads to the state.

Table 21 shows the average number of assessments and cases that survey respondents indicated carrying at any given time. Overall, there were 23 workers who estimated they averaged almost 15 assessments per month. Also, 16 respondents indicated that they averaged approximately 8 active cases at a time.

Table 21: Average Number of Assessments and Cases Assigned

	Average Number of Assessments (n=23)	Average Number of Cases (n=16)
Caseworker	14.8	8.3

Table 22: Current Number of Assessments and Cases Assigned

	Current Number of Assessments (n=21)	Current Number of Cases (n=18)
Caseworker	13.2	8.2

Table 22 shows the number of assessments and cases being worked by respondents at the time of the fatality review. It should be noted that the number of individuals providing information for this measure is different from the average due to several workers recently changing jobs, or being in the transition to a new job (e.g., being promoted from a worker to supervisor, changing from on-going work to intake, etc.). Overall, 21 individuals reported having an average of 13 assessments open while 18 workers indicated that they had 8 ongoing cases being worked.

As the numbers reported were based on workers who were involved in the 13 cases included in the fatality review, they should not necessarily be used as an indicator of the average caseload of workers across Colorado. Therefore, Colorado's Statewide Automated Child Welfare System, Trails, was used to get an additional estimation. Using a point in time analysis (open assessments and cases on 12/31/2007), Trails indicated that the average number of open assessments assigned to primary workers was 7, with a median of 5. It also showed a mean of 10 open cases per primary worker, with a median of 8. It should also be remembered that these are case counts, and do not show the number of children on each workers caseload. To this end, 22 respondents indicated that the average number of children per case was 2. An analysis of Trails data found the same. Therefore, ongoing workers would have around 16 children on their caseload on any particular day.

Throughout the fatality review process and through regional reports from Colorado's State Self Assessment conducted in 2007, counties complained about an overworked and under funded workforce. While some of the counties indicate that they are adequately staffed, others feel overwhelmed and identify adequate staffing and worker turnover as major safety systemic issues.

Due to the lack of accurate data and standards, a better analysis would involve looking at workload, and not simply caseload. While caseload standards simply look at a count of cases, workload initiatives address that different types of cases demand more or less time from workers. As such, time studies are needed to determine how much time various case types, and the various tasks (e.g., court) associated with each, drive for workers. This would then allow for a more accurate analysis of how many cases of each type workers could be expected to have on their caseload while still meeting best practice standards and achieving positive outcomes for Colorado's children. The most recent Colorado workload information is from the June 20, 1994 Settlement Agreement between the State of Colorado, Department of Social Services, Division of Child Welfare and the Colorado Lawyers Committee. The staffing recommendation and agreement was that "The total number of child welfare professional staff statewide shall be increased by 390 net additional professional staff…the additional professional staff will be to reduce caseloads in the child welfare areas, and at least 90% of the additional professional staff shall be caseworkers and supervisors." A workload analysis was not completed in 1994. Instead, the Colorado Lawyers Committee agreed to use the Child Welfare League of America (CWLA) recommended caseload number of 12 as a guide. Even today, the CWLA recommends a

caseload of no more than twelve cases. However, they also now recommend workload studies within individual agencies based on caseworkers assigned responsibilities.[50]

It is recommended that a full workload analysis be conducted and that the state seek statutory clarification for reporting requirements of counties related to staffing levels, workloads, education and training so that these items can be assessed and monitored statewide.

3.2.4.4 Policy Characteristics

3.2.4.4.1 Third Party Abuse Versus Intra-familial Abuse

Another issue identified through the 13 fatalities reviewed, as well as through the Screen Out Review, is confusion and misunderstanding about when to investigate allegations as third party abuse versus intra-familial. Confusion may partly be due to the fact that Volume VII does not provide clear definitions for intra-familial or third party abuse. As shown in the Volume VII Citations inset below, it simply refers back to the Colorado Revised Statutes (C.R.S.) for the definition of intra-familial, and states simply that third party abuse is anything that does not fit the previously provided definitions for intra-familial or institutional abuse. In addition, the section of the C.R.S. that is referenced does not actually provide a definition for these types of abuse, but instead sets forth the process and procedures for conducting investigations. In order to get the definitions, one must go to the definitions section, C.R.S. 19-1-103 (see below).

Volume VII Citations

7.202.52 Investigation requirements [Rev. eff. 2/1/07]

The investigation of intra-familial, institutional, or third party abuse shall be conducted as set forth in Sections 19-3-308(2), (3), (4) through 19-3-308.5, C.R.S.

7.7.202.54 Institutional abuse or neglect investigation shall: [Rev. eff. 2/1/07]

A. Include those reports of child abuse or neglect by staff in any private or public facility that provides out-of-home child care, including 24-hour care and child care homes and centers.

7.202.55 Third party abuse or neglect reports shall: [Rev. eff. 2/1/07]

A. Include any reports of abuse or neglect by a person who is not relating to the child in the contexts described in the previous Intrafamilial or institutional abuse sections.

C.R.S. 19-1-103 Definitions

(67) "Intrafamilial abuse", as used in part 3 of article 3 of this title, means any case of abuse, as defined in subsection (1) of this section, that occurs within a family context by a child's parent, stepparent, guardian, legal custodian, or relative, by a spousal equivalent, as defined in subsection (101) of this section, or by any other person who resides in the child's home or who is regularly in the child's home for the purpose of exercising authority over or care for the child; except that "intrafamilial abuse" shall not include abuse by a person who is regularly in the child's home for the purpose of rendering care for the child if such person is paid for rendering care and is not related to the child.

While the definition provided in C.R.S. appears clear and well defined, the process of getting to this definition is convoluted at best. Having the definition this difficult to find may create some of the lack of clear understanding and application in the field. As such, Colorado's child welfare professionals may be better served if the C.R.S. definition was included specifically into Volume VII (instead of just a reference) as well as CORE and Supervisor trainings updated to more clearly articulate the current statute.

However, even with this definition, there still remains confusion. For example, some county departments or individual workers include degree of separation in terms of relationship and the amount of contact that a relative may have with a child. For example, a situation where an uncle who lives out of state and does not

regularly have contact with a child is the alleged perpetrator is sometimes investigated as Intrafamilial, while other times is assigned as a Third Party investigation. This confusion may arise because, while the uncle is a relative, they do not reside in the child's home, nor do they ordinarily have any authority or responsibility for care of the child.

4.2.4.5 Practice Characteristics

This section identifies areas that, while perhaps more clear in Volume VII and training, were not being implemented in a valid and/or consistent manner across CPS agencies. While some areas may have differed primarily between county departments, other areas were found to vary at the level of individual workers.

4.2.4.5.1 Receiving and Assigning Referrals

The first decision a county department has to make in regard to ensuring child safety is how to respond to referrals from community members. This is a critical step, as it involves applying the definitional standards of abuse and neglect and weighing investigating an allegation against limiting unnecessary intrusion into a family.

Volume VII Citation

7.200.6 REFERRALS [Add eff. 12/1/05]
"Referral" means a report made to the county department that contains one or more of the following:

A. Allegations of child abuse or neglect as defined by Section 19-1-103[1], C.R.S;
B. Information that a child or youth is beyond the control of his/her parent;
C. Information about a child or youth whose behavior is such that there is a likelihood that the child or youth may cause harm to him/herself or to others, or who has committed acts that could cause him/her to be adjudicated by the court as a delinquent
D. Information indicating that a child or youth meets specific Program Area 6 requirements and is in need of services.

Chart 1, shown below, displays the trends of referrals received and those accepted for assessment since 1995. This includes data from Colorado's legacy data system, CWEST, and the current SACWIS system, Trails. Specifically, the transition from CWEST to Trails occurred in early 2001.

After remaining relatively constant from CY 1995 through CY 2000, the overall number of referrals received increased dramatically over the next seven years. While 2001 showed a large dip, this is probably due to the rollout of the Trails system and counties acclimating to the new system. Overall, the number of referrals increased from just over 50,000 in 2000 to slightly over 71,700 in 2007, representing a 43% increase in referrals in seven years.

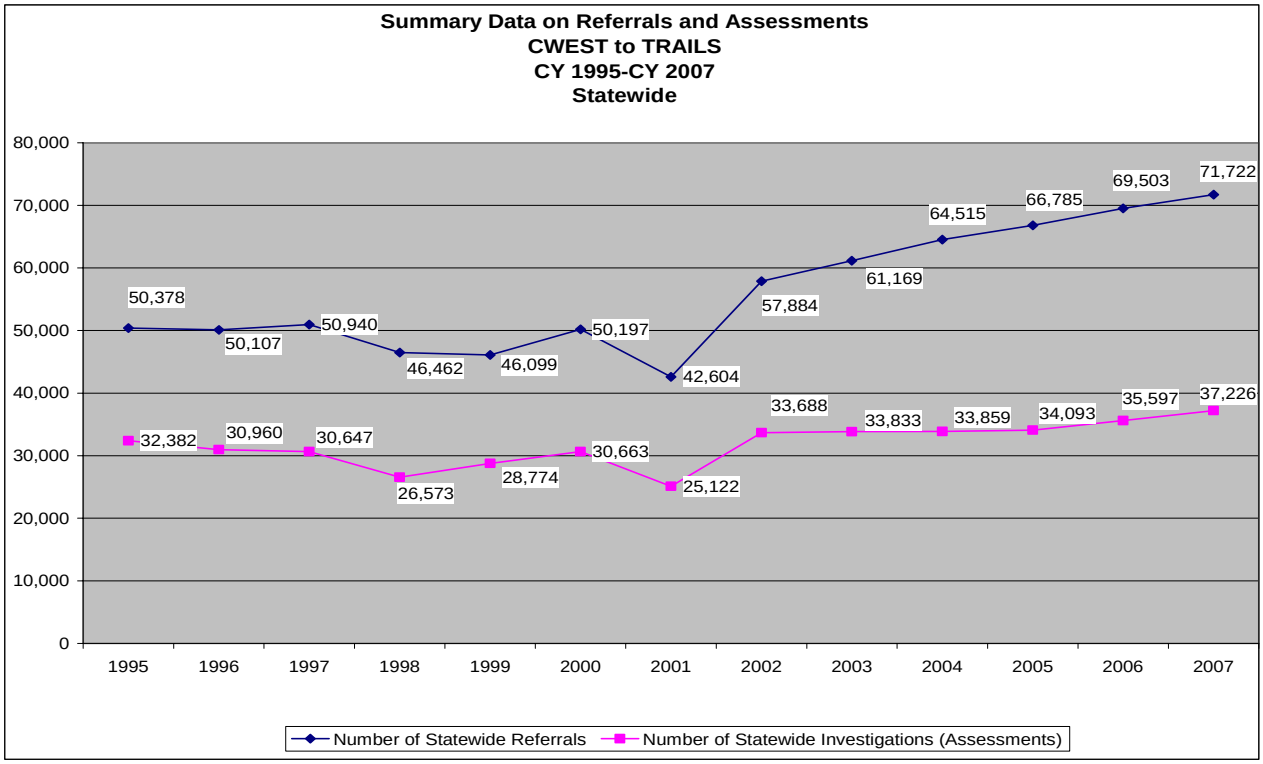
While referrals received have increased dramatically, the number of referrals accepted for assessment has remained relatively stable. Referrals received since 2002 have increased by 13,838 and yet the number accepted for assessment have only increased by 3,538 (most of which occurred in the past two years). As the chart visibly shows, the number of referrals accepted for assessment paralleled the number of referrals received until 2002. Since that time referrals accepted for assessment have remained relatively flat, while the number of referrals received continues to climb.

