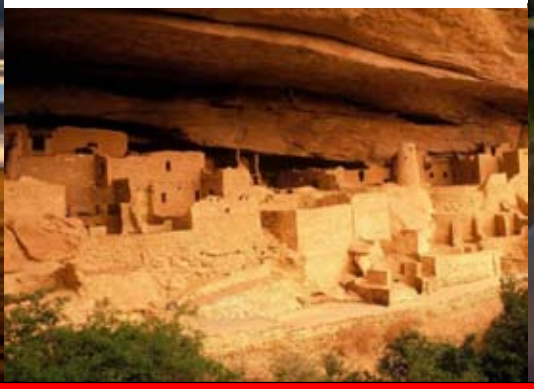
Office of Colorado's

CHILD PROTECTION

OMBUDSMAN

2014-2015 Annual Report



September 1, 2015

Dennis G. Goodwin	Ombudsman
Sabrina Byrnes	Deputy Ombudsman
Karen Nielsen	Intake and Administrative Coordinator
Lisa Kreutzer-Lay	Investigator

I am pleased to present the FY 2014-2015 Annual Report detailing the work of the Office of Colorado's Child Protection Ombudsman. This report contains information regarding our outreach efforts, goals, and accomplishments, statistical highlights of the program, our legislative efforts and our county and state recommendations to improve child protection in Colorado.

AN ELECTRONIC VERSION OF THIS REPORT IS AVAILABLE AT
WWW.PROTECTCOLORADOCHILDREN.ORG

Table of Contents

Executive Summary

I am pleased to present the 2014-2015 Annual Report detailing the work of the Office of Colorado's Child Protection Ombudsman (OCCPO) from July 1, 2014, to June 30, 2015. It's been a very exciting and successful year at OCCPO.

The legislature overwhelmingly recognized the value OCCPO provided to the citizens of Colorado and wanted to ensure its autonomy and permanency as part of Colorado's child protection system. The passage of SB 15-204 places OCCPO as an independent office within the judicial branch, effective January 1, 2016. A twelve-member board will provide accountability for the Ombudsman Office and select the Ombudsman.

As a key advisor to the legislature, the OCCPO was instrumental this legislative session in the formulation and passage of bills designed to improve Colorado's child protection system.

OCCPO has forged important partnerships with the state and county departments of human services that have had a positive impact on child protection casework. The Colorado Department of Human Services (CDHS) made significant progress in completing all 31 systemic recommendations from the OCCPO since the inception of the OCCPO. In addition, county departments of human services completed 67 recommendations from the OCCPO, which were designed to improve case practice and services for children and families. These recommendations were a product of 257 reviews and investigations conducted this fiscal year.

The OCCPO, the OCCPO partners, and stakeholders continue to discover how this ombudsman concept can impact case practice by building public trust through transparency. For example, Denver and Jefferson counties took the initiative to request that OCCPO conduct objective investigations into the casework of two difficult cases. CDHS and the Governor's legal counsel asked OCCPO to investigate and report on a case with systemic and juvenile justice questions. Most recently, the Mayor of the City and County of Denver asked that the ombudsman serve on his Child Safety Net Impact Team formed to make recommendations for improving children's safety. OCCPO also has been asked to present at the United States Ombudsman Association Conference in October 2015.

Of course, the OCCPO cannot be successful without the support and collaboration of our partners, stakeholders and the citizens who seek our assistance. The Ombudsman Office would like to extend special thanks to:

- The National Association of Counsel for Children and its board of directors for taking on this program and supporting us throughout our first four years;
- State Senators Linda Newell and Kevin Lundberg, and House Representative Jonathan Singer for their leadership on SB 15-204 and their unending support of the Ombudsman Office;
- The OCCPO partners from CDHS for their willingness to have us at the table discussing strategies and workable solutions for Colorado's children and families;

- The OCCPO county partners, for their willingness to work with the OCCPO to improve case work and service delivery to children and families;
- The OCCPO Advisory Council members, for their willingness to volunteer their time and expertise to our office;
- The Judicial Branch for their willingness to provide us a home; and
- The families and stakeholders who contact the OCCPO. We are grateful and honored to have your trust.

As the OCCPO begins our fifth year, it looks forward to its transition to the Judicial Branch and to the continued efforts to collaborate with the entire child protection system. The OCCPO is humbled and thankful to be working together for Colorado's children.

Working Together for Colorado's Children,

Dennis G. Goodwin, Child Protection Ombudsman

Legislative History and Authority

OCCPO opened in May 2011, and is managed and hosted by the National Association of Counsel for Children (NACC), the Colorado-based non-profit selected by CDHS as the vendor to operate the Child Protection Ombudsman Program. OCCPO was established through the unanimous passage of Senate Bill 10-171 in 2010 by the Colorado General Assembly. The bill was brought to the governor and legislature by the Colorado Child Welfare Action Committee as a top priority among twenty-nine recommendations offered to improve Colorado's child protection system.

Pursuant to C.R.S. Sections 19-3.3-101 through 109, C.R.S., OCCPO has the power and duty to facilitate a process of independent, impartial review of family and community concerns to request independent, accurate information, and to conduct case reviews to help resolve child protection and overall systemic issues. Anyone may file a confidential complaint or concern with OCCPO. OCCPO must report annually to the governor, the legislature, and the Executive Director of CDHS regarding systemic issues, data trends, and recommendations for improvements within the child protection system. OCCPO also serves as a resource and "systems navigator" to stakeholders and the general public by assisting with individual cases and providing ongoing public education and resources to promote the best interest of children and families.

"THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN HAS THE POWER AND DUTY TO FACILITATE A PROCESS OF INDEPENDENT, IMPARTIAL REVIEW OF FAMILY AND COMMUNITY CONCERNS; REQUEST INDEPENDENT, ACCURATE INFORMATION AND TO CONDUCT CASE REVIEWS TO HELP RESOLVE CHILD PROTECTION ISSUES AND OVERALL SYSTEMIC ISSUES."

SENATE BILL 10-171

Legislative Efforts 2014-2015

OCCPO actively participated in SB 14-201 (Child Protection Ombudsman Work Group), SB 15-204 (Independent Functioning of the Office of Colorado's Child Protection Ombudsman), and SB 15-087 (Concerning the Safe Placement of Children in Foster Care) during FY 2014-2015. SB 14-201 and SB 15-204 directly impacted OCCPO's future and are described in our legislative history and authority section. A full version of SB 15-204 can be found in Appendix A.

SB 14-201

Concerning Reestablishing a Child Protection Ombudsman Advisory Work Group to Develop a Plan for Accountable Autonomy for the Child Protection Ombudsman Program

SB 14-201 was enacted in 2014 and re-established a child protection ombudsman advisory work group to "develop a plan for accountable autonomy for the Child Protection Ombudsman Program." The work group issued its report on December 1, 2014. Although there were many valuable and informative discussions about the autonomy of the program, the work group was unable to reach a consensus on where the program should be housed.

SB 15-204

Concerning the Independent Functioning of the Office of the Child Protection Ombudsman, and, In Connection Therewith, Making and Reducing Appropriations

SB 15-204, "Concerning the Independent Functioning of the Office of the Child Protection Ombudsman" was signed by Governor Hickenlooper on June 2, 2015. This legislation creates an independent office within the Judicial Branch of the state government. A twelve-member board will be appointed by the governor, the Legislature and the Chief Justice of the Supreme Court by August 1, 2015. The OCCPO will move to the Judicial Branch by January 1, 2016.

> ***"ON OR BEFORE JANUARY 1, 2016, THE INDEPENDENT OFFICE OF THE CHILD PROTECTION OMBUDSMAN…IS ESTABLISHED IN THE JUDICIAL DEPARTMENT AS AN INDEPENDENT AGENCY FOR THE PURPOSE OF ENSURING THE GREATEST PROTECTIONS FOR THE CHILDREN OF COLORADO." -SENATE BILL 15-204***

SB 15-087

Concerning the Safe Placement of Children in Foster Care

The OCCPO support of, and testimony for this legislation during the 2015 legislative session was based on the issue of county departments of human services that did not conduct the required background checks prior to placing a child into a foster home. An audit conducted by CDHS discovered that many county departments of human services were not conducting the required background checks. This audit prompted SB 15-087, a bill that clarifies existing background check requirements; allows access to criminal history information for a Guardian *ad* Litem assigned to the case; specifies sanctions if background checks are not completed; and requires the court to ensure background checks are completed. The bill also amends the list of disqualifying criminal offenses for persons providing foster care or other types of out-of-home placement to include any offense involving unlawful sexual behavior, not just felony offenses. This amendment was the direct result of a review conducted by OCCPO that discovered placement could be made if a sexual offense only resulted in a misdemeanor conviction.

Accomplishments and Goals: FY 2014-2015

FY 2014-2015 Accomplishments

Prior to FY 2014-2015, OCCPO outlined many goals and objectives for this fiscal year. OCCPO views this past fiscal year as a success in the areas outlined below:

- Supported the efforts of SB 15-204, which converted OCCPO from a contractual program to an independent agency in state government housed in the Judicial Branch.
- Supported the efforts of the SB 14-201 work group by providing information about OCCPO as requested by the group.
- Provided testimony and technical advice to SB 15-087 requiring background checks for placements of children outside the home. OCCPO identified a gap in the previous statute and requested that any conviction for unlawful sexual behavior be a disqualifier for placement.
- Partnered with CDHS to complete all the performance audit recommendations issued by the Office of the State Auditor.
- Enacted procedures within the OCCPO to improve data entry into the current database and improve case file accuracy by initiating a supervisory review of every case.
- Improved the accuracy of the information entered into the database by directing the intake administrator to confirm all entries and closures in the system after supervisor approval.
- Worked with a vendor to create a new database to improve overall case management and data collection within the OCCPO. OCCPO staff will be able to enter case notes directly into the database, scan documents into the database, and the supervisor will be able to approve work within the database.
- The results of every review with recommendation was communicated to the director of the county departments of human services, or other entity reviewed, in writing. Each case file contains a copy of these letters, as well as the agency's response, and all recommendations are charted and tracked for completion. A copy of this chart can be found in this report.
- Used a portion of the dollars approved by the Joint Budget Committee to increase outreach and education to citizens who may not know about OCCPO's role and efforts.
- Continued to build on the collaborative partnership with CDHS and the sixty-four county departments of human services to improve child protection case work.
- Increased statewide outreach to county departments of human services and stakeholders via OCCPO's newsletter and twenty-two speaking engagements.

- Continued to use training and professional development to increase the OCCPO staff's knowledge and expertise. This included attending relevant conferences and specialized education classes provided by various human services agencies. The most significant training topics covered included medical aspects of child abuse and neglect, differential response, mandatory reporter training, and the ombudsman training conference.

- Partnered with CDHS and county departments of human services regarding implementing recommendations provided during the course of reviews and investigations. CDHS has made significant progress in completing all thirty-one of OCCPO's recommendations.

- Made sixty-seven recommendations to sixteen county departments of human services for improving case practice.

- Assisted CDHS in the promulgation of rules outlining the authority and practice of the Ombudsman Office in relation to other child protection partners. These rules were approved on February 1, 2015.

- Continued to serve on the CDHS Child Fatality Review Team and the Colorado Department of Public Health & Environment (CDPHE) Child Fatality Prevention System State Review Team.

- As a result of OCCPO investigation into Denver Department of Human Services' concerns regarding fraudulent documentation, Denver Department of Human Services requested CDHS change the TRAILS database to include a legal warning regarding documenting false information in the system.

FY 2015-2016 Goals:

OCCPO continues to improve its overall function, as well as impact the child protection system and improve service delivery to children and families across Colorado. In doing so, OCCPO has outlined the following goals for FY 2015-2016:

- Continue to increase outreach and education efforts to citizens and stakeholders who may not be familiar with OCCPO and its function.

- Continue to outreach to county departments of human services and stakeholders via the OCCPO newsletter, speaking engagements, meetings and introductory visits to the region or agency.

- Partner with CDHS and county departments of human services regarding implementing OCCPO's recommendations identified during the course of reviews and/or investigations.

- Maintain a strong working relationship with CDHS through monthly and quarterly meetings.

- Provide technical assistance and expertise toward the development of an administrative memorandum of understanding between OCCPO and the judicial department per SB 15-204.

- Collaborate with CDHS, the judicial department and the new 12-member board to ensure that the transition of OCCPO to the judicial department, authorized by SB 15-204, is smooth.

- Enable the OCCPO staff to work efficiently and effectively in collaborating with the transition team from the judicial department to ensure that construction of OCCPO office space is conducive to the staff's needs while maintaining the required confidentiality of citizen communication.

- Continue to explore how OCCPO may provide information about its role to juveniles committed to the CDHS, Department of Youth Corrections (DYC).

- Provide additional outreach to foster care and adoptive parents and foster youth.

- Provide training and professional development opportunities to increase the OCCPO staff's knowledge and expertise.

- Continue to build upon the positive collaboration with CDHS and the sixty-four county departments of human services demonstrated in FY 2014-2015.

- Provide recommendations to law enforcement and other agencies responsible for child protection when gaps in practice are identified through reviews or investigations.

Budget

OCCPO is funded by state General Fund dollars as determined by the enabling legislation in 2010. In FY 2014-2015, the Joint Budget Committee approved a budget increase. The full budget allocation is based on the state's fiscal year, which begins July 1 of every year. The appropriations provided to the OCCPO by the Colorado General Assembly each year is outlined in Table 1.

Table 1. Ombudsman Office Appropriations (all numbers are rounded)*

	FY 11-12	FY 12-13	FY 13-14	FY 14-15
Contract Services	$343,000	$343,000	$343,000	$504,250

The additional dollars approved last year were used to fund a substantial increase in call volume (tripled since the initial year), staff resources and retention, IT and office equipment needs, and increases in outreach and public education. The funds enabled OCCPO to develop a new database to track cases, improve data collection, increase investigator efficiency and provide supervisor approval during various stages of an investigation. In addition, OCCPO was able to fund changes to its website which will feature a new look, intuitive navigation and a simplified complaint process. It is scheduled to launch in the fall of 2015.

Advisory Council

The Child Protection Ombudsman Advisory Council (Council) serves as an advisory body to OCCPO, ensuring that it is responsive to its statutory mandates. The Council also keeps OCCPO informed of any public policy concerns that may arise regarding child welfare. The Council assists OCCPO with community outreach and educating the public about it. The Council consists of individuals who are passionate about ensuring that the Colorado child protection system operates in the best interest of children and committed to improving the system when it does not.

With the passing of SB 15-204, the Council will be replaced by a Child Protection Ombudsman Board (Board). The Board will be appointed by the Governor, the Chief Justice of the Supreme Court and the Legislature and must have child welfare expertise or experience. The Board will be responsible for the appointment of an Ombudsman, assist with the development of a memorandum of understanding with CDHS, collaborate with the judicial department and the OCCPO on the creation of an administrative MOU between the OCCPO and the Judicial Branch and ensure that policies, standards of conduct and reporting requirements are followed. The Board will be in place by August 1, 2015.

OCCPO would like to thank all of the Council members for their service to OCCPO and their dedication in making the lives of Colorado children better.

The Council members and their affiliations are listed in Table 2.

TABLE 2. OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN ADVISORY COUNCIL 2014-2015

First Name	Last Name	Representing	City	Stakeholder Category
Sister Michael Delores	Allegri	Colorado Foster Parent Association/Mt. St. Vincent Home/Current Foster Parent	Denver	Foster Care & Provider
Terraine	Bailey	Bailey Law Firm	Denver	Guardian Ad Litem
Jim	Barclay	Lutheran Family Services Rocky Mountains	Denver & Colorado Springs	Child Placement Agencies/Foster Care
Debi	Brilla	Foster Parent	Greeley	Foster Parent
Sabrina	Byrnes	Office of Colorado's Child Protection Ombudsman	Aurora	Deputy Ombudsman
Deborah	Cave	Colorado Coalition of Adoptive Families/Adoptive Parent	Louisville	Adoption
Brian	Cotter	Denver Police Department/Foster Parent	Denver	Law Enforcement
Dennis	Goodwin	Office of Colorado's Child Protection Ombudsman	Aurora	Ombudsman
Martha	Johnson	La Plata County Department of Human Services	Durango	County Department of Human Services
Lisa	Kreutzer-Lay	Office of Colorado's Child Protection Ombudsman	Aurora	Investigator
Kendall	Marlowe	National Association of Counsel for Children	Aurora	Director
Lori	Moriarity	National & Colorado Alliance for Drug Endangered Children	Arvada	Substance Abuse and Law Enforcement
Karen	Nielsen	Office of Colorado's Child Protection Ombudsman	Aurora	Intake & Administrative Coordinator
Ann	Rosales	Colorado Department of Human Services	Denver	State Department of Human Services
Janet	Rowland	Center for Local Government, Colorado Mesa University	Grand Junction	Local Government
Shari	Shink	Rocky Mountain Children's Law Center	Denver	Legal Advocate
Kathryn	Wells	Denver Department of Human Services, Denver Health	Denver	Medical Professional
Julie	Westendorff	La Plata County	Durango	County Commissioner
Tom	Westfall	Parent Educator/Trainer/Former County Department of Human Services Director	Sterling	Consultant

Outreach Efforts

> *"THE OMBUDSMAN WILL EDUCATE THE PUBLIC ABOUT CHILD MALTREATMENT AND THE ROLE OF THE COMMUNITY IN STRENGTHENING FAMILIES AND KEEPING KIDS SAFE."*
>
> SENATE BILL 10

A key charge of OCCPO is to provide outreach and education to members of the public and professional colleagues within the child protection community. Outreach efforts are designed to not only provide general education to the public regarding OCCPO's function, but also to engage community members and child protection professionals regarding their ability and shared responsibility to improve the child protection system and their role in the prevention and identification of child abuse and neglect.

OCCPO embraces its crucial responsibility to educate the public and professional community about the importance of joining together to ensure that families are strengthened and children remain safe. In FY 2014-2015, OCCPO reached approximately 929 individuals in over twenty different community forums. OCCPO also was invited to record a webcast for students attending the Metropolitan State University School of Social Work. This webcast will educate countless young professionals on the function and purpose of OCCPO and discuss their charge as professional social workers.

OCCPO's efforts have included speaking engagements presenting to citizens, stakeholders and professionals within the child protection arena. In addition to speaking publicly regarding OCCPO and relevant child protection issues, OCCPO maintains a public-facing website and Facebook page in an effort to inform the public about ongoing issues and trends affecting the children and families of Colorado.

Professional development of the Ombudsman Office staff is also viewed as a priority. Staff members routinely participate in community events and educational forums in an effort to remain current on child protection trends and changes to case practice. In addition to the outreach and professional education components, staff members also sit on various committees and participate in public awareness campaigns concerning issues directly related to child protection. This year, the OCCPO continued to serve in its role on the CDHS Child Fatality Review Team. Participation on this team consists of reviewing the circumstances surrounding the deaths of children known to the child protection system and working collaboratively with other stakeholders on ways to improve overall child protection within Colorado. The Deputy Ombudsman serves on the CDPHE Child Fatality Prevention System State Review Team. This role enables OCCPO to be

involved in reviewing all child deaths in Colorado and assist in developing large scale prevention strategies to protect the state's most vulnerable population. During this fiscal year, OCCPO also partnered with the Colorado Alliance for Drug Endangered Children, and various other community stakeholders, on a public awareness campaign entitled, "Smart Choices Safe Kids." This campaign was designed for individuals providing any level of care to children, addressing the topics of substance use and parenting, as well as how to engage youth in the conversation around substance use.

