2015-16

NAVIGATE INVESTIGATE ILLUMINATE REFORM

ANNUAL REPORT

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From the Ombudsman

September 1, 2016

This report marks the first submitted by the Office of Colorado's Child Protection Ombudsman (CPO) as an independent state agency. The report represents six months of my predecessor's tenure and six months of mine. It therefore reflects my predecessor and the staff's achievements as well as my own early observations and plan for the role.

I was one of many involved in the creation and development of this office. I have observed as it evolved from a program operated under the Colorado Department of Human Services to becoming an independent agency located in the Colorado State Judicial Department.

This office was born out of tragedy. Twelve children died of abuse in 2007 – all of them were known to a child welfare agency within five years of their death. We are the response to the public's cry for oversight and improvement of child protective services.

Creation of the CPO and its evolution to an independent state agency has been long and difficult. The debates surrounding the need for a CPO were often times polarizing. They created distractions from the mission of the office, which is to respond to individual complaints about child protection and identify systemic concerns for the betterment of the system.

The language in our authorizing statute provides that the CPO is charged with receiving the public's complaints concerning *child protective services* administered by *any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of the child.*

Unlike some other national child ombudsman offices, the Colorado office is charged with addressing the public child protection system not solely child welfare human service delivery. This is an important distinction for our work and for the children and families we serve in the future. Our statute recognizes the complexity of the child protection system and the need for collaboration in moving that system forward.

As a newly formed independent agency, we now have an opportunity to focus fully on the work that the Colorado Legislature tasked us with five years ago. We also have an opportunity to reflect upon our past practices, learn from our mistakes, build on our strengths and, in turn, create a new direction for this office.

That direction will drive this office into new territory. Communities and agencies unfamiliar with — and in some cases unaware of — this office will learn how we can serve them. During the past nine months, we have met with countless stakeholders and asked, "How can we serve your community?" The answers revealed a diverse group of agencies working to protect children in Colorado, each of their needs as unique as the areas they serve. Now, more than ever, this office recognizes its role in meeting those needs. By taking a deeper dive into the problems plaguing the child protection system, talking less and listening more, this office can work with agencies in this state to create a stronger system to protect children.

In closing, I want to thank those who helped establish Colorado's first independent child protection ombudsman office. I would like to thank Governor Hickenlooper for recognizing the significance of the office and signing into law Senate Bill 15-204 which allowed full independence of the CPO.

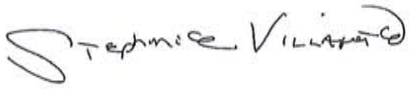
I also would like to thank the legislature for their continued support and their vote of confidence in granting us independence. We will work hard to ensure that we continue to provide quality service to all Coloradans while working in a manner that is thoughtful and informative.

I would like to thank Chief Justice Nancy Rice and the staff at the Colorado State Judicial Department for welcoming our office and aiding us in a smooth transition that allowed us to continue our important work uninterrupted.

Finally, I am grateful for our Board members who have given us the benefit of their vast knowledge and expertise and in doing so helped us develop a statewide vision for this office.

I look forward to building on the work of this office and to serving Colorado's children and families.

Stephanie Villafuerte



Child Protection Ombudsman

Introduction

The Office of the Child Protection Ombudsman (CPO) is charged with fielding and reviewing complaints regarding the state's child protection system and making recommendations for practice improvements and systemic change. Through the years the CPO's staff, statutes and even location have changed. But the mission has remained constant – improving the child protection system through objective study and education. During the past fiscal year, the CPO gained independence, moving from the Colorado Department of Human Services (CDHS) and becoming an independent government agency. That transition gave the CPO the opportunity to look back on where it's been so that steps forward are decisive and informed. The 2015-2016 Annual Report explains, for the first time, the role of an ombudsman, the work the CPO is doing in Colorado and its strategies for becoming a more effective office moving forward.

"The staff was very professional and listened to my concerns. They followed through on 'checking out' my concerns with a very thorough 'investigation.' They kept me advised of what was going on with the situation and answered all of my questions. It was a very positive experience."

-Chad D.
Contacted the CPO in 2015 with concerns about a child in the child protection system.

Using data, real-life examples and a breakdown of the CPO's procedures, this report demonstrates the work of the office. It will also outline the intense work that took place over the last six months to create a sophisticated approach to becoming a better resource for the public and stakeholders, as well as the challenges that lay ahead. Because, while change marked the end of the CPO's first five years, opportunity has defined its future.

Mission

The mission of the CPO is to bring accountability and transparency to the child protection system and promote better outcomes for children and families. The CPO fields and reviews complaints regarding child protection agencies, defined in C.R.S. 19-3.3-103 as, "any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of the child." Those agencies include – but are not limited to – CDHS, law enforcement, public health providers, educators, day care providers, medical professionals and treatment providers. The CPO serves the children of Colorado by driving policy reform and improving best practices within the child protection system.

History: From a Program to an Independent Agency

The Office of Colorado's Child Protection Ombudsman (CPO) was established in June 2010, under Senate Bill 10-171. This legislation provided that the CPO would operate as a program through a contract with a local non-profit agency, issued and managed by the CDHS.

The original legislation was passed in response to child abuse fatalities. The CPO was created to respond to the public outcry concerning the children's deaths and the belief that the Colorado child protection system required a greater degree of oversight, accountability and transparency to prevent such tragedies in the future.

Vision

Ensuring safety for Colorado's children today and envisioning a stronger child protection system for the future.

The CPO was codified under C.R.S. 19-3.3-101. Under that mandate, some of the CPO's primary duties include:

- Maintain a highly visible, statewide grievance process;
- Treat all complaints as confidential;
- Field and review citizen and stakeholder complaints regarding Colorado's child protection system;
- Make recommendations for better practice and systemic change;
- Use information gained from reviews and investigations to educate and advise citizens, the legislature and the Governor on key child protection issues, policies and improvements.

From 2011 through 2015, the CPO was housed by the nonprofit, the National Association of Counsel for Children, and was supervised by the CDHS. From the beginning, the CPO has responded to citizen complaints about the sufficiency of the child protection system and evaluated whether it is performing in an optimal way to keep children safe.

Since its inception, the CPO has made 206 recommendations to agencies within the child protection system. Of those recommendations, 18 were directed toward statewide issues at the CDHS.

Through these recommendations, the CPO has been instrumental in improving service delivery to children and families across Colorado. The CPO has also had a presence at the state Capitol and has provided expert consultation and testimony related to several pieces of legislation.

The CPO has had two prior ombudsmen. Each ombudsman preceding the current appointee has continued to move the CPO forward in a positive direction and played a significant role in the CPO obtaining independence.

On June 2, 2015, Senate Bill 15-204, *Concerning the Independent Functioning of the Office of the Child Protection Ombudsman*, was signed into law. This legislation transformed the original "program" housed within CDHS, into a distinct independent state office. The new, independent CPO opened in January 2016.

Additionally, the legislature created the Child Protection Ombudsman Board in 2015. The Board is the first of its kind in the nation. By law, this board is required to oversee the Ombudsman's performance as well as serve as an advisory board on strategic direction and outreach.

Since becoming independent, the CPO has relocated and is now housed in the Colorado State Judicial Branch. The Colorado legislature allocated money to the judicial department for the cost of building and furnishing a new space for the CPO as well as providing ongoing accounting, budget and human resource assistance.

Colorado's newest Child Protection Ombudsman, Stephanie Villafuerte, was appointed in December 2015 by the Board and took office in January 2016.

Our Purpose

Throughout the existence of the CPO, there has been a great deal of discussion about what an ombudsman does and what the role of an ombudsman should be in the Colorado child protection community.

So what is an ombudsman?

An ombudsman serves as an independent, neutral problem solver and works to help citizens navigate government systems that are large, complex and generally inaccessible by people who rely upon them for critical services.

They act as subject matter experts, readily available to take citizen complaints and grievances and identify resolutions for their problems. Designed to serve people in a way that humanizes their concerns, the ombudsman is a resource for citizens who might not otherwise have the knowledge or resources to pursue answers to their questions.

Ombudsmen have existed for hundreds of years and currently operate throughout the world, specializing in everything from health care to labor relations. Ombudsmen have a significant membership and resource base. The American Bar Association and the United States Ombudsman Association have developed best practices that guide an ombudsman's work to ensure impartial, independent reviews and investigations.

However, in addition to responding to citizens' concerns, the ombudsman role has historically been designed to also drive *system* reform through impartial collaboration, data driven analysis and public awareness. They research and investigate problems and educate the public and stakeholders on ways to solve them. The ombudsman's effectiveness does not reside in an ability to mandate compliance. Instead, it drives reform by illuminating problems within an agency and creates detailed recommendations for change.

As a specialty, child ombudsman offices have evolved over the past three decades. Internationally, these ombudsman offices tend to be dedicated to the protection of children's human rights. There are approximately 33 child protection ombudsman offices in the U.S. — Colorado being one of the newest. All of these offices vary in structure, scope and responsibility.

In like tradition, the CPO serves Colorado citizens by responding to their inquiries, researching their complaints and providing recommendations for system improvement. The ombudsman has independent access to child abuse information that is not otherwise available to the public. This information provides the ombudsman with the tools to not only assist each individual child *but also* provides the ombudsman with a "window" to the broader system.

During its five years, the CPO has continued to refine its process for handling complaints. The CPO is making changes to improve consistency and efficiency. Since its inception, the goal of the CPO has remained the same. The CPO was built to:

- Help people navigate the child protection system
- Objectively review and investigate complaints
- Provide agencies with recommendations for improvement

- Drive systemic reform through research and education

The CPO accomplishes these initiatives by carefully evaluating each complaint and providing objective findings.

Authority of the CPO

Under Colorado law, the CPO has the authority to:
• Serve as a resource and systems navigator • Facilitate independent and impartial reviews • Offer the complainant options for resolving the concern • Identify and resolve child protection concerns and systemic issues • Provide recommendations to child protection agencies, the Governor and the legislature
The CPO is not authorized to:
• Directly respond to emergencies regarding child safety • Investigate allegations of child abuse and/or neglect • Review complaints concerning domestic relations issues, such as Court and Family Investigator, court rulings and custody orders • Overturn the acts or decisions of judges or their staff • Investigate complaints or concerns regarding the conduct of judges, magistrates, attorneys or guardians ad litem • Provide legal advice • Intervene in criminal or civil judicial proceedings • Intervene in any criminal investigations by law enforcement

The Staff

Collectively, the CPO staff has over 84 years of experience serving children and families within the child protection system in a variety of roles. Currently, the CPO is comprised of four full time staff and one part-time employee. Further, the CPO has developed an internship program, comprised of two interns specializing in the fields of public policy and human services. The skill sets that each CPO staff member possesses creates one of the most unique perspectives within the child protection community. The staff include the following:

- **Stephanie Villafuerte, Child Protection Ombudsman**
  Ms. Villafuerte has over 25 years of experience dedicated to the legal and public policy fields in the area of child maltreatment. She has worked extensively in state and federal court, the legislature and as the executive director of a statewide, nonprofit agency dedicated to serving children. In a variety of roles, Ms. Villafuerte has worked to solve the myriad of needs of Colorado's abused and neglected children. Ms. Villafuerte took office in January 2016.

- **Sabrina Burbidge, Deputy Ombudsman**
  Ms. Burbidge has been working in the areas of public and private child welfare for 22 years. Ms. Burbidge has worked within Colorado's child protection system as a caseworker, supervisor and trainer for caseworkers and foster parents. She has served as a subject matter expert at the state legislature and has offered training on child welfare specific issues both nationally and internationally. Ms. Burbidge joined the CPO in January 2012.

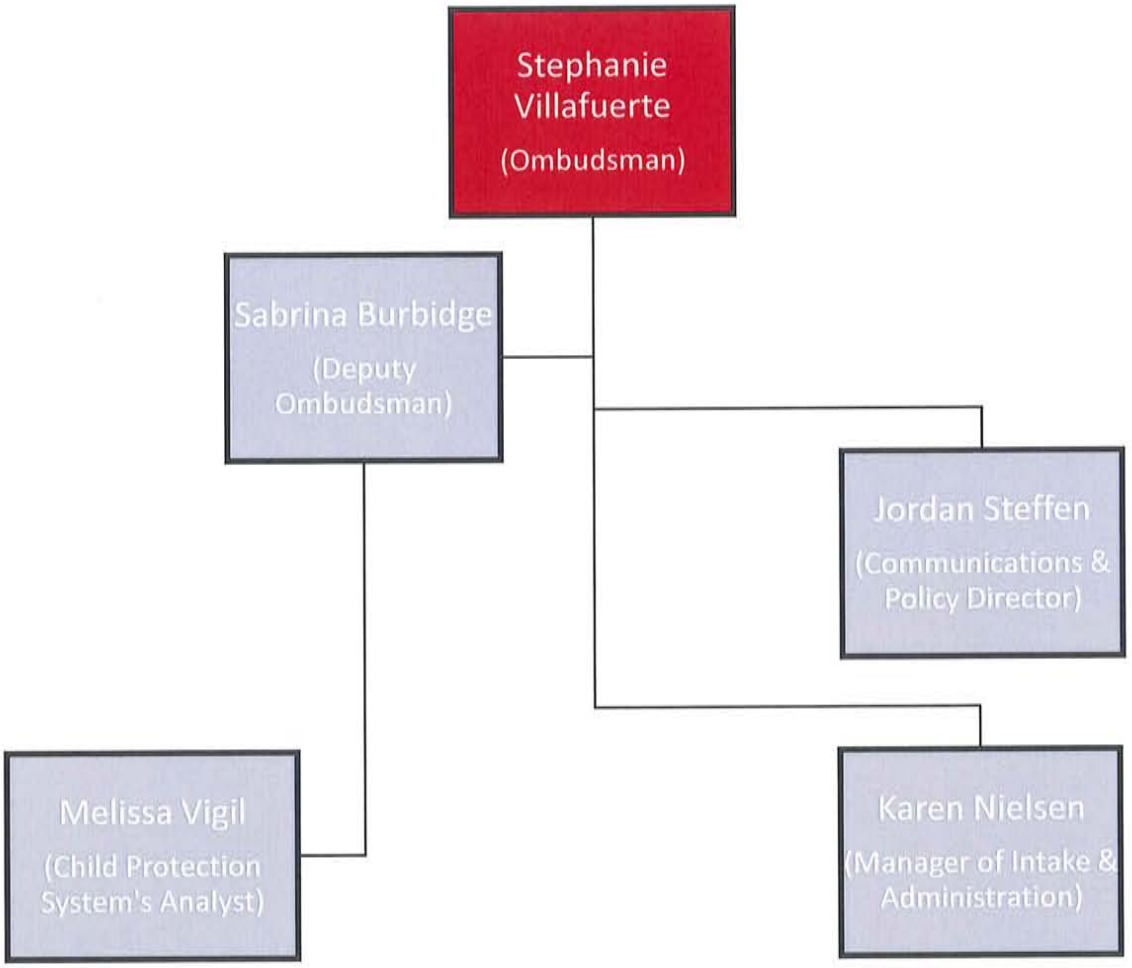
- **Jordan Steffen, Communications and Policy Director**
  Ms. Steffen has worked in the field of journalism, researching and analyzing public policy, law and rule as it relates to child welfare for over five years. Ms. Steffen has spent extensive time researching long-standing state policies and practices for preventing child abuse and has reported on the shortcomings within the child welfare system. Ms. Steffen joined the CPO in July 2016.

- **Karen Nielsen, Manager of Intake and Administration**
  Ms. Nielsen worked with families within the child welfare system, assisting them with their substance abuse treatment needs for 24 years. She has been a member of various committees within the child protection system addressing needs for treatment services, as well as offering strategies to build a more collaborative system. Ms. Nielsen joined the CPO in March 2013.

- **Melissa Vigil, Child Protection System's Analyst**
  Ms. Vigil has served as a caseworker and lead child protection intake worker within Colorado's public child welfare system for eight years. She has extensive experience providing crisis intervention services, as well as investigating allegations of abuse and neglect, with a specialty in sexual abuse investigations. Ms. Vigil also has her Master's Degree in Criminology, as well as experience within the criminal justice system and local police departments. Ms. Vigil joined the CPO in May 2016.

Child Protection Ombudsman Organizational Chart

The CPO is currently comprised of four full-time employees: The Ombudsman, Deputy Ombudsman, Child Protection System's Analyst and Manager of Intake and Administration. The position of Communications and Policy Director is currently a part-time position[1]. The CPO also has two internships.



[1] The Policy and Communication's Director position (.5 FTE) was allocated to the CPO for FY 16-17. Ms. Steffen joined the CPO in July 2016.

Child Protection Ombudsman Board

In creating an independent agency, the legislature also created the Child Protection Ombudsman Board. Through partnership with the CPO the Board serves as a unique extension of the office. Not only will the Board act as a key advisor of the office, it will also utilize their professional experiences and backgrounds to advance the mission and goals of the CPO.