Feedback from various groups of Child Welfare professionals in Colorado indicates several possible explanations for this dramatic shift in referral and assessment trends statewide. First, counties may be entering referrals they receive at a higher rate due to the Division of Child Welfare allocation model that was begun in 2003. This allocation formula was modified in recent years to include an indicator related to the number of referrals received and assessments completed by counties each year. As money is now more directly tied to entering this data, counties may be more likely to ensure that referrals and assessments are entered into the system. A second explanation could be that with the "new" Trails system, counties are entering multiple

referrals on what historically presented as a single referral. For example, if several different reporting parties called in the same referral, Trails may reflect this as separate referrals, although historically this would have been captured (counted) as one single referral.

A third possible explanation is that county departments are now receiving more reports that do not meet the criteria required for assessment. While it is likely that a combination of factors are responsible for this trend, this last idea will be explored further in the next section. First, it is important to determine if the statewide number is representative of general county CPS agency experiences.

Chart 1: Statewide Referral and Assessment Trends CY 1995 through CY 2007



It should be stated that, while number of referrals accepted for assessment had remained relatively stable from 2002 through 2005, since that time many of Colorado's counties have experienced a significant increase in the number of referrals on which they conduct assessments. When breaking this information out by county, there is a wide variance across referral acceptance trends. For example, Table 23 displays the number of referrals accepted for assessment for Colorado's Ten Large Counties (TLC) over the course of the last three years. At

Table 23: Number of Referrals Accepted for Assessment across Colorado's Ten Large Counties from 2005 to 2007*

County	CY 2005	CY 2006	% Change 05-06	CY 2007	% Change 06-07	% Change 05-07
ADAMS	3052	3072	1%	3369	10%	9%
ARAPAHOE	3631	3916	8%	3942	1%	8%
BOULDER	1817	1818	0%	1981	9%	8%
DENVER	3425	4477	31%	5306	19%	35%
EL PASO	4854	4821	-1%	4893	1%	1%
JEFFERSON	3115	3384	9%	3535	4%	12%
LARIMER	2823	3245	15%	3039	-6%	7%
MESA	1482	1398	-6%	1225	-12%	-21%
PUEBLO	1620	1352	-17%	1363	1%	-19%
WELD	1553	1521	-2%	1680	10%	8%

* Table 23 is assessment level data and does not represent the number of children assessed. There may be multiple children involved in each assessment

the extremes of the range, Denver County increased the percent of referrals assigned for assessment by 35%, while Mesa County's number of referrals accepted for assessment declined by 21%. While more work with each county would be necessary to explain the vast differences, it is important to note that the statewide numbers are not necessarily reflective of the experiences of any one individual county.

If a county department CPS does not assign a referral for an assessment/investigation (commonly referred to as being "screened out"), they must document a reason for this decision. Specifically, Trails provides a pick list from which supervisors select an overall reason for the screen out. As part of the Screened Out Review, reviewers were asked to capture information regarding whether the selected reason was accurate (i.e., matched the written narrative reason for why the decision was made not to assign the referral), and if not, what the accurate reason should have been. As part of this process, it was discovered that over 60% of the time, supervisors were selecting the pick list option of "Other". I t was further determined that this was due to the fact that the Trails system would only allow supervisors to document supporting narrative in a comment box if the Other option was selected. As such, the data from the pick list field entered is not useful in determining meaningful reasons for not assigning a referral for an assessment.

Volume VII Citation

7.202.4 INITIAL ASSESSMENT [Rev. eff. 2/1/07]

F. The county department shall assign a referral for assessment and investigation if it:
   1. Contains specific allegations of known or suspected abuse or neglect as defined in statutes and regulations. A "known" incident of abuse or neglect would involve those reports in which a child has been observed being subjected to circumstances or conditions that would reasonably result in abuse or neglect. "Suspected" abuse or neglect would involve those reports that are made based on patterns of behavior, conditions, statements or injuries that would lead to a reasonable belief that abuse or neglect has occurred or that there is a serious threat of harm to the child.
   2. Provides sufficient information to locate the alleged victim.
   3. Identifies a victim under the age of 18.
   4. Meets the conditions of #2 and #3 above, results in a third report of suspected child abuse or neglect within a two year period and the two previous reports were not accepted for investigation. All reports with a child welfare concern occurring in any jurisdiction concerning any child in the family are to be counted towards the three or more reports.

However, using the reasons entered by the reviewers, who were asked to read the narrative and provide a more specific category when the one in Trails was inaccurate (or not specific, in the case of "Other"), does allow a better understanding. Table 24 (on Page 25)displays the aggregate reasons for screening out referrals. More than half (54.1%) of all referrals received that were screened out were not assigned for assessment because they did not meet the definition of abuse and neglect. n other words, community members are frequently calling into CPS agencies making reports that do not rise to the level of abuse and neglect and therefore do not require intervention. Interestingly, 19% of the screened out referrals did not match any of the available categories. As such, the Division of Child Welfare may want to examine these further to determine if the categories available should be expanded, thus allowing easier and more thorough tracking of this issue in the future.

When receiving referrals from concerned community members, Volume VII (7.202.4 C, D 1-3, E 1-15; See Volume VII citation on Page 25) has specific guidelines for the type of information that should be attempted to be obtained prior to making the decision as to whether to accept the referral for an assessment. Also, as defined by Volume VII (7.200.61), county departments are required to enter all reports that meet the definition of a referral into Trails.

Table 24: Reasons Referral Not Accepted for Assessment in Screened Out Review Study

	Frequency	Percent
No information available from reporter of an Abuse or Neglect as defined in law	689	54.1%
Other - Describe in Comment	241	18.9%
Other Department of Social/Human Services, Other Agency or Individual	93	7.3%
Insufficient information to locate child/family or to proceed	65	5.1%
Third Party Abuse	44	3.5%
I/R, follow-up required	39	3.1%
No Documentation - Unable to Determine	35	2.7%
Similar allegation already investigated	28	2.2%
Repeated unsubstantiated allegations made by the same party	23	1.8%
Referral to community supports	13	1.0%
Subject of report is over age 18	2	0.2%
Court Ordered, so screened out - but case open	1	0.1%
Total	1273	100.0%

Volume VII Citation

7.202.4 INITIAL ASSESSMENT [Rev. eff. 2/1/07]

C. The county department shall provide appropriate referral information to the reporting party in those situations in which there are inadequate grounds to constitute assignment for assessment and investigation. Either casework or supervisory staff shall inform, whenever possible and appropriate, the reporting party of the decision not to investigate and the reasons for that decision.

D. The county department shall enter all referrals into Trails as outlined in Sections 7.200.6 and 7.200.61, and conduct an initial assessment. The initial assessment shall decide the appropriateness of further investigation. It shall include, but not be limited to, the following activities:

1. Checking the State Department's automated system.
2. Reviewing county department files.
3. Obtaining information from collateral sources, such as schools, medical personnel, law enforcement agencies, or other care providers.

E. The county department shall gather and document the following information as available:

1. Family members and birth dates.
2. Relationships of individuals in the household.
3. Identified alleged victims, birth dates, and their current location.
4. Reasonable effort to secure the identity of the person alleged to be responsible of the abuse or neglect, as well as the responsible person's date of birth, Social Security Number, and last known address.
5. Presenting problems – specific allegations.
6. Reporter's credibility and name, address, and phone number.
7. Relationship of reporter to family.

(Continued next page)

Volume VII Citation

8. Other potential witnesses.
9. Collateral agencies and individuals involved with the family.
10. Records check – results of internal and State automated system inquiries.
11. Date and time intake report received.
12. Response assessment based upon reporter's information.
13. Referrals made.
14. Decision as to investigation response and caseworker's signature (name).
15. Supervisory approval of the decision and signature.

In 2 of the 13 fatalities reviewed, referrals were not entered into Trails, even though the county departments acted upon these referrals. In addition to the referrals not entered into Trails, in one of the fatalities reviewed, a referral was not entered into Trails until four and a half months after the receipt of the referral. In approximately 23% (3 of 13) of the fatalities reviewed, county departments did not obtain additional information and clarification from reporting parties before deciding what actions to take on a referral. With regard to the findings of the fatality review, it was found that for six of the recent child fatalities, it was not clear that the county departments adequately reviewed the prior history in Trails before initiating the assessments.

Table 25: Findings of the 2007 Screen Out Review Regarding Information Collected As Part of Decision to Not Investigate

Information Collected During Referral	Percent of Time Collected
Presenting problems - specific allegations	95.9%
Records check	93.9%
Relationship of reporter to family	90.2%
Reporter's name	89.1%
Alleged victims birthdates/age	86.5%
Reasonable efforts to secure the identity of the PRAN	83.8%
Alleged victim's current location and/or address	81.6%
Reporter's phone	80.8%
Relationships of individuals in the household	71.3%
Reporter's credibility	68.8%
Reasonable efforts to secure the PRAN's DOB	67.7%
Family members and birthdates/age	63.5%
Reasonable efforts to secure the PRAN's SS#	45.9%
Reporter's address	42.9%
Reasonable efforts to secure the PRAN's last known address	39.0%
Collaterals involved with the family	23.7%
Any action taken by the reporting source	21.5%
Other potential witnesses	20.8%
Referrals made by the county	11.0%
Reporter is identified as Anonymous	9.5%

Table 25 shows the information that was gathered as part of the referral process, while Table 26 shows what other sources of information were used to gather more information after the initial call.