Table 3 details the Ombudsman Office's outreach efforts for FY 2014-2015.

TABLE 3. FY 2014-2015 OUTREACH/PRESENTATIONS

DATE	TOPIC	AUDIENCE	LOCATION	OCCPO REPRESENTATIVE	NO. OF ATTENDEES
08/06/2014	Ombudsman Introduction	Law Enforcement Executive & Command Stand	Lakewood, CO	Dennis Goodwin	25
08/13/2014	Senate Bill 14-201 and Work Group Update	Collaboration in 2014 and Beyond	Golden, CO	Dennis Goodwin	35-40
08/28/2014	The Ombudsman Office Q and A	President of Colorado Foster Parent Association	Edgewater, CO	Dennis Goodwin	1
09/24/14	Human Services Resource and Networking Fair	Human Services Network of Colorado	Denver, CO	Lisa Kreutzer-Lay Karen Nielsen	250
09/30/2014	Ombudsman Office Briefing	Senate Bill 14-201 and Work Group	Denver, CO	Dennis Goodwin Sabrina Byrnes	25
10/08/2014	Ombudsman Introduction	Children's Law Center Annual Breakfast	Denver, CO	Sabrina Byrnes	20
10/22/2014	What is an Ombudsman?	Pueblo DHS, DA, CASA and Community Members	Pueblo, CO	Dennis Goodwin Sabrina Byrnes	70
10/30/2014	Ombudsman Introduction	Colorado DEC Annual Meeting	Denver, CO	Sabrina Byrnes	50
12/09/2014	Ombudsman Update	Joint Budget Committee	Denver, CO	Dennis Goodwin Sabrina Byrnes	35-40

01/06/2015	Ombudsman Introduction	Law Enforcement Academy	Littleton, CO	Dennis Goodwin	30
01/12/2015	Ombudsman Office Update	Colorado Children's Caucus	Denver, CO	Dennis Goodwin Sabrina Byrnes Lisa Kreutzer-Lay Karen Nielsen	50
01/13/2015	Ombudsman Introduction	Colorado DEC	Denver, CO	Sabrina Byrnes	15
01/21/2015	Ombudsman Introduction	Gateway Battered Women's Shelter	Denver, CO	Sabrina Byrnes Lisa Kreutzer-Lay	30
01/28/2015	Ombudsman Introduction	Law Enforcement Academy	Littleton, CO	Dennis Goodwin	25
02/04/2015	Senate Bill 15-087	Senate Health and Human Services Committee	Denver, CO	Dennis Goodwin Sabrina Byrnes	25
02/18/2015	Senate Bill 15-087	Senate Judiciary Committee	Denver, CO	Dennis Goodwin	25
03/09/2015	Ombudsman Office Update	Colorado Children's Caucus	Denver, CO	Dennis Goodwin Sabrina Byrnes	50
04/22/2015	Ombudsman Introduction	Arapahoe County Diversion	Aurora, CO	Dennis Goodwin Sabrina Byrnes	50
04/22/2015	Ombudsman Introduction	United Way, Colorado DEC, Marijuana Advocates	Denver, CO	Dennis Goodwin Sabrina Byrnes	35
06/02/2015	Ombudsman Introduction	Metro State University	Denver, CO	Dennis Goodwin	Ongoing webcast for students
06/04/2015	Ombudsman Introduction	Foster and Adoptive Parents	Breckenridge, CO	Dennis Goodwin Sabrina Byrnes	60
06/04/2015	Ombudsman Introduction	Senator Aguilar Town Hall Meeting	Denver, CO	Dennis Goodwin	13

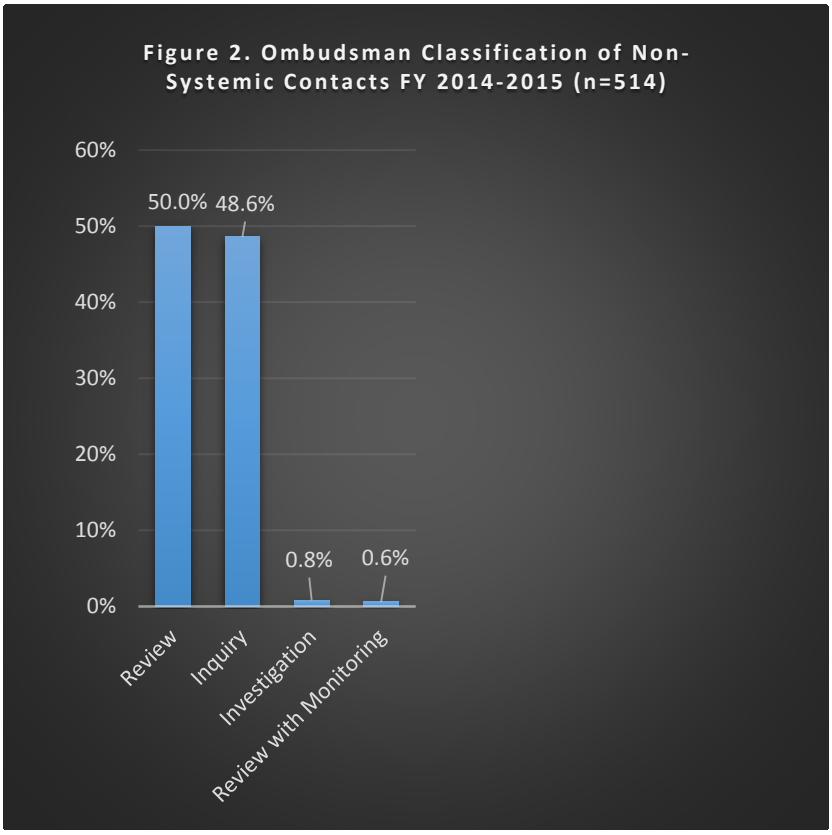
Overview of Contacts to the Ombudsman Office

From July 1, 2014, to June 30, 2015, OCCPO received 515 total contacts (Appendix B) representing an increase from FY 2013-2014 when OCCPO received 405 total contacts, and a substantial increase from FY 2011-2012 when OCCPO received 156 total contacts. This is a total increase of 27 percent over last fiscal year and a 230 percent increase over OCCPO's first full year of operation. Overall contact increases from FY 2011-2012 through the conclusion of FY 2014-2015 are detailed in Figure 1.

Figure 1. Systemic and Non-Systemic Contacts for FY 2011/12 through FY 2014/15					
	Year 1	Year 2	Year 3	Year 4	Percentage Change From Year 1
Systemic	21	20	4	1	-95%
Non-Systemic	135	297	401	514	280%
Total	156	317	405	515	230%

Classification of Contacts

A contact to OCCPO can be classified in one of four ways: inquiry, review, review with monitoring, and investigation. As shown in Figure 2, 48.6 percent of the contacts (250) during FY 2014-2015 were classified as inquiries (i.e., a question or a request for information, assistance, resource referral, declined to investigate, closed per complainant, or closed lack of information), or other information that is relevant for tracking but is not considered a review. Fifty percent (257) of the contacts to OCCPO during the FY 2014-2015 were classified as reviews. During a review, OCCPO conducts an initial search of the TRAILS database (the statewide computer database used to document efforts on a child protection investigation or case) and the Colorado court database to gather any other information necessary for determining whether the complaint warrants further review and/or an investigation by OCCPO. Reviews with monitoring (three for this year) generally involve a court issue or an agency issue that precludes OCCPO from resolving the case for an extended period of time. When those issues are resolved, OCCPO completes its review and issues its findings.



Investigations generally include a review of records, as well as an additional assessment of the documented facts, as well as, complete interviews with caseworkers, supervisors and other department staff, law enforcement, or any other party that may provide insight into the complaint being investigated. OCCPO initiated four investigations in FY 2014-2015.

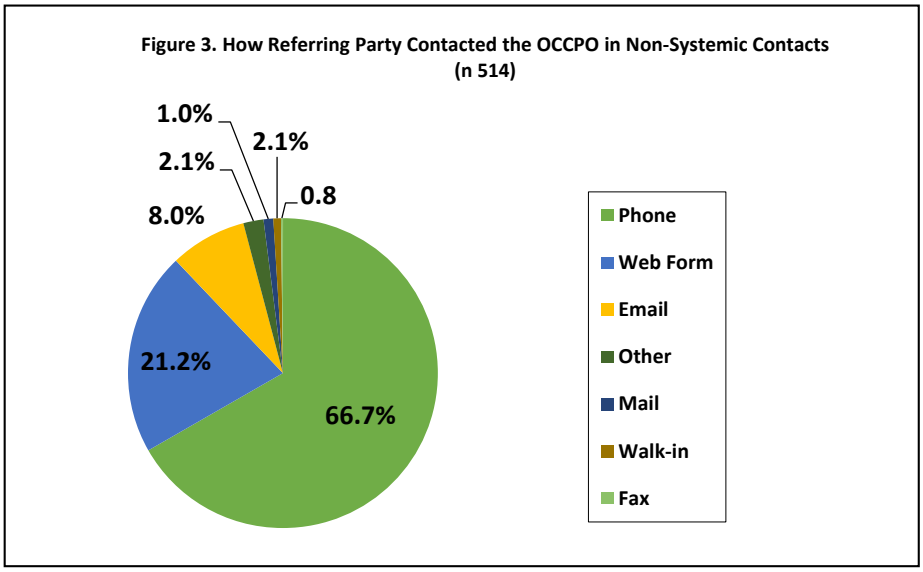
Data Summary

The following is a breakdown of data collected during FY 2014-2015. The data includes charts related to the following:

- How OCCPO received contacts;
- The race or ethnicity of the child involved in the case;
- The complainant's relationship to the case about which they are concerned;
- How complainants heard about OCCPO;
- The nature of the contacts to OCCPO; and
- Contacts received and resolved by month.

How Contacts Were Received

OCCPO accepts contacts from citizens and agencies through a variety of means. As shown in Figure 3, citizens can call OCCPO using the local or toll-free telephone number, complete and submit a complaint form on the website, email office staff, or download a complaint form and fax or mail it to OCCPO.



Child Specific Information on Non-Systemic Cases

The contacts to OCCPO involve a diverse population of children and families as outlined in the table below.

Total number of non-systemic cases	514
Total number of children covered by the non-systemic cases	612
Average number of children per OCCPO case	1.19
Race of Children Involved in OCCPO Cases	
African American	8.5%
Asian	0.0%
Hispanic	17.2%
Multi-Racial	11.6%
Native American	1.1%
Refused/Unknown	3.8%
White, Non-Hispanic	51.1%
No Race Specified	6.7%
Number	**(612)**

Complainant Relationship

As the chart shows, most citizens contacting OCCPO about a complaint are related to the children in the case. OCCPO also receives a number of calls from community professionals that can be directly attributed to its outreach efforts.

Relationship of Referring Party to the Family or Child on the Case, Current Fiscal Year*	
Child's Parent	43.6%
Child's Grandparent	12.3%
Child's Other Relative	10.3%
Community Professional	8.2%
Unknown	7.9%
Friend/Neighbor	3.7%
Foster/Adoptive Parent/Legal Guardian	3.1%
Not Applicable	2.9%
Advocate	2.3%
DHS Employee	1.9%
Attorney	1.0%
Doctor/Medical Personnel	0.8%
Legislator	0.8%
Law Enforcement	0.6%
Child	0.4%
Licensed Day/Group Care Provider	0.2%
CASA	0.0%
Judge Commissioner	0.0%
Attorney General's Office	0.0%
Number	**(514)**

* Table excludes systemic cases.

How Did They Hear About Us?

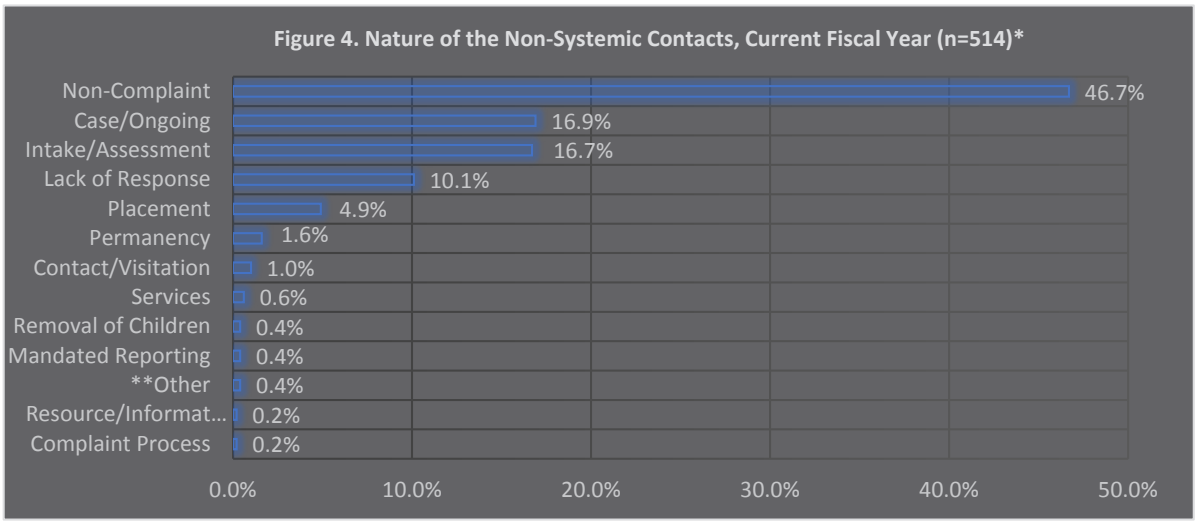
OCCPO's website and social media continue to be the most popular means for getting out the word about OCCPO (31.7 percent). About 14.8 percent of contacts came from citizens who were familiar with OCCPO through a previous contact. The most significant increase came from community agencies contacting OCCPO, viewed as a direct result in the increase this fiscal year in outreach efforts to a variety of community programs.

How Did Referring Party Hear about the Ombudsman Office, Current Fiscal Year*	
Facebook Profile, Twitter Feed, Internet, or Ombudsman Website	31.7%
Previous Contact with Ombudsman Office	14.8%
Unknown	10.9%
State DSS	9.3%
Community Agency	9.1%
Family or Friend	5.3%
County DSS	4.9%
Media	4.3%
Attorney	1.6%
Conference, Training, or Workshop	1.4%
Advisory Board	1.0%
Advocate	1.0%
Other Child Welfare Agency	0.8%
Attorney General's	0.6%
Governor's Office	0.6%
Legislator's Office	0.6%
Medical Personnel	0.6%
Law Enforcement	0.4%
Court Clerk or Other Staff Member	0.4%
Foster Parent	0.4%
Law Enforcement	0.4%
CASA	0.2%
Educator	0.2%
Judge/Commissioner	0.2%
GAL	0.0%
Judicial	0.0%
Number	**(514)**

* Table excludes systemic cases.

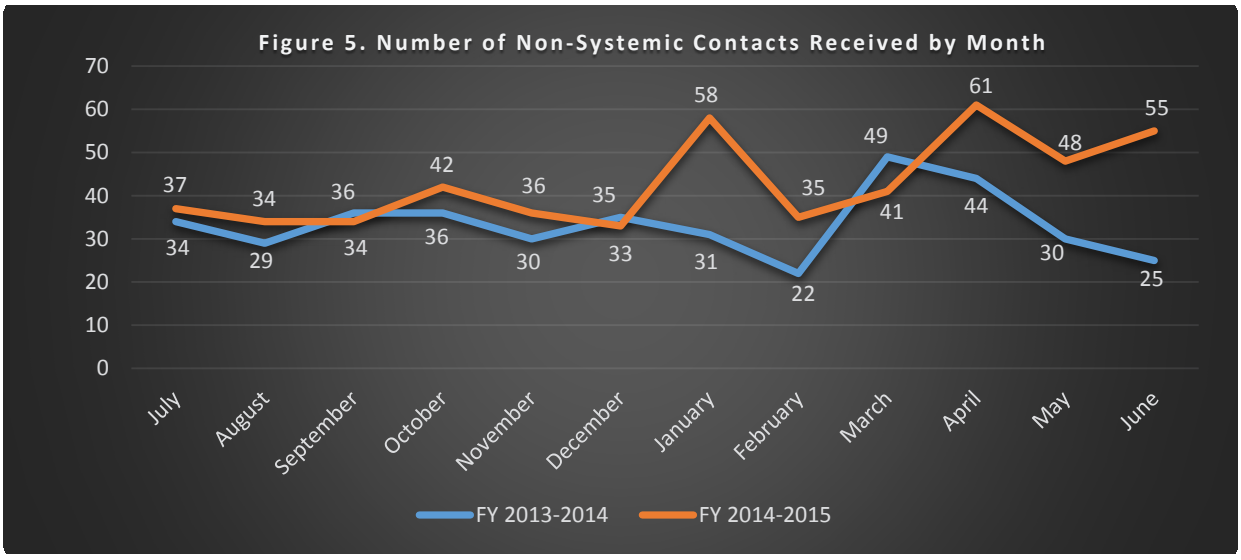
Nature of Non-Systemic Contacts

When a caller contacts OCCPO, the staff can identify whether the caller has a complaint to review or is inquiring about a facet of the child protection system. An inquiry may be a systems navigation question or result in a referral to a community agency. In Figure 4, 46.7 percent of the calls are classified as non-complaint (e.g., general referrals or systems navigation questions). The majority of the reviews conducted involve complaints about specific case work, the intake or assessment process, lack of response to alleged safety concerns, or concerns regarding the child's placement.