Senate Bill 15-2014 established that the Board will consist of no more than 12 members.

Board Members

Chief Justice Appointments

- Kenneth Plotz, Board Chair
- Charles Greenacre
- Pax Moultrie
- Simone Jones

Governor Appointments

- Karen Beye
- Constance Lee Linn
- Dee Martinez
- Sarie Ates-Patterson
- Joe Carrica*
- George Kennedy*
- Jose Mondragon*

Senate President Appointment

- Victoria Black

Senate Minority Leader Appointment

- Peg Rudden

Speaker of the House Appointment

- Ginny Riley, Board Vice-Chair

House Minority Leader Appointment

- Vacant

*Reflects past board members

Our Work

Increased Demand

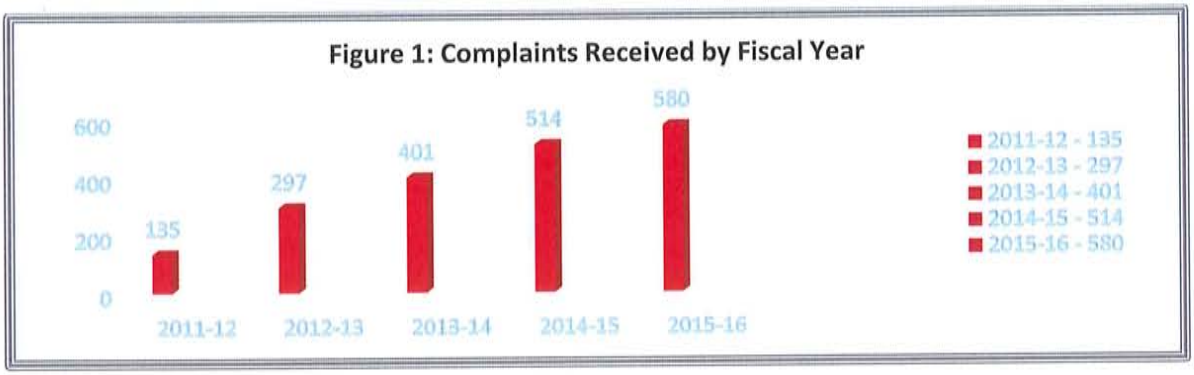
CPO's data reflects a steady increase in the public's use of its services:

- The number of complaints rose by 13% compared to Fiscal Year 2014-2015 and by 330% since the inception of the CPO.
- The CPO has made 60 recommendations to county and state departments of human services in FY 15/16.

In order to more effectively serve Colorado's citizens, the CPO has collected data on how its services are being used by the public. The CPO has seen tremendous growth in the number of people contacting the office. In its first year of operation, the CPO received 135 complaints. During Fiscal Year 2015-2016, the CPO received 580 complaints – a 330 percent increase compared to its first year of operations. (See Figure 1.) A chart detailing the complaints the CPO received during the past fiscal year, by agency, location and type can be found in Appendix A.

The CPO also monitors the geographic locations of the agencies under review. Each year urban counties account for an average of 65 percent of all non-systemic contacts the CPO receives while less than one third of total contacts are expressing concern regarding rural child protection systems. The purpose of this analysis is to ensure the CPO is effectively reaching complainants statewide.

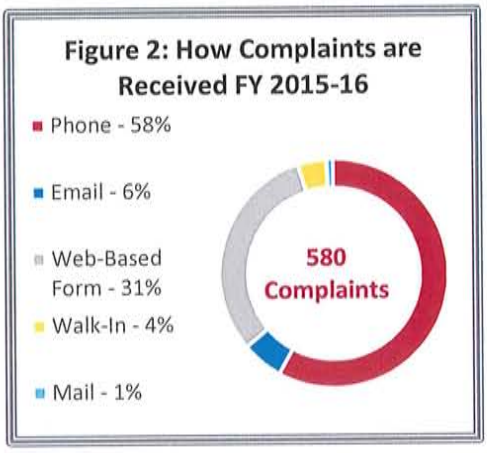
Figure 1: Complaints Received by Fiscal Year



How Complaints Are Received

The CPO tracks how it receives complaints from citizens in an effort to ensure that it is accessible to all members of the public. During Fiscal Year 2014-2015, 67 percent of people contacting the CPO did so via telephone and 21 percent of people contacted the office using the online form. In Fiscal Year 2015-2016, the number of complaints submitted online increased by 10 percent and the number of people contacting the office via telephone decreased by nine percent. (See Figure 2.)

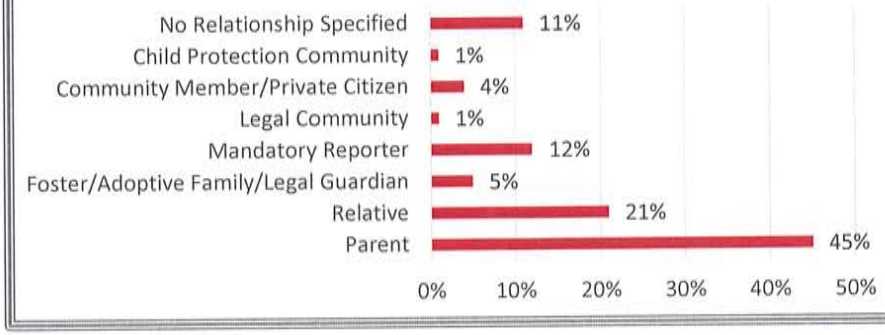
Figure 2: How Complaints are Received FY 2015-16



Who Contacted the CPO

To identify trends or systemic problems within the child protection system, the CPO tracks who is contacting the office. For example, if a specific group of people repeatedly contacts the office about the quality and/or availability of services, it would alert the CPO to a possible systemic issue. During Fiscal Year 2015-2016, the CPO saw a 2 percent increase in the number of foster and adoptive parents contacting the office compared to the year before. (See Figure 3).

Figure 3: Who Contacted the CPO FY 2015-16



How Complainants Heard About the CPO

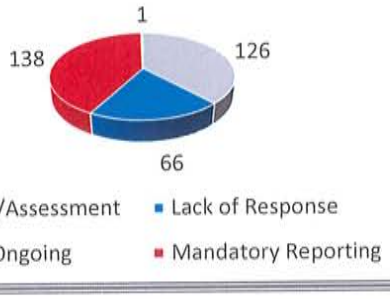
In the upcoming fiscal year, the CPO will launch new initiatives to reach new communities where its services may be needed. In order to decipher how to best expand the reach of its services, the CPO must track how people first heard about the office. (See figure 4.)

Figure 4: How Complainants Heard About the CPO FY 2015-16

What are Complainants Concerned About

Similar to tracking who contacts the office with complaints, the CPO also monitors what the original complaint is concerning. Definitions for complaint types can be found in Appendix D. This information helps the CPO focus its efforts on specific practices within the child protection system. For example, compared to the past fiscal year the CPO saw an increase in the number of complaints in the Case/Ongoing category, such as the permanency of a child who has been removed from their home. (See Figure 5.)

Figure 5: What are Complainants Concerned About FY 2015-16



Phases of a Complaint

The CPO responds to complaints in three distinct phases:

1. Inquiries
2. Reviews
3. Investigations

A process flow chart illustrating how a complaint moves through the three phases may be found in Appendix B.

Phase One: Inquiries

Each complaint begins in the Inquiry Phase. An inquiry is typically a question or request for information to help navigate the child protection system.

During this phase, staff must decide whether the complaint falls within the CPO's jurisdiction, as outlined in statute. If the complaint does not fall within the CPO's jurisdiction, then the CPO will serve as a systems navigator for the complainant. The CPO will provide the complainant with information about relevant agencies and possible options for resolving their concern. Inquiries will not move into the second phase if there is not enough information or the complainant requests that no further action be taken.

Cases that are not within the CPO's jurisdiction will be closed as an inquiry. If the CPO determines a complaint falls within its jurisdiction, it will move into Phase Two.

Phase Two: Reviews

Once a complaint moves into Phase Two, a review is automatically opened and assigned to a staff member. Reviews are the most common type of involvement by the CPO. Reviews often involve the most research for staff as they **work to determine if an agency followed or violated agency policy or Colorado law.**[2] To make this determination, staff will gather relevant information from third parties such as law enforcement, the judicial department and schools. They will also gather documentation and other information from the agency that is being reviewed.

A review looks at specific concerns brought to the CPO by a complainant, such as a decision by a caseworker in an ongoing case, a communication concern between caseworkers and law enforcement or alleged violations of parental rights. Often during Phase Two, the CPO will identify and review peripheral concerns that were not related to or listed in the original complaint.

Reviews represent some of the most detailed and important work of the CPO, as trends identified in reviews have repeatedly revealed systemic concerns within the child protection system. They are also the foundation upon which the CPO writes most of its recommendations. In the past five years, 72 percent of the recommendations made by the CPO were the result of a review.

Phase Three: Investigations

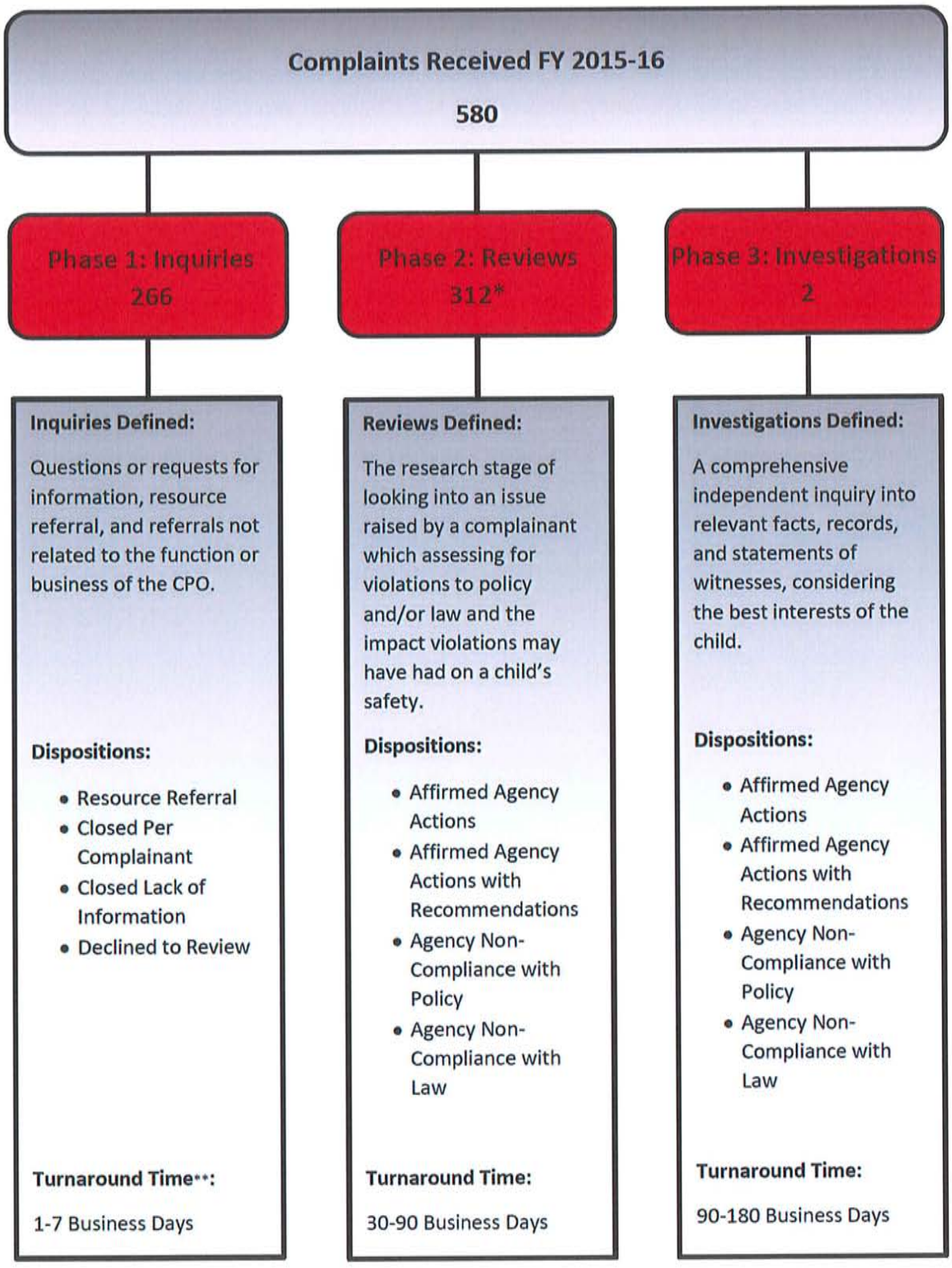
The highest level of intervention by the CPO is an investigation. An investigation is a comprehensive, independent inquiry into relevant facts, records, and statements of witnesses, considering the best interests of the child. A review will move into the investigation phase if the CPO determines that there

[2] Definitions of agency policies and Colorado Law may be found in Appendix D.

was **a violation of policy and/or law and that action, or inaction, by an agency that harmed a child** or **placed a child in imminent danger or harm**.

During an investigation, the CPO builds on the research completed during the review phase of the case. But the inquiry now goes deeper and broader. Moving beyond the isolated complaint assessed in the review, an investigation includes collecting additional facts, testimony and any new details that could shed light on systemic concerns within the agency. Additional findings and recommendations may be revealed through an investigation.

Since its inception, the CPO has completed 12 investigations. Half of those investigations involved cases where a child died of abuse and/or neglect and had prior contact with child protection services. In total, investigations have resulted in 39 recommendations to agencies – those account for 19 percent of the CPO's total recommendations to date.



*This total number includes 3 "Reviews with Monitoring" which is no longer used as a classification for CPO work.
**Turnaround Time is the estimated time it takes to reach disposition within each phase and may be affected by the availability of documents from outside agencies.

What is the difference between a review and investigation?

The CPO carefully evaluates each case to decide the appropriate level of response. When deciding whether to move a case from the review phase to the investigation phase, the CPO considers several factors. Below is an example of an investigation and review to demonstrate the difference between the two.

One of the best illustrations of this involves a family first introduced to the CPO in 2013. The CPO was contacted about the family again in 2014. In the first case the CPO found that the actions of the county child welfare agency violated law, violated policy and harmed the child in the case. As a result, the CPO opened an investigation. But in the second case, the agency's violations of policy did not harm or endanger a child and the case was closed in the Review phase. Both cases are detailed below.

Case One: Investigation

Phase One – Inquiry

In August 2013, the CPO received a complaint concerning a county child welfare department. The complainant alleged that a child was seriously injured after the department allowed the child to remain living in an environment that the complainant believed was dangerous.

Phase Two – Review

The CPO opened a review. According to documents in the case, the children were living with relatives in July 2012. The department received a call that one of the children had numerous bruises. A caseworker advised the female caregiver to take the child to the hospital after they viewed the child's bruises. Medical professionals at the hospital did not have any concerns about abuse or neglect. During a follow-up interview the caseworker noted that the caregivers gave inconsistent explanations for how the child was injured.

Before the assessment into that incident was completed, the department received a second call about the family notifying them that the child was at the hospital being treated for a broken femur. While the child was at the hospital it was discovered that the child also had a broken arm that was in the process of healing. The doctor treating the child alerted the caseworker to their concerns about the caregiver's explanation for the injuries.

Despite their knowledge of the child's injuries, the department allowed the children to remain with the caregivers. The caseworker did not note any concerns with the family between August and December 2012.

In December 2012, the department was informed that the same child was in the emergency room being treated for a significant burn on their face that had occurred days earlier. The caregiver told the caseworker that she had left the child in the bath tub alone and the child had poured hot water over their face. The child remained in the hospital until January 2, 2013. Five days after the child was released from the hospital, the caseworker learned that the caregivers had yet to fill a prescription for a cream to treat the child's burns.

Still, the children remained with these caregivers until March 11, 2013. On that date the caseworker was notified that the child had severe burns on their bottom, which the caregiver said was the result of the child pouring bleach in their stroller. The physician treating the child reported that the injuries were not consistent with the caregiver's explanation.

After reviewing the case the CPO found that there were several violations of policy in handling the case. Due to imminent safety concerns for the children, the CPO contacted the county director. The department immediately responded to the concerns of the CPO and found that it was necessary to remove the children.

Once the CPO found there were policy violations, it assessed whether those actions harmed the child or placed the child in imminent danger.

The CPO found that the caseworker violated Volume VII when they did not properly document or assess the child's bruises in 2012. They also violated policy when they did not properly document or assess the discovery of the child's broken arm and femur. Even after witnessing severe injuries on the child, the CPO found that the caseworker did not properly investigate the concerns and assess the child's safety. These actions, combined with the department's history with the family, placed the children in **imminent danger**. As a result, the CPO opened an investigation.