As shown in Table 25, there are 20 different pieces of information that Screeners (i.e., the county department staff members who receive the calls from community members) are required to attempt to gather. Overall, it appears that some of these areas are routinely asked and documented, while others are either not requested or not documented. It should be noted that, due to the high amount of workload experienced by Screeners, that if the reporting party does not have information regarding one of these items, the Screener may not document this in an effort to save time while still capturing the most critical information that the reporting party does know.

Table 26: Findings of 2007 Screen Out Review Regarding Information Collected As Part of Decision to Not Investigate

Source	Source was used to gather more information during Referral
Trails records search	88.9%
Other database records search	45.5%
Law Enforcement	9.8%
Alleged PRAN(s)	8.0%
Parent(s)	7.9%
None	5.5%
Call backs to the reporting party	4.5%
Other - Describe in comments	3.9%
Sibling(s)	3.7%
Relatives	3.3%
Alleged Victim(s)	3.2%
Schools/Child Care	2.9%
Doctor/Hospital	2.7%
Criminal records check	2.5%
Other DHS Agencies	1.8%
Mental Health	0.9%
Utility company	0.5%
Probation/Parole	0.4%
ADAD	0.3%
Shelters	0.2%
Public Health/WIC	0.1%

Table 26 shows that, the additional sources of information most used are a Trails search as well as a search of other databases. In general terms, it is important to note that these other sources may not always be applicable to all referrals, so other than Trails and other databases, one would not expect to see any of these items at a full 100%. Due to time demands, and to ensure confidentiality for the family, workers should only be expected to check pertinent sources of additional information. For example, if the child is in school and the referral is of a nature that school officials or day care providers might have concerns or be able to add information (e.g., absences, marks regarding physical abuse, dirty clothes and poor personal hygiene, etc.), then a call to school officials or day care providers should be made. In other instances, a follow-up call would not be needed or appropriate. However, Table 26 makes it clear that CPS agencies are making decisions regarding accepting referrals for assessment on limited information from limited sources. Due to this limited amount of information, this is one of the more difficult decision making points of the assessment process, but also one of the most critical, as it represents the agency's first decision as to whether or not to intervene.

Lastly, it is important to consider whether the decisions being made, when compared to the standards to be applied to the information gathered, are being made accurately. Results from the review of the 13 fatalities directly examined for this report found that on at least three occasions, referrals were not assigned when they met the criteria for assignment. In one instance, a referral was made on an open case , however the referral was not assigned for assessment. In another instance, a referral was made that contained information that met the definition of "suspected abuse" and ultimately met the criteria for assignment however the referral was not assigned. In addition, during the Screen Out Review, the initial review team found that approximately 13% of the referrals not assigned for review appeared to have met the criteria for assignment. As part of the screen out process, it is critical to understand that this initial decision was made based upon data available in Trails only. For many of these referrals, when the county departments were contacted, they were able to provide additional data from their hard copy files that showed that, with the additional information they had gathered, the referral really did not meet the criteria and were properly screened out. Therefore, this percent may be a better indication of lack of documentation in Trails than it is a statement on quality of decision making. However, given the earlier findings of a lack of communication between counties and prior history as an indicator of risk, not having thorough documentation in the statewide data system is still concerning.

3.2.4.5.2 Supervision

During the interviews of child welfare professionals conducted as part of this review, numerous individuals commented that models of supervision are not consistent across counties, or even across teams within counties. For example, some individuals reported consistent weekly supervision, while others reported to have no set schedule but that supervision was available "when they needed it." Guidelines in Volume VII (7.301.3 E) only require a formal review of the case between supervisor and worker once every 90 days. Such infrequent and/or unstructured supervision makes it difficult to ensure that empirically supported best practice models are communicated to staff and consistently applied. In fact, during interviews some of the workers

were not aware of policy changes, agency letters, etc., indicating that there is not a clear channel of communication through the various levels of the child welfare system down to the workers who are actually responsible for the direct provision of services. Inconsistent supervision is also a concern due to the fact that the initial Child and Family Services Review in 2002 found that a key component to improving practice and achieving positive outcomes (i.e., safety) for children and families was strong supervision.

Volume VII Citations

7.301.3 FAMILY SERVICES PLAN REVIEW AND UPDATES [Rev. eff. 4/1/01]

E. The Family Services Plan shall be reviewed in conference with the caseworker and supervisor every 90-calendar days. The six-month Administrative Review of children in out-of-home placement may substitute for a 90 days review. The conference shall address:

1. Appropriateness of the services being provided to the child, parent(s) and foster parent(s), if applicable;
2. If applicable, appropriateness of the child's placement and how it meets the child's needs;
3. That the child's safety is protected in the placement;
4. The child, the parents, and other appropriate family members are receiving the specific services mandated by the Family Services Plan and are progressing toward the specific objectives identified in the plan;
5. Identification of barriers hindering the progress;
6. Appropriateness of existing timetables;
7. Whether additional or different services are needed and how they will be provided;
8. Appropriateness of the child's permanency goal:
    a. Appropriateness of efforts to finalize a permanent plan;
    b. Appropriateness of efforts to finalize a permanent placement.

3.2.4.6 Policy and Practice Conflict

While the prior sections dealt with issues that were more clearly identifiable as being singularly related to either policy or practice, this section deals with areas where lack of clear policy may lead to inconsistent practice.

3.2.4.6.1 Safety Model

After nearly a year of workgroups held with county CPS supervisors, co-facilitated by ACTION for Child Protection and the Division of Child Welfare, a significant change was made to the safety model in Colorado. The new rules supporting this change were effective in Volume VII on 2/1/2007. While the specific rules are listed in Appendix A, background of the model will be provided here.

The Federal Government designation ACTION for Child Protection as the National Resource Center for Child Protection in 2004. In addition, they have worked with numerous states in the past, with at least 11 other states adopting a version of their safety model. As the new model is one of the variables considered as a potential factor associated with the sudden increase of maltreatment fatalities where CPS agencies had prior involvement, these other states were interviewed regarding their experience adopting ACTION's safety model. Table 27, below, shows the states interviewed, how long they have been using the model, whether they have conducted any type of formal evaluation process, and whether they believe it helps them better protect children.

Table 27: Results of Interviews with other States Using Action for Child Protection's Safety Model

State	Years Used with Model	Structure	Conducted Formal Evaluation	Believe Kids are Safer Because of the Model
Wisonsin	17	Partially State Administered,Partially County Administered	No	Yes
South Dakota	7	State Administered	Process Evaluation	Yes
Alabama	6	State Administered	Just Starting	Yes
Arizona	6	State Administered	Process Evaluation	Yes
New Jersey	4	State Administered	No	Yes
Alaska	2	State Administered	No	Yes
Nevada	2	State Supervises, County Administered	No	Yes
Nebraska	1	State Administered	No	Yes
Oregon	1	State Administered	No	Yes
West Virginia	<1	State Administered	No	Yes
Ohio	<1	State Supervises, County Administered	Process Evaluation	Yes

Overall, there is great range in how long states have used the model, with Wisconsin having the most experience at approximately 17 years, while West Virginia and Ohio have been using it less than a year (although Hamilton County Ohio has used the model for approximately 4 years). Over half of the states have used the model for 4 years or less. In addition, 8 of the 11 have State Administered systems, with 2 states being operated similar to Colorado in that they are a State Supervised, County Administered system. Perhaps more interesting is that, while every state interviewed stated that they believed the model was helping them keep children safer, only three have had any type of evaluation on its effectiveness. These evaluations will be discussed later in this section.

As part of the above interview, states were asked to respond to an open ended question regarding what they believed was working well with the model. While a complete listing is too long to include here, the following are the most common themes across all of the states:

- 5 of the 11 (45.5%) states indicated that the model provided a standard protocol and framework with clear and concise guidelines that increased their consistency in assessing safety.
- 5 states (45.5%) reported that the model provided a logical, analytical, structured decision making process that helped move away from "gut level decisions" and provided more information to defend agency decisions.
- 4 states (36%) felt that it has moved them away from an incident based, investigative methodology towards a more clinical, comprehensive assessment of the family.
- 3 states (27%) indicated that it helped them focus on the specific behaviors and conditions that would need to change to improve child safety, which led to more targeted interventions.
- 3 states (27%) believed that the tools (e.g., safety assessment, parental caregiver capacity, and vulnerable child decision) were a strength in that they clearly identify specific and limited safety criteria while also focusing on the strengths of the caregiver's protective capacity.

Interviewees were also asked to respond to an open ended question regarding what areas of the model were not working well for them. The following list indicates the commonalities across responses:

- 5 states (45.5%) indicated that it took a lot of work, time, and resources to implement and integrate the new model and that training alone is not sufficient to successfully implement the model, rather, consistent monitoring and reinforcement of the concepts were required. This was also referenced as an issue made all the more difficult due to high turnover rates of workers.
- Related to the point above, 2 states reported that it was a major "paradigm shift" for workers, as it moved them from away from an investigatory, "law enforcement" methodology where they focused on the reported incident, to one requiring a more thorough assessment of the family.
- 4 states (36%) reported that a key to successful implementation was in having strong, clinically focused, supervision conducted by supervisors thoroughly trained and supportive of the model. As a

result, more time is required to supervise, with at least one state removing other responsibilities from supervisors so they could focus more on the safety model.

- 4 states (36%) also mentioned that, as the model involves more critical thinking and a more thorough assessment of the family that must happen over time, it is more labor intensive and was based on smaller caseloads than most states realistically have.
- Lastly, 2 states mentioned experiencing difficulty with getting consistent application of the tools and model by all of their workers. In other words, workers may be interpreting and applying the concepts, definitions, and assessments differently. Specific examples provided included some workers using the safety assessment as a checklist rather than a thorough assessment guideline.