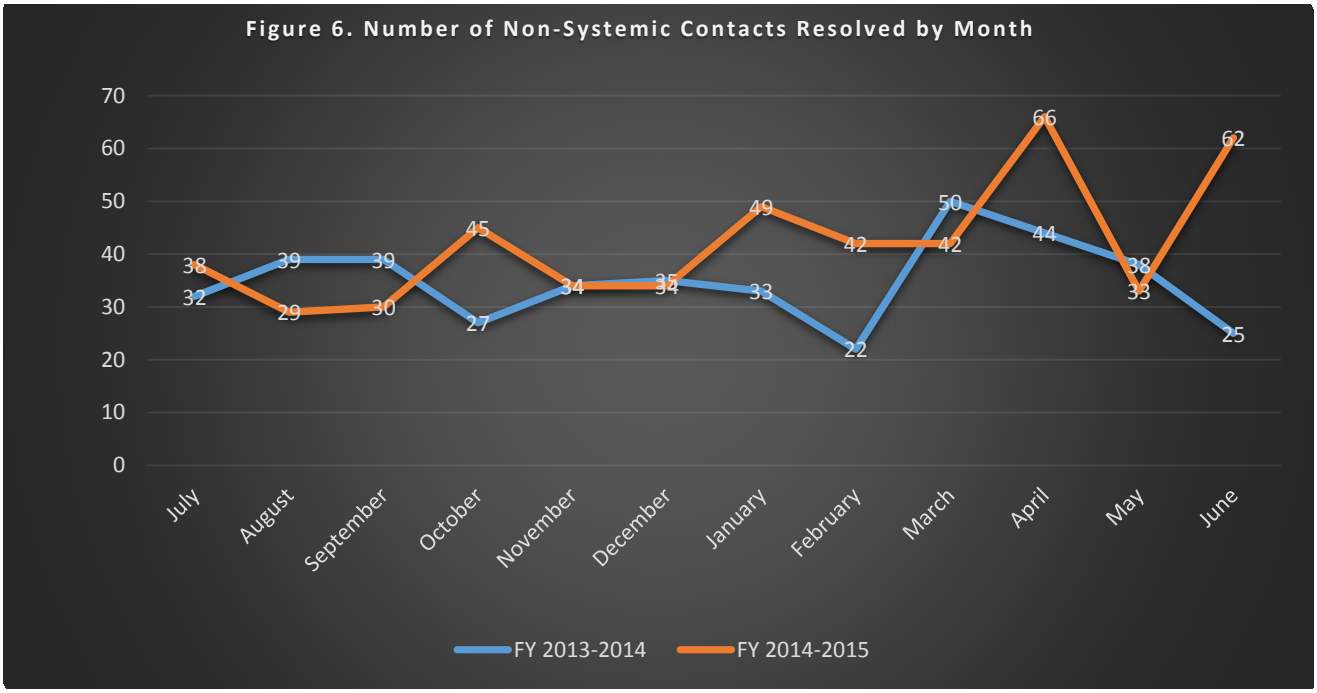
Contacts by Month

Figure 5 shows the number of contacts coming into OCCPO by month during the current fiscal year (FY 2014-2015), and the previous fiscal year (FY 2013-2014). OCCPO received 514 non-systemic contacts in the current year compared to 401 the previous year representing an increase of 27 percent. OCCPO received an average of forty-three contacts a month this year compared to last year's monthly average of thirty-three contacts per month.



Resolved Contacts for FY 2014-2015

During FY 2014-2015, the Ombudsman Office resolved a total of 504 contacts, which includes unresolved reviews from FY 2013-2014. A monthly breakdown of these closures can be seen in Figure 6. At the conclusion of this fiscal year, OCCPO will be continuing work on sixteen unresolved reviews, which should be resolved in the upcoming fiscal year.



FY 2014-2015 Investigations

During FY 2014-2015, OCCPO concluded one investigation that began in FY 2013-2014 and was related to a complaint concerning Pueblo County. OCCPO initiated three new investigations in FY 2014-2015. These investigations were regarding complaints received concerning Denver County, and a multi-agency complaint concerning Boulder County, Boulder Mental Health Partners and the Municipal Court, City and County of Broomfield. Only one of the Denver investigations has been published publically. Because the second investigation is currently involved in an ongoing criminal case, public release of the completed investigative report is restricted. OCCPO has released the reports to the Denver Department of Human Services and has been working diligently with Denver County management on implementing the recommendations. The reports on the Pueblo, Denver and the multi-agency investigations have been published to the website and can be found in Appendix C of this report.

- **Restrictions on Release:** Oftentimes, cases that OCCPO has under review and/or investigation also are involved in criminal or civil proceedings that preclude the release of information prior to the resolution of those matters. In one of these investigations, OCCPO received a request from the District Attorney to withhold releasing any information until further notice. Once the request is rescinded, or the criminal and/or civil proceeding has concluded, OCCPO will compile the information necessary to

complete the investigative report and issue the findings to the county, CDHS, and the public.

CDHS-OCYF Recommendation Summary

OCCPO, CDHS, and CDHS, OCYF continue to work on the resolution of recommendations made by OCCPO in Years 1 and 2 (Appendix D). These recommendations were generated through the investigations conducted during the first three years of OCCPO's operations. They were designed to improve policy and practice, and ultimately improve the safety, health and well-being of children in Colorado. During FY 2013-2014, OCCPO and CDHS-OCYF worked together to develop a plan of action for implementing the recommendations. OCCPO and CDHS-OCYF met routinely, discussed progress and barriers of each recommendation, and collaborated on positive ways to reach successful resolution. A complete list of the recommendations, per fiscal year, as well as implementation strategies and projected completion dates, can be found in Appendix D.

OCCPO values the working relationship with the CDHS-OCYF and would like to recognize the continued efforts of CDHS-OCYF in implementing these recommendations. OCCPO is committed to continuing its collaboration with CDHS-OCYF in the upcoming year toward a successful implementation of all of the remaining recommendations.

County Recommendation Summary

In FY 2013-2014, OCCPO implemented a new disposition in reviews entitled, "Review with Recommendations." The purpose of this designation was to ensure that in cases where there were practice concerns, but no policy or law violations, information still could be tracked and feedback on areas within the child protection system that needed improvement would be provided. During FY 2014-2015, OCCPO made sixty-seven recommendations to sixteen different county departments of human services. OCCPO has received positive feedback regarding the "review with recommendations" designation from the county departments of human services and the recommendations have been valuable in improving overall practice across the state.

OCCPO OF CHILD PROTECTION OMBUDSMAN SHALL BE "A KEY ADVISOR CONCERNING ISSUES RELATED TO CHILD SAFETY AND PROTECTION IN COLORADO BY VIRTUE OF HIS OR HER RESPONSIBILITY AND AUTHORITY TO MAKE ADVISORY RECOMMENDATIONS TO THE STATE DEPARTMENT, COUNTY DEPARTMENTS, COUNTY COMMISSIONERS, THE GOVERNOR, AND THE GENERAL ASSEMBLY, BASED UPON THE OMBUDSMAN'S EXPERIENCE AND EXPERTISE."

(C.R.S. 19-3.3-102)

As Table 4 demonstrates below, county departments of human services are embracing the feedback and implementing change in their overall practice modalities. OCCPO would like to recognize the county departments of human services for accepting this form of feedback, for their longstanding commitment to protecting the children, and for strengthening families within their communities.

TABLE 4. FY 2014-2015 RECOMMENDATIONS BY COUNTY

County	Recommendation Date	Recommendation Type	Acknowledged Receipt	Response
Adams	08/28/14	• Family engagement and communication training • Monitoring staff communication • Training on monthly face-to-face contacts with parents	Yes	Complete
	09/16/14	• Training regarding notification to parents of surgical or major medical procedures on children prior to occurring	Yes	Complete
Alamosa	03/23/15	• Increase supervision of caseworker's work to ensure Volume VII rules are being followed in completing assessments • Ongoing review of identified expectations with caseworker and supervisor	Yes	In Progress
	03/25/15	• Ongoing assessment of all possible placements for a youth in the department's custody	Yes	Complete
Arapahoe	11/25/14	• Training regarding partnering for safety frameworks in TRAILS for RED Teams	Yes	Complete
Baca	3/31/15	• Training and technical assistance from CDHS regarding ICPC issues and cases • Develop a network of rural county resources	Yes	Complete
Boulder	6/29/15	• Review with caseworkers Volume VII requirements of documentation of contacts with clients and collaterals in Trails	Yes	Complete

Denver	11/25/14	• Work with District Attorney regarding filing of charges • Training and technical assistance surrounding supervision of casework staff to include how to recognize concerning casework documentation and overall practice and work ethic • Implement policy and procedures related to supervision of casework practice to ensure that documentation of contacts and assessment steps are accurate • Ensure that all staff responsible for the supervision and management of caseworkers is trained on the new policies and procedures implemented regarding review of casework practice	Yes	In Progress
	12/15/14	• Ongoing evaluation of RED Teams • Review policy and practice surrounding implementation of RED Team decisions • Develop written policy and provide training to all staff and supervisors concerning overturning RED Team decisions • Training for staff and supervisors regarding the ongoing assessment of safety and risk on voluntary cases • Receive training and technical assistance surrounding supervision • Documentation • Training for ongoing staff and supervisors regarding the requirements of completing an assessment regarding new allegations of abuse and neglect • Training for staff and supervisors on thorough completion of safety	Yes	In Progress

		assessments, including when to complete • Training for staff and supervisors regarding accurate completion of safety plans • Training for staff and supervisors regarding the requirements of monthly face-to-face contacts		
	3/24/15	• Review Volume VII assessment requirements for contacts with residents and their legal custodian during institutional abuse investigations	Yes	In Progress
	3/31/15	• Training concerning Volume VII regulations: kinship placements and background check compliance • Agency policy concerning background checks and emergency placements • In-depth review of cases concerning background checks • Training for all staff regarding ongoing safety and risk assessment on cases in which children remain in the family home and decision points regarding changing tracks from voluntary to court involved cases • Implement policy and procedure for supervisory review • Consider holding caseworkers and supervisors accountable for their actions and inactions on the identified case	Yes	In Progress
Dolores	2/24/15	• Review Volume VII requirements for documenting assessment of safety and well-being during monthly face-to-face contacts	Yes	Complete
Douglas	1/8/15	• Case documentation • TRAILS placement pages completed	Yes	Complete

El Paso	6/9/15	• Policy training regarding face-to-face contact during assessments	Yes	In Progress
	11/12/14	• Review Volume VII rule regarding updating demographic information in Trails for alleged perpetrators and victims. • Review memorandum of understanding with local law enforcement	Yes	In Progress
Jefferson	11/24/14	• When records are being released, the County Attorney ensures that all proper redaction has occurred	Yes	Complete
	6/12/15	• Training on policy around face-to-face contacts at assessment • Internal review of caseworker assessments to ensure accuracy and timeliness • Ongoing evaluation of caseworker assessments to ensure accuracy and timeliness	Yes	In Progress
	6/29/15	• Conduct an internal review of past assessments completed by caseworker to determine issues of timely completion of assessments • Ongoing evaluation of caseworker's assessments to ensure all information is entered and completed in a timely manner	Yes	Complete
Las Animas	09/02/14	• Safety assessment training • Safety plan training • Diligent search training • Family engagement documentation • Training and support on how to work with families with multiple challenges	Yes	In Progress
La Plata	3/5/15	• RED Team training • Documentation training • Supervision • Training around identifying when to screen in or out a referral	Yes	Complete

Larimer	6/16/15	• Documentation	Yes	Complete
Pueblo	9/10/14	• Review definitions of founded, unfound, and inconclusive	Yes	Complete
	10/9/14	• Volume VII requirements on family services plans and 90-day review completion • Documentation	Yes	Complete
	10/15/14	• Documentation • Consider developing a structured outline for home visits	Yes	Complete
	4/1/15	• Develop a policy regarding concerning background checks for relatives during voluntary placements	Yes	Complete
	4/21/15	• Documentation • Volume VII requirements on family services plans and 90-day review completion • Case file audit • Supervisor training on the use of 90-day reviews and Administrative Review Division reports	Yes	Complete
Rio Grande	9/4/14	• Review Volume VII assessment requirements	Yes	In Progress
Weld	12/10/14	• Caseworkers meet the minimum standard as required by Volume VII to have documentation in TRAILS every six months • Supervisors ensure that documentation of 90-day reviews and court reviews, as well as other pertinent documentation, is entered into TRAILS in a timely fashion	Yes	Complete

Data Highlights for FY 2014-2015

The following are key findings of a statistical analysis of information recorded by OCCPO staff on all contacts to it during FY 2014-2015:

- 515 contacts were received (514 non-systemic contacts and one systemic contact).
- Outreach was provided to over nine hundred citizens in over twenty different forums.
- Most contacting parties were biological parents (43.6 percent), grandparents (12 percent), and other relatives (10 percent).
- County and state agencies referred nearly 15 percent of OCCPO contacts.
- Most contacting parties learned about OCCPO through previous contact (15 percent) or through OCCPO's website, Facebook page, and Twitter feed (31 percent).
- A significant number of contacts (48 percent) were classified by OCCPO as an inquiry and 50 percent were classified as reviews.
- Eighty-six percent of all reviews were resolved with an affirmation of agency and/or caseworker actions.
- OCCPO made sixty-seven recommendations for improving child protection practice in Colorado to various county departments of human services and CDHS-OCYF.
- OCCPO received an average of forty-three contacts per month.
- OCCPO resolved an average of forty-two contacts per month, including contacts carried over from previous months.
- OCCPO closed one investigation that was initiated during the previous fiscal year.
- OCCPO initiated and resolved three investigations during.

References

- Colorado Child Protection Ombudsman Program Work Group. (2010). *Detailed Plan for the Establishment and Operation of the Child Protection Ombudsman Program.* Denver, CO

- Colorado Department of Human Services. (2009). *Second Interim Report of the Governor's Child Welfare Action Committee.* Denver, CO

- Colorado Revised Statutes, Sections 19-3.3-101 to 109. (2010). Retrieved July 24, 2013, from: http://www.state.co.us/gov_dir/leg_dir/olls/sl2010a/sl_225.pdf.

- Office of Colorado's Child Protection Ombudsman. (2012). *2011-2012 Annual Report.* Aurora, CO

- Office of Colorado's Child Protection Ombudsman. (2013). *2012-2013 Annual Report.* Aurora, CO

- Colorado Office of the State Auditor. (2014). *Department of Human Services Child Protection Ombudsman Program Performance Audit.* Denver, CO

- Colorado General Assembly. (2014). *Senate Bill 14-201.* Denver, CO

- Colorado General Assembly. (2015), *Senate Bill 15-204.* Denver, CO

- State of Colorado Child Protection Ombudsman *Advisory Work Group Report*. December 1, 2014. Denver, CO

Appendix A:
Colorado Senate Bill 15-204

SENATE BILL 15-204

BY SENATOR(S) Newell and Lundberg, Aguilar, Baumgardner, Carroll, Cooke, Crowder, Grantham, Guzman, Hodge, Holbert, Johnston, Kefalas, Kerr, Lambert, Marble, Martinez Humenik, Merrifield, Scott, Steadman, Todd, Ulibarri, Woods, Heath, Jahn, Roberts, Scheffel, Cadman;
also REPRESENTATIVE(S) Singer, Garnett, Kraft-Tharp, Lebsock, Lee, Lontine, McCann, Melton, Moreno, Primavera, Rankin, Rosenthal, Ryden, Salazar, Tate, Tyler, Winter, Young, Hamner, Kagan, Lawrence.

CONCERNING THE INDEPENDENT FUNCTIONING OF THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN, AND, IN CONNECTION THEREWITH, MAKING AND REDUCING APPROPRIATIONS.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **repeal and reenact, with amendments,** 19-3.3-102 as follows:

19-3.3-102. Office of the child protection ombudsman established - child protection ombudsman board - qualifications of ombudsman - duties. (1) (a) ON OR BEFORE JANUARY 1, 2016, THE INDEPENDENT OFFICE OF THE CHILD PROTECTION OMBUDSMAN, REFERRED TO IN THIS ARTICLE AS THE "OFFICE", IS ESTABLISHED IN THE JUDICIAL DEPARTMENT AS AN INDEPENDENT AGENCY FOR THE PURPOSE OF ENSURING

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

THE GREATEST PROTECTIONS FOR THE CHILDREN OF COLORADO.

(b) THE OFFICE AND THE RELATED CHILD PROTECTION OMBUDSMAN BOARD, ESTABLISHED IN SUBSECTION (2) OF THIS SECTION, SHALL OPERATE WITH FULL INDEPENDENCE. THE BOARD AND OFFICE HAVE COMPLETE AUTONOMY, CONTROL, AND AUTHORITY OVER OPERATIONS, BUDGET, AND PERSONNEL DECISIONS RELATED TO THE OFFICE, BOARD, AND OMBUDSMAN.

(c) THE OFFICE SHALL WORK COOPERATIVELY WITH THE CHILD PROTECTION OMBUDSMAN BOARD ESTABLISHED IN SUBSECTION (2) OF THIS SECTION, THE DEPARTMENT OF HUMAN SERVICES AND OTHER CHILD WELFARE ORGANIZATIONS, AS APPROPRIATE, TO FORM A PARTNERSHIP BETWEEN THOSE ENTITIES AND PERSONS, PARENTS, AND THE STATE FOR THE PURPOSE OF ENSURING THE GREATEST PROTECTIONS FOR THE CHILDREN OF COLORADO.

(2) (a) THERE IS ESTABLISHED AN INDEPENDENT, NONPARTISAN CHILD PROTECTION OMBUDSMAN BOARD, REFERRED TO IN THIS ARTICLE AS THE "BOARD". THE MEMBERSHIP OF THE BOARD MUST NOT EXCEED TWELVE MEMBERS AND, TO THE EXTENT PRACTICABLE, MUST INCLUDE PERSONS FROM THROUGHOUT THE STATE AND PERSONS WITH DISABILITIES AND MUST REFLECT THE ETHNIC DIVERSITY OF THE STATE. ALL MEMBERS MUST HAVE CHILD WELFARE POLICY OR SYSTEM EXPERTISE OR EXPERIENCE.

(b) THE BOARD MEMBERS MUST BE APPOINTED ON OR BEFORE AUGUST 1, 2015, AS FOLLOWS:

(I) THE CHIEF JUSTICE OF THE COLORADO SUPREME COURT SHALL APPOINT:

(A) AN INDIVIDUAL WITH EXPERIENCE AS A RESPONDENT PARENTS' COUNSEL;

(B) AN INDIVIDUAL WITH EXPERIENCE DEFENDING JUVENILES IN COURT PROCEEDINGS;

(C) AN INDIVIDUAL WITH LEGAL EXPERIENCE IN DEPENDENCY AND NEGLECT CASES; AND

(D) AN INDIVIDUAL WITH EXPERIENCE IN CRIMINAL JUSTICE

INVOLVING CHILDREN AND YOUTH.

(II) THE GOVERNOR SHALL APPOINT:

(A) AN INDIVIDUAL WITH PREVIOUS PROFESSIONAL EXPERIENCE WITH A RURAL COUNTY HUMAN OR SOCIAL SERVICES AGENCY OR A RURAL PRIVATE CHILD WELFARE ADVOCACY AGENCY;

(B) AN INDIVIDUAL WITH PREVIOUS PROFESSIONAL EXPERIENCE WITH THE DEPARTMENT OF HUMAN SERVICES;

(C) AN INDIVIDUAL WITH PREVIOUS PROFESSIONAL EXPERIENCE WITH AN URBAN HUMAN OR SOCIAL SERVICES AGENCY OR AN URBAN PRIVATE CHILD WELFARE AGENCY; AND

(D) AN INDIVIDUAL WITH EXPERIENCE IN PRIMARY OR SECONDARY EDUCATION.

(III) THE PRESIDENT AND MINORITY LEADER OF THE SENATE SHALL APPOINT:

(A) AN INDIVIDUAL WHO WAS FORMERLY A CHILD IN THE FOSTER CARE SYSTEM; AND

(B) AN INDIVIDUAL WITH PROFESSIONAL EXPERIENCE AS A COUNTY AND COMMUNITY CHILD PROTECTION ADVOCATE; AND

(IV) THE SPEAKER AND THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT:

(A) A CURRENT OR FORMER FOSTER PARENT; AND

(B) A HEALTH CARE PROFESSIONAL WITH PREVIOUS EXPERIENCE WITH CHILD ABUSE AND NEGLECT CASES.