Phase Three – Investigation

Once the investigation was opened, the CPO expanded its scope and began collecting law enforcement reports, conducted interviews with individuals not previously interviewed during the review – including additional medical professionals and law enforcement personnel. Some people interviewed for the review phase of the case were re-interviewed to give the CPO a better understanding of the case as a whole and department-wide practices, as compared to the actions of a specific caseworker.

At the conclusion of its investigation, the CPO found that the department:

- Failed to document concerns and contacts with the family
- Failed to properly assess and document risk and safety concerns
- Failed to document concerns about the safety of the child's siblings
- Failed to investigate concerns of injuries to the child

The investigation resulted in six improvement recommendations for the department. A full copy of the investigation can be found on the CPO's website.

Case Two: Review

Phase One – Inquiry

In October 2015, the CPO was again contacted about the family. The second complainant alleged that one of the children made a disclosure of sexual abuse and the same county child welfare department did not investigate the disclosure, nor did they report the disclosure to law enforcement.

Phase Two – Review

The CPO opened a review. The children had previously been removed from the caregivers' home and placed into foster care in March 2013. Both caregivers pleaded guilty to child abuse resulting in serious injury in April 2014.

Five months after the former caregivers pleaded guilty, one of the children said they were sexually abuse while they were in their care. The child was in a place where they felt safe when they made the disclosure on September 17, 2014. The assigned caseworker originally stated they documented that information and reported the allegation to law enforcement. But the CPO found no evidence to support that claim and later confirmed that the disclosure was never investigated by caseworkers. After speaking with the district attorney's office, the CPO also confirmed that the information was never provided to law enforcement. The CPO found that the department had violated policy and law. The CPO also assessed whether the case should move into the investigation phase. But because the disclosure was made after the child was placed in a new environment where they felt safe, the department's violations did not harm the child nor did it place them in imminent danger.

Due to the criminal nature of the outcries, the CPO contacted the assigned detective to report the concerns. The case was concluded in the review phase and three recommendations were sent to the department.

Results of Our Work

Dispositions

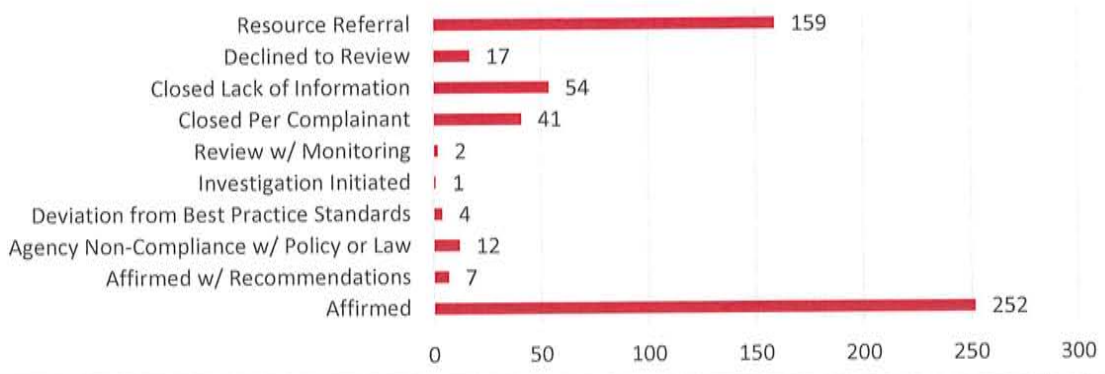
At the conclusion of each phase, the CPO will assign a disposition of the action taken by the CPO. In total, the CPO has eight dispositions — or conclusions — that it may reach at the conclusion of the three phases. (See Figure 6.) If the complaint remains in the Inquiry phase, it may be assigned one of the following dispositions:

- Resource Referral
- Closed per the complainant's request
- Closed due to lack of information
- Declined to Review

Should the complaint rise to the Review or Investigative phases, the CPO will assign one of the following dispositions at the conclusion of the review and/or investigation:

- Affirmed Agency Actions
- Affirmed Agency Actions with Recommendations
- Agency Non-compliance with Policy
- Agency Non-compliance with Law

Figure 6: CPO Dispositions FY 2015-16



Definitions for each disposition may be found in Appendix D.

Affirmed Agency Actions

The CPO assigns the disposition, Affirmed Agency Actions, when the CPO finds no violations of policy or law in the agency's handling of a case. In reviewing the 580 complaints the office received during the past fiscal year, the CPO affirmed the action of the agency under review in 252 completed reviews.

Affirmed Agency Actions with Recommendations

On occasion, the CPO will find that although all policies and laws were followed, there remain areas that the agency could improve. In these instances, the CPO will affirm the actions of the agency and provide recommendations. In Fiscal Year 2015-2016 the CPO affirmed the actions of the agency under review and provided recommendations in 11 cases.

Example: Affirmed Agency Actions w/ Recommendations

A complainant alleged that a county child welfare department was not providing enough support for a caretaker and the child who was recently placed in their care. The CPO opened a review and collected documents from the case for assessment. During its review, the CPO spoke with the county department and learned the caretaker was receiving several forms of assistance such as gas cards, stipends for daycare and had been assigned a kinship support worker.

The CPO affirmed the actions of the department, but was concerned that the caseworker was not properly documenting their interactions with the family. As a result, the CPO recommended the department hold a training for its staff and supervisors about the rules surrounding case documentation. Lapses in documentation could result in ineffective and/or duplicative services in the future.

Agency Non-compliance with Policy

The CPO consults multiple polices and laws when reviewing agencies. These policies dictate the standards for which an agency must provide services to children and families. Currently, the most frequent violation of policies are violations of Volume VII.

Example: Agency Non-compliance with Policy

The CPO received a complaint that a county child welfare department was failing to respond to allegations of abuse and/or neglect concerning a 15-year-old juvenile. The CPO opened a review in the case and immediately started collecting documents. Police files revealed three occasions in which law enforcement contacted the county child welfare department with concerns about the juvenile's safety after the juvenile had made statements to mandatory reporters that they did not feel safe with their father.

The CPO found no evidence that the caseworker assigned to the case recorded any of the concerns from law enforcement. The caseworker later told the CPO that they had an "extensive file" on the family. But they did not feel the concerns of law enforcement rose to the level of abuse and/or neglect and they did not document the concerns in the TRAILS Database. (See Appendix D).

Not documenting the concerns violated Volume VII (7.200.61), which requires caseworkers to enter any allegations of abuse and/or neglect into TRAILS. The CPO found that the concerns expressed by law enforcement were serious enough that that they should have been further investigated by caseworkers. Failing to note the concerns in the TRAILS is worrisome because it left gaps in the child's abuse and neglect history. Anyone accessing the juvenile's file in the future would not be aware of the concerns and the juvenile's relationship with their father. At the conclusion of the review, the CPO recommended the department hold ongoing training for caseworkers on documenting allegations of abuse and/or neglect. It was also recommended the department work with local law enforcement to improve communication between the two agencies.

Agency Non-compliance with Law

While the CPO reviews violations of state and federal law, and agencies' policies, the most common transgressions the CPO finds are violations of the Colorado Children's Code. In most instances, when the CPO finds a violation of law, a violation of policy also exists.

Example: Agency Non-compliance with Law

Shortly after a child died of abuse, a complaint was filed against a county department of human services alleging that it failed to investigate multiple concerns of abuse and neglect before the child was killed. The CPO opened an investigation. Through a review of documents in the case, the CPO quickly identified five instances before the child's death in which the department could have addressed safety concerns in the home.

Prior to the child's death, the department received reports from mandatory reporters concerning domestic violence, physical abuse, neglect and drug use by the children's parents. In one report, the children's mother was in the hospital following the birth of her youngest child and her baby tested positive for marijuana. None of the concerns were assigned to a caseworker to investigate.

The CPO found there were obvious areas where the department could have intervened and assessed the family's need for services. The department violated C.R.S. 19-3-102(1)(g) and Volume VII (7.202.4(G)). There was a clear pattern of risk and the five reports that were not investigated could have provided early warning signs of the incidents that led to the child's death. It was recommended that the department hold trainings for staff and supervisors, as well as evaluate decisions on whether to investigate concerns of abuse and/or neglect. Recognizing risk early on provides an opportunity to offer preventative services before a child is in imminent danger of harm.

Investigations Published in 2015-2016

The CPO published three investigations during the past fiscal year. All three of the investigations were initiated in Fiscal Year 2014-2015 one of them was completed in the same fiscal year. Two of these investigations involved children who died of abuse. The third involved the unreported sexual assault of a 14-year-old juvenile. All three cases resulted in criminal prosecutions. As a result, prosecutors requested that the investigations not be published until the conclusion of the related criminal cases. The CPO complied with these requests to maintain the integrity of the court proceedings. Once the proceedings were concluded, the CPO sought the agencies' response to its findings. The CPO published the investigations on its website after receiving all three responses.

Complete versions of the investigations, along with the agencies' responses, may be found in Appendix C.

Recommendations

During its first five years, the CPO released 206 recommendations. Recommendations were sent to 23 counties during the CPO's first five years. Once the CPO has written its recommendations, they are sent to the agency under review and that agency's supervising entity.

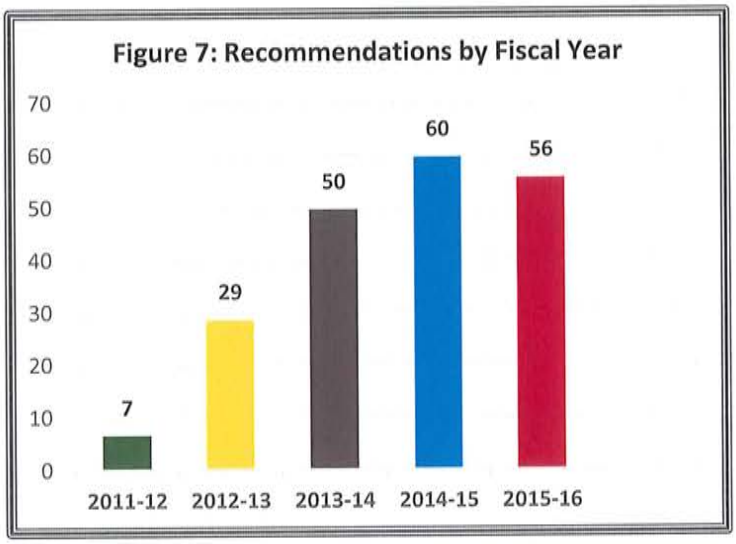
Each of the CPO's recommendations were developed out of hours of research and investigations into case-specific issues and systemic problems within the child protection system. (See Figure 7.) Recommendations are one of the most critical services the CPO provides the public, as they help to

improve the child protection system on all levels. Some recommendations address the training needs of a specific caseworker or agency employees. Others target concerns that are affecting the delivery of services in a county or region in Colorado. Many are aimed at correcting statewide problems. But all of the recommendations the CPO delivers help create a stronger child protection system.

Repeatedly, the CPO has used recommendations as a way to close loopholes in state law and/or policy that could potentially harm children. In one case, a recommendation from the CPO closed the gap in Volume VII that allowed caseworkers to place children – with the permission of their parents – in the care of family or friends without running a background check first. The CPO was also instrumental in securing legislation that ensured that children would no longer be placed with relatives that had been convicted of any level of sexual assault.

The CPO has also used recommendations to identify ongoing trends. For example, monitoring the recommendations made in the past two years, the CPO has learned that adoptions are being unnecessarily delayed in some counties. This is a subject the CPO plans to research further in the upcoming year.

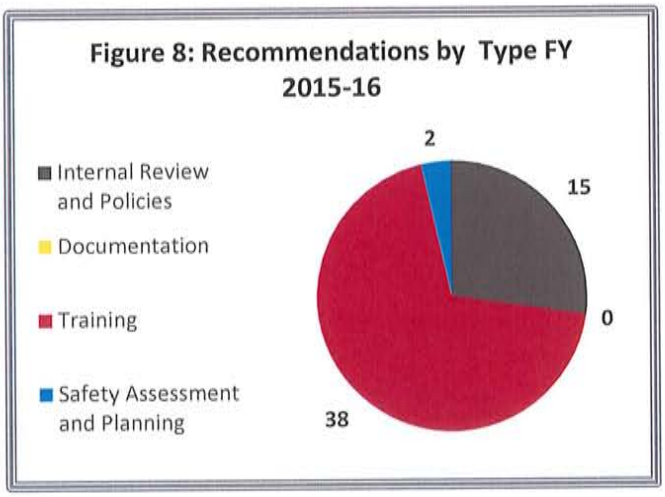
To date, the CPO has made recommendations for improvement to county child welfare departments, the CDHS, mental health providers, hospitals and law enforcement. In all but one recorded instance, recommendations sent to county child welfare departments have been acknowledged and in many cases the departments have implemented the changes.



Recommendations by Type

While recommendations cover a multitude of issues, typically they fall into one of four categories. One case may contain recommendations that fall into more than one category. (See Figure 8.)

- Documentation
- Safety Assessment and Planning
- Training
- Internal Review and Policies



Documentation

Any recommendation that addresses inaccuracies or lapses in documentation while handling a case fall into this category. This category may also include recommendations for training and reviews that would improve an agency's documentation practices. Properly documenting a case is vital in creating a history of the family and providing a detailed summary of the family's involvement with the child protection system should they become involved with the system in the future.

Case Example: Documentation Recommendation

The CPO received a complaint alleging that children with an open case with a county child welfare department had not had any contact with their mother, despite the fact that the "no contact" order in the case had been lifted by a judge. The complainant was also concerned that family therapy sessions between the mother and the children had not started and the mother was not notified of her son's suicide attempt.

During its review of the case, the CPO confirmed that the "no contact" order was lifted and the judge ordered that family therapy begin. But while reviewing the case file, it became clear that there was no documentation of efforts to begin family therapy and there were no notes explaining the delays. By the conclusion of the CPO's review it was apparent that there was a lack of documentation in the case for a period of seven months. The CPO sent the department a recommendation to improve timeliness of documentation.

Safety Planning and Assessment

This category includes any recommendations aimed at improving how a child's safety is assessed by agency employees or any recommendations that address improvements in creating a safe environment for a child. Understanding the environment in which a child is living is vital to ensuring their physical and emotional safety. When concerns about safety are underestimated, it may put a child in harm's way. Over assessing unnecessarily infringes on a family's ability to care for a child. Recommendations for improved or ongoing training surrounding these issues may also be included in this category.

Case Example: Safety Planning and Assessment Recommendation

In October 2013, the CPO received a complaint alleging that a county child welfare department missed opportunities to intervene in a family with four young children. The four children had been removed from the home and both parents were charged with felony child abuse. All of the children were non-verbal when they were removed and none of them were potty-trained, according to documents in the case. The complainant claimed the department received multiple reports of concern for the children's safety and well-being before they were removed from the home, however the department failed to act and ensure the safety of the children.

The CPO opened a review in the case. During its review, case documents showed that a neighbor told the department the family's apartment was "filthy" and "all of the children are in diapers and the beds are soiled with piss and mold." But that report was not assigned to a caseworker for assessment. The department said the reason the concern was not investigated was because the report didn't include information about abuse or neglect "as defined in law," according to notes in the case file.

Not assigning the concern to a caseworker violated Volume VII (7.202.4(G)) and (7.202.601(2)(b)). The CPO found that the information provided by the neighbor was concerning enough that it should have triggered an assessment by the department to determine if the children were being abused and/or neglected. Had the concern been further assessed by a caseworker it is likely that the children would have been removed from the home and provided services sooner.

When caseworkers did visit the home following a subsequent report, they failed to properly document concerns about the children's safety in the home. This violated Volume VII (7.202.52(E)). Failing to properly document concerns about a child's safety could impact the services and level of intervention a child may later receive.

The CPO recommended that the department train all of its staff on how to assess a child's safety, specifically when a report is first received.

Training

This category includes any recommendations that are designed to improve, continue or provide additional training in any area of concern. Recommendations can be aimed an individual employee, supervisors or all of an agency's staff. Proper training regarding the provision of child protection services is crucial to children and their families.

Case Example: Training Recommendation

The CPO received a complaint concerning a child who died of abuse. The complainant alleged that a county child welfare department had an open case for the family and caseworkers mishandled a report of physical abuse made in April 2015, shortly before the child was killed.

A review was opened and documents in the case showed that the department did receive a report of suspected abuse before the child's death. The reporter stated that there were concerns about the mother's behavior toward the child and said she had "been observed being rough" with the child before. The reporter also indicated that the child had a bruise on their chest and was concerned that the mother may have caused the bruise.

The department did not assign a caseworker to assess the concern because it found there was not enough information – as defined in law – to show that the child was being abused or neglected, according to notes in the case file. It was determined by the department that the family would benefit from preventive services, but the prevention services unit was at capacity and was unable to accept the case. Because of a deficit within the state database, the prevention services unit was unable to document that the case was not assigned for further services. The child was killed in May 2015. The mother's boyfriend was arrested and charged with the toddler's death.