Given some of the concerns listed above, it is more interesting to note that three of the states (36%) also qualified their statement that the model made children safer only when "applied correctly", "implemented correctly", and "when staff is skilled in the model". As some of the concerns indicated consistency as an issue, the results from the three evaluations conducted become more critical.

South Dakota reported only that they conducted evaluations on the use of the model during initial assessments and during ongoing case services and that the response to both was "very positive". While this indicates that staff may have felt positive, it does not provide any actual data that children are safer, or even as safe as they were previously. Wisconsin and Ohio stated that ACTION for Child Protection conducted evaluations within their state. The results of both indicated that staff were not completing the assessment tools at all or that, often, when they were completed, the staff was not collecting accurate, relevant information and ultimately not using the model to make good decisions. Given the lack of empirical data and sound outcome focused evaluation, and the lack of consistent application of the model found in the few evaluations conducted combined with the aforementioned qualified statements that the model will only lead to better safety when applied correctly, it is impossible to state whether or not children are safer as a result of the use of the model from ACTION for Child Protection.

Even more telling is that many of the statements and issues discussed above seem to mirror Colorado's experience in adopting ACTION's model for safety management. For example, while county responses in Colorado's Child and Family Services Review of State Self Assessment on the Safety Outcomes indicated that the new safety model and safety assessments were systemic strengths, there have also been multiple concerns raised. The findings from this fatality review, in conjunction with results from the reviews conducted by the State's Administrative Review Division (ARD), corroborate some of these concerns.

For example, the fatality review found 4 instances where protective and safety concerns were not accurately assessed and/or documented on the safety assessment. On a more positive note, reviews conducted by the ARD over the past four months indicate that in 93.5% of the referrals reviewed, safety concerns were accurately documented in the Safety Assessment.

As part of the assessment, CPS workers are required (7.202.52 A & B) to interview or observe the alleged victim within the assigned response time and outside the presence of the alleged perpetrator (if appropriate). There were two instances found as part of the fatality review where this did not occur. In addition, Table 28 shows the aggregate results from ARD reviews since November of 2007. Overall, only 80% of the referrals reviewed met these criteria. In the majority of the times the requirements were not met (80%), the CPS agency did not interview the alleged victim within the assigned response time. In almost half, the alleged victim was not seen outside the presence of the alleged perpetrator when it would have been appropriate.

Table 28: ARD Results Showing Percent of Children Interviewed Within Assigned Response Time and Outside Presence of Alleged Perpetrator

		Yes	No	NA	Compliance Percent
Does the assessment document that the alleged victim(s) was/were interviewed/observed face-to-face outside the presence of the alleged perpetrator and within the assigned response time?		402	99	13	80.2%
	No, not outside presence of alleged perpetrator		40		
	No, not within assigned response time		80		

Volume VII also requires (7.202.533 C) that the Safety Assessment be completed within 30 days from the date of the referral. However, one of the systemic findings from the fatality review was this was not always occurring. In addition, reviews conducted by the ARD found that only 87% of referrals reviewed had the Safety Assessment entered into Trails within the required 30-day timeframe.

Table 29: ARD Results Showing Percent of Safety Assessments Entered into Trails Timely

	Yes	No	NA	Compliance Percent
Was the Colorado Safety Assessment completed in Trails within 30 calendar days from the date the investigation/assessment was received?	440	66	8	87.0%

For open cases, Colorado also requires that the Colorado Assessment Continuum (which includes the Safety Assessment, Risk Assessment and the North Carolina Family Assessment Scale (NCFAS)) be completed within set timelines (7.301.1 C, 7.202.533 C, 7.202.62 E). As Table 30 (Page 28) shows, this battery of assessments is only completed timely in 65% of the In-home cases reviewed since November 2007.

Table 30: ARD Results Showing Percent of CAC Completed Timely for In-home Cases

		Yes	No	NA	Compliance Percent
Was the Initial Colorado Assessment Continuum completed timely in		141	76	79	65.0%
	No Initial Risk		25		
	No Safety		13		
	No NCFAS		58		

3.2.4.6.2 Disposition/Findings

When it is determined that abuse or neglect has occurred, Volume VII (7.202.63) requires that the Assessment in Trails must be given an overall disposition (sometimes referred to as a finding) and the individual allegations within the Assessment should also be given a disposition. These dispositions are documented in Trails as Founded, Unfounded, Inconclusive, or No Abuse/Neglect (Program Area 4: Youth in Conflict). (During CY 2004, there was a change to Trails allowing for a finding to identify those assessments that were not abuse or neglect assessments but involved youth in conflict issues.) Within an assessment, there may be multiple allegations. Each of these individual allegations may have findings associated with them as well (the Trails system does not require a disposition for each individual allegation, just for the overall assessment).

Chart 2 (Page 32) shows the overall dispositions of referrals accepted for assessment in CY 2006 by county size and statewide. Overall, approximately 20% of all assessments were founded. It should be noted that this is regarding the overall allegation, not each allegation for each child and as such is not victim level, but rather referral level data. This approximates national numbers reported from 2005 where approximately 25% of referrals were substantiated and 60% were unfounded.[4]

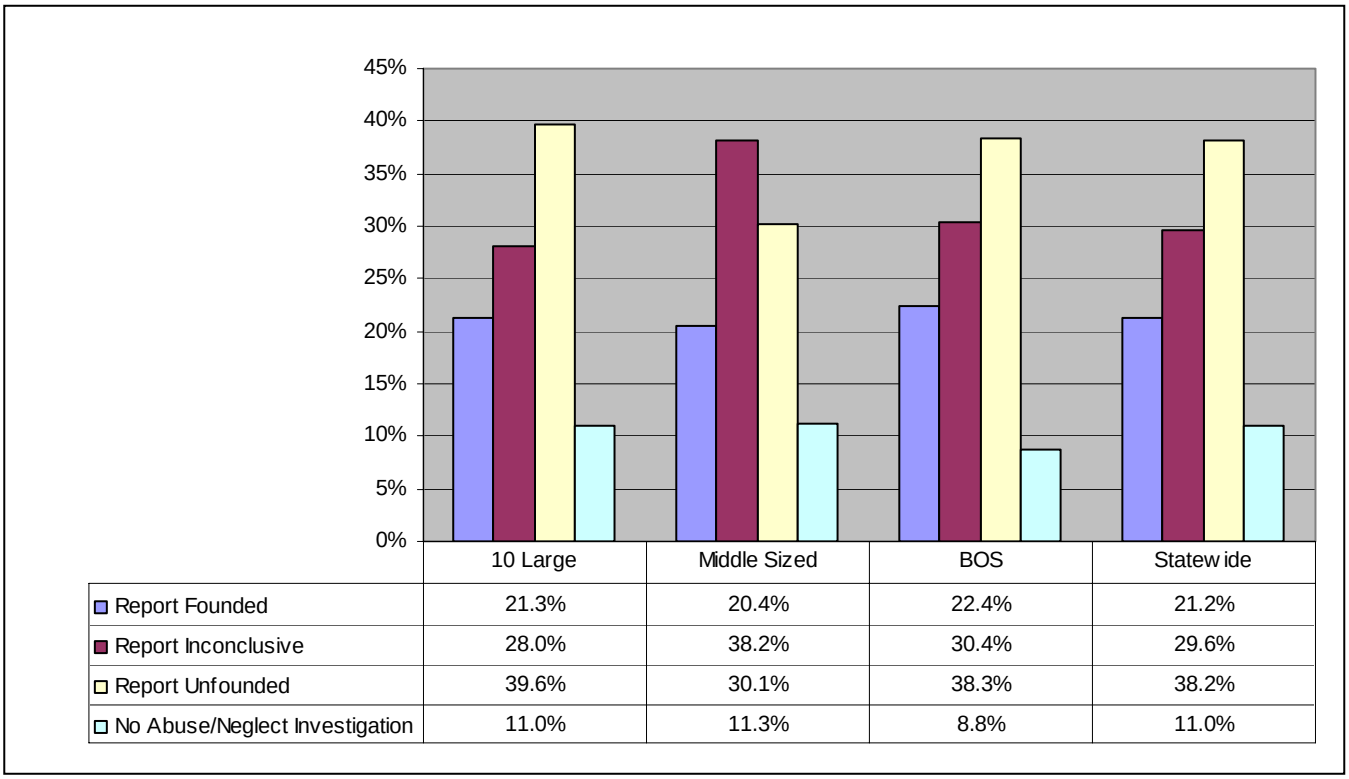
However, upon further exploration of this data, there appears to be great variance in how these dispositions are being interpreted and applied. Chart 3 (Page 33) highlights the overall dispositions entered into Trails by the Ten Large Counties (TLC) during CY 2006. When comparing the overall dispositions selected by the TLC, there is a clear difference in the percent of assessments that are founded. For example, El Paso County selected Founded in 13.6% of their assessments whereas Adams County selected Founded in approximately 30% of assessments.

A more important finding in this analysis was the variance in the overall dispositions of Inconclusive and Unfounded. As Chart 3 (Page 33) shows, Arapahoe County had 6% of assessments with an overall disposition of Report Inconclusive and 60% of Unfounded compared to El Paso County with 55.4% Inconclusive and 18.5% Unfounded. The remaining counties in the TLC show a similar, if somewhat smaller, variance in the use of Inconclusive versus Unfounded. However, this data should not be used to assume that any particular county is applying dispositions incorrectly.

While Volume VII provides a definition for the disposition type of Founded at 7.202.52 N, there are no corresponding definitions for Inconclusive and Unfounded. As such, each county (and perhaps each supervisor and worker) is left to create and apply their own definition. In fact, while conducting In-Home Quality Assurance reviews in several counties, staff from the Administrative Review Division found that workers and supervisors in some counties are confused about when to use Unfounded versus Inconclusive. During an in home review in one of Colorado's Ten Large counties, it was found that workers were using the overall disposition of inconclusive when the report seemed to be false or yielded no child protection concerns and unfounded when the assessment yielded a concern for abuse/neglect but lack of evidence to support the finding. This conflicted with how many of the other ten large counties interpreted and applied the overall dispositions of unfounded and inconclusive. It is difficult to have consistency when there is a lack of clear definitions for use. Volume VII should be updated to with clear definitions for these concepts.