(c) BOARD MEMBERS SHALL SERVE FOR TERMS OF FOUR YEARS; EXCEPT THAT, OF THE MEMBERS FIRST APPOINTED, TWO MEMBERS APPOINTED PURSUANT TO SUBPARAGRAPHS (I), (II), AND (III) OF PARAGRAPH (b) OF THIS SUBSECTION (2) AND ONE MEMBER APPOINTED PURSUANT TO SUBPARAGRAPH (IV) OF PARAGRAPH (b) OF THIS SUBSECTION

(2), AS DESIGNATED BY THE APPOINTING OFFICIALS, SHALL SERVE INITIAL TERMS OF TWO YEARS. THE APPOINTING OFFICIALS SHALL FILL ANY VACANCIES ON THE BOARD FOR THE REMAINDER OF ANY UNEXPIRED TERM.

(d) THE BOARD SHALL MEET A MINIMUM OF TWO TIMES PER YEAR AND ADDITIONALLY AS NEEDED. AT LEAST ONE MEETING PER YEAR MUST BE HELD OUTSIDE OF THE DENVER METROPOLITAN AREA.

(e) BOARD MEMBERS SHALL SERVE WITHOUT COMPENSATION BUT MAY BE REIMBURSED FOR ACTUAL AND REASONABLE EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES.

(f) EXPENSES INCURRED FOR THE BOARD MUST BE PAID FROM THE GENERAL OPERATING BUDGET OF THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN.

(3) THE BOARD HAS THE FOLLOWING DUTIES AND RESPONSIBILITIES:

(a) TO OVERSEE PERSONNEL DECISIONS RELATED TO THE OMBUDSMAN, INCLUDING, BUT NOT LIMITED TO:

(I) ON OR BEFORE DECEMBER 1, 2015, AND AS NECESSARY THEREAFTER, APPOINTING A PERSON TO SERVE AS THE CHILD PROTECTION OMBUDSMAN AND DIRECTOR OF THE OFFICE, REFERRED TO IN THIS ARTICLE AS THE "OMBUDSMAN". THE OMBUDSMAN APPOINTED BY THE BOARD ON OR BEFORE DECEMBER 1, 2015, SHALL ASSUME HIS OR HER POSITION ON THE EFFECTIVE DATE OF THE MEMORANDUM OF UNDERSTANDING BETWEEN THE JUDICIAL DEPARTMENT AND THE OFFICE, DEVELOPED PURSUANT TO SECTION 19-3.3-102 (3) (e). THE BOARD MAY ALSO DISCHARGE AN ACTING OMBUDSMAN FOR CAUSE. A TWO-THIRDS MAJORITY VOTE IS REQUIRED TO HIRE OR DISCHARGE THE OMBUDSMAN. THE GENERAL ASSEMBLY SHALL SET THE OMBUDSMAN'S COMPENSATION AND SUCH COMPENSATION MAY NOT BE REDUCED DURING THE TERM OF THE OMBUDSMAN'S APPOINTMENT.

(II) FILLING ANY VACANCY IN THE OMBUDSMAN POSITION;

(b) TO ENSURE ACCOUNTABILITY AND CONSISTENCY IN THE OPERATING POLICIES AND PROCEDURES, INCLUDING REASONABLE RULES TO ADMINISTER THE PROVISIONS OF THIS ARTICLE AND ANY OTHER STANDARDS OF CONDUCT AND REPORTING REQUIREMENTS AS PROVIDED BY LAW;

(c) TO WORK COOPERATIVELY WITH THE OMBUDSMAN TO PROVIDE FISCAL OVERSIGHT OF THE GENERAL OPERATING BUDGET OF THE OFFICE, TO ASSIST WITH TRAINING, AS NEEDED, AND PROVIDE ANY OTHER ASSISTANCE TO ENSURE THAT THE OFFICE AND OMBUDSMAN OPERATE IN COMPLIANCE WITH THE PROVISIONS OF THIS ARTICLE AND WITH STATE AND FEDERAL LAWS RELATING TO THE CHILD WELFARE SYSTEM;

(d) TO ASSIST WITH THE MEMORANDUM OF UNDERSTANDING BETWEEN THE OFFICE AND THE STATE DEPARTMENT. THE MEMORANDUM OF UNDERSTANDING MUST BE COMPLETED AND SIGNED NO LATER THAN NOVEMBER 1, 2015;

(e) TO COLLABORATE WITH THE JUDICIAL DEPARTMENT AND THE OFFICE ON THE CREATION OF AN ADMINISTRATIVE MEMORANDUM OF UNDERSTANDING BETWEEN THE OFFICE AND THE JUDICIAL DEPARTMENT. THE MEMORANDUM OF UNDERSTANDING MUST BE COMPLETED AND SIGNED NO LATER THAN NOVEMBER 1, 2015, AND HAVE AN EFFECTIVE DATE OF NO LATER THAN JANUARY 1, 2016. THE MEMORANDUM OF UNDERSTANDING MUST CONTAIN, AT A MINIMUM:

(I) A REQUIREMENT THAT THE OFFICE HAS ITS OWN PERSONNEL RULES;

(II) A REQUIREMENT THAT THE OMBUDSMAN HAS INDEPENDENT HIRING AND TERMINATION AUTHORITY OVER OFFICE EMPLOYEES;

(III) A REQUIREMENT THAT THE OFFICE MUST FOLLOW JUDICIAL FISCAL RULES;

(IV) A REQUIREMENT THAT THE OFFICE OF THE STATE COURT ADMINISTRATOR SHALL OFFER THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN LIMITED SUPPORT WITH RESPECT TO:

(A) PERSONNEL MATTERS;

(B) RECRUITMENT;

(C) PAYROLL;

(D) BENEFITS;

(E) BUDGET SUBMISSION, AS NEEDED;

(F) ACCOUNTING; AND

(G) OFFICE SPACE, FACILITIES, AND TECHNICAL SUPPORT LIMITED TO THE BUILDING THAT HOUSES THE OFFICE OF THE STATE COURT ADMINISTRATOR;

(V) ANY OTHER PROVISIONS REGARDING ADMINISTRATIVE SUPPORT THAT WILL HELP MAINTAIN THE INDEPENDENCE OF THE OFFICE;

(f) TO ASSIST WITH TRAINING FOR THE OMBUDSMAN, OFFICE, OR AS OTHERWISE NEEDED; AND

(g) TO ASSIST WITH REPORTING REQUIREMENTS TO THE GENERAL ASSEMBLY.

(4) MEETINGS OF THE BOARD ARE SUBJECT TO THE PROVISIONS OF SECTION 24-6-402, C.R.S., EXCEPT FOR EXECUTIVE PERSONNEL ACTIONS OR MEETINGS REQUIRING THE PROTECTION OF CONFIDENTIALITY FOR CHILDREN'S OR PARENTS' PERSONAL DATA PURSUANT TO THE FEDERAL "CHILD ABUSE PREVENTION AND TREATMENT ACT", PUB.L. 93-247, AND STATE PRIVACY LAWS.

(5) THE RECORDS OF THE BOARD AND THE OFFICE ARE SUBJECT TO THE PROVISIONS OF PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S.

SECTION 2. In Colorado Revised Statutes, 19-3.3-103, **amend** (1) (a) (I) (A), (2) (b), (2) (e), (3), and (5) as follows:

19-3.3-103. Office of the child protection ombudsman - powers and duties - access to information - confidentiality - testimony - judicial review. (1) The ombudsman has the following duties, at a minimum:

(a) (I) (A) To receive complaints concerning child protection services made by or on behalf of a child relating to any action, inaction, or decision of any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, ~~and~~ OR well-being of the child. The ombudsman may, INDEPENDENTLY AND IMPARTIALLY,

investigate and seek resolution of such complaints, which resolution may include, but need not be limited to, referring a complaint to the state department or appropriate agency or entity and making a recommendation for action relating to a complaint.

(2) The ombudsman has the following powers, at a minimum:

(b) To review and evaluate the effectiveness and efficiency of any existing grievance resolution mechanisms and to make recommendations to the GENERAL ASSEMBLY, executive director, and any appropriate agency or entity for the improvement of the grievance resolution mechanisms;

(e) To recommend to the GENERAL ASSEMBLY, THE executive director, and any appropriate agency or entity statutory, budgetary, regulatory, and administrative changes, including systemic changes, to improve the safety of and promote better outcomes for children and families receiving child protection services in Colorado.

(3) ~~An agency or organization that is awarded the contract for the operation of the program;~~ The ombudsman, employees of the ~~program~~ OFFICE, and any persons acting on behalf of the ~~program~~ OFFICE shall comply with all state and federal confidentiality laws that govern the state department or a county department with respect to the treatment of confidential information or records and the disclosure of such information and records.

(5) IN THE PERFORMANCE OF HIS OR HER DUTIES, the ombudsman shall act independently of the divisions within the state department that are responsible for child welfare, youth corrections, or child care, ~~and~~ of the county departments ~~in the performance of his or her duties~~ OF HUMAN OR SOCIAL SERVICES, AND OF ALL JUDICIAL AGENCIES, INCLUDING, BUT NOT LIMITED TO, THE OFFICE OF THE CHILD'S REPRESENTATIVE, THE OFFICE OF THE RESPONDENT PARENTS' COUNSEL, THE OFFICE OF STATE PUBLIC DEFENDER, THE OFFICE OF ALTERNATE DEFENSE COUNSEL, AND THE OFFICE OF ATTORNEY REGULATION COUNSEL. Any recommendations made by the ombudsman or positions taken by the ombudsman do not ~~necessarily~~ reflect those of the state department, JUDICIAL DEPARTMENT, or of the county departments OF HUMAN OR SOCIAL SERVICES.

SECTION 3. In Colorado Revised Statutes, **amend** 19-3.3-106 as

follows:

19-3.3-106. Award of contract - extension - repeal. (1) (a) Subject to the provisions of subsection (2) of this section, the executive director, in accordance with the "Procurement Code", articles 101 to 112 of title 24, C.R.S., shall issue the request for proposals for the administration of the ~~program~~ OFFICE. The proposal submission period, the review of submissions, and the award of the contract shall be completed within sixty days after the issuance of the request for proposals.

(b) The request for proposals shall include language prohibiting the award of the contract to a contractor who will continue to be involved in providing child protection services or involved in the legal representation of children after the award of the contract or who has any other conflict of interest or who is unable to independently and impartially perform the duties of the ~~program~~ OFFICE.

(2) Notwithstanding any provisions of this article to the contrary, the executive director shall not award a contract for the operation of the ~~program~~ OFFICE until such time as the executive director determines that sufficient moneys are available or have been committed for the operation of the ~~program~~ OFFICE.

(3) THE EXECUTIVE DIRECTOR MAY EXTEND A CONTRACT AWARDED PURSUANT TO THIS SECTION UNTIL DECEMBER 31, 2015. THE CONTRACT EXTENSION MAY BE REVOKED UPON THE AGREEMENT OF ALL PARTIES, BUT NO SOONER THAN THE EFFECTIVE DATE OF THE MEMORANDUM OF UNDERSTANDING BETWEEN THE JUDICIAL DEPARTMENT AND THE OFFICE, DEVELOPED PURSUANT TO SECTION 19-3.3-102 (3) (e).

(4) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2016.

SECTION 4. In Colorado Revised Statutes, 19-3.3-107, **amend** (4); and **add** (5) as follows:

19-3.3-107. Child protection ombudsman program fund - created - repeal. (4) Any moneys in the fund not expended for the purposes of this article may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and

unencumbered moneys remaining in the fund ~~at the end of a fiscal year shall remain in the fund and~~ AS OF JANUARY 1, 2016, shall ~~not revert or be credited or~~ BE transferred to the general fund. ~~or to another fund.~~

(5) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2016.

SECTION 5. In Colorado Revised Statutes, 19-3.3-108, **amend** (2) and (3) as follows:

19-3.3-108. Office of the child protection ombudsman - annual report. (2) The ombudsman shall transmit the annual report to the executive director for review and comment. The ~~executive director~~ OMBUDSMAN shall distribute the WRITTEN report to the governor, THE CHIEF JUSTICE, and ~~to the health and human services committees of the house of representatives and of the senate, or any successor committees~~ THE GENERAL ASSEMBLY. The ombudsman shall present the report to the health and human services committees of the house of representatives and of the senate, or any successor committees. ~~upon request of those committees.~~

(3) The ~~state department~~ OMBUDSMAN shall post the annual report ~~issued by the ombudsman to the web site of the state department~~ ON THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN'S WEB SITE AND THE GENERAL ASSEMBLY'S WEB SITE.

SECTION 6. In Colorado Revised Statutes, **add** 19-3.3-110 as follows:

19-3.3-110. Funding recommendations. THE OMBUDSMAN SHALL MAKE FUNDING RECOMMENDATIONS TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY FOR THE OPERATION OF THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN. THE GENERAL ASSEMBLY SHALL MAKE ANNUAL APPROPRIATIONS, IN SUCH AMOUNT AND FORM AS THE GENERAL ASSEMBLY DETERMINES APPROPRIATE, FOR THE OPERATION OF THE OFFICE.

SECTION 7. In Colorado Revised Statutes, 19-3.3-108, **amend** (1) introductory portion and (1) (a) as follows:

19-3.3-108. Office of the child protection ombudsman - annual report. (1) On or before September 1 of each year, commencing with the September 1 following the first fiscal year in which the ~~program is~~

~~implemented~~ OFFICE WAS ESTABLISHED, the ombudsman shall prepare a written report that shall include, but need not be limited to, information from the preceding fiscal year and any recommendations concerning the following:

(a) Actions taken by the ombudsman relating to the duties of the ~~program~~ OFFICE set forth in section 19-3.3-103;

SECTION 8. In Colorado Revised Statutes, **amend** 19-3.3-109 as follows:

19-3.3-109. Review by the state auditor's office. The state auditor shall conduct or cause to be conducted a performance and fiscal audit of the ~~program~~ OFFICE at the beginning of the third year of operation of the ~~program~~ OFFICE. Thereafter, at the discretion of the legislative audit committee, the state auditor shall conduct or cause to be conducted a performance and fiscal audit of the ~~program~~ OFFICE.

SECTION 9. In Colorado Revised Statutes, 24-37-302, **amend** (3) (b) as follows:

24-37-302. Responsibilities of the office of state planning and budgeting. (3) (b) The department of state, the department of the treasury, the department of law, the judicial department, the office of state public defender, the office of alternate defense counsel, the independent ethics commission, ~~and~~ the office of the child's representative, AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN shall use the state agency budget submissions described in paragraph (a) of this subsection (3) as a guideline for the submission of their budgets to the joint budget committee.

SECTION 10. In Colorado Revised Statutes, 24-37.5-105, **amend** (11) (b) (I), (11) (b) (II), (11) (b) (IV), (11) (b) (VI), and (11) (c) (II) as follows:

24-37.5-105. Office - responsibilities - rules. (11) (b) The electronic budgeting system should, at minimum:

(I) Allow access by the principal departments of the executive branch of state government, as specified in section 24-1-110, the legislative branch agencies, the judicial department, the office of state public defender

created in section 21-1-101, C.R.S., the office of alternate defense counsel created in section 21-2-101, C.R.S., the independent ethics commission established in section 24-18.5-101 (2) (a), the office of the child's representative created in section 13-91-104, C.R.S., THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN CREATED IN SECTION 19-3.3-102, C.R.S., the office of state planning and budgeting, and the joint budget committee staff;

(II) Allow for the confidential development of the governor's annual budget request and the annual budget requests of the legislative branch agencies, the judicial department, the office of state public defender created in section 21-1-101, C.R.S., the office of alternate defense counsel created in section 21-2-101, C.R.S., the independent ethics commission established in section 24-18.5-101 (2) (a), and the office of the child's representative created in section 13-91-104, C.R.S., AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN CREATED IN SECTION 19-3.3-102, C.R.S.;

(IV) Allow for the electronic communication of the governor's annual budget request and the annual budget requests of the legislative branch agencies, the judicial department, the office of state public defender created in section 21-1-101, C.R.S., the office of alternate defense counsel created in section 21-2-101, C.R.S., the independent ethics commission established in section 24-18.5-101 (2) (a), and the office of the child's representative created in section 13-91-104, C.R.S., AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN CREATED IN SECTION 19-3.3-102, C.R.S., to the joint budget committee staff;

(VI) Allow the joint budget committee staff to view the final version of the governor's annual budget requests and the budget requests of the legislative branch agencies, the judicial department, the office of state public defender created in section 21-1-101, C.R.S., the office of alternate defense counsel created in section 21-2-101, C.R.S., the independent ethics commission established in section 24-18.5-101 (2) (a), and the office of the child's representative created in section 13-91-104, C.R.S., AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN CREATED IN SECTION 19-3.3-102, C.R.S.;

(c) The feasibility and requirements study should also assess the cost and feasibility to implement the following potential system components:

(II) A web-based interface that will allow the legislative branch agencies, the judicial department, the office of state public defender created in section 21-1-101, C.R.S., the office of alternate defense counsel created in section 21-2-101, C.R.S., the independent ethics commission established in section 24-18.5-101 (2) (a), and the office of the child's representative created in section 13-91-104, C.R.S., AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN CREATED IN SECTION 19-3.3-102, C.R.S., to upload and submit budget documents and requests to the joint budget committee staff;

SECTION 11. In Colorado Revised Statutes, 2-7-202, **amend** (5) (a); and **add** (13.5) as follows:

2-7-202. Definitions. As used in this part 2, unless the context otherwise requires:

(5) (a) "Department" means the judicial department, the office of state public defender, the office of alternate defense counsel, the office of the child's representative, THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN, the public employees' retirement association, the Colorado energy office, the office of economic development, and the principal departments of the executive branch of state government as specified in section 24-1-110, C.R.S., including any division, office, agency, or other unit created within a principal department.

(13.5) "OFFICE OF THE CHILD PROTECTION OMBUDSMAN" MEANS THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN CREATED IN SECTION 19-3.3-102, C.R.S.

SECTION 12. In Colorado Revised Statutes, 2-7-204, **amend** (1) (c) and (3) (b) as follows:

2-7-204. Performance management systems. (1) (c) No later than August 1, 2013, and no later than August 1 of each year thereafter, the department of state, the department of the treasury, the department of law, the office of state public defender, the office of alternate defense counsel, the Colorado energy office, the office of economic development, and the office of the child's representative, AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN shall each publish their components of the performance management systems for their respective department, office,

or commission. These instructions must be posted on the official web sites administered by the respective departments, offices, and commissions.

(3) (b) Each department's performance plan shall be posted on the official web sites of the department and the office of state planning and budgeting. The state treasurer, the attorney general, the secretary of state, the state court administrator for the judicial department, the office of state public defender, the office of alternate defense counsel, the public employees' retirement association, the Colorado energy office, the office of economic development, ~~and~~ the office of the child's representative, AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN shall ensure the office of state planning and budgeting receives the information required to be posted on the office of state planning and budgeting's web site pursuant to this paragraph (b). The office of state planning and budgeting shall not have access to edit any information provided by the state treasurer, the attorney general, the secretary of state, the state court administrator for the judicial department, the office of state public defender, the office of alternate defense counsel, the public employees' retirement association, the Colorado energy office, the office of economic development, ~~or~~ the office of the child's representative, OR THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN.