The report about the bruise on the child – in addition to details about the family's history – were concerning enough to warrant further investigation by the department. Not assigning a caseworker to assess the report violated Volume VII (7.202.4(G)(1)). Because of this violation the CPO recommended that the department continue training its staff to ensure that all the information in a report is collected and considered when handling a report of abuse and/or neglect. The CPO also made a recommendation to the CDHS to build a fix to the state database to ensure that all program areas within the department can enter and access necessary documentation when making decisions on cases.

Internal Review and Policies

Often reviews will reveal areas of improvement that may be addressed by an agency completing an internal review, such as examining the files of a specific employee or analyzing a practice used agency wide. Any recommendations that suggest an agency develop internal or external policies to improve practice also fall into this citatory.

Case Example: Internal Review and Policies Recommendations

The CPO received a complaint concerning a county child welfare department and a case in which a child had been removed from the mother's custody and not placed with their father.

A review was opened and documents in the case showed that the child was removed from their mother's care after the department received a report about suspected drug abuse and domestic violence. The child was moved to a kinship placement. The CPO affirmed this decision by the department, but identified concerns with how long it took the caseworker to assess the home where the child was placed. It took the caseworker longer than the required 60 days to complete the assessment, which was a violation of Volume VII (7.104.131(A)). It was also discovered that this caseworker was previously the subject of a different complaint the CPO reviewed. In that complaint, the accuracy of the caseworker's documentation was questioned.

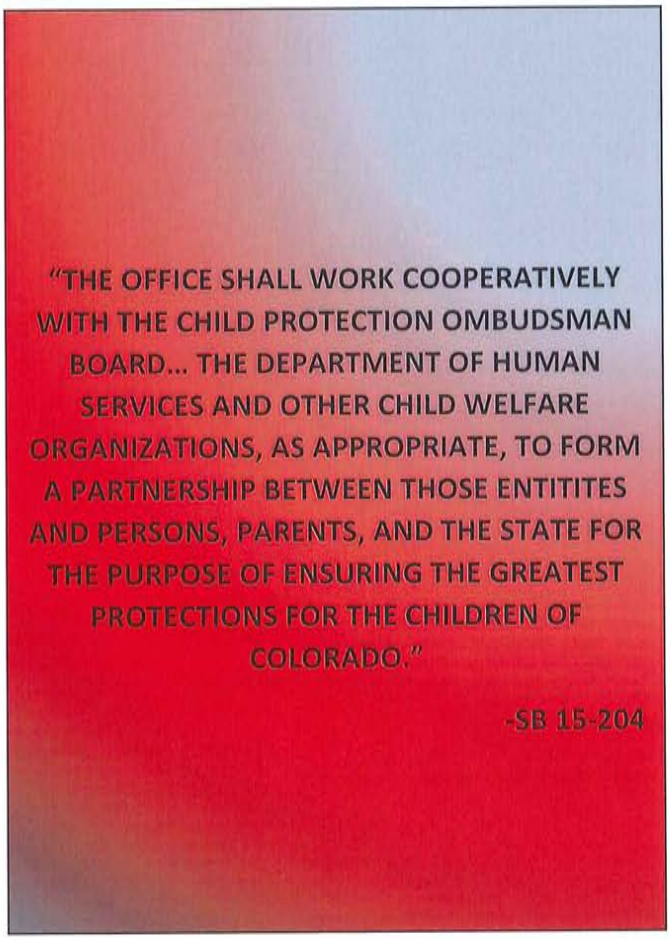
Because of the caseworker's history, the CPO recommended that the department conduct an internal review of the caseworker's files to determine if there were any additional concerns with their work.

Fiscal Year 2015-2016 Highlights

Change has been one of the defining characteristics of the CPO during the past year. The CPO gained independence half way through the fiscal year. Independence has brought the office to a place of new potential and has exposed it to new resources to complete the mission outlined in statute. But it has also brought about reflection in the CPO. Since becoming independent, the CPO has meticulously analyzed its first five years and has stringently created efficient and aggressive strategies for moving forward.

Despite the physical and internal shifts brought about in the past year, the CPO was uninterrupted in providing services to the public. The past year was marked by some of the CPO's strongest strides. In addition to the increased work the CPO is doing for citizens, entities within the child protection community have also started utilizing the CPO as a resource to improve the system.

Since becoming independent, the CPO has relocated and is now housed in the Colorado Judicial Branch. The CPO has also successfully completed more than a dozen goals in key areas – infrastructure, internal operations, human resources and outreach – to establish the basic functions of an independent government agency. The CPO continues to move forward in providing services to children and families and connecting with key stakeholders. Again, these tasks were completed while maintaining the continuity of the CPO's day-to-day business.



Budget

During Fiscal Year 2015-2016, before becoming an independent state agency, the CPO was funded by moneys from the state General Fund, through a contract with the CDHS. After becoming an independent state agency, the Joint Budget Committee (JBC) allotted the CPO an additional $13,471 to accommodate expenses associated with creating the Child Protection Ombudsman Board and legal services with the Colorado Attorney General's Office. The total appropriation for Fiscal Year 2015-2016 was $484,762. Figure 9 depicts the total appropriations for each fiscal year the CPO has been in operation.

Figure 9: Office of Child Protection Ombudsman Yearly Appropriations				
FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
$343,000	$343,000	$343,000	$504,250	$484,762[3]

The internal budget of the CPO functions within the following categorical breakdowns:

- **Advisory Board Services**—These expenses are required for the fulfillment of the statutory mandates as they relate to the board. These expenses include travel for out of town board members, statewide board meetings and outside facilitation for various board development needs.
- **Judicial Professional Services**—Expenses related to the human resource, payroll and fiscal assistance provided by the Judicial Branch.
- **Legal Services**—Expenses related to the utilization of the Attorney General, such as Board development, CORA requests, legal establishment of CPO operating and fiscal policies.
- **Personnel Services**—Expenses associated with salaries and benefit packages for employees.
- **General Operating Fund**—General expenses related to the day- to-day functioning of the CPO.

This fiscal year was unique in that for the first two quarters, the CPO was a program within the CDHS and under the program management of the NACC. (See Figure 10.) Beginning January 2016 and continuing through the second half of Fiscal Year 2015-2016, the CPO began to assess the fiscal needs of the CPO and budget for anticipated and unanticipated expenditures related to the transition from a program to a fully functioning independent office within state government.

Figure 10: FY 2015-16 Budget Allocations	
Expenditure	**Cost**
Advisory Board Services	$7,200
NACC Indirect Expenses (Quarters 1 & 2)	$22,241
Judicial Professional Services (Quarters 3 & 4)	$10,000
Legal Services	$27,838
Personnel Services	$355,884
General Operating Fund	$61,599
TOTAL BUDGET ALLOCATION FOR FY 2015-16	**$484,762**

[3] The reduction in funds between FY 14/15 and FY 15/16 was a result of CPO becoming an independent agency. The funds previously allocated to the NACC were reevaluated and reduced after the CPO was moved under the judicial department.

Accomplishments

Increasingly during the past fiscal year, the CPO was used as a resource by law enforcement, city government, juveniles and even a county child welfare department. These contacts and collaborations represent significant strides for the CPO. Being utilized by not only private citizens but entities within the child protection system is a vital role of the CPO as an educator. While the CPO experienced growth in several areas during the past fiscal year, the examples below highlight key areas in which the CPO has expanded.

First Juvenile Contact

For the first time since its inception, the CPO received a complaint from a juvenile. A juvenile in the metro area contacted the CPO with concerns that their relationship with their caseworker was hindering progress in the case and negatively affecting the juvenile. In their complaint, the juvenile alleged that they had attempted to discuss their concerns with the county child welfare department, but they did not believe their concerns were heard and/or seriously considered.

"I really enjoyed my time meeting with Sabrina, she was cool. I appreciate her taking the time to ask me about my caseworker."

Gabby A.
Juvenile Contact

The CPO opened a review and quickly learned that several people involved with the juvenile's case had also become concerned that the relationship had reached a level that was detrimental. There were reports that the caseworker had missed meetings. One professional involved in the case said they viewed the relationship as "unsupportive." The CPO also became concerned that the relationship was negatively affecting the permanency of the juvenile. Those concerns and findings were presented to the department under review. The CPO also made recommendations to review the case and the caseworker assignment. It has since been reported that a new caseworker was assigned to the case and the juvenile is doing well.

Selected to Serve on the Denver Child Safety Net Impact Team

In July 2015, Denver Mayor Michael Hancock selected the CPO to serve on the Denver Child Safety Net Impact Team. The team was created in response to the death of a 23-month-old who died of abuse that summer. The child's family had been the subject of several calls to child protection services. In addition to creating recommendations for ways to improve Denver's child-welfare system, the team was also charged with reviewing all areas – from technology to training – that affect child protection. Denver Public Schools, the Denver City Attorney's Office, the Denver District Attorney's Office, the CDHS, the Boys & Girls Club and others were also selected to serve on the team.

Contacted by Rural Area Law Enforcement

The CPO has launched aggressive efforts to reach more members of the child protection community in rural areas. During the past fiscal year, the CPO completed an investigation that was triggered when law enforcement reported concerns with the local child welfare department. The allegations were egregious and through its investigation the CPO revealed serious law and policy violations by both a director and supervisor. A complete copy of the investigative report may be found in Appendix C. The impact of this investigation highlights the value of CPO's independent evaluations. But it also demonstrates the ongoing need for outreach efforts to rural communities that are less familiar with the services of the CPO.

Outreach

More outreach initiatives were completed and launched in Fiscal Year 2015-2016 than in any other year of the CPO's existence. Connecting with and serving new communities ensures that the CPO is well versed in the diverse needs of agencies across the state and is a crucial part of improving the child protection system. During the past fiscal year, the CPO completed site visits to the Indiana Department of Child Services Ombudsman Bureau and the Office of the Family and Children's Ombudsman in Tukwila, Washington to help design smart and effective initiatives and policies. The CPO delivered informational sessions during conferences for several stakeholders in the child protection community and has maintained a presence on multiple committees, such as the Child Fatality Review Team and the Colorado Department of Public Health and Environment's Child Fatality Prevention System State Review Team. In an effort to continually improve the CPO's outreach strategy, the office also started collecting surveys on public awareness of the CPO, including surveys sent to the Foster Parent Association and judicial officers.

Opening an Independent Agency

In becoming an independent government agency, the CPO, in many ways, opened a new office. During the last six months of Fiscal Year 2015-2016, the CPO maintained seamless communication with the public while it acquired phones, computers and necessary software. It continued investigating and reviewing complaints as it also worked with the judicial department to construct a permanent office space in the Ralph L. Carr Colorado Judicial Center. The CPO also worked to improve the office as it became an independent agency by completing a rebranding initiative and developing an internship program.

Moving Forward

As an essential process of opening a new office, the Ombudsman completed an extensive assessment of the CPO's operations. This assessment included a review of the office's statewide outreach, its performance in investigating systemic issues and its efforts to improve the office's transparency. This evaluative process was informative and will be ongoing.

Strategic Plan

Following the review of the past five years, the CPO created a strategic plan to move forward effectively. While there are many objectives the CPO plans to work towards during the next fiscal year, below are three key strategies it will focus on:

- Increase statewide outreach and awareness of the office
- Increase the number of systemic reviews/investigations
- Improve transparency

Statewide Outreach

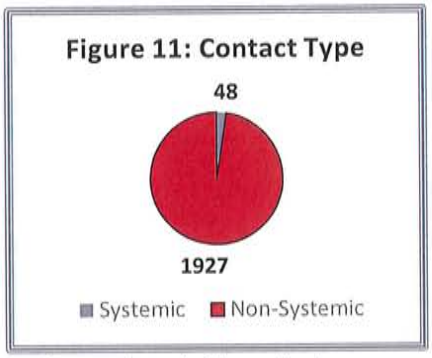
The CPO is tasked with creating a well-publicized, easily accessible and transparent grievance process for the public to voice their concerns about the child protection system. Additionally, the office is required to make systemic recommendations to the General Assembly to improve the safety of and promote better outcomes for children and families receiving services.

To accomplish these goals, the CPO needs to dramatically increase its statewide outreach efforts. It is impossible to promote the services of the office, or to learn about the needs of children, families and child protection stakeholders across Colorado if the CPO does not dedicate substantial time and resources to increasing our statewide knowledge.

This summer the Ombudsman and the CPO staff began a "listening tour" throughout Colorado to speak to stakeholders in rural Colorado. Most recently, the CPO completed a trip to southwest Colorado where staff met with partners and learned about the challenges facing a rural community's ability to provide child protective services to children and families. These initial efforts have broadened the community's understanding of the CPO and informed the CPO about ways to expand its role from responding to citizen complaints to proactively serving as a resource for the child protection system.

Systemic Reform

During the past five years, this office has focused almost entirely on individual complaints about child welfare human services agencies. In fact, only 48 of the 1,927 complaints the CPO has received have been concerning systemic issues. As this report indicates, these individual complaints have been vitally important and have resulted in numerous changes in policy and practice. And while this work will continue, the CPO is expanding its focus on the child protection system as a whole. In order to ensure the CPO is meeting its mandate, as established in SB 15-204, it must work to improve the child protection system in its entirety.



The overall number of calls that the CPO receives has increased by more than 300 percent in the past five years, yet the number of investigative staff has remained the same. It will be critical to increase the investigative capacity of this office so that it can promptly and thoroughly respond to the public's concerns about systemic problems. Due to the lack of proper funding and staffing, the CPO has not yet had the ability to consistently dedicate resources toward these issues. These are problems that impact not just one or two children, but potentially generations of children and their families.

Currently, the CPO has started researching several systemic issues affecting hundreds of children in the state. Without additional funds, however, those initiatives run the risk of taking years to complete or, in some cases, never starting. More funding will be required so that these investigations can be pursued. Despite this challenge, the CPO is utilizing all resources available to it.

Utilizing the resources that are currently available while also seeking to expand the CPO will be key in advancing the office's mission. Systemic reviews can provide valuable information to other state departments and the legislature.

Transparency

Historically, one of the biggest frustrations by the public is the lack of information that they receive about child protection cases. This lack of information has created uncertainty and even distrust about the proper functioning of the child protection system.

While the CPO is bound by both federal and state confidentiality laws, the CPO does have the mandate to provide data to the public about the child protection system. To date, the CPO has had insufficient resources to consistently and regularly inform the public about how the child protection system is functioning.

One tool that will aid the CPO's ability to communicate more precisely to the public about system wide problems is the use of a new computer database that will begin in October 2016. Prior to the new database, the CPO had no ability to quantify the nature of complaints and develop systemic trend data. The new database has been designed to collect both the primary and secondary natures of complaints – allowing the CPO to identify areas of systemic concern and communicate them to the public. The database will also track violations to policy and law to demonstrate either a need for clarification to a particular policy or statute, or improved training statewide.

Additionally, the CPO hired its first ever Communications and Policy Director. This part-time position will allow the CPO to develop a strong communications strategy that serves to consistently educate the public on CPO findings recommendations and overall programming.

Conclusion

The CPO serves a vital function in the improvement of the child protection system. However, there is room to improve our performance and expand our services. The CPO is looking forward to the next chapter in the evolution of the office. There is a lot of work to be done and it cannot be done alone. The protection of Colorado's children is everyone's responsibility, not only as professionals but as human beings. It is a charge, and one the CPO does not take lightly. Ensuring a positive and healthy future for Colorado's children will take the efforts of each and every citizen of Colorado. We look forward to working alongside the members of the child protection community, and citizens of Colorado, to ensure a stronger child protection system for the future.