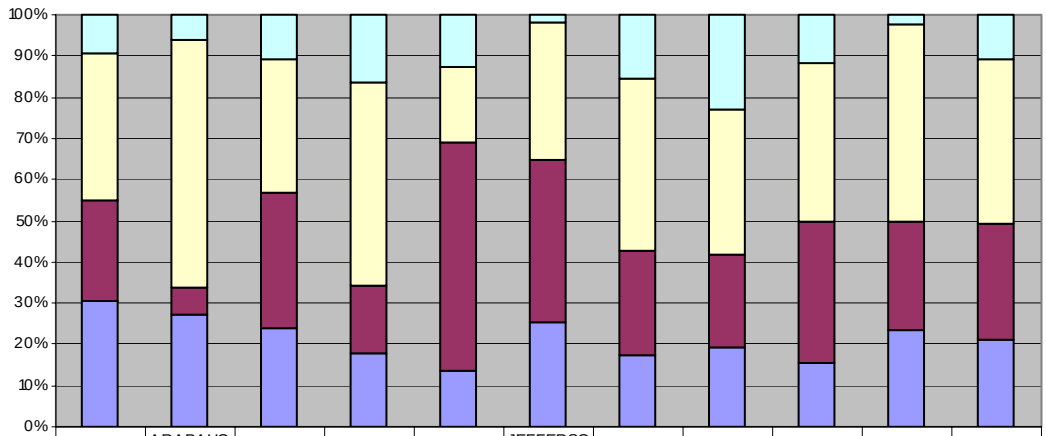
> 7.202.52 Investigation Requirement [Rev. eff. 10/1/2004]
>
> N. Upon completion of an investigation, the county department shall consider a report confirmed if there is a preponderance of evidence to support that abuse occurred.

Chart 2: Overall Dispositions of Referrals Accepted for Assessment CY 2006 Statewide by County Size



	10 Large	Middle Sized	BOS	Statewide
Report Founded	21.3%	20.4%	22.4%	21.2%
Report Inconclusive	28.0%	38.2%	30.4%	29.6%
Report Unfounded	39.6%	30.1%	38.3%	38.2%
No Abuse/Neglect Investigation	11.0%	11.3%	8.8%	11.0%

Chart 3: A Comparison of Colorado's Ten Large Counties Overall Dispositions of Assessments CY

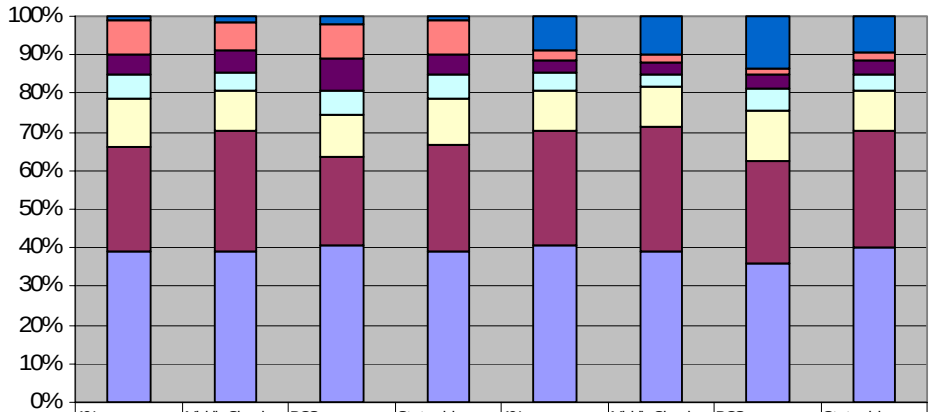


	ADAMS	ARAPAHOE	BOULDER	DENVER	EL PASO	JEFFERSON	LARIMER	MESA	PUEBLO	WELD	TLC
No Abuse/Neglect Investigation	9.6%	6.0%	10.8%	16.5%	12.5%	2.1%	15.3%	23.1%	11.6%	2.4%	11.0%
Report Unfounded	35.4%	60.1%	32.5%	49.5%	18.5%	33.2%	41.7%	34.9%	38.6%	47.9%	39.6%
Report Inconclusive	24.5%	6.6%	32.8%	16.1%	55.4%	39.5%	25.4%	22.7%	34.2%	26.1%	28.0%
Report Founded	30.4%	27.4%	23.9%	18.0%	13.6%	25.2%	17.5%	19.3%	15.6%	23.6%	21.3%

3.2.6.4.3 Timely Completion of Assessments

Volume VII, at 7.202.56, requires that all assessments be closed within 30 days, unless circumstances that have prevented this are documented. This documentation occurs through a request for, and supervisory approval of, an extension in Trails. Chart 4, shows that only about 40% of all assessments were closed within the required 30 days in both SFY 2005 and 2006.

Chart 4: Statewide Timeliness of Closing Assessments In Trails for SFY 2005 and 2006



	10 Large	Middle Sized	BOS	Statewide	10 Large	Middle Sized	BOS	Statewide
	2005				2006			
Investigation is Still Open in Trails	0.90%	1.60%	2.20%	1.00%	9.00%	10.10%	13.40%	9.40%
Investigation was completed after 180 days	9.10%	7.50%	9.00%	8.80%	2.30%	1.80%	1.70%	2.20%
Investigation was completed between 121 and 180 days	5.20%	5.40%	7.90%	5.40%	3.40%	3.20%	3.80%	3.40%
Investigation was completed between 91 and 120 days	6.10%	4.90%	6.50%	5.90%	4.40%	3.30%	5.70%	4.30%
Investigation was completed between 61 and 90 days	12.50%	10.40%	10.70%	12.10%	10.40%	10.20%	12.90%	10.50%
Investigation was completed between 30 and 60 days	27.20%	31.00%	23.10%	27.60%	29.60%	32.50%	26.80%	29.90%
Investigation was completed in less than 30 days	39.00%	39.20%	40.70%	39.10%	40.80%	38.90%	35.80%	40.30%

In addition, as shown in Table 31, the ARD has found that only 38.6% of the assessments reviewed that were open for longer than 30 days had the required request for an extension.

Table 31: ARD Results Showing Percent of Assessments Open Longer Than 30 Days with the Required Request for an Extension

	Yes	No	NA	Compliance Percent
If the assessment was open longer than 30 days, is there a documented reason for extending the assessment?	32	51	26	38.6%

There are serious consequences for not documenting actions on assessments in a timely manner as required. For example, in some of the 13, fatality cases reviewed, new referrals were not accepted for assessment due to the fact that screeners did a search of Trails and found an open assessment. The assumption was, due to the appearance of an ongoing assessment, that the intake worker assigned to the open assessment would be conducting a thorough assessment that would consider the issues in the new referral. However, during the reviews it was discovered that the open assessment had actually been completed and no one was having current contact with the family, but the assessment had just not been closed in Trails. The result of this confusion can mean that a new referral is never assessed, and an opportunity to intervene on behalf of a child might be missed.

As part of the Safety Model, workers can use a Protective Plan to control for Present Danger 7.202.53 C). During their reviews of assessments and in-home cases, the ARD examines if the county determined a Protective Plan was required, the Protective Plan met all of the requirements outlined in Volume VII (7.202.51 C 1-6). Table 32 shows that only 55.2% of the required Protective Plans actually met the minimum requirements. Specifically, the aspects most often missing were descriptions of the present danger, who would be responsible for the child's safety, and signatures of those participating in the plan indicating their agreement to fulfill their responsibilities.

Table 32: ARD Results Showing Percent of Required Protective Plans Meeting Volume VII Criteria

		Yes	No	NA	Compliance Percent
If the county determined that a Protective Plan(s) was required, was it used in accordance with Volume 7 requirements?		37	30	743	55.2%
	No, description of present danger		16		
	No description of actions for all parties		8		
	No persons responsible for child's safety		16		
	No timeframes of the plan		9		
	No signatures of parents, caregivers, and others		13		
	No parental agreement/willingness to participate		5		
	No hard copy		4		

As the Protective Plan was intended as a tool to help control for Present Danger, the ARD also captures data regarding whether the Protective Plan was used appropriately. For example, if the worker used a Protective Plan in the absence of Present Danger, this would not constitute an appropriate use. Table 33 shows that, the Protective Plan is being used appropriately in only 44.6% of the times it is used.

Table 33: ARD Results Showing Percent of Time Protective Plan Used Appropriately

	Yes	No	NA	Compliance Percent
In the reviewer's opinion was the Protective Plan(s) used appropriately?	37	46	727	44.6%

Also part of the Safety Model, a Safety Plan is intended to be used to control for Impending Danger (7.202.531 B). Once again, the ARD collects data indicating, if the county determined a Safety plan was necessary, whether it met the minimal requirements for a Safety Plan as outlined in Volume VII (7.202.535). Overall, as displayed in Table 34, only 46.8% of the Safety Plans reviewed since November 2007 have met the minimum requirements.

Table 34: ARD Results Showing Percent of Required Safety Plans Meeting Volume VII Criteria

		Yes	No	NA	Compliance Percent
If the County determined that a Safety Plan was required, was it used in accordance with Volume 7 requirements?		52	59	700	46.8%
	No hard copy		18		
	No signatures of parents, caregivers, and others		23		
	No least restrictive response for assuring safety		6		
	No immediate impact on controlling safety concerns		10		
	No activities corresponding to safety concerns		13		
	No safety response available at level required		4		
	No identification of participants in the plan		17		
	No parental agreement/willingness to participate		15		
	No caseworker activities to oversee safety plan		32		
	No documentation in Trails		9		

Similar to the Protective Plan, the ARD also captures information about whether or not the Safety Plan was used appropriately. In other words, was it used to manage impending danger, rather than present danger or risk. Table 35 shows that the Safety Plan was used appropriately 75% of the time. This would indicate that CPS workers have a better understanding of the concept of impending danger and when to use the Safety Plan.