SECTION 13. In Colorado Revised Statutes, 2-7-205, **amend** (1) as follows:

2-7-205. Annual performance report. (1) (a) (I) Except as provided in subparagraph (II) of this paragraph (a), no later than November 1, 2014, and no later than November 1 of each year thereafter, the office of state planning and budgeting shall publish an annual performance report for each department except the department of state, the department of the treasury, the department of law, the judicial department, the office of state public defender, the office of alternate defense counsel, the Colorado energy office, the office of economic development, and the office of the child's representative, AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN. The annual performance report must include a summary of each department's performance plan and most recent performance evaluation. The annual performance report must be clearly written and easily understood and must be limited to a maximum of four pages per department.

(II) The office of state planning and budgeting shall prepare the section of the annual performance report for the department of higher education by reviewing the institutions of higher education's progress towards the goals set forth in the institution of higher education's performance contract described in section 23-5-129, C.R.S., and the outcomes of the recommended performance funding plan required in section 23-1-108 (1.9) (b), C.R.S.

(b) No later than November 1, 2014, and no later than November 1 of each year thereafter, the department of state, the department of the treasury, the department of law, the judicial department, the office of state public defender, the office of alternate defense counsel, the Colorado energy office, the office of economic development, ~~and~~ the office of the child's representative, AND THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN shall each publish an annual performance report including a summary of its performance plan and most recent performance evaluation. The annual performance reports must be clearly written and easily understood and must each be limited to a maximum of four pages.

SECTION 14. In Colorado Revised Statutes, 19-3.3-101, **amend** (2) introductory portion as follows:

19-3.3-101. Legislative declaration. (2) The general assembly further finds and declares that the establishment of the OFFICE OF THE child protection ombudsman ~~program~~ will:

SECTION 15. In Colorado Revised Statutes, 19-3.3-103, **amend** (1) (a) (I) (B) and (1) (c) as follows:

19-3.3-103. Office of the child protection ombudsman - powers and duties - access to information - confidentiality - testimony - judicial review. (1) The ombudsman has the following duties, at a minimum:

(a) (I) (B) The ombudsman shall treat all complaints received pursuant to sub-subparagraph (A) of this subparagraph (I) as confidential, including the identities of complainants and individuals from whom information is acquired; except that disclosures may be permitted if the ombudsman deems it necessary to enable the ombudsman to perform his or her duties and to support any recommendations resulting from an

investigation. Records relating to complaints received by the ~~program~~ OFFICE and the investigation of complaints are exempt from public disclosure pursuant to article 72 of title 24, C.R.S.

(c) To report at least annually, pursuant to section 19-3.3-108, concerning the actions taken by the ombudsman with respect to the goals and duties of the ~~program~~ OFFICE.

SECTION 16. In Colorado Revised Statutes, **amend** 19-3.3-104 as follows:

19-3.3-104. Qualified immunity. The ombudsman and employees or persons acting on behalf of the ~~program shall be~~ OFFICE ARE immune from suit and liability, either personally or in their official capacities, for any claim for damage to or loss of property, or for personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities pertaining to the ~~program~~ OFFICE, including but not limited to issuing reports or recommendations; except that nothing in this section shall be construed to protect such persons from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of ~~any such~~ THAT person.

SECTION 17. Appropriation - adjustments to 2015 long bill. (1) To implement this act, the general fund appropriation made in the annual general appropriation act for the 2015-16 state fiscal year to the department of human services for the child protection ombudsman is decreased by $270,372.

(2) For the 2015-16 state fiscal year, $351,086 is appropriated to the judicial department. This appropriation is from the general fund and is based on an assumption that the department will require an additional 2.2 FTE. To implement this act, the department may use this appropriation as follows:

(a) $10,000 for general courts administration, which amount is based on an assumption that the department will require an additional 0.2 FTE;

(b) $133,812 for courthouse capital and infrastructure maintenance;

and

(c) $207,274 for the office of the child protection ombudsman, which amount is based on an assumption that the office will require an additional 2.0 FTE.

SECTION 18. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Bill L. Cadman
PRESIDENT OF
THE SENATE

Dickey Lee Hullinghorst
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED 2:26 PM 6/2/15

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Appendix B:
Detailed Data Runs

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Adams	41	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Permanency Placement	10 9 3 15 2 2	Inquiry Review	16 25	Affirmed Agency/Caseworker Actions Closed per Complainant Declined to Investigate Deviation from Best Practice Standards Resource Referral	22 1 1 2 15
Alamosa	7	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	2 2 1 2	Inquiry Review	2 5	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Closed Lack of Information Resource Referral	2 3 1 1
Arapahoe	37	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Placement Services	4 9 3 16 4 1	Inquiry Investigation Review	16 1 20	Affirmed Agency/Caseworker Actions Closed per Complainant Declined to Investigate Deviation from Best Practice Standards Resource Referral	18 2 1 1 13
Archuleta	1	Lack of Response	1	Review	1		
Baca	3	Intake/Assessment Non-Complaint	1 2	Inquiry Review	2 1	Deviation from Best Practice Standards Resource Referral	1 2
Bent	2	Non-Complaint	2	Inquiry	2	Resource Referral	2

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Boulder	17	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Placement	3 2 1 10 1	Inquiry Investigation Review	10 1 6	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Closed per Complainant Closed Lack of Information Deviation from Best Practice Standards Investigation Initiated Resource Referral	4 1 1 1 1 1 8
Broomfield	2	Intake/Assessment Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Closed Lack of Information	1 1
Chaffee	0						
Cheyenne	1	Intake/Assessment	1	Review	1	Affirmed Agency/Caseworker Actions	1
Clear Creek	1	Services	1	Review	1	Affirmed Agency/Caseworker Actions	1
Conejos	1	Non-Complaint	1	Inquiry	1	Closed per Complainant	1
Costilla	2	Lack of Response Non-Complaint	1 1	Inquiry	2	Closed per Complainant Closed Lack of Information	1 1
Crowley	5	Intake/Assessment Lack of Response Non-Complaint	2 2 1	Inquiry Review	1 4	Affirmed Agency/Caseworker Actions Resource Referral	4 1
Custer	1	Lack of Response	1	Review	1		
Delta	4	Case/Ongoing Lack of Response Non-Complaint	1 1 2	Inquiry Review	2 2	Resource Referral	2

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Denver	46	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Placement Services	11 4 5 18 7 1	Inquiry Investigation Review Review with Monitoring	20 2 23 1	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Agency/Caseworker Non-Compliance with Policy or Law Closed per Complainant Closed Lack of Information Declined to Investigate Duplicate Referral Investigation Initiated Other*** Resource Referral Review with Monitoring	15 1 4 1 1 2 1 2 1 15 1
Dolores	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
Douglas	13	Case/Ongoing Intake/Assessment Non-Complaint Placement	3 6 3 1	Inquiry Review	3 10	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Closed Lack of Information Resource Referral	9 1 1 2
Eagle	0						
Elbert	2	Case/Ongoing Intake/Assessment	1 1	Review	2	Affirmed Agency/Caseworker Actions	2

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
El Paso	47	Case/Ongoing Contact/Visitation Intake/Assessment Lack of Response Non-Complaint Other*** Placement	8 1 9 5 21 1 2	Inquiry Review	23 24	Affirmed Agency/Caseworker Actions Agency/Caseworker Non-Compliance with Policy or Law Closed per Complainant Closed Lack of Information Resource Referral	22 2 3 4 16
Fremont	15	Case/Ongoing Contact/Visitation Intake/Assessment Lack of Response Non-Complaint Placement	4 1 4 2 3 1	Inquiry Review	4 11	Affirmed Agency/Caseworker Actions Closed per Complainant Closed Lack of Information Declined to Investigate Resource Referral	10 1 1 1 1
Garfield	3	Lack of Response Non-Complaint	2 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Declined to Investigate	2 1
Gilpin	0						
Grand	0						
Gunnison	2	Lack of Response Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Resource Referral	1 1
Hinsdale	0						
Huerfano	2	Case/Ongoing Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Closed Lack of Information	1 1
Jackson	2	Case/Ongoing Lack of Response	1 1	Review	2	Affirmed Agency/Caseworker Actions Closed per Complainant	1 1

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Jefferson	56	Case/Ongoing Contact/Visitation Intake/Assessment Lack of Response Non-Complaint Permanency Placement Removal of Children	17 2 10 7 17 1 1 1	Inquiry Review Review with Monitoring	17 38 1	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Agency/Caseworker Non-Compliance with Policy or Law Closed per Complainant Resource Referral Review with Monitoring	32 1 1 2 15 1
Kiowa	2	Case/Ongoing Intake/Assessment	1 1	Review	2	Affirmed Agency/Caseworker Actions	2
Kit Carson	3	Mandated Reporting Non-Complaint	2 1	Inquiry Review Review with Monitoring	1 1 1	Declined to Investigate Review with Monitoring	1 1
Lake	0						
La Plata	1	Intake/Assessment	1	Review	1	Agency/Caseworker Non-Compliance with Policy or Law	1
Larimer	26	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Permanency Removal of Children	2 6 2 13 2 1	Inquiry Review	15 11	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Closed per Complainant Closed Lack of Information Duplicate Referral Resource Referral	10 1 2 2 1 10
Las Animas	4	Non-Complaint Placement Resource/Information	2 1 1	Inquiry Review	2 2	Affirmed Agency/Caseworker Actions Resource Referral	2 2
Lincoln	0						

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Logan	3	Intake/Assessment Non-Complaint Placement	1 1 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Close per Complainant	2 1
Mesa	8	Intake/Assessment Lack of Response Non-Complaint Placement	4 1 2 1	Inquiry Review	2 6	Affirmed Agency/Caseworker Actions Closed Lack of Information Resource Referral	6 1 1
Mineral	0						
Moffat	5	Case/Ongoing Non-Complaint	2 3	Inquiry Review	3 2	Affirmed Agency/Caseworker Actions Closed per Complainant Resource Referral	2 1 2
Montezuma	3	Non-Complaint	3	Inquiry	3	Resource Referral	3
Montrose	6	Case/Ongoing Intake/Assessment Non-Compliant	3 1 2	Inquiry Review	3 3	Affirmed Agency/Caseworker Actions Agency/Caseworker Non-Compliance with Policy or Law Closed, Lack of Information Duplicate Referral Resource Referral	2 1 1 1 1
Morgan	5	Case/Ongoing Intake/Assessment Lack of Response	1 1 3	Review	5	Affirmed Agency/Caseworker Actions	5
Otero	0						
Ouray	0						
Park	2	Intake/Assessment Lack of Response	1 1	Review	2	Affirmed Agency/Caseworker Actions	2
Phillips	1	Non-Complaint	1	Inquiry	1	Resource Referral	1
Pitkin	0						
Prowers	0						

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Pueblo	22	Case/Ongoing Contact/Visitation Intake/Assessment Lack of Response Non-Complaint Permanency Placement	6 1 2 2 9 1 1	Inquiry Review	9 13	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Agency/Caseworker Non-Compliance with Policy or Law Closed per Complainant Deviation from Best Practice Standards Resource Referral	6 4 1 1 1 8
Rio Blanco	0						
Rio Grande	1	Intake/Assessment	1	Review	1	Agency/Caseworker Non-Compliance with Policy or Law	1
Routt	0						
Saguache	1	Intake/Assessment	1	Review	1	Affirmed Agency/Caseworker Actions	1
San Juan	0						
San Miguel	0						
Sedgwick	0						
Southern Ute	0						
Statewide	2	Non-Complaint	2	Inquiry	2	Resource Referral	2
Summit	2	Non-Complaint Placement	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Resource Referral	1 1
Teller	2	Non-Complaint Placement	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Resource Referral	1 1
Washington	1	Permanency	1	Review	1	Affirmed Agency/Caseworker Actions	1

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Weld	20	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Other*** Permanency	3 5 6 4 1 1	Inquiry Review	4 16	Affirmed Agency/Caseworker Actions Closed per Complainant Declined to Investigate Deviation from Best Practice Standards Resource Referral	14 1 1 1 2
Yuma	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
Colorado Department of Human Services	1	Complaint Process	1	Review	1	Affirmed Agency/Caseworker Actions	1
Department of Youth Corrections	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
Unknown**	77	Non-Complaint	77	Inquiry	77	Closed per Complainant Closed, Lack of Information Declined to Investigate Duplicate Referral Other*** Resource Referral	5 24 1 1 1 45

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

Overview of Ombudsman Contacts
Fiscal Year 2014-2015

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2014-2015*							
County	Number of Contacts	Nature of Contacts (n=514)		Ombudsman Response to Contacts (n=514)		Disposition of Resolved Contacts (n=498)	
		Nature	Number	Response	Number	Result	Number
Total	514	Case/Ongoing	87	Inquiry	250	Affirmed Agency/Caseworker Actions	209
		Complaint Process	1	Investigation	4		
		Contact/Visitation	5	Review	257	Affirmed Agency or Caseworker Actions with Recommendations	12
		Intake/Assessment	86	Review with Monitoring	3		
		Lack of Response	52				
		Mandated Reporting	2			Agency/Caseworker Non-Compliance with Policy or Law	11
		Non-Complaint	240				
		Other***	2				
		Permanency	8			Closed, per Complainant	25
		Placement	25			Closed, Lack of Information	40
		Removal of Children	2			Declined to Investigate	9
		Resource/Information	1			Deviation from Best Practice Standards	7
		Services	3			Duplicate Referral	4
						Investigation Initiated	3
						Other***	2
						Resource Referral	173
						Review with Monitoring	3

*OCCPO recognizes that the number of calls per county may or may not be indicative of systemic issues within that county, and may be attributable to awareness of OCCPO in that particular location or some other variables yet to be identified. As OCCPO continues to collect data in the next year or two, the trends should become clearer as to frequency of calls per county.

**Callers with an unknown county include those needing help with systems navigation or looking for other, general information.

***Foster Care Home Study/Suggestion/Civil Litigation & Conflict/Records

Appendix C:
Ombudsman Investigative Reports

Executive Summaries

OFFICE OF THE COLORADO'S CHILD PROTECTION OMBUDSMAN

November 24, 2014

Investigative Report

Senate Bill 10-171

The Office of the Colorado Child Protection Ombudsman was established through Senate Bill 10-171 to "improve accountability and transparency in the child protection system and to promote better outcomes for children and families involved in the child protection system."

Case # 10577

Pueblo County

(303) 864-5111

www.protectcoloradochildren.org

Executive Summary

The Office of the Colorado Child Protection Ombudsman received a complaint that a child suffered numerous significant injuries in the care of relatives who were receiving services through Pueblo County Social Services. After reviewing the documentation of injuries in Trails and out of concern, OCCPO brought it to the attention of Colorado Department of Human Services and Pueblo County Social Services to notify them that one child remained in the custody of the alleged abusers with no oversight. CDHS representatives directed Pueblo County to make contact with the remaining child to determine safety and completed a site visit. The child was contacted and did not disclose any concerns and therefore remained in the home with the alleged perpetrators until their arrest.

The child and her two siblings were in the care of relatives due to the children's biological mother being deported back to Mexico. A referral had been received by Pueblo County Social Services on July 27, 2012 stating the child presented with numerous bruises and the reporting party was concerned about abuse and neglect as these were not the only injuries she had. An assigned caseworker and a law enforcement officer were dispatched and witnessed the child to have numerous injuries. The female caregiver was interviewed and gave recollection of how the injuries were received. She was advised to take the child to the emergency room to be checked out. A physician's assistant at St. Mary-Corwin Medical Center did not have any concern about abuse or neglect. During a follow up interview with the male caregiver, his recollection of the injuries did not match the stories of the female caregiver. The caseworker noted the female caregiver attempted to get her significant other to stop telling the story by shaking her hand no at him.

On August 6, 2012, before the initial investigation was completed, the caseworker received notification that the child was being seen at the hospital for a broken femur. The treating physician also noted the child had an old arm break in the healing stage. The doctor was concerned about neglect as was the hospital social worker due the lack of supervision and explanation of the injuries by the caregiver. The caseworker also noted that the child sought comfort from the doctor when the female caregiver attempted to pick up the child.

A voluntary case was opened to provide services to the family. The caseworker did not note any concerns with the family from August 6, 2012 through December 31, 2012.

On December 31, 2012, the ongoing caseworker was informed the child was being seen in the emergency room for a significant burn to her face that had happened days prior. The female caregiver reported that the child had turned on the hot water while in the bath unsupervised. The caseworker made a home visit on January 7, 2013 which was five days since the child's release from the hospital. At that time, the caseworker learned that the caregivers had not filled a prescription for a cream to treat the child's burn.

On March 11, 2013, the caseworker received a call informing her that the child had "severe burns to her bottom" which occurred three days prior to the caseworker being contacted. The treating physician determined that the injuries were not consistent with the events reported by the female caregiver and custody of the child and her two siblings was granted to Pueblo County Social Services.

The OCCPO identified policy and practice violations during the course of the family's involvement with Pueblo County Social Services. The OCCPO recommendation's listed on page five call for the county to provide their staff with intensive training, review internal policies and evaluate agency standards on an ongoing basis to improve the quality of their casework to ensure adequate service delivery to the children, youth and families of Pueblo County. Pueblo County Social Services has already taken steps to improve practice, communication and response. They have arranged for OCCPO staff to provide an informative presentation regarding the ombudsman function and multidisciplinary collaboration.

ALLEGATIONS

The Office of the Colorado Child Protection Ombudsman (OCCPO) initiated an investigation on August 27, 2013 into the response of Pueblo County Social Services during the time Pueblo County Social Services were providing services to the children. The initial call was from a concerned citizen who reported Pueblo County Social Services allowed a child to remain in a dangerous living situation in the child protection case which resulted in the child sustaining serious injuries. During the review of human services documentation by OCCPO, concern arouse about the response of Pueblo County Social Services to the child's injuries over the course of approximately nine months.

INVESTIGATION OVERVIEW

OCCPO reviewed Colorado Department of Human Services' documentation to determine if Pueblo County Social Services complied with policy and procedures outlined in the Colorado Children's Code and Volume Seven of the Colorado Department of Human Services' Rules and Regulations upon receiving any reports of concern regarding the family or involvement with the family during the course of an investigation or open child welfare case. The OCCPO conducted reviews of collateral contacts with medical professionals and law enforcement to determine if the actions of the professionals in anyway contributed to the continued abuse and neglect of the child. The OCCPO's investigation in to these allegations could not be concluded until the completion of all associated criminal proceedings. On April 1, 2014, the male caregiver plead guilty to Child Abuse Resulting in Serious Bodily Injury—Negligence pursuant to a plea agreement and was immediately sentenced to four years in prison and three years parole. The female caregiver also plead guilty on April 1, 2014 to Child Abuse Resulting in Serious Bodily Injury—Negligence pursuant to a plea agreement. She was sentenced on June 6, 2014 to four years in prison and three years parole.

During the course of the investigation OCCPO reviewed the following information:

- Colorado Trails, the database utilized by all Colorado county social services offices
- Colorado Courts Database
- Pueblo Sheriff's Department Reports
- Pueblo Police Department Reports
- Pueblo County Social Services' case file
- Interviews with Pueblo County Social Services Administrator and Caseworker on September 23, 2013.
- Colorado Department of Human Services Child Fatality Non-Confidential Case Specific Executive Review Report.