Appendix A: Fiscal Year 2015-16 Data Analysis

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Adams	23	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	8 3 6 6	Inquiry Review	7 16	Affirmed Agency/Caseworker Actions Closed per Complainant Closed Lack of Information Declined to Investigate Resource Referral Open Case(s)/No Disposition	13 1 1 2 3 3
Alamosa	2	Intake/Assessment	2	Review	2	Affirmed Agency/Caseworker Actions Agency/Caseworker Non-Compliance with Policy or Law	1 1
Arapahoe	49	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	16 11 8 14	Inquiry Review	16 33	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 Resource Referral	30 2 1 1 3 1 1 10
Archuleta	2	Intake/Assessment Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Closed per Complainant	1 1
Baca	1	Lack of Response	1	Review	1	Affirmed Agency/Caseworker Actions	1
Bent	6	Intake/Assessment Non-Compliant	3 3	Inquiry Review	3 3	Affirmed Agency/Caseworker Actions Closed Lack of Information Closed per Complainant Resource Referral	3 1 1 1

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Boulder	9	Case/Ongoing Intake/Assessment Non-Complaint	1 2 6	Inquiry Review	6 3	Affirmed Agency/Caseworker Actions Closed Lack of Information Close per Complainant Declined to Investigate Resource Referral	3 2 1 1 2
Broomfield	4	Case/Ongoing Lack of Response Non-Complaint	1 2 1	Inquiry Review	1 3	Affirmed Agency/Caseworker Actions Closed per Complainant	3 1
Chaffee	3	Case/Ongoing Intake/Assessment	2 1	Review	3	Affirmed Agency/Caseworker Actions Open Case(s)/No Disposition	1 2
Cheyenne	0						
Clear Creek	1	Non-Complaint	1	Inquiry	1	Closed per Complainant	1
Conejos	3	Intake/Assessment Lack of Response Non-Complaint	1 1 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Resource Referral	2 1
Costilla	3	Case/Ongoing Intake/Assessment	1 2	Review	3	Affirmed Agency/Caseworker Actions	1
Crowley	2	Case/Ongoing Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Resource Referral	1 1
Custer	0						
Delta	3	Case/Ongoing Intake/Assessment	2 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Closed per Complainant	2 1

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Denver	60	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	12 13 12 23	Inquiry Investigation Review Review with Monitoring	24 1 34 1	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Agency/Caseworker Non-Compliance with Policy or Law Closed Lack of Information Closed per Complainant Declined to Investigate Deviation from Best Practice Standards Resource Referral Open Case(s)/No Disposition	26 1 2 2 2 1 1 19 6
Dolores	1	Lack of Response	1	Review	1	Affirmed Agency/Caseworker Actions	1
Douglas	11	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	2 2 1 6	Inquiry Review	6 5	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Resource Referral	4 1 6
Eagle	3	Intake/Assessment Lack of Response	2 1	Review	3	Affirmed Agency/Caseworker Actions	3
Elbert	0						
El Paso	45	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	10 2 2 18	Inquiry Review	18 27	Affirmed Agency/Caseworker Actions Agency/Caseworker Non-Compliance with Policy or Law Closed Lack of Information Resource Referral Open Case(s)/No Disposition	25 1 2 16 1

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Fremont	12	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	3 3 1 5	Inquiry Review	6 6	Affirmed Agency/Caseworker Actions Closed per Complainant Closed Lack of Information Duplicate Referral Resource Referral	6 3 1 1 1
Garfield	5	Case/Ongoing Non- Complaint	2 3	Inquiry Review	3 2	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Closed Lack of Information Resource Referral	1 1 2 1
Gilpin	3	Case/Ongoing Non-Complaint	1 2	Inquiry Review	2 1	Affirmed Agency/Caseworker Actions Closed per Complainant	1 2
Grand	0						
Gunnison	7	Intake/Assessment Lack of Response	5 2	Review	7	Affirmed Agency/Caseworker Actions Duplicate Referral	6 1
Hinsdale	0						
Huerfano	3	Case/Ongoing Intake/Assessment Lack of Response	1 1 1	Review	3	Affirmed Agency/Caseworker Actions	3
Jackson	1	Lack of Response	1	Review	1	Affirmed Agency/Caseworker Actions	1
Jefferson	44	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	11 16 6 11	Inquiry Review	15 29	Affirmed Agency/Caseworker Actions Agency/Caseworker Non-Compliance with Policy or Law Closed Lack of Information Closed per Complainant Declined to Investigate Resource Referral Open Case(s)/No Disposition	25 1 2 3 3 9 1

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Kiowa	0						
Kit Carson	2	Intake/Assessment Mandated Reporting	1 1	Inquiry Investigation	1 1	Agency/Caseworker Non-Compliance with Policy or Law Closed per Complainant	1 1
Lake	1	Non-Complaint	1	Inquiry	1	Closed per Complainant	1
La Plata	6	Intake/Assessment Lack of Response Non-Complaint	1 2 3	Inquiry Review	4 2	Affirmed Agency/Caseworker Actions Closed per Complainant Declined to Investigate Resource Referral	2 1 1 2
Larimer	32	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	11 8 1 12	Inquiry Review	14 18	Affirmed Agency/Caseworker Actions Closed Lack of Information Closed per Complainant Declined to Investigate Resource Referral Open Case(s)/No Disposition	16 2 3 2 7 2
Las Animas	4	Case/Ongoing Intake/Assessment Lack of Response	2 1 1	Inquiry Review	1 3	Affirmed Agency/Caseworker Actions Resource Referral Open Case(s)/No Disposition	2 1 1
Lincoln	2	Lack of Response Non-Complaint	1 1	Inquiry Review	1 1	Resource Referral Open Case(s)/No Disposition	1 1
Logan	3	Intake/Assessment Lack of Response Non-Complaint	1 1 1	Inquiry Review	2 1	Affirmed Agency/Caseworker Actions Closed per Complainant Resource Referral	1 1 1

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Mesa	20	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	5 7 3 5	Inquiry Investigation Review	5 1 14	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Agency/Caseworker Non-Compliance with Policy or Law Closed Lack of Information Declined to Investigate Investigation Initiated Resource Referral Open Case(s)/No Disposition	7 1 3 1 1 1 4 2
Mineral	0						
Moffat	0						
Montezuma	11	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	2 3 2 4	Inquiry Review	5 6	Affirmed Agency/Caseworker Actions Closed Lack of Information Closed per Complainant Resource Referral	6 1 3 1
Montrose	8	Case/Ongoing Intake/Assessment Non-Complaint	2 2 4	Inquiry Review	4 4	Affirmed Agency/Caseworker Actions Closed Lack of Information Resource Referral	4 3 1
Morgan	3	Intake/Assessment Non-Complaint	2 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Closed Lack of Information	2 1
Otero	4	Intake/Assessment Lack of Response	3 1	Review	4	Affirmed Agency/Caseworker Actions	4
Ouray	0						
Park	0						
Phillips	1	Lack of Response	1	Review	1	Affirmed Agency/Caseworker Actions	1
Pitkin	2	Case/Ongoing	2	Review	2	Affirmed Agency/Caseworker Actions	2

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*

County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Prowers	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
Pueblo	33	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	19 7 3 4	Inquiry Review	4 29	Affirmed Agency/Caseworker Actions Agency/Caseworker Non-Compliance with Policy or Law Closed Lack of Information Deviation from Best Practice Standards Resource Referral Open Case(s)/No Disposition	17 2 1 2 3 8
Rio Blanco	9	Case/Ongoing Intake/Assessment Non-Complaint	4 1 4	Inquiry Review	4 5	Affirmed Agency/Caseworker Actions Closed Lack of Information Closed per Complainant Resource Referral Open Case(s)/No Disposition	4 2 1 1 1
Rio Grande	0						
Routt	1	Non-Complaint	1	Inquiry	1	Resource Referral	1
Saguache	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
San Juan	0						
San Miguel	2	Intake/Assessment Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Resource Referral	1 1
Sedgwick	0						
Southern Ute	0						
Statewide	0						
Summit	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
Teller	6	Case/Ongoing	6	Review	6	Affirmed Agency/Caseworker Actions	6

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Washington	4	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint	1 1 1 1	Inquiry Review	1 3	Affirmed Agency/Caseworker Actions Closed per Complainant Deviation from Best Practice Standards	2 1 1
Weld	17	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Permanency	7 1 3 5 1	Inquiry Review Review with Monitoring	5 10 2	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions with Recommendations Closed Lack of information Closed per Complainant Declined to Investigate Resource Referral Review with Monitoring Open Case(s)/No Disposition	6 1 1 2 1 1 2 3
Yuma	3	Case/Ongoing Non-Complaint	1 2	Inquiry Review	2 1	Affirmed Agency/Caseworker Actions Closed Lack of Information Resource Referral	1 1 1
Colorado Department of Human Services	2	Intake/Assessment	2	Review	2	Affirmed Agency/Caseworker Actions Declined to Investigate	1 1
Department of Youth Corrections	2	Non-Complaint	2	Inquiry	2	Closed Lack of Information	2
Unknown**	95	Non-Complaint	95	Inquiry	95	Closed per Complainant Closed Lack of Information Resource Referral	9 23 63

CHILD PROTECTION OMBUDSMAN of COLORADO

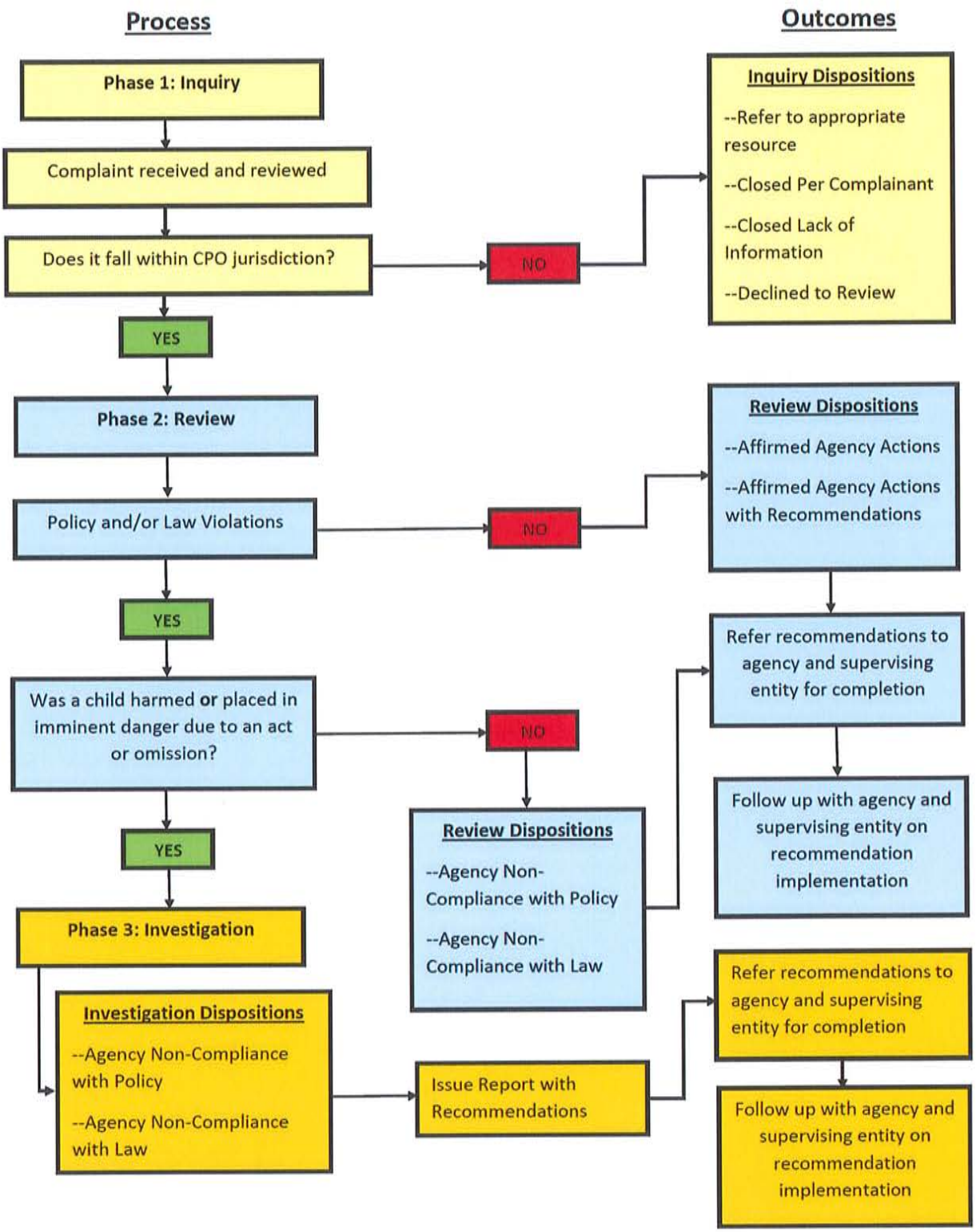
Overview of Ombudsman Contacts
Fiscal Year 2015-2016

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2015-2016*							
County	Number of Contacts	Nature of Contacts (n=582)		Ombudsman Response to Contacts (n=582)		Disposition of Resolved Contacts (n=551)	
		Nature	Number	Response	Number	Result	Number
Total	580	Case/Ongoing	137	Inquiry	266	Affirmed Agency/Caseworker Actions	252
		Intake/Assessment	126	Investigation	3	Affirmed Agency or Caseworker Actions with Recommendations	7
		Lack of Response	66	Review	308	Agency/Caseworker Non-Compliance with Policy or Law	12
		Mandatory Reporting	1	Review with Monitoring	3	Closed, per Complainant	41
		Non-Complaint	249			Closed, Lack of Information	54
		Permanency	1			Declined to Investigate	14
						Deviation from Best Practice Standards	4
						Duplicate Referral	3
						Investigation Initiated	1
						Resource Referral	159
						Review with Monitoring	2
						Open Case(s)/No Disposition	31

*OCPO 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 OCPO in that particular location or some other variables yet to be identified. As OCPO 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.

Appendix B: CPO Process Flow Chart


Process
Outcomes
Phase 1: Inquiry
Complaint received and reviewed
Does it fall within CPO jurisdiction?
NO
Inquiry Dispositions
--Refer to appropriate resource
--Closed Per Complainant
--Closed Lack of Information
--Declined to Review
YES
Phase 2: Review
Policy and/or Law Violations
NO
Review Dispositions
--Affirmed Agency Actions
--Affirmed Agency Actions with Recommendations
YES
Was a child harmed or placed in imminent danger due to an act or omission?
NO
Refer recommendations to agency and supervising entity for completion
Follow up with agency and supervising entity on recommendation implementation
YES
Review Dispositions
--Agency Non-Compliance with Policy
--Agency Non-Compliance with Law
Phase 3: Investigation
Investigation Dispositions
--Agency Non-Compliance with Policy
--Agency Non-Compliance with Law
Issue Report with Recommendations
Refer recommendations to agency and supervising entity for completion
Follow up with agency and supervising entity on recommendation implementation

Appendix C: Investigations

OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN

November 25, 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 #10991/11037

Denver County
Arapahoe County

(303) 864-5111

www.protectcoloradochildren.org

Executive Summary

[redacted] came to the attention of the Denver Department of Human Services on May 15, 2014 after a report was filed that she was born prematurely and her mother had tested positive for marijuana. At the time of the report, there was not a positive toxicology screen back on [redacted]. Per Denver County Department of Human Services policy, the referral was staffed through RED Team and assigned to a caseworker for assessment on May 16, 2014 with an appropriate five-day response timeframe.

A new referral regarding the same child was made to the Department on July 27, 2014. The reporting party indicated that the child had been admitted to The Children's Hospital with significant life-threatening injuries. This referral was immediately assigned for assessment. The child succumbed to the injuries on July 31, 2014. This referral is not the subject of this investigation; however, it is mentioned due to the fatality of the child. An internal review by Denver County Department of Human Services was initiated and revealed inconsistencies in the case record and other resources. At that time, the Denver County Department of Human Services contacted the Office of Colorado's Child Protection Ombudsman and requested that the Office conduct an independent review of the matter.

Our investigation revealed that the caseworker responsible for the May 15, 2014 referral missed opportunities to offer prevention and support services to the family. Through interviews with hospital staff, family members, DHS Staff and reviewing outside documentation, the OCCPO found no evidence to support the entries made by the caseworker into the TRAILS database, the official child welfare reporting database. Accuracy and currency of the information entered into the TRAILS database are fundamental requirements of human services practice in Colorado and constitute the official public record of the facts and actions taken. Interviews and documentation reviewed by the OCCPO also showed that the hospital staff, family and children were never seen or interviewed by the assigned caseworker, despite detailed documentation by the assigned caseworker in the assessment summary to the contrary. The OCCPO found that the entries made by the caseworker with regards to all aspects of the investigation were false. The caseworker resigned her position shortly after [redacted]'s death. The investigation did find violations of law, and identified changes that can be made to improve overall practice.

The OCCPO found it to be a strength of DDHS to identify inconsistencies in the caseworker's practice and to reach out to the OCCPO to request an independent review of their staff's work. Further the OCCPO found the steps taken since the Department became aware of the concerns with this caseworker's work were proactive and transparent in nature and accountable for identifying service gaps and improving the work that they do for the children and families of Denver County. It should be noted that DDHS has completed a review of all referrals assigned to this caseworker during her tenure at DDHS and has taken appropriate steps based upon their findings.

The Complaint:

On September 25, 2014, the OCCPO was contacted by the Director of Denver Department of Human Services ("DDHS" or "The County"). The County stated that on September 18, 2014, DDHS staff discovered multiple inconsistencies between information received from external parties, as compared with the caseworker's recorded documentation. The County subsequently requested that the OCCPO complete an independent and thorough review of the May 15, 2014 Assessment Summary and the casework that was documented in the official case record.