Table 35: ARD Results Showing Percent of Time Safety Plan Used Appropriately

	Yes	No	NA	Compliance Percent
In the reviewer's opinion was the Safety Plan used appropriately?	99	33	678	75.0%

Information was gathered from the Statewide Self Assessment, a debrief session with all of the child welfare professionals who conducted the 13 fatality reviews, interviews with other states using the Action Safety Assessment and Planning curricula and statements made by county workers and supervisors during meetings with the ARD. All of these sources agreed upon systemic issues regarding the safety and risk assessments. Similar to the issues listed by interviewees from other states who adopted Action's model, the reviewers felt that the Safety and Risk Assessments were not used correctly, but instead only being used as a checklist to complete prior to closing the case. Reports indicate that the Safety Assessment is not being used to inform safety decisions, but are completed at the time of closing the case as a checklist. It was also noted that the Safety Assessment in Trails could be backdated, so that while it was being filled out at the end of the process, the date entered for completion may be much earlier (e.g., in one case reviewed, a Safety Assessment was backdated almost two years).

4. Recommendations

4.1 90-Day Recommendations

The following are recommendations, in no particular order, the Department will accomplish within 90 days from the date of the release of this report.

4.1.1 Regulation Clarification

1. Clear definitions for intra-familial, third party abuse, and institutional abuse should be added to Volume VII.
2. Volume VII provides a definition for the disposition type of Founded at 7.202.52, there are no corresponding definitions for Inconclusive and Unfounded. Definitions of these terms should be added to Volume VII, and trainings updated to reflect the new definitions.
3. Enhance current Volume VII definitions regarding response times to referrals so that they include the consideration of risk factors, such as those identified in this study; age of victims, age of parents, high mobility, drug and alcohol use, isolation, etc. instead of focusing solely on the concepts of Present and Impending danger.
4. Clarify the rules and expectations of the involvement/inclusion of all parties in multigenerational households in assessment, case planning, and service delivery.
5. The Division of Child Welfare should clarify rules on what prior history the county is expected to review prior to, and as part of, the investigation. This would include strengthening 7.202.52 J to require a review of the case history of any case regardless of the number of referrals. The rules 7.202.4D and 7.202.4F require review upon two or more referrals within two years must result in an investigation of the third referral needs to be monitored and enforced.
6. The Division of Child Welfare should amend rules to require more detailed documentation of interviews and other client contacts in Trails.
7. Amend rules to define the purpose of and use of extensions for assessments open longer than 30 days.
8. Define requirements related to the timely documentation of case/assessment activity that occurs on weekends, holidays, and after hours must be developed.
9. Develop a rule mandating the reporting county must contact the receiving county to verify receipt of the referral.
10. Develop a rule requiring counties to use the following two free web based searches for any assessment or case that involves allegations of a sexual nature to search for registered sex offenders.
    - www.NSOPR.gov/ a national web based search that can be done by name. This is through the United States Department of Justice.
    - www.sor.state.co.us Colorado Bureau of Investigation's (CBI) web based search that can be done by name. CBI has links to different county and city Sex Offender Registries. Many of these sites can not do a name specific search and can only do a neighborhood search.

4.1.2 Initiatives

1. Introduce legislation for the Department to have access to county department employee records, including but not limited to, the number and classification of employees, job descriptions, responsibilities, caseload, educational levels, background checks and trainings attended.
2. The Department will activate access for the counties to COGNOS, an innovative business intelligence platform that will allow counties access to county-specific and statewide data on the Child and Family Services Review (CFSR) measures as well as being able to compare and contrast their performance.
3. In the current Long Bill HB098-1375, the Department is slated to receive six new FTEs for county department foster care and kinship monitoring and Trails data integrity. The Department will determine overall job functions and qualifications and begin the process for hiring starting July 1, 2008.
4. Request legislation requiring the Department to conduct a county organizational assessment. The State received a supplemental to conduct a state level organizational effectiveness assessment that explores the extent to which some of the systemic issues identified in this report (e.g., difficulty of communication

new policies and practice models down through the various levels of child welfare professionals) are due to the organizational structure of Colorado's child welfare system and makes recommendations for how to overcome any identified barriers. This legislation will be the companion piece.

5. Request an Executive Order establishing a child welfare action committee to examine and make recommendations with the potential to assist in implementing long-term systemic changes related to the issues identified in this report.

4.1.3 State Organizational Effectiveness Assessment

1. The State received a supplemental to conduct a state level organizational effectiveness study that explores the extent to which some of the systemic issues identified in this report (e.g., difficulty of communicating new policies and practice models down through the various levels of child welfare professionals) are due to the organizational structure of Colorado's child welfare system and makes recommendations for how to overcome any identified barriers.

4.2 Long-Term Recommendations

4.2.1 Training

1. Given that the Safety Model has only been in policy for just over a year, require all supervisors and caseworkers across Colorado to be trained in the relevant concepts and their application is crucial to its valid implementation.
2. Create a continuing education model of training that requires supervisors to complete a specified amount of in-service training each year on supervisory specific topics to include recent rules and regulations or legislation.
3. The Division of Child Welfare, in coordination with counties and those providing state funded training, should develop a workgroup to explore the current training milieu available and develop additional training modules as needed.
4. Provide caseworker and supervisory training to enhance the use of the Colorado Assessment Continuum as a tool in the decision-making process.
5. Partner with the School of Social Work in higher education to enhance their curriculum so that social workers with an undergraduate degree are better prepared to work in the field at a county department.
6. Develop and invest in the Child Welfare Training Academy, which would include a certifying process for child protection workers before receiving a caseload
7. In an effort to increase its consistent application, the Division of child Welfare should provide a review of the recent safety and risk assessment training and current Volume VII rules with county staff and enhance the rules and trainings as necessary making certain that the trainers/trainings present congruent information.

4.2.2 Initiatives

1. Partner with other state agencies to develop a public health initiatives, such as parenting classes specifically targeted for younger parents may be an important component to positively impacting child maltreatment rates in general, and fatalities specifically.
2. Develop an initiative to conduct a pilot based on the prevalence of domestic violence. The pilot sites would provide services for families and children with domestic violence history, as well as, provide training to caseworkers to identify domestic violence in the home.
3. Consider recommendations from Senate Bill 07-064 – Child Foster Care Adoption Task Force.

4.2.3 Communication/Collaboration

1. Ensure that individuals at all levels are aware of policy changes, agency letters, etc. The Division of Child Welfare needs to develop a clear channel of communication through the various levels of the child welfare system down to the workers who are actually responsible for the direct provision of services. For example, a "listserv" should be used only for the distribution of Volume VII updates and Agency Letters. All child welfare professionals should be enrolled in this "listserv" during New Employee Orientation, and current employees should be required to register as well. In addition, the Division of Child Welfare should create another "listserv" solely for county directors and administrators that could be used for distributing information regarding proposed rules.
2. The Division of Child Welfare should develop regional supervisory groups that meet on a regular schedule to review new rules and regulations, discuss implementation and provide feedback to State staff about their questions regarding the rules and implementation.
3. In cases in which the county department, mental health and substance abuse agencies are providing services to a family, address the issue of access and sharing of confidential information that may be hindered due to Health Insurance Portability and Accountability Act (HIPAA) requirements.
4. Develop a statewide MOU or cross agency policy that requires all courts to send notices of restraining orders involving children to DSS agencies and law enforcement agencies statewide.
5. Explore the use of Lexis/Nexis for a more accurate background check on possible sexual offenders. Lexis/Nexis provides a more thorough check of all charges, convictions, and restraining orders for the individual being searched. There is a fee associated with this type of search.

4.2.4 State Oversight

1. The State Division of Child Welfare should provide clarity, guidance and training on the written forms, policies and procedures that are required of both the State Division of Child Welfare and County departments when a child fatality has occurred. Standards and processes should be defined for internal reviews of fatalities (i.e., who must be involved, by when and what constitutes an acceptable outside expert to assist counties). A standard format should be developed for all counties to use as their internal review process.
2. There should be an analysis of all Volume VII rules. This is necessary in order to update the rules to reflect the Trails environment, decrease the number of contradictions, and accurately reflect current practice.
3. Request Technical Assistance from the National Resource Center of Organizational Improvement to review the policy, rules and statute for compliance with federal regulations i.e. Child Abuse Prevention and Treatment Act (CAPTA).

4.2.5 Workload Analysis

1. Recommendation will be made to conduct a rigorous, sound analysis of the workload required of different case types and the various activities associated with each and use the results to build a model that extrapolates from the time and effort required for the various activities, but not limited to, realistic caseload standards for intake and ongoing workers as well as supervisors of each.

4.2.5 Trails

1. A number of data integrity issues were identified throughout this process. A workgroup should be developed to include: The Division of Child Welfare, the Administrative Review Division, the Division of Youth Corrections, Trails ITS staff, members from County Trails User Group (CTUG), and other County staff to review the effectiveness of Trails, the efficiency of Trails, and quality of Trails data. A purpose of this workgroup shall include reviewing and implementing Trails changes recommended in the white paper on referral and assessment trends, findings from the Screen Out Review process, and findings from this fatality review. Incorporated into these recommendations would be the need for Alerts when there have been two previous reports of suspected child abuse or neglect within a two-year period and the two previous reports were not accepted for investigation.
2. The Division of Child Welfare, in cooperation with the counties, should reconcile the multiple fatality lists that exist. For those children who have been victims of fatal child abuse/neglect within the last five

years, dates of death should be recorded in Trails. The data integrity of the ACCESS database maintained by Division of Child Welfare should be identical to what is reflected in the Trails database.

3. Investigate the possibility of developing a Trails pop-up "Alert" to identify high-risk children/families who have high rates of mobility.
4. When making the decision to "screen out" a referral in Trails, the Trails system only allows supervisors to document supporting narrative in a comment box if the "Other" option was selected. As such, the data from the pick list field entered is not useful in determining meaningful reasons for not assigning a referral for an assessment. It is recommended that a change be made to Trails to allow a comment field to be added.

5. Glossary

Abuse

"Abuse" or "child abuse or neglect" means an act or omission in one of the following categories that threatens the health or welfare of a child:

(I) Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence;

(II) Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102 (9),

(III) Any case in which a child is a child in need of services because the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take.

(IV) Any case in which a child is subjected to emotional abuse. As used in this subparagraph (IV), "emotional abuse" means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development.