The OCCPO's investigation in to these allegations began before any criminal charges were filed but could not be concluded until the completion of all associated criminal proceedings.

INVOLVEMENT WITH HUMAN SERVICES

On July 27, 2012, referral came in to Pueblo County Social Services stating the child had a bruise behind the left knee, right hip and on the back. Reporting party was concerned about abuse and neglect in the home because the child had numerous injuries. Reporting party stated this was the second call made to the abuse hotline and the first had been earlier in the week when The child presented with "a mean scrap from the bottom of her chin that extended to her neck and a gash on the back of her head." At that time, the reporting party was advised social services would not be investigating since the female caregiver told the reporting party these injuries were due to an accident because the child is clumsy. The reporting party was advised to contact law enforcement to make a report. Referral # 2301161 was assigned as an immediate and/or same day response.

The child was observed by the assigned caseworker and a Pueblo County Sheriff's Deputy. Both professionals documented the child to have numerous bruises. The deputy and assigned caseworker with the assistance of Spanish speaking Pueblo County Social Services worker interviewed the female caregiver who is Spanish speaking only. The female caregiver stated in October 2011, she took in the child and her two siblings when their mother was deported to Mexico. The female caregiver provided her version of events causing each of the child's injuries. The child was reunited with the female caregiver at which time "the child became upset and started to cry." The child sought comfort from the caseworker and "would not look at" the female caregiver.

The children were allowed to leave the facility with the female caregiver but the caseworker requested she have the child checked out by medical staff at the local emergency room. The caseworker's documentation noted the hospital social worker contacted the caseworker to inform the child was seen in the emergency room. A physician's assistant and doctor believed the injuries were normal and "did not feel there was evidence of abuse or neglect."

During a home visit by the intake caseworker, the male caregiver was interviewed as part of the social services investigation. He provided numerous stories as to how the child incurred her injuries that did not match the stories the female caregiver had provided. The caseworker noted the female caregiver attempted to get the male caregiver to stop telling the story by shaking her hand no at him.

On August 6, 2012, the intake caseworker received notification from Pueblo Police Department that the child was being seen in the St. Mary-Corwin Medical Center for a broken femur. The doctor reported the child had an old break in her left arm that was in the healing stages. The doctor noted numerous "scratches and bumps" and was concerned about neglect but did not categorize injuries as a result of abuse or neglect. The hospital social worker noted the broken femur was a spiral fracture and the female caregiver offered several stories to the emergency room staff as to how the injury occurred. The caseworker noted the social worker's "great concern about the safety of the children in the home." After the child's leg was set, the child sought comfort from the doctor when the female caregiver attempted to pick her up.

A voluntary case was opened on August 16, 2012 which became court involved on December 20, 2012 to give legal custody of the children to the caregivers. On December 31, 2012, the ongoing caseworker was contacted by law enforcement informing her the child was in the emergency room at St. Mary-Corwin Medical Center due to a significant burn on her face that had happened days earlier. The female caregiver stated she had left the child unattended in the bath tub while the female caregiver left the room and the child pour hot water over her face. The female caregiver did not seek medical care until after a community resource worker working with the family told the caregivers to take the child to seek medical care. Pueblo Sheriff's Deputies went to the family home and noted the water in the home became hot quickly. The child remained hospitalized until January 2, 2013.

During a home visit on January 7, 2013, the caseworker noted the female caregiver had not yet filled a prescription for a cream to treat the child's burn.

On March 11, 2013, the ongoing caseworker received a call informing her that the child had "severe burns to her bottom" reportedly occurring three days prior caused by the child pouring bleach into her stroller. The child was seen in the emergency room. The attending physician reported the injuries were "not consistent with the story that was told to DSS or Sheriff's Deputies." Custody of the three children was granted to Pueblo County Social Services and the children were placed in foster care.

RECOMMENDATIONS

Based upon the findings during the investigation, the Office of the Colorado Child Protection suggests the following recommendations to improve practice among child protection agencies including the District Attorney's Office, law enforcement agencies, and medical professionals in Pueblo County:

1. All staff investigating allegations of abuse, and/or supervising such staff, receive additional training on abuse recognition.
2. Pueblo County Social Services identify available resources to assist them in making determinations of patterns of abuse in cases when abuse is suspected but not disclosed by victims such as the Pueblo County Children's Advocacy Center and/or the Kempe Center's START team.
3. Increase training to better understand and recognize Battered Children's Syndrome.
4. Pueblo County Social Services review and update the Memorandum of Understanding with Law Enforcement to work collaboratively and train accordingly.
5. Improve Trails documentation to include every contact with family members and collaterals to include names, agencies, and contact information.
6. Pueblo County Social Services revisit an agency standard to have caseworkers conduct investigations on their ongoing cases. All allegations of abuse and/or neglect should be assigned to an intake worker including allegations involving current, open child protection cases.

OFFICE OF THE COLORADO'S CHILD PROTECTION OMBUDSMAN

November 24, 2014

County Response

Senate Bill 10-171

The Office of the Colorado Child Protection Ombudsman was established through Senate Bill 10-171 to "improve accountability and transparency in the child protection system and to promote better outcomes for children and families involved in the child protection system."

Case # 10577

Pueblo County

(303) 864-5111

www.protectcoloradochildren.org

The family came to the attention of the Pueblo County Department of Social Services in July of 2012. At this time, the children were being cared for by relatives. While assessing the needs of the children, there were critical points in the case were family support services were needed. During these times, the Pueblo County DSS Staff in collaboration with other community support agencies, made appropriate referrals for the children and family members to receive services conducive to meeting the identified need (i.e. health care, medical care, education, and household needs) to promote the safety and well-being of the children while they remained in the care of their relatives. In parallel, when critical safety concerns were noted that placed the children at risk of abuse or neglect the Pueblo County DSS Staff took appropriate action to provide more services (i.e. open a child welfare case, filing a dependency and neglect petition, and requesting legal and physical custody) to protect the health and welfare of the children. In addition, the Pueblo County DSS also made arrangements to provide culturally responsive services to the children and family by collaborating with available community support services for Spanish immigrants.

The Pueblo County Department of Social Services appreciates the fact that Colorado has a Child Protection Ombudsman to investigate matters related to Child Welfare practices, and how agencies respond to the needs of children, youth and families. We also recognize that there is always room for improvement in our practice to ensure that every child and family served will be treated with the utmost respect and dignity and to ensure the safety and well being of children being served by our agency. Therefore, the Pueblo County Department of Social Services seeks to provide continuous quality "best practice" training to our workforce and within the past year has made available quality improvement trainings to all Child Welfare staff concerning Intake/Assessment Investigations of Child Abuse and Neglect reports, Utilization of Child Advocacy Center, Safe Care Colorado and training from the Colorado Child Protection Ombudsman, to list a few. Many of the trainings were enlisted and approved by the Colorado Department of Human Services and are designed to inform participants on policies and best practices concerning the provision of Child Welfare services.

OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN

April 3, 2015

Investigative Report

Senate Bill 10-171

The Office of the Colorado Child Protection Ombudsman was established through Senate Bill 10-171 to "improve accountability and transparency in the child protection system and to promote better outcomes for children and families involved in the child protection system."

Case #11092

Denver County

(303) 864-5111

www.protectcoloradochildren.org

Executive Summary

[redacted] came to the attention of the Denver Department of Human Services on October 16, 2013 after a report was filed that there was suspicion of drug use in the home. Per Denver Department of Human Services policy, the referral was staffed through RED Team and assigned to a caseworker for assessment on October 22, 2013 with an appropriate five working day response timeframe.

The caseworker made contact with the family on October 22, 2013. Due to concerns observed by the caseworker, the mother's boyfriend (father to [redacted]) was asked to voluntary take placement of the children on this date. On October 24, 2013, the mother of the children advised the Department that she had given temporary custody of the children to her boyfriend for a period of one year. On October 28, 2013, the caseworker inquired of the mother all the names and identifying information of any adults that would be in a caretaking role of the children so appropriate background checks could be completed. The case remained open on a voluntary basis with the Denver Department of Human Services

On November 27, 2013, the Denver Department of Human Services advised the family, that due to lack of compliance in the voluntary case, a dependency and neglect action had been filed in Denver District Court. The children were to remain with the mother's boyfriend. Court was held on the Department's petition on December 3, 2013 and the children were ordered to remain in placement with the mother's boyfriend. A safety plan was in place that the mother was to have no unsupervised contact with the children outside of the Department.

On April 29, 2014, the mother was found at the home with the children. At this time the children were removed from the boyfriend's custody and placed with their maternal grandmother.

Our investigation revealed that the caseworkers responsible for the initial assessment and placement, as well as the subsequent placement with the maternal grandmother completed thorough background checks prior to placing the children with the substitute caregivers; however, failed to comply with Volume VII rules regarding placement with individuals with criminal histories. Through discussions with DHS Staff and reviewing case file documentation, the OCCPO found that the caseworkers were aware that the mother's boyfriend was a registered sex offender and had criminal charges related to sexual assault on a child prior to placement with him. Further, the caseworker that authorized the placement with the maternal grandmother was also aware, prior to placement, that the maternal grandmother had been charged, and convicted of, child abuse within the last 10 years. These charges were related to one of the children that was being placed in her care. The investigation did find violations of policy, and identified changes that can be made to improve overall practice.

The Complaint:

On September 25, 2014, the OCCPO received a complaint stating that a sibling group of five children had been removed from their mother's care in October 2013 and placed with a known registered sexual offender. The complainant further stated that when the family was not compliant with the requests of Denver Department of Human Services, the children were moved to their grandmother's home. The complainant stated that the grandmother has a child abuse conviction and was concerned that the children had been placed in potentially dangerous situations on two occasions.

Decision to Investigate:

The OCCPO opened a review into the complaint on September 25, 2014. According to the TRAILS database, the County assigned the referral concerning the alleged substance abuse in the mother's home on October 22, 2013. The timeframe for response was "five working days", which the OCCPO found to be in compliance with Volume VII. During the course of the review, the OCCPO interviewed staff of the Denver Department of Human Services, reviewed the Colorado Court's Database, conducted a thorough case file review of the Denver Department of Human Service's case file, as well as reviewed all of the information in the TRAILS database. Based on the information gathered throughout these interviews, as well as the review of TRAILS reports and collateral documentation, the OCCPO determined that there were egregious actions taken by the caseworkers with regards to the two separate placements of these children. As a result, the OCCPO notified Penny May, Director of Denver County Department of Human Services and Executive Director Reggie Bicha of the Colorado Department of Human Services that an investigation had been opened concerning the Velasquez/Chapman children on December 17, 2014.

Investigative Overview:

During the course of this investigation, the OCCPO reviewed all of the TRAILS documentation, interviewed professional collaterals, spoke with Denver County Department of Human Services staff and reviewed court records related to all members of the family. The OCCPO also reviewed the practice of Denver Department of Human Services for any notable practice concerns, as well as overall compliance with Volume VII and the Colorado Children's Code. Based on the findings listed below, the OCCPO has closed out this investigation as "Agency/Caseworker non-compliance with Policy" and has offered recommendations for the improvement of practice and service delivery within the Denver Department of Human Services. Based on a thorough review of the case file to date, the OCCPO believes that the actions by the caseworkers involved with this case, specifically related to the children's placements, were egregious in nature and

have directly impacted the safety of the children.

Findings

The OCCPO finds that the caseworkers associated with this case, and the two separate placements have violated the rules as outlined in Volume VII regarding placement with a kinship provider. The following Volume VII violations that would have directly impacted the County Department's response and intervention strategies are as follows:

Volume VII outlines Colorado's Child Protection rules for County and State Human Services staff, including parameters for placement with kinship care providers. The following identifies the specific rule violations noted by the OCCPO during the course of this investigation.

- **7.202.54 Colorado Family Risk Assessment**

  In the completion of the risk assessment, the OCCPO found the following errors by the caseworker:

  - N10: Recent or history of domestic violence in the household

    On October 24, 2013, a safety assessment was completed. Under the "Adult Functioning" section of the safety assessment, the caseworker indicated that the boyfriend/caregiver admitted to having a domestically violent past and being violent with the children's mother. It further goes on to say that the boyfriend has anger issues. The caseworker marked this as "no" on the Family Risk Assessment. This should have been marked "yes".

    On November 19, 2013, an advocate from Denver Department of Human Services met with the mother and her children that were living with her at the time. During the meeting the mother admitted to domestic violence with her boyfriend and stated that the children had witnessed this abuse.

  - A7: Caregiver involved in disruptive/volatile adult relationships

    Based on the information provided in the interviews with both parents, completed by the caseworker, there is ample evidence to support that the couple's own relationship was disruptive and volatile. This should have been marked "yes" indicating a heightened risk factor; however, the caseworker marked it "no".

  - A9: Cargeiver(s) has history of mental health treatment

    In the "Adult Functioning" section of the Colorado Safety Assessment, completed by the caseworker on October 24, 2013, the documentation reflects that the mother was diagnosed with bipolar, depression and anxiety and was actively engaged in therapy. The caseworker selected, "no,

neither caregiver". The proper selection would have been "either caregivers".

The OCCPO acknowledges that although there were errors in the completion of this assessment tool, the overall score would not have changed; however, the OCCPO would argue that the risk factors related to the mother's boyfriend and their relationship together warranted further exploration by the caseworker, prior to authorizing placement of the children in his care. Further, these indicators would have prompted additional treatment services to have been initiated in the treatment plan phase of this case, to ensure that all of the issues that led the family to the attention of the Department were being addressed.

- **7.304.21 (D)(2)(f)(7)(a)(c)(e)**

  A county department or a local law enforcement agency shall not make an emergency placement or continue the emergency placement of a child with a person who has been convicted of one or more of the following offenses:

  a) Child abuse, as described in Section 18-6-401, C.R.S.;

On April 29, 2014, after finding that the mother and her boyfriend (and placement provider for the children) were not complying with the Department's and Court's conditions regarding the mother's contact with the children, the children were removed from the above kinship provider's home and placed with their maternal grandmother. Background checks were completed on April 29, 2014 by the caseworker. This background check revealed that the grandmother had felony charges for dangerous drugs from 2005, was sentenced to two years in the Department of Corrections in 2007 for controlled substance charges, received felony dangerous drugs charges in 2008 and child abuse charges in 2010 stemming from an incident with one of the children placed in her care. On June 5, 2014, a member of the CDHS Administrative Review Division pointed out the child abuse charge and the violation of the rules outlined in Volume VII to the Denver Department of Human Services. This led to the removal of the children from their grandmother's care and resulted in their placement into alternative substitute care. The decision of the caseworker to not consider the child abuse charges, as well as the pattern of substance abuse related history, is a direct violation of the rules outlined in Volume VII.

Practice Concerns:

During the course of reviews and/or investigations, the OCCPO seeks to review overall caseworker practice and offer feedback regarding concerns or strengths noted throughout the review. This investigation identified several points of concern for the OCCPO.

Of first and most concern to the OCCPO was the placement of the children with the mother's boyfriend based on significant arrests noted in his criminal background check.

During the course of the investigation by the OCCPO, the information revealed that the caseworker completed a background check on [redacted] father and the four other children's step-father on October 24, 2013. The caseworker asked that this individual take voluntary placement of the children on October 22, 2013 and continued to support the placement of these children with him until April 29, 2014. The background check revealed that this individual was charged with felony sex assault on a child, and other related felony charges, in 1998. In 1999, he plead to misdemeanor third degree sexual assault and is currently a registered sexual offender in the Denver metro area. Although he is not listed on an online registry, had further efforts been made to explore the charge, the Denver Department of Human Services would have found the registration. Further, on May 20, 2014, the Denver Department of Human Services was made aware of the sex offender registration and concerns were voiced by local law enforcement that the children were in this placement. The background check also revealed felony dangerous drugs charges from 2010, which were plead to misdemeanors, as well as multiple misdemeanor assault charges. Despite these charges and convictions, the caseworker chose to place the children on an emergency basis with this individual, which directly placed the children's safety in jeopardy.

The OCCPO was also concerned with the documentation of ongoing substance use/abuse concerns by the mother which either were unaddressed or were not addressed in a timely manner. The following is an outline of those concerns:

- On October 29, 2013, the mother's hair follicle test returned positive for cocaine and her urine screen was dilute. At this time, the mother had her youngest child (aged 21 months) in her care. The caseworker discussed the results with the mother at which time she denied use, and a meeting was set for October 31, 2013. There were no indications in the case file or documentation reviewed by the OCCPO that the caseworker took any steps to plan for the child's safety in the interim.
- On November 8, 2013, the mother again tested positive for cocaine in a urine screen. At this time, the mother was to have two of her children in her care. The caseworker asked the mother about this and she stated she had the children's father provide care for the children while she was using. The documentation does not reflect that either father confirmed that they were providing care for the children. The caseworker set a Team Decision Making meeting for November 13, 2013. There were no indications in the case file or documentation reviewed by the OCCO that the caseworker took any steps to plan for the children's safety in the interim.
- On November 13, 2013, a Team Decision Making meeting was held and the mother and her boyfriend reported they were resuming their relationship. No

plans were devised to ensure that the mother did not use illegal substances while providing care for, or in the presence of, her children.

- On November 18, 2013, the mother's boyfriend reported to the caseworker that two of the children had witnessed their mother using cocaine and he had found drug paraphernalia consistent with cocaine use in the home. The caseworker interviewed the children and they confirmed witnessing their mother using cocaine. The caseworker contacted the mother and informed her that she must drop a urine screen. At this time, the mother told the caseworker that her boyfriend has criminal charges on his record. There is no documentation to report the results of the urine screen, or any follow up on the mother's statements concerning her boyfriend's criminal history. Furthermore, there was no documentation of a safety plan to ensure that the children were safe in the presence of their mother based on these new concerns.
- On November 25, 2013, the caseworker spoke with the mother regarding a missed urine screen and advised if she does not submit to a urine screen a case will be opened. The children remained in the custody of the mother and her boyfriend at this time. There was no documentation of a safety plan to ensure that the children were safe in the presence of their mother.

The OCCPO acknowledges that based on the mother's continued lack of compliance, the Denver Department of Human Services filed a Petition in Dependency and Neglect on November 25, 2013. The OCCPO further finds the caseworker's efforts for family engagement were a strength within this case; however, the OCCPO believes that the mother's lack of compliance and ongoing substance use with vulnerable children in her care warranted more immediate action in the filing of a dependency and neglect action and exploring substitute care for the children.