Decision to Investigate:

At the request of Denver Department of Human Services, the OCCPO opened a review into the complaint on September 25, 2014. According to the TRAILS database, the County assigned the referral concerning [redacted]'s premature birth and subsequent in-utero drug exposure on May 16, 2014 for investigation by an intake caseworker. 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 hospital staff mentioned in the Assessment Summary, as well as family members and staff of the Denver Department of Human Services. The OCCPO also made attempts to interview the caseworker who completed the investigation in May 2014; however, multiple phone calls and messages were not returned. Based on the information gathered throughout these interviews, as well as the review of birth and hospital records, TRAILS reports and collateral documentation, the OCCPO determined that there were egregious actions taken by the caseworker in this assessment. 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 [redacted] on November 6, 2014.

During the review of this case, the OCCPO identified a referral that had been made to Arapahoe County Department of Human Services on June 3, 2014. The reporting party was a mandated reporter expressing concern for the well-being of one of [redacted]'s siblings. The reporting party was relaying information that had been told to her by an individual that had reportedly received this information directly from the family. The mandated reporter did not have direct knowledge of the family, nor had they seen the children to verify this information. The reporting party stated that the mother was struggling with post-partum depression, had five children and that recently the mother had gotten mad at her 2-year-old and slammed their head into the tub leaving significant injuries. The person reporting did not have any contact information for the family, or the correct spelling of the family names. The OCCPO reviewed the information in the TRAILS database and although ACDHS staff attempted to locate the family in the various assistance databases, as well as TRAILS, they did not re-contact the

reporting party to attempt to gain more information on the family's whereabouts. The referral was closed out with the disposition "Insufficient information to locate child/family or to proceed."

Based on this information, Arapahoe County Department of Human Services was included in this investigation and notification of such was sent to Cheryl Ternes, Director of Arapahoe County Department of Human Services and Reggie Bicha, Executive Director of the Colorado Department of Human Services on November 7, 2014.

INVESTIGATIVE OVERVIEW:

During the course of this investigation, the OCCPO reviewed all of the TRAILS documentation, interviewed professional and personal collaterals, spoke with Denver County Department of Human Services staff and reviewed police and medical records related to [redacted]. The OCCPO also made multiple attempts to contact the intake caseworker responsible for the May 2014 investigation in question; however, those attempts to contact were unsuccessful. The OCCPO also reviewed the practice of both Denver County and Arapahoe County Departments of Human Services for any notable practice concerns, as well as overall compliance with Volume VII and the Colorado Children's Code.

Denver County Investigation

Volume VII outlines Colorado's Child Protection rules for County and State Human Services staff, including rules for the completion of assessments related to allegations of abuse and/or neglect. Volume VII clearly states that all reports of physical injury consistent with child abuse and/or neglect should be thoroughly assessed by the appropriate county department. Further, Volume VII defines the specific steps of an assessment to include face to face interviews with the victim listed in the referral, siblings associated with and/or living in the same residence as the victim, as well as the alleged perpetrator and non-offending parent or caregiver. In this instance, the OCCPO found multiple inconsistencies in the reporting of this caseworker which led to the conclusion that the information documented in the Assessment Summary for the referral made to Denver County Department of Human Services was false. The following outlines a portion of the inconsistencies noted by the OCCPO during the course of this investigation.

- On two occasions the caseworker noted having visited [redacted] in the Neonatal Intensive Care Unit (NICU) shortly after her birth. The OCCPO spoke with hospital officials regarding the caseworker's visits and were informed that the caseworker did not make any visits to the hospital. The OCCPO also spoke with family members and confirmed that the caseworker was not present at the hospital as the Assessment Summary indicates.

- On two occasions the caseworker noted that [redacted] was being cared for in the NICU and was receiving supplemental oxygen due to her prematurity. The Assessment Summary notes also state that [redacted] was sent home on oxygen. The OCCPO requested hospital birth records and reviewed such records. The records indicated that [redacted] was on room air following birth and never required supplemental oxygen. The records further documented that [redacted] was discharged home to her parents on room air with no supplemental oxygen. The OCCPO also interviewed family members and hospital staff who confirmed that [redacted] was never provided supplemental oxygen at any point after birth.

- On two occasions the caseworker noted that information was received from the hospital indicating that test results were pending with regard to [redacted]'s substance exposure. One of the notations in the Assessment Summary states that the caseworker received a voice message from hospital staff stating that [redacted]'s meconium test results were negative for all substances. The OCCPO spoke with hospital staff who reported that they did not leave such a message and that the person documented as leaving the message was out of town at the time that the caseworker documented the call. The OCCPO also gathered medical records to investigate the caseworker's statements that [redacted] had tested negative for all substances. The medical records indicated that [redacted]'s meconium had tested positive for THC which is contrary to that which the caseworker noted.

- The caseworker noted in the Assessment Summary that a home visit was completed at which time all of the children were either interviewed or observed. The Assessment Summary also documents interviews with both of [redacted]'s parents. The OCCPO interviewed family members and was advised that at no time did a caseworker come to the family home, nor did the caseworker make any attempts to outreach to the family by telephone.

Denver County Findings

The OCCPO finds that the caseworker for Denver County Department of Human Services may have violated statute as outlined in the Colorado Criminal Code (Colorado Revised Statutes Title 18) by entering false information into the TRAILS database. Other criminal charges may certainly be warranted as well, based on the OCCPO findings.

The following Volume VII violations that would have directly impacted the County Department's response and intervention strategies are as follows:

Risk Assessment (7.202.54)

- N8: Primary Caregiver has a Substance Use Problem
    - Caseworker marked this as "NO" and it should have been "YES"

- N10: Recent or History of Domestic Violence in the Household
    - Caseworker marked this as "NO" and it should have been "YES"
- A7: Caregiver(s) Involved in Disruptive/Volatile Adult Relationships
    - Caseworker marked this as "NO" and it should have been "YES"
- A9: Caregiver(s) has History of Mental Health Treatment
    - Caseworker marked this as "NO" and it should have been "Either Caregiver"
- A10: Secondary Caregiver has a Substance Use Problem
    - Caseworker marked this as "NO" and it should have been "Other drugs or drugs and alcohol combined"

Had the above factors been scored correctly, the overall risk score would have been "High" rather than "Moderate". With a "High" overall risk score, the caseworker would have been required to explain how the risk factors had been remediated or provide preventative services to ensure the overall wellbeing of the children.

Safety Assessment (7.202.533)

The caseworker indicated that there were no safety threats noted; however, due to [redacted] being born positive for THC, Volume VII specifies what constitutes a safety threat as follows:

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

The safety concerns definition for this safety threats includes "Baby is exposed in-utero to alcohol and/or drugs". Had the caseworker accurately checked this box, she would have been required to assess further the protective capacities of the parents and make a determination regarding if the child would remain safe with her parents or if the family would benefit from intervention services.

Denver County Recommendations:

1. Denver County Department of Human Services should consult with the Denver District Attorney regarding possible criminal charges.

2. Denver County Department of Human Services should receive training and technical assistance surrounding supervision of casework staff to include how to recognize concerning casework documentation and overall practice and work ethic (ie: cut and paste, limited detail in contact summaries, work attendance and overall performance).

3. To ensure best practice and accountability of all Human Services staff, Denver County Department of Human Services will implement policy and procedures related to

supervision of casework practice to ensure that documentation of contacts and assessment steps are accurate. (i.e. spot checks to ensure contact is being made with clients, shadowing of caseworkers by supervisors, etc.)

4. In addition, Denver County Department of Human Services should ensure that all staff responsible for the supervision and management of caseworkers is trained on the above policies and procedures implemented regarding review of casework practice.

Denver County Response to Recommendations

Denver Department of Human Services reviewed the above report and recommendations and reported the following steps that have been taken to address the concerns outlined and the associated recommendations:

- The County reports it has several trainings that are either in progress or completed. These trainings include, but are not limited to: Group Supervision and Coaching, RED Team Format Refresher, Intake Referral and Assessment Practice and Procedures, Risk Assessment and Goal Statement Development, and Intake Supervisor Procedures including TRAILS Data Entry Requirements. The County reported they should continue to provide ongoing training in these areas to ensure that casework and supervisory skills are well established.
- The County reports it continues to train staff on both RED Team and Group Supervision. Both represent evidence-informed models of practice aimed at enhancing decision-making on child welfare cases.
- The County reports that it has re-instituted the position of Training Manager for the Division of Child Welfare, and has filled that position with a new hire. The Training Manager is developing an annual training plan to include training for supervisors and managers that is specifically aimed at enhancing skills in identifying "signals" associated with employees who are struggling, as well as proactive coaching techniques. The Division's training plan will drive training priorities for the 2015 calendar year, and will be assessed regularly under Continuous Process Improvement practices.

The OCCPO concurs with these steps and acknowledges the work that Denver Department of Human Services has taken, and continues to take, in order to ensure effective and thorough service delivery to the children and families of Denver County.

Arapahoe County Investigation

During the course of the investigation into the concerns of Denver County's caseworker's lack of response to the allegations listed in the May 15, 2014 referral, the OCCPO discovered a referral of concern was made to Arapahoe County Department of Human Services on June 3, 2014. While reviewing the referral, the OCCPO found that the referral was screened out due to insufficient information to locate the family. The OCCPO acknowledges Arapahoe County's efforts to locate the family through running the information provided to them through the various assistance databases, as well as through TRAILS. The OCCPO further acknowledges that the information provided to Arapahoe County was limited and spellings of names were incorrect.

Arapahoe County Findings

The OCCPO did not find that Arapahoe County Department of Human Services violated Volume VII or the Children's Code with reference to this concern. The OCCPO did find that there was a concern with regards to practice related to this referral. The OCCPO believes that further steps could have been taken to recontact the reporting party in an effort to gain any other possible contact information for the family.

The OCCPO reviewed the Collaborative Fatality Report submitted by Denver County Department of Human Services and Arapahoe County Department of Human Services. In the report, Arapahoe County Department of Human Services acknowledged that they could have called the reporting party to elicit further information regarding the family. The OCCPO concurs with this finding. As a result of their internal review, Arapahoe County Department of Human Services has provided all staff with training as to the completion, and importance of, proper Partnering for Safety Frameworks in TRAILS for RED Teams.

Arapahoe County Recommendations

1. Arapahoe County Department of Human Services should maintain staff training regarding the completion and importance of proper Partnering for Safety Frameworks in TRAILS for RED Teams.

Arapahoe County Response

Arapahoe County indicated that they were comfortable with the findings and appreciated the recommendation made.

OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN

August 21, 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 #11445

Denver County

(303) 864-5111

www.protectcoloradochildren.org

Executive Summary

The [redacted] family has an extensive social services history from 2011-2014. On July 21, 2014, the Denver Department of Human Services was advised of a child that was in the hospital due to excessive head trauma. That child subsequently passed away a short time later due to his injuries. The Office of Colorado's Child Protection Ombudsman (OCCPO) became involved after receiving a call of concern that the [redacted] family had extensive history with Arapahoe and Denver Departments of Human Services and that Denver Department of Human Services was working with the family at the time of the child's death.

During the course of the review and subsequent investigation, the Office of Colorado's Child Protection Ombudsman examined referrals and assessments that preceded the death of [redacted], as well as reviewed documents related to the death of [redacted], spoke with professionals that were involved with the [redacted] family and met with the administration of the Denver Department of Human Services.

The OCCPO investigation revealed a pattern of issues concerning the response to reports related to domestic violence. On multiple occasions, the Denver Department of Human Services was notified of incidents of domestic violence behavior and those reports were screened out or not assigned for further assessment. The OCCPO found the family had six reports of suspected abuse and neglect made to Denver County from 2013 through 2014 (not including the fatality). Of these six reports, three were not assigned for assessment and three were assigned. Further the OCCPO investigation found that in instances where the referral was assigned for investigation, not all parties were spoken to and the concerns of domestic violence were not thoroughly assessed.

The investigation by the OCCPO revealed there was the lack of services provided to the [redacted] family. On two separate occasions, during two assessments directly leading up to the child's death, the family was identified as one that would benefit from preventative services through Colorado's SafeCare program; however, no referral for services was ever made.

The OCCPO believes that the actions, and inactions, by the Department's staff involved with this family, failed to be in compliance with policy on multiple occasions. The OCCPO believes these failures had a potential impact on the children's safety and well-being. The OCCPO 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 recognizes and appreciates the work and efforts that the Denver Department of Human Services has been doing over the course of the last year to improve their practice and response to concerning reports of abuse and/or neglect within their community. The OCCPO supports the ongoing training system which has been implemented in Denver to improve case practice and would encourage ongoing efforts to maintain this moving forward.

The Complaint:

On April 29, 2015, the OCCPO received a complaint stating that an infant, while in the care of his father, and under the supervision of the Denver Department of Human Services, had passed away in July 2014. The complainant was concerned that the family had extensive social services history, and that several concerning reports had been made to the Denver Department of Human Services, of which a many lacked a response by the Department.

Decision to Investigate:

The OCCPO opened a review into the complaint on April 29, 2015. According to the TRAILS database, the [redacted] family had prior history with Arapahoe County and Denver County Departments of Human Services dating back to 2002. This investigation looked into reports made from 2012 through 2015. The OCCPO notified Denver Department of Human Services of the review on May 6, 2015. Subsequently the OCCPO conducted a review of the complete case file at Denver Department of Human Services on May 8, 2015 and met with DDHS staff on May 15, 2015. During the course of the review, the OCCPO found that the family had 3 prior referrals involving these children in Arapahoe County and 6 prior referrals involving these children with Denver County. At the time of the youngest child's death, there was an open assessment with the Denver Department of Human Services. The OCCPO found that during a prior assessment, the Denver Department of Human Services determined the need for preventative services for the father and the children residing in his home; however, the OCCPO found this referral to the Colorado SafeCare program was never made. Further, the OCCPO found errors in previous referrals and assessments that had a potential impact on the safety of the children. As a result, on July 28, 2015, the OCCPO notified Don Mares, Director of Denver Department of Human Services and Executive Director Reggie Bicha of the Colorado Department of Human Services that an investigation had been opened concerning Denver Department of Human Services involvement with the Herron/Lucero children.

Investigative Overview:

During the course of this investigation, the OCCPO reviewed all of the TRAILS documentation, interviewed professional collaterals, spoke with Denver Department of Human Services staff and reviewed court records, medical records, coroner's reports and police reports related to all immediate 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.

Findings

The following Volume VII violations that would have directly impacted the County Department's response and intervention strategies are as follows:

Referral 2465822: July 15, 2014

- 7.202.41 Referral Response Process

  The OCCPO found that this referral alleging physical abuse leaving injury to a child was assigned improperly as a 5 day response time and met criteria for a 3 calendar day response due to the age and vulnerability of the children in the home and past history of father's volatile behavior.

- 7.202.52(B) Assessment Requirements

  "Within the assigned response timeframe, the assessment shall include a face-to-face interview with or observation of the child who is the subject of a referral of abuse or neglect. An interview shall occur if the child has verbal capacity to relate information relevant to safety decisions; otherwise an observation of the child is sufficient."

  The OCCPO found that [redacted] was noted as participating in a face to face contact on July 22, 2014; however, there are no notes discussing him in the summary. The OCCPO would note that [redacted] was in the hospital on July 21, 2014, due to injuries sustained while in his father's care and could not have been present for a face to face in the father's home on July 22, 2014. The note also did not detail the conditions of the oldest child in the home as observed by the caseworker. The details of the injury are not noted in the summary as required.

- 7.202.52(E) Assessment Requirements

  "The assessment shall include use of the Safety Intervention Model as described in Section 7.202.53. To assess for safety, interviews shall be conducted with all children, caregivers, and family members in the home to gather information that is relevant for determining whether a child is safe. These interviews shall determine: Extent of child maltreatment; circumstances surrounding the child maltreatment; child functioning on a daily basis; adults and caregiver functioning on a daily basis, parenting practices; and disciplinary practices."

  The OCCPO found that the caseworker documented information regarding [redacted] in the safety assessment; however, did not see the child as a

course of the investigation and did not gain this information until after the child's death, during a conversation with the pediatrician on July 25, 2014. Specifically the caseworker stated, "He presents as being on target developmentally"; however, the caseworker does not have a face to face contact documented with the child.

Referral 2453178: May 13, 2014

- 7.202.41 Referral Response Process

  The OCCPO found that this referral alleging physical abuse leaving injury to a child was assigned improperly as a 5 day response time and met criteria for a 3 calendar day response due to the age and vulnerability of the children in the home and past history of father's volatile behavior. The OCCPO will note that the RED Team assignment agreed on a 3 day calendar response; however, it was not assigned as such.

- 7.202.52(A) Assessment Requirements

  "Within the assigned response timeframe, the assessment shall include a face to face interview with or observation of the child who is the subject of the referral of abuse or neglect. An interview shall occur if the child has verbal capacity to relate information relevant to safety decisions; otherwise, an observation of the child is sufficient."