(V) Any act or omission described in section 19-3-102 (1)(a), (1)(b), or (1)(c);

(VI) Any case ion which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in section 18-18-102 (5), C.R.S., is manufactured or attempted to be manufactured;

(VII) Any case in which a child tests positive at birth for either a schedule-I controlled substance, as defined in section 18-18-203, C.R.S., or a schedule II controlled substance as defined in section 18-18-204, C.R.S. unless the child tests positive for a schedule II controlled substance as a result of the mother's lawful intake of such substance as prescribed.

(Colorado Revised Statutes, 19-1-103 (1)(a)).

ACTION for Child Protection

ACTION for Child Protection (ACTION) is a private non-profit organization with its headquarters in Charlotte, North Carolina and its executive office in Albuquerque, New Mexico. In October 2004, ACTION for Child Protection was awarded a five-year cooperative agreement by the Children's Bureau (CB), Administration on Children, Youth and Families, Administration for Children and Families, Department of Health and Human Services to operate the National Resources Center for Child Protective Services (NRCCPS).

Child and Family Services Review (CFSR)

The Child and Family Services Reviews (CFSRs) are conducted by the Children's Bureau, within the U.S. Department of Health and Human Services (HHS), to help States improve safety, permanency, and well-being outcomes for children and families who receive services through the child welfare system. The CFSRs monitor States' conformity with the requirements of title IV-B of the Social Security Act. The first round of reviews took place between 2000 and 2004 and all States were required to implement Program Improvement Plans (PIPs). The second round of reviews began in early spring of 2007.

Child and Family Services Review (CFSR) (continued)

Colorado will have their second CFSR in March 2009. (http://www.acf.hhs.gov/ programs/cb/cwmonitoring /general_info/fact_sheets/governorsfactsheet.htm)

Child Welfare Services

"Child Welfare Services" means the provision of necessary shelter, sustenance, and guidance to or for children who are or who, if such services are not provided, are likely to become neglected or depenedent, as defined in section 19-3-102, C.R.S. "Child Welfare Services" includes but is not limited to:

(a) Child protection;
(b) Risk assessment;
(c) Permanency planning;
(d) Treatment planning;
(e) Case management;
(f) Core services, as defined in section 19-3-208, C.R.S.;
(g) Adoption and subsidized adoption;
(h) Emergency shelter;
(i) Out-of-home placement, including foster care;
(j) Utilization review;
(k) Early intervention and prevention;
(l) Youth-in-conflict functions; and
(m) Administration and support functions

(Colorado Revised Statutes 26-5-101 (3))

Colorado Children's Code

Title 19 of the Colorado Revised Statutes, is known as the "Colorado Children's Code". The Colorado Children's Code contains some of Colorado's civil statutes regarding child welfare services.

Colorado Revised Statutes

Colorado revised statues are all laws passed by the General Assembly of the State of Colorado.

Colorado Safety Assessment

"Colorado Safety Assessment" refers to the instrument in TRAILS that guides a caseworker through a safety assessment process. *(Volume VII 7.202.531)*

Colorado State Board of Human Services

The State Board of Human Services was created pursuant to Section 26-1-107 C.R.S. promulgates rules for program areas in the Colorado Department of Human Services.

Colorado State Board of Human Services (continued)

The State Board is a Type 1 body (which means that it has rule-making authority) comprised of nine members appointed by the Governor and confirmed by the Senate for terms of four years, with state-wide representation including three county commissioners as required by statute.

County Department

"County department" means the county or district department of social services. *(Colorado Revised Statutes Title 26-1-103 (3))*

CWEST (Child Welfare Eligibility and Tracking System)

A statewide, automated data collection and retrieval system for case-level client, child, service, and placement information. Colorado Trails superseded this system. *(Colorado Child Welfare Handbook, 2004)*

Disposition

This is the decision about whether to confirm a report of child abuse and neglect. The disposition decision is made in accordance with Colorado law. The decision is based on whether the caseworker has sufficient evidence to constitute a reasonable belief (preponderance of evidence) that a child has been abused or neglected. Under the Indian Child Welfare Act the burden of proof increases to clear and convincing evidence. *(Colorado's Child Welfare Practice Manual, 2004)*

Family Services Plan

An individualized Family Services Plan documents and guides the intervention process for children and their families. It contains information about the services necessary to facilitate a child's development and enhance the family's capacity to assure the child's needs for safety, permanency, and well-being are met. Through the FSP process, family members and service providers work as a team to plan, implement, and evaluate services tailored to the family's unique concerns, priorities, and resources.

The Family Services Plan shall document:

A. That services to be provided are directed at the areas of need identified in the assessment. Outcomes to be achieved as a result of the services provided will be described in terms of specific, measurable, agreed upon, realistic, time-limited objectives and action steps to be accomplished by the parents, child, service providers and county staff.
B. That services to be provided are designed to assure that the child receives safe and proper care.
C. That services to be provided are culturally and ethnically appropriate. *(Volume VII 7.202.531)*

Impending Danger

"Impending danger" refers to threats to child safety that are based on specific referral information or a more thorough evaluation of individual and family conditions that create an immediate threat to child safety in the near future. *(Volume VII 7.202.531)*

National Resource Center for Child Protective Services (NRCCPS)

NRCCPS provides expert consultation, technical assistance and training to States, local, Tribal and other publicly administered or supported child welfare agencies to build capacity to achieve safety, permanency and well-being for children and families.

NCANDS

The National Child Abuse and Neglect Data System (NCANDS) is a national data collection and analysis system created in response to the requirements of the Child Abuse Prevention and Treatment Act (Public Law 93-247) as amended. The NCANDS consists of two components. The Summary Data Component (SDC) is a compilation of key aggregate child abuse and neglect statistics from all states, including data on reports, investigations, victims, and perpetrators. The Detailed Case Data Component (DCDC) is a compilation of case-level information from those child protective services agencies able to provide electronic child abuse and neglect records.

Neglect

(1) A child is neglected or dependent if:
- (a) A parent, guardian, or legal custodian has abandoned the child or has subjected him or her to mistreatment or abuse or a parent, guardian, or legal custodian has suffered or allowed another to mistreat of abuse the child without taking lawful means to stop such mistreatment or abuse and prevent it from recurring;
- (b) The child lacks proper parental care through the actions or omissions of the parent, guardian, or legal custodian;
- (c) The child's environment is injurious to his or her welfare;
- (d) A parent, guardian, or legal custodian fails or refused to provide the child with proper or necessary subsistence, education, medical care, or any other care necessary for his or her health, guidance, or well-being;
- (e) The child is homeless, without proper care, or not domiciled with his or her parent, guardian, or legal custodian through no fault of such parent, guardian, or legal custodian;
- (f) The child has run away from home or is otherwise beyond the control of his or her parent, guardian, or legal custodian;
- (g) The child tests positive at birth for either a schedule-I controlled substance, as defined in section 18-18-203, C.R.S., or a schedule –II controlled substance, as defined in section 18-18-204, C.R.S., unless the child tests positive for a schedule –II controlled substance as a result of the mother's lawful intake of such substance as prescribed.

(2) A child is neglected or dependent if:
- (a) A parent, guardian, or legal custodian has subjected another child or children to an identifiable pattern of habitual abuse; and
- (b) Such parent, guardian, or legal custodian has been the respondent in another proceeding under this article in which a court has adjudicated another child to be neglected or dependent based upon allegations of sexual or physical abuse, or a court of competent jurisdiction has determined that such parent's, guardian's, or legal custodian's abuse or neglect ahs caused the death of another child; and
- (c) The pattern of habitual abuse described in paragraph (a) of this subsection (2) and the type of abuse described in the allegations specified in paragraph (b) of this subsection (2) pose a current threat to the child.

(Colorado Revised Statutes Title 19-3-102)

Preponderance of Evidence

"Preponderance of the Evidence" means credible evidence, put forth by either party that the claim is probably more true than false. *(Volume VII 7.202.3(B)(4))*

Present Danger

"Present Danger" refers to an immediate, significant and clearly observable threat to child safety that is actively occurring or in process of occurring at the point of contact with a family and will likely result in severe harm to a child. *(Volume VII 7.202.531)*

Safety Planning

There are four (4) danger criteria that must be present to determine that a safety concern exists. These are:

1. The threat to child safety is specific and observable.
2. The threat or conditions reasonable could result in sever harm to a child.
3. The caregiver(s) is unable to control conditions and behavior that threaten child safety.
4. The potential that a child could experience severe harm is imminent, which means that it could occur at any point in the near future.

Safety plans do not have to be developed if the safety analysis results in a decision that out-of-home placement is the only plan that is sufficient to control impending danger safety concerns.
A safety plan shall be developed for all other situations in which the safety intervention analysis has indicated that an in-home safety plan can sufficiently control safety concerns. It shall be documented in the state's automated system. All children in the household assessed to be unsafe shall be included in the one plan. *(Volume VII 7.202.535)*

Screening

The method for determining the appropriateness of a referral and the legal base for investigation. *(Colorado Department of Human Services, Volume 7 Training Manual, 1993)*

Screen Out Review

During the week of September 17, 2007, a group of approximately 34 people came together from Child Welfare, ARD and the County Departments of Human Services to conduct the Statewide Screen Out Review. Within three (3) days, 7-paired review teams reviewed 1,273 screened out referrals from around the state. The review instrument focused on referrals that had been "Screened Out" or those referrals that the county did not accept for assessment.

Trails

Trails is Colorado's Statewide Automated Child Welfare Information System (SACWIS), as mandated and approved by the Federal government. It is an online data management and analysis system used for Division of Child Welfare Services and Division of Youth Correction (DYC) case management documentation. All 64 counties and the Division of Youth Corrections, and the Division of Child Care use Trails.

Volume VII

Volume VII is the Colorado Department of Human Services policy manual. Volume VII sets forth rules and regulations that guide child welfare practice in Colorado. The Colorado State Board of Human Services is responsible for promulgating these rules and regulations.

Appendix A – Excerpts from Volume VII

7.202.53 Safety Intervention Model [Eff. 2/1/07]

A. The Safety Intervention Model is the action and decisions required throughout CPS involvement to:

1. Identify and assess threats to child safety;
2. Plan for an unsafe child or children to be protected;
3. Facilitate caregivers in taking responsibility for child protection; and,
4. Manage plans designed to assure child safety while a safe and permanent home is established.