The OCCPO further identified concerns regarding past substance use by the boyfriend, whom had placement of the children. The following is an outline of those concerns:

- On October 24, 2013, a safety assessment was completed. In the "Adult Functioning" portion of the assessment, the caseworker noted that there was a history of substance abuse by the boyfriend, who admitted to being clean for 5 months. This information is not documented in any interview between the caseworker and the boyfriend, nor is there any additional evidence to support that this was explored further by the caseworker to ensure that there was not current use that may put the children at risk.
- On November 19, 2013, an advocate from Denver Department of Human Services met with the mother and her children that were living with her at the

time. During the meeting the mother reported that her boyfriend had a history of methamphetamine use and that would become abusive when "coming down." There is no documentation in the case file that demonstrates that there was any follow up regarding the reports of the boyfriend's use of methamphetamine. On November 27, 2013, an advocate from the Denver Department of Human Services met with the mother and advised her that that a Petition in Dependency and Neglect was being filed due to her refusal to submit to a urine screen. At this time, the mother admitted to using cocaine with her boyfriend and advised that her boyfriend was dealing. It was notable that at the time of the home visit the mother presented as having been assaulted. She reported that she had been in a bar fight. The implications of this on the children were not addressed in any case documentation. The case file further fails to provide any documentation that the boyfriend's drug use was followed up on.

Recommendations:

1. The Denver Department of Human Services should offer training for staff and supervisors concerning Volume VII regulations as they relate to kinship placement requirements and background check compliance.

2. The Denver Department of Human Services should develop policy regarding how they will handle concerning background checks when they relate to emergency placements.

3. The Denver Department of Human Services should conduct an in-depth review of current cases to ensure that required background checks have been completed when applicable.

4. The Denver Department of Human Services provide training for staff and supervisors regarding the ongoing assessment of safety and risk on cases in which children remain in the family home and decision points regarding changing tracks from voluntary to court involved cases.

5. To ensure best practice and accountability of all Denver Human Services staff, Denver Department of Human Services should implement policy and procedure related to supervision of casework practice to ensure proper documentation, accurate safety assessment completion, ensure that all background checks are completed and overall casework is in compliance with Volume VII.

6. The Denver Department of Human Services should consider holding the applicable caseworkers and supervisors responsible for their actions or inactions in this case.

7. The Colorado Department of Human Services should review Volume VII as it relates to requirements that preclude placement of children in specific homes. Specifically, the OCCPO recommends that the portion of rule which specifies the county department or local law enforcement agency shall not make an emergency placement or continue the emergency placement of a child with a person who has been convicted of one or more of the following offenses "a felony offense involving unlawful sexual behavior" be revised, excluding the word "felony", disallowing any emergency placement with an individual that has been convicted of any unlawful sexual behavior.

Denver County Response to Recommendations

In response to the recommendations offered herein, the Denver Department of Human Services (DDHS) respectfully submits the following response:

Recommendation #1: Training concerning Vol. VII regulations: kinship placements and background check compliance.

Pursuant to Volume 7, all DDHS staff with job titles outlined in 7.603.1(M): hotline workers, hotline staff supervisor, SCW trainee, SCW, and SCW supervisor; are initially certified through the state training academy pursuant to 7.603.1(C), to conduct casework practice and/or supervision. In order to maintain certification, DDHS staff also complete 40 hours of annual training, of which a minimum of 16 hours is focused on the staff person's primary job responsibilities. Core competencies identified in Volume 7 and targeted for continuing education training for identified staff includes, but is not limited to:

- *Safety;*
- *Risk;*
- *Permanency;*
- *Well-being;*
- *Assessment;*
- *Interviewing;*
- *Family engagement;*
- *Legal issues;*
- *Indian Child Welfare Act;*

- *Foster care, kinship care, and adoption;*
- *Effects of child abuse/neglect on development;*
- *Principles of strengths based, family-focused, child-centered and culturally responsive case planning and case management;*
- *Sexual abuse issues;*
- *Behavioral health issues;*
- *Domestic violence issues;*
- *Cultural disparity;*
- *Leadership and management;*
- *Data informed practice; and,*
- *Worker safety.*

Staff training hours are reported to CDHS annually to monitor staff certification requirements as outlined in 7.603.1(O). The DDHS also requires that its Child Welfare staff maintain certification as a condition of continued employment in accordance with 7.603.1(A)(B)(C). All training activities are monitored through the division training manager.

The staff in this particular case disregarded their training and state rule. The DDHS subsequently completed appropriate disciplinary action on the staff involved in this case. Overall, the results of Denver's 2014 Quality Assurance Review identified that the DDHS has outperformed the statewide average in many areas of assessment practice. Nonetheless, recognizing there are always opportunities to further educate workers, the DDHS has also completed the following additional trainings:

- A series of trainings was completed by the Child Welfare training manager on: September 16, 18, 22, and 23, 2014. The trainings covered the assessment process, including current requirements for fingerprint-based background checks;
- January 15, 2015 - training was conducted for Child Welfare division staff regarding state requirements governing background checks and procedures for initiating fingerprint-based checks;
- February 12 & 13, 2015 - training was conducted at Child Welfare all staff meetings covering revised procedures for completing required background checks, including fingerprint-based background checks and methods for processing concerning background checks of non-certified kinship providers;
- February 18, 2015 - a training entitled, "Coaching Versus Supervision" was conducted by the NCCD Children's Research Center personnel; and,

- The 2015 Child Welfare Division training schedule also includes additional trainings on February 26th, March 12th, May 21st, June 23rd, August 27th, September 29th, and December 17th; focusing on kinship placement procedures, including fingerprint and other required background check requirements and utilization of family finders.

Recommendation #2: Agency policy concerning background checks and emergency placements.

The DDHS revised its policy/procedure beginning in Spring 2014 regarding conducting all required background checks, including fingerprint-based background checks. Most recently, the DDHS moved the requirement for implementing and monitoring background check requirements to the Division's Family Finding Unit. Child Welfare staff was updated on this change during their all staff meetings conducted on February 12 & 13, 2015. The update is also available on the DDHS intranet as a resource to support ongoing operations. The identification of, "concerning background checks when they relate to emergency placements", and assuming this refers to findings otherwise allowed in current rule, is also addressed in the Division's current procedure and includes a color coding system utilized by the Family Finding Unit to determine specific requirements for continued placement when background check information uncovers findings that are not disallowed by state rule.

Recommendation #3: In-depth review of cases concerning background checks.

The DDHS began a division level analysis of fingerprint-based background checks in April 2014 when a routine review of work identified discrepancies in the fingerprint process being utilized. Then, in June 2014 the Administrative Review Division (ARD), during a semi-annual case file review, notified the Child Welfare management team that while comprehensive background checks were regularly completed as required, fingerprinting was not consistent. With the assistance of our internal quality control team, the DDHS subsequently launched an in-depth case review of homes used for child placement. Detailed results from our review were shared with the Director of the Office of Children, Youth, and Families, Colorado Department of Human Services (CDHS); in a letter dated August 25, 2014 and amended on August 28, 2014. The DDHS subsequently entered recommendations to the court to move children in 13 of the 369 cases reviewed (represents number of homes used for child placements as of August 28, 2014). Of these, the court maintained placement in 10 cases and granted the Department's request to move children in 3 cases (represents fewer than 1% of homes used for child placements as of August 28, 2014).

Recommendation #4: Training for staff and supervisors regarding the ongoing safety and risk assessment on cases in which children remain in the family home and decision points regarding changing tracks from voluntary to court involved cases.

To this recommendation, the DDHS has considered information from multiple sources, including: ARD, the State Fatality Review Team, multiple state audits, and the investigation of the OCCPO. Based on the information received from the above mentioned sources, it is clear that the findings of this investigation cannot be generalized to Division level operations more broadly. For example, the ARD, acting in accordance with the Code of Federal Regulations, 45 CFR 1357(u) and 45 CFR 1355.34(c)(3), as a part of the statewide Quality Assurance System, identified a representative sample of the DDHS workload volume with a 95% confidence interval, and conducted both administrative and case reviews for the first quarter of SFY 2015 from July 1 – September 30, 2014. The results of the ARD Quality Assurance Review identified that the DDHS outperformed the statewide average for:

- Identifying when a safety assessment is not required (100% DDHS/60% SW);
- Accuracy of safety assessment (82% DDHS/77% SW); and,
- Safety planning (89% DDHS/37% SW).

Moreover, the ARD found that, "Intervening at the appropriate level given the documented levels of safety and risk", was one of several identified strengths at the DDHS (Denver County Quality Assurance Review Report, 17). Accuracy of risk assessment was identified as an area of needed improvement in Denver and statewide. The ARD also recognized that CDHS was in the process of a number of planned changes to the risk assessment tool to improve statewide performance. In fact, the CDHS has long recognized the need to revise the current risk assessment tool being used across the state. After nearly two years of careful development and testing of a revised tool, the CDHS has initiated training that will run from January – July 2015 statewide. The DDHS began receiving training on the revised risk assessment tool from state trainers on January 6, 2015. State training is estimated to be completed by July 2015, after which DDHS staff will begin using the new tool. The ARD will measure Denver's performance in future reviews to determine if increased accuracy has been achieved in response to the revised tool. The DDHS will use this data, as well as data collected by its internal continuous improvement team, in its ongoing training of staff related to risk assessment.

Recommendation #5: Implement policy and procedure for supervisory review.

Again, supervisors in this case disregarded their training and state rule. The DDHS is an organization that is governed by state rule and law and, as confirmed by CDHS, the specific competencies required of staff engaged in the supervision of casework practice are already articulated in state rule. Supervisors are required to complete an initial certification to supervise casework practice vis-à-vis the state training academy then complete 40 hours of continuing education annually to maintain certification thereafter. DDHS provides CDHS with training reports annually to monitor supervisor requirements for continued certification. To

assess and correct for supervision and/or practice that is misaligned; DDHS utilizes a series of checks and balances such as having standard language in each intake supervisor's Performance Evaluation Plan requiring weekly individualized supervision of casework staff, ARD reviews, internal continuous improvement checks through its internal review team, etc.

Targeted process improvement strategies are utilized to re-align practice to rule where necessary. For instance, in Spring 2014 DDHS identified inconsistencies and discrepancies in the fingerprinting process being utilized for non-certified kinship caregivers. Following are some of the procedural revisions DDHS implemented as a result of their review:

- Revised the Non-Certified Kinship Provider Fingerprinting Procedures;
- Updated the form case workers use to secure fingerprint-based background checks, adding information that will help them complete the process;
- Distributed updated procedures, forms and instructions to all staff; and,
- Trained staff on the revised form and the expectations regarding fingerprinting procedures in accordance with rule.

DDHS instituted a quarterly review of non-certified kinship placements via a random sampling of cases pulled by the agency's internal quality control team to ensure proper procedures are being followed. DDHS also completed a meeting with CDHS staff to review the results of their non-certified kinship file review, discuss the procedural changes that have been made by DDHS to date, and review next steps in the process, including a review of background check requirements in six months.

Moreover, the DDHS is in the process of scheduling an initial meeting with state staff, tentatively scheduled for February 2015, to review assessment protocols and supervisor training in accordance with their request in a letter from the Director of the Office of Children, Youth, and Families, dated February 2, 2015. The DDHS is committed to working with CDHS during their review to implement additional changes as necessary to ensure that Child Welfare operations are in compliance with state rule.

Recommendation #6: Consider holding caseworkers and supervisors accountable for their actions and inactions in this case.

Disciplinary investigations and/or disciplinary actions were completed against the four workers initially placed on investigatory leave related to this case.

Recommendation #7: CDHS should consider changing Volume 7 to remove the word "felony" from existing rules governing emergency placement related to unlawful sexual behavior.

This is a recommendation for the CDHS therefore Denver will not offer a response.

CDHS, Division of Children, Youth and Families Response to Recommendations

Recommendation #7: CDHS should consider changing Volume 7 to remove the word "felony" from existing rules governing emergency placement related to unlawful sexual behavior.

The Colorado Department of Human Services received the final report, #11092, from the Office of Colorado's Child Protection Ombudsman (OCCPO) dated February 12, 2015. This report includes one recommendation for the Colorado Department of Human Services (CDHS).

CDHS sent a Dear Director letter on August 27, 2014 asking counties to voluntarily begin completing sex offender register checks by both name and address when the county was involved with a change of a child's residence. CDHS conducted a desk review of background checks for non-certified kinship care providers over the months of late August 2014 through November 2014. The review consisted of a random sampling of providers from each of Colorado's 64 counties to see whether county offices are conducting proper background and fingerprint checks of non-certified kinship care providers.

The reviewers found checks were missing in nearly every county. Since this time, CDHS has offered additional training and assistance to counties, and has conducted on-site visits to help ensure counties are complying with the law and Volume VII rules.

OCCPO received the results of this review and stated in a letter to CDHS, dated January 9, 2015, that OCCPO is in full support of the efforts being initiated by CHS to resolve this issue.

The Colorado Department of Human Services (CDHS) is aware that there is currently a bill (SB15-87) that has been presented to the Colorado General Assembly. The bill outlines the required background checks under various placement conditions, including emergency placements. It is expected that some version of this bill will pass and become law. Once the final statute is determined, CDHS will ensure that rules are revised to be consistent with statute. CDHS has been made aware by the Colorado Ombudsman's that they believe that this recommendation will be resolved through SB15-87 and would be in agreement with CDHS's response.

CDHS will continue to be actively involved as SB15-87 moves through the process and will immediately put forward revised rules once the new law is passed.

OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN

April 20, 2015

Investigative Report

Senate Bill 10-171

The Office of the Colorado Child Protection Ombudsman was established through Senate Bill 10-171 to "improve accountability and transparency in the child protection system and to promote better outcomes for children and families involved in the child protection system."

Case #11046

Boulder County Housing and Human Services

Mental Health Center of Boulder County, Inc.

Broomfield Municipal Courts

(303) 864-5111

www.protectcoloradochildren.org

Executive Summary

On November 12, 2014, the Office of Colorado's Child Protection Ombudsman met with the Governor's Deputy Legal Counsel Ben Figa and CDHS Medical Director Patrick Fox regarding a complaint. The OCCPO was asked to investigate the 2001 criminal case of the complainant and whether the complainant received due process in that case. In addition, the Office was asked to review, to the extent possible, whether there was a notable pattern or practice of plea coercion in deferred judgment cases involving the Mental Health Center of Boulder County, Inc. (Family and Community Team).

The complainant, 16 years of age at the time, was charged with battery in Broomfield Municipal Court as a result of an altercation with her caretaker on July 15, 2001. On September 10, 2001, the complainant entered a no contest plea to the charge and was granted a deferred judgment. The case was dismissed upon successfully fulfilling certain conditions, including continuing the treatment program that was already in place through FACT.

The OCCPO investigation identified a need to examine how a plea to a deferred judgment is explained to juvenile defendants in municipal code criminal cases to ensure that they are aware of the possible collateral consequences of such a plea to a criminal charge.

In addition, the evidence revealed during the criminal investigation of July 15, 2001 may have been insufficient to support the proof beyond a reasonable doubt standard required to convict the complainant.

The OCCPO learned that the case of the complainant was assigned to the Family and Community Team (FACT) in January of 1999. At that time, Boulder County Housing and Human Services contracted with Mental Health Center of Boulder County, Inc. to provide community-based mental health treatment designed to prevent out-of-home higher level placements or at least maintain youth in community placements if out-of-home placement is necessary. FACT was a multi-disciplinary team that would meet on a regular basis to coordinate care and services for youth and families.

The OCCPO identified that the Family and Community Team and Mental Health Center of Boulder County, Inc. had standard policies and practices in place at the time of this case. Roles within the disciplines on the team appeared to be well defined and provided multidisciplinary coordination of care for youth and families. In this specific case, the assigned therapist may have been acting outside of standard policy and practices.

The scope of the review of the Family and Community Team practice was limited due to confidentiality rules requiring a waiver or consent from individual clients to review their cases.

The Complaint:

On November 12, 2014, the Office of Colorado's Child Protection Ombudsman met with the Governor's Deputy Legal Counsel Ben Figa and CDHS Medical Director Patrick Fox regarding a complaint. The OCCPO was asked to investigate the 2001 criminal case of the complainant and whether the complainant received due process in that case. In addition, the Office was asked to review to the extent possible whether there was a notable pattern or practice of plea coercion in deferred judgment cases involving the Mental Health Center of Boulder County, Inc. (Family and Community Team). The OCCPO was asked to contact the complainant to obtain further information and documentation.

Decision to Investigate:

On November 12, 2014, the OCCPO opened a review into this complaint. Upon reviewing the documentation which included police reports, criminal proceedings documentation, transcripts and progress notes from the therapist, the review revealed significant questions about the strength of the evidence and the therapist's role in the agreement to a deferred judgement. In addition, the OCCPO reviewed the role of FACT members in an attempt to learn if the members of the team were often as heavily involved in the criminal process as they appeared to be in the case of the complainant or if this was an isolated occurrence.

As a result, the OCCPO notified Director Reggie Bicha of the Colorado Department of Human Services, Boulder Housing and Human Services, Broomfield Municipal Courts and Mental Health Center of Boulder County, Inc. that an OCCPO investigation was initiated concerning this juvenile case and the Family and Community Team (FACT).

Investigative Overview:

During the course of this investigation, the OCCPO reviewed the records in the criminal case including police reports, voluntary witness statements, court records, transcripts and post-conviction records, Boulder County Housing and Human Services records and Mental Health Center of Boulder County, Inc. records relating to this case. In addition, the complainant provided 2 discs of information containing case reports, transcripts of conversations, human services records, mental health records, court documents, over 300 emails and several videos.

The OCCPO spoke to Boulder County Human Services Administration, Mental Health Center of Boulder County, Inc. Administration, and interviewed caseworkers and supervisors who were familiar with FACT, as well as extensive interviews and conversations with the complainant. The complainant began treatment with FACT in March of 1999 and successfully completed treatment in September of 2001.

Limitations to the Investigation

The scope of the review of the Family and Community Team was limited due to federal privacy rules that restrict when and how client records are released. A waiver or consent from the individual client is needed to review their individual records. Specifically, the federal privacy rules known as HIPAA (45CFR Parts 160 and 164), federal substance use confidentiality rules

(42 CFR Part 2), state rules (CFR 27-65-121) and Office of Behavioral Health regulations require a client authorization or subpoena to obtain those records. However, the OCCPO was able to talk to professionals involved in FACT at the time of this open case to gain significant insight into the purpose, process and roles of the professionals in this program.
This investigation involved events which occurred in 1999 to 2001. The OCCPO was able to review the documentation preserved by the complainant and the agencies involved; however, many of the individuals interviewed did not have specific recollection of this case outside of the documentation presented.

The OOCPO attempted to interview the complainant's caretaker and therapist assigned to the complainant; however they declined an opportunity to be interviewed.

Investigation into the Criminal Case and Court Process:
The complainant, 16 years of age at the time, was charged with battery in Broomfield Municipal Court as a result of an altercation with her caretaker on July 15, 2001. On September 10, 2001, the complainant entered a no contest plea to the charge and was granted a deferred judgment. The case was dismissed upon successfully fulfilling certain conditions including continuing the treatment program that was already in place through FACT.