  The OCCPO found that [redacted] was not seen within the assigned response times. Further, the TRAILS documentation reflects that [redacted] was involved in a face to face contact on May 16, 2014; however, there is no documentation in the summary to reflect that he was assessed for safety.

- 7.202.52(F) Assessment Requirements

  "Other persons identified through the assessment who may have information regarding the alleged maltreatment shall be interviewed, if possible, as part of the assessment."

  The OCCPO found that no attempts were made to interview the mother of the children, or observe her residence. [redacted] advised on multiple occasions that the children were staying with the mother for periods of time and also expressed concern for the safety of the children around other adults residing with the mother. The caseworker did not investigate the concerns with the mother's residence, nor did she speak with the mother concerning the allegations of domestic violence.

Referral 2452913: May 12, 2014

7.202.4(G)(1) Procedures for Referrals of Abuse or Neglect

"The county department shall assign a referral for assessment if it: contains specific allegations of a known or suspected abuse or neglect as defined in statutes and regulations. A "known" incident of abuse or neglect would involve those referrals in which a child has been observed being subjected to circumstances or conditions that would reasonably result in abuse or neglect. "Suspected" abuse or neglect would involve those referrals that are made based on patterns of behavior, conditions, statements or injuries that would lead to a reasonable belief that abuse or neglect has occurred or that there is a serious threat of harm to the child.

Denver Department of Human Services screened out this referral as, "No information available from reporter of abuse and neglect as defined in law." The OCCPO found this referral to have clear information, from a mandated reporter, that would meet assignment criteria. The reporter clearly stated that there were concerns with the father's anger and aggression and this concern was compounded by the fact that the father was the primary caretaker of the children. The reporting party further stated that the family appears to lack coping skills and that security had been called on the father multiple times to de-escalate his behavior.

Referral 2397226: September 23, 2013

7.202.4(G)(1) Procedures for Referrals of Abuse or Neglect

"The county department shall assign a referral for assessment if it: contains specific allegations of a known or suspected abuse or neglect as defined in statutes and regulations. A "known" incident of abuse or neglect would involve those referrals in which a child has been observed being subjected to circumstances or conditions that would reasonably result in abuse or neglect. "Suspected" abuse or neglect would involve those referrals that are made based on patterns of behavior, conditions, statements or injuries that would lead to a reasonable belief that abuse or neglect has occurred or that there is a serious threat of harm to the child.

Denver Department of Human Services screened out this referral as, "No information available from reporter of abuse and neglect as defined in law." The OCCPO believes that a domestic violence incident, which subsequently led to the father's arrest, which occurred in the presence of a vulnerable child meets criteria for assignment as an "Injurious Environment." Further, the history of domestic violence reports to the Denver Department

of Human Services, and the Department's recent history of involvement with the family for concerns of domestic violence demonstrate a pattern of behavior which places the child's safety and well-being at risk.

Practice Concerns:

In reviewing the TRAILS documentation, the OCCPO found the following deficits in casework practice:

Referral 2465822: July 15, 2014

- Inaccuracies in documentation of the face to face contact
- Incomplete investigation into the concerns of physical abuse
- Incorrect "Referral Reason" listed on the referral
- Inaccuracies in documentation of contacts with collaterals
- Referral for SafeCare services was discussed; however, a referral was never made.
- Inaccurate completion of the Risk Assessment Tool

The OCCPO was concerned with the accuracy of the face to face contacts documented in the TRAILS database, as it is clear that the date of the face to face contact is incorrect. Further, the OCCPO was concerned that although the caseworker documents that [redacted] did have a scratch on his face, there are no details documented regarding the injury although the caseworker documents that the injury was "consistent with the explanation". Further, there is no documentation that the child underwent a complete body check for any further injury, which is best case practice when investigating allegations of physical abuse. During the course of this review, the OCCPO also spoke with collaterals concerning their contacts with the Caseworker. The OCCPO spoke with a member of the father's treatment team regarding the information documented regarding their contact with the DDHS caseworker. The collateral believed that the information documented did not accurately reflect the concerns and needs of the father that had been portrayed in the conversation with the caseworker. The TRAILS documentation states, "she did not have any major concerns"; however, when reviewing this with the collateral, she reported that was not correct as evidenced by her making the report as she believed the father was extremely overwhelmed and needed support with his parenting."

At assessment closure on July 29, 2014, the caseworker documented in the "worker impressions" section and the "closure summary" section that a referral had been made for the father to the SafeCare program; however, the OCCPO found that no referral was made.

The OCCPO found inaccuracies in the completion of the "Abuse" scale on the Risk Assessment Tool. These inaccuracies are noted for training purposes. The OCCPO notes that

the inaccuracies would not have changed the overall Risk Assessment Score.

Referral 2453178: May 13, 2014

- Inaccuracies in documentation of the face to face contact
- Incomplete investigation into the concerns of domestic violence
- Inaccurate completion of the Risk Assessment Tool
- Referral for SafeCare services was discussed; however, a referral was never made
- Inaccuracies in documentation of contacts with collaterals

The OCCPO found that the face to face contact documented for May 22, 2014 reflects seeing [redacted] in his father's home; however, he is not listed in the participants of the contact.

The initiating referral was one that reflects out of control and potentially domestic violence behavior on the part of the father; however, the OCCPO found that this was not explored with the mother and not thoroughly investigated with the father. The caseworker notes that the father admitted to domestic violence with the mother; however, no further discussion is noted. Further, Department history reflects a history of violence between the parents which should have demonstrated a pattern of concern for the caseworker to explore deeper.

The OCCPO found inaccuracies in the completion of the "Abuse" scale on the Risk Assessment Tool. The OCCPO notes that the inaccuracies would have changed the overall Risk Assessment Score from moderate to high risk, which would have required to the caseworker to mediate out the risk factors prior to closure. The OCCPO is uncertain as to why the approving supervisor did not recognize the errors in the assessment tool prior to approving closure.

The caseworker documents that she spoke with the father and his case manager and advised that she would be referring the father to the SafeCare program. The OCCPO found that the caseworker did not make a referral for the preventative services program. The OCCPO is uncertain as to why the approving supervisor did not identify that the referral for SafeCare was not made prior to approving the closure of the assessment.

As a normal portion of the review, the OCCPO spoke with appropriate collaterals to insure the accuracy of the documentation of contacts. The OCCPO spoke with the father's case manager regarding documentation in TRAILS that stated that the case manager had reported to the DDHS Caseworker that "she did not report any safety/risk concerns." The

case manager reported this to be inaccurate. The case manager stated to OCCPO that she believed she had extensively discussed her concerns with the DDHS Caseworker regarding the father being overwhelmed and needing support and that she was expecting SafeCare to become involved with the father; however, that did not occur. The case manager did not believe the contact summary written by the DDHS caseworker accurately documented her concerns.

Referral 2452913: May 12, 2014

- Inaccurate documentation of history in RED Team Framework

The OCCPO found that during the RED Team screening process, inaccurate information was presented for review when assessing response to the concerns. The RED Team documentation states, "Screen out, FOC has an anger issue with mother's family but no history of abuse or neglect on his child. No open cases or allegations of abuse and neglect on the child he has been caring for." In OCCPO research of TRAILS, the father has a founded sexual abuse allegation (2066202) against his daughter in 2009. Further, OCCPO found that there was an open FAR Case (1743278) that was initiated at the birth of [redacted].

The OCCPO finds that proper weight was not given to the reports of domestic violence during the RED Team screening process. In addition, the RED Team failed to adequately analyze the reports regarding father's criminal history which included disturbing the peace, domestic violence and threats, which all demonstrate a pattern of potentially out of control behaviors.

During the course of this review, the OCCPO also looked at the ongoing child protection case that is open with the family (TRAILS Case ID: 1774419) and found several Volume VII violations related to documentation to include:

- 7.301.3 (E): No 90 Day Reviews Documented in TRAILS
- 7.301.22(1): A Treatment Plan for DDHS was not completed until March 2015
- 7.301.24: Placement pages for the children were incomplete
- 7.301.24(J): Visitation Plans were incomplete
- 7.202.1(F): There was no documentation of Face to Face contacts in November 2014, December 2014 and February 2015.

The OCCPO brought these to the attention of the Denver Department of Human Services on May 18, 2015. The OCCPO would also note that these concerns were found on the ARD Review that had been previously completed on the case. At the writing of this report, Denver

Department of Human Services has completed documentation of their face to face contacts for December 2014 and February 2015. There is no documented face to face contact in the child's residence for November 2014. Denver Department of Human Services has also since entered all necessary 90 day reviews and completed visitation plans and placement pages for the children. It is unknown to the OCCPO why these missing components were not identified by the supervisor during routine supervisions and 90 day reviews conducted with the caseworker. Further, the OCCPO is further unclear as to why these issues were not addressed at the time they were initially identified by the Administrative Review Division.

Based on the above policy violations and the practice concern also outlined, the OCCPO will be closing this investigation as "Agency/Caseworker Violation of Policy" and makes the following recommendations:

Recommendations:

1. Training for caseworkers, supervisors and administrators responsible for the completion and supervision of the Colorado Risk Assessment Tool on the accuracy of completion of the tool.
2. Training for caseworkers, supervisors and administrators surrounding domestic violence issues to include how to assess for domestic violence, as well as, the safety threats and risk concerns that domestic violence can pose to a child.
3. Training for RED Teams regarding the importance of accurately presenting, reviewing, and documenting prior referral history when making determinations regarding the assignments of a referral for further assessment.
4. Training for all caseworkers and supervisors regarding the process for completion of referrals to the SafeCare Program.
5. Training for supervisors and administrators on assessment closure requirements and the necessity to thoroughly review all assessments for closures for accuracy of documentation, compliance with face to face contacts and other Volume VII requirements, as well as to ensure that all appropriate referrals that were referenced in the assessment have been made prior to disengaging with a family that is high risk.
6. Training for supervisors and administrators on the utilization of ARD Reviews for case tracking and supervision needs.
7. Training for caseworkers regarding Volume VII requirements concerning the completion of all components of the Family Services Plan in TRAILS, to include, treatment plans for the Department, visitation plans, placement pages and 90 day reviews.

Denver County Response to Recommendations

At the conclusion of the criminal proceedings in this case, the CPO requested a response from the DDHS concerning the investigation is provided them in October 2015. The DDHS provided a timely response in August 2016. The response was as follows:

"In response to your prompt, we received the final report on October 21, 2015. Since that time, all recommendations have been adopted and incorporated into ongoing training and practice. All recommended trainings were provided to staff and continued to be updated. New caseworkers, including the 51.5 new caseworkers approved through May Hancock's Child Net Safety Team, receive the recommended trainings through the CDHS training academy and our internal 12 week training program for new caseworkers. Additionally, we've updated our SafeCare referral process and have provided guidance on making referrals to caseworkers, including our Prevention team."

The Office of Colorado's Child Protection Ombudsman Investigation Report

Kit Carson County Health and Human Services

Case ID: 11603

June 7, 2016

I. Introduction

The Office of Colorado's Child Protection Ombudsman (CPO) was created to ensure that agencies across Colorado, responsible for providing child protection services, comply with Colorado child protection policy known as Volume VII and the laws developed to protect children, known as the Colorado Children's Code. These laws and policies were designed as a road map for child protection workers defining how to perform their duties in the best way possible to protect Colorado's children. When these policies and laws are compromised by an employee or agency, the CPO is charged with investigating the work of the agency, identifying the compliance issues and authoring recommendations to the agency to improve practice.

II. Complaint Summary

On October 16, 2014, the CPO received a complaint regarding Kit Carson County Health and Human Services (KCCHHS) failure to comply with both Volume VII and the Colorado Children's Code relating to their requirements to report third party child abuse and/or neglect to local law enforcement. The complainant stated that on two occasions, the Director of KCCHHS (Director) and a Child Welfare Supervisor (Supervisor) had been made aware of allegations of third party sexual assault on a child and had failed to report these allegations to local law enforcement for investigation.

As part of the CPO's initial review of the complaint, the CPO reviewed relevant rules and statutes outlined in Volume VII and the Colorado Children's Code relating to third party abuse and/or neglect and mandated reporting. The complete statutes and rules that were explored are included in Appendix A.

In reviewing the complaint, the CPO also took into consideration the statutory definition of sexual assault as defined in C.R.S. 18-3-405(1) which states:

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

In this case, it is alleged that the Director and the Supervisor of KCCHHS were made aware of a situation where a fourteen-year-old female had delivered a baby and the alleged father was twenty-one years of age.

III. Decision to Investigate

The CPO initiated a review of the allegations on October 16, 2014. During the course of the review, the CPO spoke with the District Attorney in Kit Carson County, reviewed law enforcement records, and all documentation that was located in the TRAILS database[1]. The CPO carefully considered the rules and statutes outlined in Appendix A, and the legislative purpose behind these rules and statutes, particularly surrounding mandatory reporting. Mandatory reporting rules and statutes were developed to guide those persons that have a high likelihood of contact with a child or children that may experience child abuse and/or neglect on what to do, what to report and whom to report to when there is a concern regarding child abuse and neglect. These rules and statutes apply to both cases of child abuse and/or neglect in which the alleged perpetrator is a family member, or in cases where the alleged perpetrator is not of any relation to the child who is alleged to being mistreated.

The evidence reviewed by the CPO staff supported the complaint that the Director and Supervisor had been made aware of allegations of child sexual assault and had failed in their duties to report such to local law enforcement as they are required under law to do. This failure to comply with child protection law and policy led the CPO to open an investigation into the concerns on October 21, 2015, at which time the Director of KCCHHS, and Executive Director Reggie Bicha of the Colorado Department of Human Services were notified. The investigation into the complaint filed with the CPO was delayed due to the criminal and legal proceedings related to this matter. Due to the pending criminal charges, as well as at the request of the District Attorney, the CPO respectfully waited for these proceedings to conclude prior to issuing a formal report as to not interfere in any way with the legal process.

IV. Investigative Summary

The CPO investigation looked into two specific reports of alleged child abuse made to the KCCHHS child welfare program. A summary of these two reports, and the actions of the KCCHHS staff in response to the reports is outlined below.

On August 6, 2014, the KCCHHS child welfare program received a report regarding a child, [redacted] (age 14), and her newborn daughter, [redacted]. The reporter notified the department that [redacted] had given birth to a child prematurely and the infant girl had been transferred to a Denver area hospital for care. The reporting party expressed concern that the young girl had hid the pregnancy and had not received any prenatal care. The report also stated concern for [redacted]'s ability to adequately parent as evidenced by her watching cartoons in the hospital while parenting education was being attempted. The reporter requested follow up

[1] TRAILS Database: the statewide database used for documenting all calls to county/state human services agencies regarding abuse and/or neglect, as well as all of the work completed by agency staff relating to reviewing and investigating allegations of abuse and/or neglect.

by the KCCHHS to offer parenting assistance for the young mother. Further, the reporting party indicated that the mother's boyfriend was approximately 20 years of age.

On August 7, 2014, KCCHHS employees, including the Supervisor and three others, reviewed the report and after evaluation did not believe there was concern for abuse and neglect and did not provide any further action or investigation into the concerns reported. In the documentation completed by department staff, it is noted that the agency's next step was to report the concerns to local law enforcement. A note that was also entered by the Supervisor states that the referral was staffed with the Director and that she concurred with the decision not to assign the referral for further follow up by the Department. The note did state that the Director thought the family should be referred to the Nurse Family Partnership program due to the extended family's prior negative history and perception of the child welfare program. The Director expressed concern that the family's prior negative experience may have an impact on the mother agreeing to participate in services through the Nurse Family Partnership. The CPO found that although department staff identified the need to notify law enforcement, this did not occur.

On August 11, 2014, KCCHHS received a second referral concerning [redacted] and her newborn child. The report was similar to the first in that it was stated that [redacted] was 14 years of age and she had just given birth to a premature baby. The reporter indicated that [redacted]'s boyfriend was 20 years old and that [redacted] had been residing with her boyfriend. The reporter expressed concern for [redacted]'s ability to adequately care for a newborn child based off her knowledge of the young mother having received special education services while she was enrolled in school. This report was again brought for RED Team with four agency staff including the Supervisor and Director involved in this complaint. The decision to not investigate these concerns any further was made based on the finding by the team that this was an allegation of third party abuse, and it was noted that this should be referred to local law enforcement. Further notations were made that the parents of [redacted] were to be contacted and advised of KCCHHS legal obligation to notify law enforcement. The team once again noted that it would be beneficial to the family to offer voluntary services; however, the CPO found no evidence to support that the KCCHHS spoke with [redacted] or any member of her family regarding voluntary services as reported to the CPO by the Director.