B. A child's safety must be considered during intervention with families at the following key decision points:

1. At the initiation of an assessment, upon first contact with an alleged child victim and family;
2. Following a new child protection referral prior to the completion of the assessment;
3. The conclusion of an assessment and promptly upon opening a child protection case;
4. Whenever there is a new CPS referral on an open CPS case or there is a significant change in family circumstances or situation that might pose a new or renewed threat to child safety;
5. Prior to reunification on an open ongoing CPS case;
6. Prior to changing the permanency goal on an open CPS case; and,
7. Prior to supervisory approval for closing a CPS case.

7.202.531 Definitions [Eff. 2/1/07] Eff 02/01/2007

A. "Colorado Safety Assessment" refers to the instrument in TRAILS that guides a case worker through a safety assessment process.

B. "Impending danger" refers to threats to child safety that are based on specific referral information or a more thorough evaluation of individual and family conditions that create an immediate threat to child safety in the near future.

C. "Present danger" refers to an immediate, significant and clearly observable threat to child safety that is actively occurring or in process of occurring at the point of contact with a family and will likely result in severe harm to a child.

D. "Protective plan" refers to a written plan designed to provide immediate protection of a child and that is put in place upon the initial contact during the assessment or at anytime present danger is identified during the safety and assessment process prior to the completion of a safety assessment.

E. "Safety plan" refers to a written arrangement between the family, safety service providers, and the county department that establishes how impending danger to a child will be controlled and managed.

7.202.532 Child Safety at Initiation of Assessment [Eff. 2/1/07] Eff 02/01/2007

A. At the point of first contact with the alleged child victim(s), assessment shall focus immediately on whether there are threats to child safety that are actively occurring (known as present danger). Upon making face-to-face contact with the alleged child victim and caregiver(s), the caseworker shall evaluate and determine if a child is in present danger.

B. If the child is in present danger, the caseworker shall initiate a safety response and shall: Eff 02/01/2007

1. Implement an immediate protective plan to manage present danger unless out-of-home placement is required as described below. The immediate protective plan shall include reasonable means by which child safety can be assured while the overall safety assessment continues. See Section 7.202.51, C, outlining the required format on which to document protective plans. Documentation of a protective plan shall be completed with the family.

2. Implement out-of-home placement (see Section 7.304, et seq., 12 CCR 2509-4), in which case no protective plan will be documented.

7.202.533 Parameters for Use of the Colorado Safety Assessment [Eff. 2/1/07] Eff 02/01/2007

A. Completion of the Colorado Safety Assessment is required:

1. At the conclusion of an investigation or assessment including when there are new allegations on an open ongoing child protective services case; or,

2. Whenever there is a significant change in family circumstances or situations that might pose a new or renewed threat to child safety; or,

3. Prior to reunification on an open CPS case; and,

4. Prior to supervisory approval for closing a CPS case.

B. Completion of the Colorado Safety Assessment is required for all Program Area 5 reports being investigated or assessed, except:

1. Institutional abuse investigations.

2. Third party investigations.

3. Fatality investigations when there are no surviving siblings.

4. When caregivers have abandoned the child.

C. The Colorado Safety Assessment shall be documented in the State's automated system no later than thirty (30) calendar days from the date the investigation/assessment was received.

7.202.534 The Colorado Safety Assessment [Eff. 2/1/07] Eff 02/01/2007

A. The Colorado Safety Assessment provides fifteen (15) safety concerns to assess for impending danger. The fifteen standardized safety concerns shall be used to analyze whether conditions within the family are threats to child safety that could result in severe harm. The fifteen standardized safety concerns are as follows:

1. Caregiver(s) in the home is out of control and/or violent.

2. Caregiver(s) describes or acts toward child in predominately negative terms and/or has unrealistic expectations likely to cause severe harm.

3. Caregiver(s) has caused harm to the child or has made a credible threat of severe harm.

4. Caregiver(s)' explanations of severe injuries present are unconvincing.

5. The caregiver(s)refuses access to the child or there is reason to believe that the family will flee.

6. Caregiver(s) is unwilling or unable to meet the child's immediate needs for food, clothing, and shelter, which is likely to result in severe harm.

7. Caregiver(s) is unwilling or unable to meet the child's moderate to severe medical or mental health care needs.

8. Caregiver(s) has not or is unable to provide sufficient supervision to protect child from potentially severe harm.

9. Child is fearful of caregiver(s), other family members, or other people living in, or having access to, the home.

10. Child's physical living conditions seriously endanger the child's immediate health.

11. Caregiver(s)' alleged or observed substance use may seriously affect ability to supervise, protect or care for the child.

12. Child sexual abuse is suspected and circumstances suggest that child safety is of immediate concern. Caregiver(s)' alleged or observed emotional instability or developmental delay seriously affects his/her ability to supervise, protect, or care for the child.

13. Caregiver(s)' alleged or observed emotional instability or developmental delay seriously affects his/her ability to supervise, protect, or care for the child.

14. Domestic violence exists in the home and places the child in danger of physical and/or emotional harm.

15. Caregiver(s) has previously abused or neglected a child or is suspected of such, and the severity of the past maltreatment or caregiver's response to previous intervention suggests impending danger to the child.

B. The list of safety concern definitions shall be referenced when assessing threats to child safety and prior to checking safety concerns in the Colorado Safety Assessment.

C. The following four (4) impending danger criteria must be present to determine that a safety concern exists. Meeting these criteria indicates that the family's behavior, condition or situation directly threatens the safety of a child and could reasonably result in severe harm to the child.

1. The threat to child safety is specific and observable.

2. The threat or conditions reasonably could result in severe harm to a child.

3. The caregiver(s) is unable to control conditions and behavior that threaten child safety.

4. The potential that a child could experience severe harm is imminent, which means that it could occur at any point in the near future.

D. Safety Assessment Conclusion

1. If none of the fifteen (15) safety concerns are identified at the conclusion of the safety assessment process, then there is no impending danger to a child and no further safety intervention is required. Although risk issues may be identified, the assessment may be closed and further intervention is a county option.

2. If one or more of the fifteen (15) safety concerns are identified, then it is necessary to consider the child's vulnerability to determine if there is impending danger.

3. If an assessment does not determine that there is a vulnerable child in the home, then there is not a threat to child safety and no further safety intervention is necessary. Although risk issues may be identified, the assessment may be closed and further intervention is a county option.

4. If an assessment indicates that there are one or more safety concerns and there is a vulnerable child in the home, then it is concluded that impending danger is present and an evaluation must be made regarding caregiver protective capacities to manage and address safety concerns.

E. Determining Caregiver Protective Capacity and Making the Safety Decision

1. Caregiver protective capacities shall be evaluated for the purpose of determining if a caregiver and/or other responsible adult in the home has the capacity and willingness to manage and/or mitigate impending danger and assure the child's protection.

2. If it is determined that a caregiver is capable and willing to manage impending danger and assure child safety, then the safety decision is that children are "safe" and no further safety intervention is necessary.

3. If an immediate protective plan was implemented prior to the completion of the safety assessment, the protective plan Is no longer in effect.

4. If emergency out-of-home placement occurred prior to the completion of the safety assessment, efforts should be made to return responsibility for the child's safety back to caregiver(s) by seeking prompt reunification.

5. If it is determined that the caregiver(s) is incapable and/or unwilling to sufficiently manage impending danger and assure child protection, then the safety decision is that children are unsafe and further safety intervention analysis and planning are necessary.

F. Safety Intervention Analysis to Determine Whether to Place in Out-of-Home Care or Develop an In-Home Safety Plan [Eff. 2/1/07] Eff 02/01/2007

1. In selecting the level of effort and intervention required to manage safety concerns, in-home safety planning shall be considered first.

2. To determine whether an in-home safety plan can sufficiently manage the safety concerns, consider and document how the following are met:

    a. The home environment is stable enough to support an in-home safety plan;

    b. Caregivers are willing to accept and cooperate with the use of an in-home safety plan; and,

    c. Resources are accessible and the level of effort required is available to sufficiently control safety concerns.

3. If in-home safety planning is not a sufficient option to handle safety concerns, then a combination of in-home and out-of home safety management shall be considered. Out-of-home safety management shall be implemented only if these levels of intervention are not sufficient.

7.202.535 Safety Planning and Documentation [Eff. 2/1/07] Eff 02/01/2007

A. Safety plans do not have to be developed if the safety analysis results in a decision that out-of home placement is the only plan that is sufficient to control impending danger safety concerns.

B. A safety plan shall be developed for all other situations in which the safety intervention analysis has indicated that an in-home safety plan can sufficiently control safety concerns. It shall be documented in the state's automated system. All children in the household assessed to be unsafe shall be included in one plan.

C. All safety plans must include the following:

1. Safety responses that are the least restrictive response for assuring safety;

2. Safety responses that have an immediate impact on controlling safety concerns;

3. Activities that correspond to each specific safety concern and describe the frequency of each action;

4. Safety response(s) that are readily accessible at the level required to assure safety;

5. Identification of each family member and safety management provider participating in the plan;

6. Parental acknowledgement of safety concerns and a willingness to participate in the safety plan; and;

7. Caseworker activities to oversee the safety plan.

D. Parents, caregivers, and others who are a part of a safety plan shall sign the safety plan and receive a copy, and the signatures and paper form shall be retained in the file.

E. The safety plan shall be documented in the State's automated system by the conclusion of the investigations or assessment.

Acknowledgements

The Colorado Department of Human Services would like to acknowledge the efforts and commitment of everyone involved in completing this review. While the list of participants is too large to list, the knowledge gained through this process could not have been accomplished without their dedication to improving Colorado's child welfare system, and ultimately the ability to keep Colorado's children safe. In addition, the candor, respect, and concern for the children and families exhibited by all of the child welfare professionals interviewed were greatly appreciated. While this report will highlight areas within the system that can be improved, Colorado is fortunate to have child welfare professionals who are passionate about improving the lives of children. For example, the Division of Child Welfare's 2006 Annual Report indicates that, during state fiscal year 2006, Colorado's child welfare professionals served 40,421 children on an ongoing basis; out of the 13,715 children who were placed into out-of-home care, 6,133 were able to be reunited with their families; and 930 children were adopted[1]. Too often the extraordinary amount of effort and investment child welfare professionals put into their work on a daily basis is overlooked. While reading this report, it should not be forgotten that Colorado's children and families are better off due to their efforts.

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