The OCCPO identified several issues in the initial police investigation and the court proceeding that raise significant doubt as to the validity of the charge and subsequent prosecution. The following outlines the issues identified through this review of the case and the OCCPO investigation:

- There were two altercations on the evening of July 15th, 2001. The first one involved name calling and physical contact over car keys between the caretaker and the complainant. The complainant sustained scratches from the caretaker. They separated for a brief period and a second episode occurred in the complainant's bedroom. In this instance, the caretaker came into the complainant's bedroom and demanded payment of ten dollars for a purchase. As a result, another physical confrontation occurred in which the caretaker appeared to be the instigator and aggressor. The complainant sustained a bite injury as the two argued. At one point during this altercation, the complainant picked up a lantern style flashlight and warned his caretaker to not continue to come at him. According to the police report the complainant warned, "If you come at me I'll use this." The caretaker came toward her and moved her arm in a striking motion. The caretaker jumped at her and she hit her with the lantern, breaking the lens and hitting her right arm. The caretaker sustained a cut on the palm when the plastic lens broke. The complainant was issued a summons for battery, taken to a juvenile facility for processing and returned home to the caretaker a few hours later.

- The police custody report indicates that the complainant had visible injuries including a scratch on her right forearm and a bite mark on the left forearm. The complainant wrote in the statement that she was bitten on the arm by the caretaker. There is no

indication in the report that charges were considered for the caretaker for child abuse/assault. In addition, the caretaker never mentioned anything about biting the complainant in the caretaker's voluntary statement completed for the investigation in 2001. There is no indication that this was questioned or considered in the investigation nor was there documentation of any follow through to Boulder Human Services.

- The physical injuries documented in the police reports support the complainant's account more so than the caretaker's account.

- The Police report indicates that the complainant was taken into custody and transported to the Link Assessment Center. A written statement was taken from the complainant without a legal guardian's consent or legal representation. The police custody report indicates in the response to rights column, "not applicable." A defense attorney could have moved for this statement to be suppressed and not considered by the court.

- The complainant was not represented by a conflict-free attorney to assist with any legal decisions. The OCCPO finds this to be particularly important in this case since the alleged victim is the complainant's caretaker. The complainant's therapist facilitated several meetings with the prosecution and drove the complainant to those meetings. The complainant did not receive any legal representation or a guardian ad litem. The complainant described the plea as "coerced by the therapist." The transcript of the sentencing hearing lists the defendant as "Appearing Pro Se."

  According to the current Broomfield City and County Attorney,

  > *The right to a court appointed attorney in criminal cases exists only for cases where incarceration is a possible sentence. Pursuant to section 1-12-020 of the Broomfield Municipal Code, an offender under the age of 18 may not be sentenced to incarceration.*

- On September 23, 2008, the complainant filed a supplemental report indicating that the caretaker admitted to lying to the police the night of the arrest. Although no specifics were given, the report indicated that "she felt bad about what happened, and reiterated that she did not think he would have been charged." The OCCPO attempted to reach the caretaker for an interview; however the caretaker did not return phone calls, or respond to cards left at the caretaker's residence.

Criminal Case and Court Findings:

1) The traditional remedy of appeal and a legal reconsideration of this case is not possible with a 2001 municipal court case that concluded in a successful completion of a deferred

judgement. The record of the underlying criminal proceeding was sealed and is no longer a public record.

2) The evidence revealed during the criminal investigation of July 15, 2001 may have been insufficient to support the proof beyond a reasonable doubt standard required to convict the complainant.

3) A plea to a deferred judgment may have collateral consequences that may not be realized by a juvenile defendant.

Recommendations for Criminal Case and Court Process

The OCCPO investigation identified a need to examine how a plea to a deferred judgment is explained to juvenile defendants in municipal code criminal cases to ensure that they are aware of the possible collateral consequences of such a plea to a criminal charge. The OCCPO will forward this report to the Colorado Juvenile Defender Coalition for consideration as a subject for future research and study.

Investigation into the Family and Community Team Process

The Ombudsman Office reviewed the Mental Health Center of Boulder County, Inc. progress notes of the primary clinician for the complainant, the report of contact documentation by the assigned Human Services caseworker and discussed this case with Boulder County Housing and Human Services and Mental Health Center of Boulder County, Inc. At that time, Boulder County Housing and Human Services contracted with Mental Health Center of Boulder County, Inc. to provide community-based mental health treatment designed to prevent out-of-home higher level placements or at least maintain youth in community placements if out-of-home placement is necessary. The OCCPO learned that the case of the complainant was assigned to the Family and Community Team (FACT) in January of 1999. FACT was a multi-disciplinary team that would meet on a regular basis to coordinate care and services for youth and families.

The OCCPO contacted Mental Health Center of Boulder County, Inc. regarding this investigation. The Chief Executive Officer provided the following information about the role of FACT:

> *The FACT team, now called the Home-Based Services Team (HBS), provides intensive treatment intervention to high-risk adolescents and their families, most frequently in their homes and in the community. These youth typically are involved with multiple systems, including Human Services, juvenile justice (police, juvenile detention, district attorney, public defender or other members of the defense bar, Division of Youth Corrections, etc.), schools, and mental health and substance abuse treatment provider(s). The goal of the*

> *FACT/HBS team is to provide community-based mental health treatment that will prevent out-of-home, higher level placements or at least maintain youth in community placements if out-of-home placement is necessary.*

The OCCPO inquired about the role of the multidisciplinary team in coordinating care for youth and families. Mental Health Center of Boulder County, Inc. explained that they attend coordinating meetings "with the goal of exchanging information to provide more effective, coordinated care for youth and families". Mental Health Center of Boulder County, Inc. staff provide information about treatment goals, progress and if known, prognosis.

The OCCPO also inquired about the role of FACT/HBS in criminal cases involving clients. In a response letter, Mental Health Center of Boulder County, Inc. stated:

> *While agency representatives may discuss recommendations for disposition of any juvenile justice involvement, MHP clinicians are supervised closely and given clear instruction that they are to practice within the scope of their training, which means not only do they employ only those treatment interventions for which they are trained, but also that final decisions with respect to legal recommendations rest with attorneys or other legal professionals involved with the youth and family, professionals who have the responsibility for communication of any final disposition of legal involvement and for whom the recommendation is within the scope of their training and practice.*

The OCCPO inquired about the actions of the therapist involved in the complainant's case. Mental Health Center of Boulder County, Inc. stated that the therapist was "*acting on his own accord, against MHP standard policy and practices, in this case.*" They went on to state, *"His actions were not, and are not, representative of how MHP works with clients who may be involved in the justice system."* The *"apparent departure from these standards was not known to us or immediate corrective action would have been taken."*

The OCCPO contacted the therapist involved in this case. The therapist, through his attorney, declined to be interviewed.

The complainant stated that she reported allegations of child abuse and sexual assault to his treatment provider and others during the course of this case. In reviewing the Boulder Housing and Human Services records, the treatment provider's progress notes, police reports, and documents provided by the complainant, the OCCPO could not find specific reports of abuse by the agencies involved. The therapist's progress notes and police reports did document two altercations between the complainant and her caretaker. There was no indication that these instances were referred to Boulder Human Services for further

assessment.

On January 22, 2015, the OCCPO interviewed the Boulder County Housing and Human Services worker assigned to this case in mid-June of 2001. The complainant was discharged from the program in September of 2001. The worker described the process and role of the team. The worker indicated that the Human Services role was to assist with core services, referrals and case management. The worker was unable to remember specifics of this individual case, but did identify the notes that were presented from the case as her own. The worker confirmed that there was no documentation of child abuse or sexual assault in her notes. The worker stated that if child abuse or sexual allegations were made they would have been documented and referred to their intake unit for investigation. When the criminal proceeding was described to the worker, the worker asked, "Was there a GAL?" (Guardian ad litem).

Family and Community Team Process Findings

The OCCPO finds that the Family and Community Team and Mental Health Center of Boulder County, Inc. had standard policies and practices in place at the time of this case. Roles within the disciplines on the team appeared to be well defined and provided multidisciplinary coordination of care for youth and families. The scope of this review of the Family and Community Team practice was limited due to confidentiality rules requiring a waiver or consent from the client to review other cases.

During the course of this investigation, the OCCPO learned that Boulder County and the IMPACT program have been viewed as national models for care coordination for youth. In addition, when the complainant contacted Mental Health Center of Boulder County, Inc. for their records last fall; they reminded their clinicians and staff of the expectations and practices involving their roles and ethical boundaries within the Home-Based Services Team.

Recommendations for Family and Community Team

Revisit with clinicians and staff their role and ethical boundaries within the Team. Best practice would be to continue to revisit this standard through in-service training and ongoing case review as warranted.

The OCCPO acknowledges that a portion of this recommendation has been completed.

Appendix D:
CDHS Investigative Recommendations Charts

Item #	Report	Ombusdman Reccomendation	Status	DCW Individual Responsible	OCCPO Contact	Due Date	Status
1	2011-2012	1. The Department of Human Services should provide training to workers involved in child protection to more accurately identify substance use:	1. The issue of substance abuse is already addressed in the New Worker Training Academy, and also in in-service training. Caseworkers are trained to assess substance use and the affects on a child. The in-service training focuses on how to see behaviors and effectively work with a family who is struggling with substance abuse issues.	Mimi Scheuermann			COMPLETE Curriculum sent to Dennis on 12/2/14.
1	2011-2012	A) The signs, indicators, and characteristics of substance use, the inherent risks of substance use to children, and how substance use impacts family dynamics and child safety.	A) This information is covered in the New Worker Training Academy and in in-service training. There are indicators that are taught, as well as effects on children and family dynamics. The entire curriculum is currently being reviewed and the reviewers will ensure that this pertinent information remains present in the training. **The curriculum which covers substance abuse is complete. CDHS will contact Mimi and provide OCCPO with a copy of the curriculum related to substance abuse issues	Mimi Scheuermann			COMPLETE Curriculum sent to Dennis on 12/2/14.
1	2011-2012	B) Drug testing, new drugs/substances being used and manufactured, and updates on the effects of substance use on the safety of children.	B) This will be addressed with the new curriculum and will continue to be offered in in-service trainings. **The curriculum which covers substance abuse issues is complete and CDHS will provide OCCPO with a copy.	Mimi Scheuermann			COMPLETE Curriculum sent to Dennis on 12/2/14.
2	2011-2012	2. The Department of Human Services should provide training to caseworkers, supervisors, and any other staff that may approve work or supervise staff around the use of the safety assessment tool, the utilization of safety plans, and the risk assessment tool, as specified in CDHS policy, Volume VII, 7.202.53 and 7.202.54.	2. Training for the new safety and risk tool will begin with three pilot counties is being completed in October and November 2014, Once this is complete and feedback is received. Training will begin with the rest of the state and all county staff in January 2015 and throughout 2015. The training will be completed through the child welfare training academy and with the KEMPE Center. If through this process, an individual county concerns are identified, DCW will complete county specific coaching and training. Currently there are three counties that are piloting the new safety and risk tool. These are Pueblo, Garfield and Eagle. The other counties began the safety and risk training in January 2015. In June 2015 Trails will be updated to require supervisor approval for the safety assessments	Mimi Scheuermann/ Korey Elger		12/1/2015	In Progress
2	2011-2012	A) CDHS should provide an annual mandatory testing process for all staff that would utilize these tools or supervise workers utilizing the tools in order to make sure staff have a functional understanding of the tools and they are being used accurately and appropriately.	A) ARD provides a review of safety assessment accuracy of completion, and CQI process. When concerns are noted, ARD and DCW engages the county for targeted training.	ARD/DCW			COMPLETE
3	2011-2012	3. The Department of Human Services should adopt policy that mandates the frequency and documentation of supervision of caseworkers and any staff responsible for intake/assessments by supervisors during assessments.	Currently training regarding the use of the new Safety and Risk Tool is set to begin with county, casework and supervisor staff in late 2014 and early 2015. The training includes specific training for supervisors. The supervisor training academy also addresses for supervisors the need for supervision and though it does not mandate the frequency it it addressed in needs for the caseworkers and the importance of documentation.	Korey Elger/ Mimi Scheuermann		1/1/2016	COmplete
3	2011-2012	A) This would require supervisors to review all relevant information in the assessment file prior to approving assessment closure.	Changes made to Volume 7 were approved by the Human Services Board on 11/7/14 will be in effect on 1/1/15. These changes require supervisors to approve assessments at the time of documentation (within 14 days for safety and within 30 days for risk), and to approve all decisions within 24 hours if a child is deteremined to be unsafe. These time frames are in addition to approval at the time of assessment closure. Copy of rules sent to Dennis Goodwin 11/28/14.	Korey Elger			COMPLETE
4	2011-2012	4. The Department of Human Services should have County DHS partner and collaborate with neighboring county DHS agencies when there are staffing issues or issues that arise with workers going on leave or having family emergencies.	4. CDHS has implemented a process by creating a list of county certified (retired) staff that are available when counties experience staffing shortage.	Mimi Scheuermann			COMPLETE
5	2011-2012	5. The Department of Human Services will develop policy around case contacts documentation in TRAILS to include completion of Face to Face contacts with children and parents within 30 days of contact, and collateral contacts and other pertinent case contacts within 45 days of contact. The CDHS will provide training as needed to County child protection staff.	This is currently being addressed in the Rule rewrite and will be followed up with training.	Korey Elger		6/14/2014	COMPLETE

5	2011-2012	A) CDHS should tighten time frames (7.002.1) in an effort to eliminate gaps in pertinent information for CDHS and other county departments that may encounter families currently working within the system.	Changes made to Volume 7 were approved by the Human Services Board on 11/7/14 will be in effect on 1/1/15. These changes require county departments to contact non-custodial parents and additional collateral contacts. Time frames and content of documentation of referral, initial review, safety and risk assessments, and assessment closures were also tightened. Copy of rules sent to Dennis Goodwin 11/28/14.	Paige Rosemond		11/14/2014	COMPLETE
6	2011-2012	6. The Department of Human Services should develop policy and provide training and direction to County Departments on how to proceed with assessments and cases when issues are present in multiple program areas (PA 4 and PA 5).	This was presented at the Child Protection Task Group, and the groupd reported that any safety concern regardless of the child's age should be addressed as long as it meets definition of a safety concern as outlined in Rule and statue.	Mimi Scheuermann and Korey Elger			COMPLETE
	AGREE						
	PARTIALLY AGREE						
	DISAGREE						

Item #	Report	Ombusdman Reccomendation	Status	DCW Individual Responsible	OCCPO Contact	Due Date	Status
1	2012-2013 (Year 2)	1. The Department of Human Services should implement additional trainings or safeguards of the current process until the new safety and risk tools become available.	1. Current practice is for ARD to review accuracy of completion of safety assessments, which is in turn reviewed at CSTAT. CDHS (county liaison) would follow up with counties in need of training or technical assistance.	Mimi Scheuermann			COMPLETE
2	2012-2013	2. The Department of Human Services should provide training regarding mandatory reporting of child abuse. Specifically an independent online discipline-specific mandatory reporter training for medical personnel, clergy, law enforcement, educators, and child care providers.	2. This web based training for mandatory reporters is being refined and made available online to participants through the public facing CDHS web page and will again be pushed in the public awareness campaign. Kempe Center has completed the training and the system has been developed to provide the participant with a certificate, as well as the database will track who is taking the training. OCCPO agrees to place this link on their website, publish it in the quarterly newsletter and market to stakeholders as able.	Katie Facchinello, Korey Elger and Mimi Scheuermann			COMPLETE
3	2012-2013	3. The Department of Human Services should provide information for child welfare professionals and other stakeholders around educating clients about system navigation, decision-making, and expectations.	3. Some counties currently use Parent Handbooks and some DR counties use FAR pamphlets for the families they are working with. This could potentially be addressed in public awareness campaign efforts (i.e. making statewide applicable Parent Handbook available on our website). Further exploration of what is currently on the web is needed. CDHS will also make this information available on their public facing webpage due to launch April 2014	Mimi Scheuermann & Katie Facchinello		11/14/2014	Complete
4	2012-2013	4. The Department of Human Services should establish a process to handle reports of threats of retribution, by county and by worker, to monitor for trends.	4. Complaint process (online instructions), Citizen Review Panels in each county, and monthly OCCPO meetings.	Korey Elger			COMPLETE
5	2012-2013	5. The Department of Human Services should provide a variety of trainings that are updated and accessible to all geographic regions of the state.	5. Four Regional training sites and Kempe as new contractor for Training Academy. Advanced in-service training is going to be made available within each region. CDHS is waiting for response from counties/regions of their specific training needs for advanced caseworkers	Mimi Scheuermann			COMPLETE
6	2012-2013	6. The Department of Human Services should review policy related to consistent adoption subsidy negotiations by county and provide consistent post-adoption services and supports for families.	6. Gretchen Russo and Connie Vigil met with Deborah Cave and Colleen Tarket from Colorado Coalition of Adoption on February 3, 2014 and are waiting for more material to be given back to them. CDHS is continuing to collect and review policies. OCCPO will be making outreach to Colorado Coalition of Adoption for futher follow up. There has been no further follow up from the Colorado Coalition of Adoption back to DCW and at the August 2014 meeting the Ombudsman's agreed to this as complete since the outreach was done by DCW	Gretchen Russo			COMPLETE
-1	2012-2013	7. The Department of Human Services should assist counties in identifying effective practices of Child Protection Team (CPT), while also assisting counties in maximizing effectiveness of time and effort spent preparing for and participating in CPTs.	the Department proposed legislation changing the statutory requirements from a "shall" to a "may". The Legislative Audit Committee denied recommended legislative changes to CPTs at this time; therefore, we have to move forward with completing recommendation 8 (below). This was not approved. SUB Pac and PAC approved for CPTG to work and make reccomendations back to SUB Pac in May 2015. June 12, 2015 there is a meeting scheduled for this group and other county partners to complete reccomendations back to SUB Pac. This also included an outreach to county partners to have members of the local CPT's complete a survey regarding the direction of CPT's for Colorado Counties. The presentation to SUB Pac is set for August 8, 2015	Korey Elger		10/1/2015	In Progress
8	2012-2013	8. The Department of Human Services should develop a process and policy to monitor the issues of after hour response to Law Enforcement Agencies for county action, inaction, and compliance with law in situations involving arrests and decisions about child care and custody.	8. Each county is to have an agreement outlining the responsibility and working relationship between the county department and LEA. 8. A tracking sheet has been started by CDHS that includes information of county agreements with law enforcement. CDHS has completed a MOU with Colorado State Patrol. CDHS will develop policy around tracking current MOU's, as well as issues with MOU compliance and ensuring that MOU's are updated regularly. A copy of the Colorado State Patrol agreement was given to OCCPO at the April 22, 2014 meeting. A copy of the spreadsheet with all of the agreements was provided after the August 2014 meeting.	Lorendia Schmidt			COMPLETE

AGREE	
PARTIALLY AGREE	
DISAGREE	

Item #	Report	Ombusdman Reccomendation	Status	DCW Individual Responsible	OCCPO Contact	Due Date	Status
1	Year (2014-2015)	Colorado Department of Human Services should consider providing ongoing trainings and support to county workers or additional funds to address Compassion Fatigue, Secondary Trauma and Post Traumatic Stress Disorder among staff.	DCW had completed a secondary Trauma plan to incorperate two additonal providers, that will have two pilot group counties to complete additional training for, while maintaining the current provider. In addtion, DCW has offered to counties that have concern the use of monthly caseworker grant funds to bring in providers to assist in needs. DCW has approved this funding for counties that have requested these funds.	Korey Elger		1/1/2015	COMPLETE
	AGREE						
	PARTIALLY AGREE						
	DISAGREE						