In speaking with the Kit Carson District Attorney, as well as reviewing law enforcement records, the CPO identified that KCCHHS failed to report the allegations of third party sexual abuse to local law enforcement in an immediate fashion as defined in statute, and further failed to cooperate with the investigation by local law enforcement into the sexual assault allegations. Kit Carson Sheriff's Department became aware of the alleged sexual assault on a child on August 12, 2014, after receiving a report from a local victim's advocate. Kit Carson Sheriff's Department contacted the KCCHHS Supervisor and spoke with her about the reports. The Supervisor acknowledged that two reports had been made; however, she advised that KCCHHS did not believe it to be their jurisdiction due to the lack of allegations of abuse and/or neglect

by a family member. The Supervisor also expressed concern that should law enforcement become involved, the family may not cooperate with services and the mother may be separated unnecessarily from the alleged perpetrator and father of her child. Kit Carson Sheriff's Department requested a copy of the email that was sent to KCCHHS reporting the alleged sexual assault, as well as any other reports received relating to the issue. The Supervisor agreed and although she complied with sending portions of the referrals to the investigating officer, she did not include all that had been requested. Kit Carson Sheriff's Department obtained a search warrant for KCCHHS records after attempts to have the reports handed over in full failed. The search warrant was issued and executed on August 14, 2014.

As part of the investigation, the CPO staff also interviewed the Director and Supervisor regarding the reported concerns of their failing to report child sexual assault to law enforcement. The Director was interviewed on October 29, 2015 and the Supervisor was interviewed on November 11, 2015. In speaking with both the Director and Supervisor, both parties advised that they had spoken with their former county child welfare attorney regarding the allegations of sexual abuse and the need to report to law enforcement and had been advised that they were not required to report. Both parties were resistant in answering questions and demonstrated a lack of understanding of the law which defines sexual assault on a child, as well as a lack of understanding on their legal responsibility to report any allegations of third party child abuse to local law enforcement. This lack of understanding was also demonstrated in the police report interviews with witnesses that attested they had spoken with the Director regarding the report and had been advised that it was not the jurisdiction of the child welfare program. Neither party accepted responsibility for failing to report and further defended their decision as being in the best interest of [redacted] and her newborn.

On October 29, 2015 and again on November 11, 2015, the CPO verbally requested of the Director and the Supervisor copies of the agency's Memorandum of Understanding with local law enforcement, any emails sent from the Supervisor to Kit Carson Sheriff's Department concerning the reports of alleged sexual assault and any attachments, the anonymous fax which precipitated the second contact with the KCCHHS on August 11, 2014 and the facsimile from the hospital regarding the initial referral on August 6, 2014. As the documents were never forwarded to the CPO, a written request was made on November 18, 2015. The documents were received by the CPO on November 20, 2015; however, the attachments to the emails sent to the Kit Carson Sheriff's Department via email from the Supervisor were not included.

During conversations with the Director regarding the ongoing services reportedly being provided to [redacted] and her child, to ensure that the child is safe and [redacted] has parenting supports, the Director acknowledged that a referral had been made to the Nurse Family Partnership program and that the KCCHHS child welfare department was monitoring [redacted] and her baby closely. CPO staff inquired as to documentation of this monitoring and was advised that the KCCHHS was under no obligation to provide that to the CPO as the family was not working with the KCCHHS under an open child welfare case. The CPO advised the

Director of the statute[2] which entitles the CPO to these documents; however, the Director refused to comply. The CPO did obtain a copy of a referral for [redacted] to receive services through the Nurse-Family Partnership program. The referral was made by the hospital staff, and not by KCCHHS as was reported by the Director.

On October 3, 2014, the Director and Supervisor were charged with a Class 3 misdemeanor of "Child Abuse-Fail to report suspected". The Director and Supervisor were engaged in a lengthy legal process which resolved on October 14, 2015. The Kit Carson District Attorney's Office notified the CPO that all charges against the Supervisor had been dropped as it was determined that she was acting at the direction of the KCCHHS Director.

On October 14, 2015, the Director pleaded guilty to Failure to Report Child Abuse or Neglect, C.R.S. 19-3-304(I), a class 3 misdemeanor and received a one year Deferred Judgment and Sentence with all terms and conditions, including determination of supervision, open to the Court. The following conditions were made as terms of the plea agreement:

A. The defendant (KCCHHS Director) will allocute in open court;
B. The defendant will participate in a joint training of mandatory Reporting requirements with the District Attorney's Office and employees of the Kit Carson Department of Human Services; and
C. The defendant will participate in additional training of Mandatory Reporting requirements with the District Attorney's Office for the benefit of the DHS of Yuma, Phillips, Sedgwick, Logan, Morgan and Washington counties, if requested by the District Attorney's Office.

The Director received 40 hours of community service as a condition of her deferred judgment. At the conclusion of the criminal proceedings, the KCCHHS Director resigned from her position with the Department.

On March 4, 2016, the CPO received documentation from the acting director of KCCHHS, outlining two new policies developed to ensure that the compliance issue relating to mandatory reporting does not happen again. The policies as sent to the CPO state:

- Policy-Child Welfare Reporting to the Office of the District Attorney

  All child welfare referrals shall be forwarded to the Office of the District Attorney of the respective judicial district of suspected jurisdiction in writing utilizing the Kit Carson County DA Reporting form. Written forms shall be faxed with a copy of successful transmission retained.

[2] **19-3.3-103(II)(A)** In investigating a complaint, the Ombudsman shall have the authority to request and review any information, records, or documents, including records of third parties, that the ombudsman deems necessary to conduct a thorough and independent review of a complaint so long as either the state department or a county department would be entitled to access or receive such information, records, or documents.

- Policy-Child Welfare Reporting to Law Enforcement

  All child welfare referrals shall be forwarded to the suspected jurisdictional law enforcement agency within 24 hours of receipt of the referral. Referrals made verbally shall be followed up with a written referral. All reporting of child welfare referrals shall coincide with the KCCHHS and law enforcement memorandum of understanding.

As a result of the plea agreement, all staff of KCCHHS (34 total members) participated in a Mandatory Reporting Training delivered by the Kit Carson District Attorney's Office. This training was completed on November 24, 2015 and was reported and confirmed to the CPO on March 16, 2016. The CPO obtained a copy of the sign in sheet for the training to verify compliance and attendance. The Director's name was not present on the sign-in sheet; however, the District Attorney verified her attendance and her refusal to sign in for the training. Further, on March 16, 2016, the CPO was advised by the Kit Carson District Attorney's Office that the relationships between the DA's Office and KCCHHS were much more open and they anticipated that these relationships will only strengthen with the hiring of a new agency director. The CPO was advised that the Director and the Supervisor are no longer employed by KCCHHS and a new director with experience in law enforcement had been hired to be the agency's new director.

V. Findings and Recommendations

In conclusion, the CPO found that the KCCHHS Director and Child Welfare Supervisor, failed to comply with the mandatory reporting rules as defined in Volume VII and mandatory reporting laws as outlined in the Colorado Children's Code (Appendix A). The Director and Supervisor demonstrated a significant lack of understanding both of the laws surrounding child sexual abuse, as well as their responsibility to protect children within their community by reporting suspected criminal child abuse to the local authorities for investigation.

This complaint was found to be an act of omission by the KCCHHS employees. Because of this, the CPO is unable to fully assess the potential number of instances in which allegations of child abuse and/or neglect and criminal acts against children have gone unreported to law enforcement without a complainant stepping forward.

This report concludes the investigation into the complaint concerning KCCHHS with a finding of Agency/Caseworker Non-Compliance with Policy and Law. This investigation was unique to the CPO in that the complaint was received after action had been taken by the Kit Carson District Attorney. Due to the ongoing criminal proceedings, and KCCHHS staff unwillingness to speak with the CPO until the criminal case was resolved, the CPO was unable to work with the KCCHHS staff on necessary changes to improve practice for a significant amount of time. As a result of the criminal case, the KCCHHS acting director implemented new policies to ensure that reporting of potential criminal acts towards children were reported to the District Attorney and

to Law Enforcement. The CPO supports the policies that were instituted in KCCHHS to address the reporting issues; however, also finds that the duty and responsibility to report suspected child abuse and/or neglect immediately is crucial in ensuring that the children within our communities are protected. In order to do so, mandatory reporters must be adequately trained on their duties and responsibilities, and understand their mandates under Colorado law. In an effort to ensure this, the CPO recommends the following:

1. Kit Carson County Health and Human Services meet quarterly with the District Attorney's Office and the Sheriff's Department to ensure that all parties remain in compliance with the mandatory reporting policies as developed by KCCHHS.
2. Kit Carson County Health and Human Services ensure that all new staff hired complete the CDHS Mandatory Reporter Online Training.
3. Kit Carson County Health and Human Services ensure that all staff, on an annual basis, complete the CDHS Mandatory Reporter Online Training.

The Child Protection Ombudsman Office of Colorado will be following annually the progress of Kit Carson County Health and Human Services to ensure ongoing compliance with training and reporting mandates.

VI. Agency Response

BOARD OF COUNTY COMMISSIONERS **Aug. 26, 2016**

The Kit Carson County Board of County Commissioners has reviewed your report dated June 13, 2016. The Board appreciates the time and effort that you invested in your investigation. Fortunately, many of the concerns that you identified had already been addressed by the Board by the time your report was provided.

First and foremost, the Board hired a new Kit Carson County Health and Human Services Director on April 1, 2016. The Board believes that the new Director's strong organizational skills coupled with her understanding of and value for collaborating with stakeholders will serve the citizens of Kit Carson County well. As reflected in your report, the new Director's law enforcement experience has already improved the relationship with the District Attorney's Office which will "only strengthen" in time. The Board agrees with this assessment.

The Board also hired a new special county attorney on June 1, 2016. The new law firm brings a multidisciplinary approach with nearly three decades of experience in the child welfare field including a strong understanding of the State Department of Human Services rules and regulations. These new additions to the Health and Human Services Department deserve particular note because the allegations which you investigated occurred nearly two years ago under the direction of individuals no longer associated with Kit Carson County. Further, the Kit Carson County Health and Human Services Department hired two new caseworkers in the Spring of 2016. Both of these individual have completed the Child Welfare Training Academy including training on mandatory reporters.

Finally, the Health and Human Services Department has already begun formalizing reporting policies, collaborating with community partners regarding mandatory reporter requirements, and drafting memorandums of understanding with law enforcement agencies and other stakeholders. We anticipate that these will be finalized in the near future.

In conclusion, the Board of County Commissioners takes the health and safety of the citizens of Kit Carson County seriously and is continuously assessing the quality of services provided and implementing improvements where necessary.

Sincerely,
The Board of County Commissioners for Kit Carson County, Colorado

Appendix A

1. **Defining "third party" abuse and/or neglect**

   Volume VII and the Colorado Children's Code both clearly define third party abuse/neglect as follows:

   7.000.2

   "Third-party abuse and/or neglect means a situation where a child is subjected to abuse and/or neglect by any person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent, or any other person not included in the definition of intrafamilial abuse or institutional abuse."

   C.R.S. 19-1-103(108)

   "Third-party abuse as used in part 3 of article 3 of this title, means a case in which a child is subjected to abuse, as defined in subsection (1) of this section, by an person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent, as defined in subsection (101) of this section, or any other person not included in the definition of intrafamilial abuse, as defined in subsection (67) of this section."

2. **Mandatory Reporting requirements:**

   7.104.31(A)

   "When the referral alleges abuse and/or neglect by a third-party ten (10) years of age or older, the county department shall immediately forward the referral to the appropriate law enforcement agency for screening and investigation."

   7.103.5(A)(6)

   "County departments may determine that a referral does not require further action and screen it out for the following reasons:

   > The person alleged to be responsible for the abuse and/or neglect is a third(3rd) party and ten (10) years of age or older. In this circumstance, the county department shall send the referral to the appropriate law enforcement agency."

   7.104.32

   "County departments shall attempt to obtain a copy of the report summarizing any investigation that was conducted by law enforcement. If the report is obtained, it shall be the basis upon which the county department enters a

founded finding of abuse and/or neglect into the state automated case management system."

C.R.S. 19-3-304(1)

"Any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions that would reasonably result in abuse or neglect shall immediately upon receiving such information report or cause a report to be made of such fact to the county department, the local law enforcement agency, or through the child abuse reporting hotline system as set forth in 26-5-111, C.R.S."[3]

[3] C.R.S. 19-3-304 outlines those persons required to report child abuse or neglect. Section (II)(cc) identifies any worker in the state department of human services and a mandated reporter under statute.

Appendix D: Definitions

Affirmed Agency Actions: This conclusion means that the CPO found no policy or law compliance issues as they relate to the complainant. In these instances, the CPO is stating that the agency under review complied with policy and law as it relates to the issues brought to the CPO's attention.

Affirmed Agency Actions with Recommendations: The agency was not found to have violated policy or law as it relates to the issues brought to the CPO's attention in the initiating complaint. However, if the CPO finds areas of practice that could be improved upon the CPO will make recommendations to the agency under review that will directly impact service delivery to children and families in a positive manner.

Agency: Any entity who receives public moneys for the purpose of providing child protection services to children and families of Colorado.

Agency Non-Compliance with Law: The CPO finds clear evidence that the agency serving a particular child or family failed to follow child protection law as outlined in the Colorado Children's Code, or any other relevant statute governing the functions of a particular agency or entity.

Agency Non-Compliance with Policy: The CPO will conclude a review with this finding if, during the course of the review, there is clear evidence that the agency or caseworker serving a particular child or family failed to follow policies developed specific to the investigated agency functions or Volume VII.

Case/Ongoing: This category includes complaints related to a child's permanency, location of placement for children in out of home care, family visitation, the provision of treatment services, agency contact and involvement with families as well as termination of parental rights.

Child Protection System: Colorado's child protection system is made up of a variety of agencies responsible for the protection of Colorado's children. These agencies include, but are not limited to: law enforcement, state and local human/social services agencies, treatment systems, medical and public health.

Closed Due to Lack of Information: This disposition is reached when a complainant does not provide the CPO with the necessary information to begin researching the complaint.

Closed Per the Complainant's Request: This disposition is reached when a complainant contacts the CPO after filing a complaint and requests that the CPO discontinue researching their concerns.

Colorado Children's Code: State laws developed to protection children which are defined in Colorado Revised Statute 19-1-101.

Complainant: Any individual contacting the CPO requesting review of the actions or inactions of a child protection agency.

Complaint: Any complaint shall be defined as an alleged action or inaction by a member or agency within the Colorado child protection system. Complaints may be specific to an individual person or may involve systems issues affecting multiple participants within the child protection system.

Declined to Review: This disposition is reached at the discretion of the Ombudsman and is typically applied when the CPO has previously reviewed a complaint and no new information has been reported warranting a re-review.

Intake/Assessment: This category includes complaints related to the removal of children, improper investigations of child protection concerns, inefficient assessment of safety and risk factors within a child abuse and/or neglect investigation as well as agency contact with family and collateral sources throughout a child abuse and/or neglect investigation.

Lack of Response: This category includes complaints regarding a lack of response by a child protection agency to reported concerns of abuse and/or neglect. These complaints are specific to allegations by a complainant that a child abuse and/or neglect report was made to a child welfare agency, and no action was taken by the agency to investigate the concerns.

Mandatory Reporting: This category includes complaints regarding those mandatory reporters outlined in statute that fail to report, or fail to cause a report to be made, concerning allegations of abuse and/or neglect.

Non-systemic Complaints: Complaints or concerns that were brought to the CPO regarding case-specific issues.

Phase One – Inquiries: Questions or requests for information, resource referral and referrals not related to the function of business of the CPO. These may also include a complaint which is not within the CPO's purview, or any complaint that does not progress to a review which may be due to lack of information, the complainant requesting no further action or a complaint which the CPO has previously reviewed.

Phase Two – Review: The research state of looking into an issue raised by a complainant. The CPO will complete a thorough review of all information that is located in TRAILS (see definition) and the Colorado court system database and will gather any other information necessary to determine merit to the complaint.

Phase Three – Investigation: A CPO investigation is defined as a comprehensive independent inquiry into relevant facts, records and statements of witnesses considering the best interests of the child. Investigations include a review of records and actions or inactions and may also include assessing additional facts, additional testimony, to include the re-interview of previous witnesses or reporting parties.

Resource Referral: This disposition is reached when, during the Inquiry Phase, the CPO provides system's navigation services to a complainant and does not elevate the complaint to a review.

Systemic Review: A systemic investigation is an investigation of systemic flaws, which may warrant recommendations to the legislature or recommendations to an agency for changes in policy and procedure as it relates to systems.

TRAILS Database: The statewide database used for documenting all calls to county and state human services agencies regarding abuse and/or neglect, as well as all of the work completed by agency staff relating to reviewing and investigating allegations of abuse and/or neglect.

Volume VII: The policies that child protection must follow when handling cases, as promulgated by the Colorado Department of Human Services Board.