

OFFICE OF COLORADO'S
CHILD PROTECTION
OMBUDSMAN

INVESTIGATION REPORT
CPO Case ID: 2017-2736



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Order of Summary Suspension

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INTRODUCTION

By the time El Pueblo Boys and Girls Ranch (El Pueblo) was closed, only 37 of the facility's 65 beds were full. During the year leading up to the residential child care facility's (RCCF) closure, the number of children residing at the facility dwindled. Concerns, however, continued to grow. These concerns were solidified in the growing number of reports about El Pueblo, which was licensed by the Colorado Department of Human Services (CDHS) and served children and youth with complex mental and behavioral health needs. Reports concerning children and youth at El Pueblo nearly doubled during the facility's last six months of operation, averaging 26 reports per month¹

When the CDHS revoked El Pueblo's license on September 25, 2017, the agency listed eight concerning incidents that occurred at the residential child care facility, most of them taking place during the prior two months. One incident involved a youth who was able to leave El Pueblo and ride a train from Pueblo, Colorado – where the facility was located – for more than 100 miles to Denver. The youth listed several reasons for running, among them a lack of food and medical attention.² A different incident listed in the order detailed a report of staff at El Pueblo pulling a child's hair, elbowing the child's body and punching the child in the mouth. According to the order, the CDHS found that El Pueblo staff repeatedly compromised child and youth safety. In total, the CDHS found that, during the 12 months prior to closing the facility, El Pueblo had:

- Eleven violations regarding the use of physical restraints.
- Six violations regarding inappropriate discipline.
- Five lack of supervision violations.³

The summary suspension order resulted in the swift closure of El Pueblo. Still the question remained:

If conditions at El Pueblo were so severe, why did it take the CDHS so long to order the closure of the facility?

That question was posed to the Office of Colorado's Child Protection Ombudsman (CPO) shortly after the facility was closed. The CPO's investigation, which was opened on October 20, 2017, examined all sides of the complex system and multiple actors tasked with ensuring the well-being and safety of children and youth in residential child care facilities. In Colorado, residential child care facilities provide 24-hour care for children and youth with serious emotional, behavioral and/or developmental disorders. The majority of the children and youth residing in such facilities are placed there through the state's public child welfare system, often after having experienced abuse or neglect in their own homes.

The CPO's analysis followed the life of a report of suspected abuse or neglect that takes place within a residential child care facility. What that analysis revealed was an ill-defined system that fails to ensure the safety and well-being of youth inside these facilities. The CDHS is responsible for developing procedures to address allegations of abuse and neglect inside the residential child care facilities it licenses.⁴ Currently, there is no adequate system to effectively and efficiently monitor the care being provided to some of the state's most vulnerable children.

¹ Per information obtained from the Trails database on November 27, 2017.

^{2,3} See Order of Summary Suspension: In the matter of the licensed child care facility, El Pueblo Boys & Girls Ranch, License No. [REDACTED] September 27, 2017. (Attachment A)

⁴ See C.R.S. § 19-3-308(4.5).

The CDHS has devised a two-stage process for investigating allegations of institutional abuse.⁵ Under the current framework, the CDHS has delegated the review of reports of institutional abuse to county human services departments (county departments) and a 10-person statewide team called the Placement Services Unit (PSU). The PSU is supervised by CDHS leadership and housed within the department. County departments are responsible for the initial response to most calls reporting suspected abuse or neglect that occurs inside residential child care facilities. In most cases, the PSU completes its review of the case after the county department has completed the first assessment.

There are significant gaps in the Code of Colorado Regulations (state regulations) regarding how the PSU and county departments are to coordinate, there are no internal operating procedures for PSU nor are there any standards for how the PSU's findings are enforced or shared. This lack of regulations and standards are impacting the safety and well-being of children and youth in residential child care facilities in three ways:

1. Without clear guidance in state regulations, there is inconsistency and inaccuracy in how reports of abuse and neglect at residential child care facilities are handled.

Currently, state regulations regarding how the PSU and county departments are to conduct reviews and communicate findings are not interpreted consistently across the state. The rules do not provide explicit direction for completing these functions and, as a result, county departments and the PSU reported using different review methods depending on the relationship between the two entities. In some instances, the regulations are not followed at all. For example, the CPO's review of the El Pueblo case found that neither the PSU nor the Pueblo County Department of Social Services (PCDSS) – which handled the majority of calls involving El Pueblo – adhered to a rule requiring communication about screened out reports of abuse or neglect at the facility.

2. The lack of standard and public operating procedures weakens the PSU's ability to sufficiently and consistently monitor residential child care facilities and enforce corrective action plans.

At the time of El Pueblo's closure, the PSU was comprised of 10 people charged with licensing and monitoring approximately 230 facilities across Colorado. The CDHS has not developed standards for how PSU staff are to conduct their reviews. Without an official set of public operating procedures, the PSU relies on residential child care facilities to self-report incidents, methods for tracking repeat violations are inadequate and the PSU struggles to enforce compliance with its corrective action plans. Neither Colorado law nor state regulations provide PSU with clear guidelines or requirements for carrying out their investigations. Such policies would theoretically guide practices such as: timelines for investigations, requirements for determining licensing violations, standards for communicating findings with facilities, disseminating findings to county departments and members of the public and protocols for ensuring previous violations have been addressed by facilities.

⁵ Volume 7, 7.000.2(A) defines Institutional Abuse as, "any case of abuse and/or neglect that occurs in any public or private facility in the state that provides out of home care for children. Institutional abuse shall not include abuse and/or neglect that occurs in any public, private, or parochial school system, including any preschool operated in connection with said system."

3. Without a public reporting process to capture the PSU's findings, county departments, parents and advocates cannot make fully informed decisions about the care, safety and well-being of children and youth placed in residential child care facilities.

Currently, there is no public reporting mechanism that allows county departments, citizens or agencies like the CPO to easily access the PSU's findings. This stands in stark contrast to other entities licensed by the CDHS, including day care facilities. Parents or caregivers selecting a daycare in Colorado may utilize a public website which lists licensing violations, inspection reports and any corrective action taken for that facility.⁶ For parents and county departments attempting to place children in 24-hour residential child care facilities, there is no such resource.

The issues above highlight an ill-defined and strained system that fosters delays and omissions that affect the safety and well-being of some of the state's most vulnerable children and youth. While the CPO's investigation was centered on the conditions surrounding the closure of El Pueblo, the circumstances at the residential child care facility confirm that the lack of regulation, resources and transparency surrounding residential child care facilities has the potential to impact children across Colorado.

⁶ See information contained on Colorado Shines website: <https://www.coloradoshines.com/search>

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COMPLAINT AND METHODOLOGY

Following the closure of El Pueblo, the CPO was contacted by several stakeholders within the child protection community. Stakeholders inquired about the revocation of El Pueblo's license and listed concerns about how the facility was monitored prior to its closure.

The CPO started a preliminary review of reports concerning suspected abuse or neglect at El Pueblo. An early review of the reports in the statewide child welfare database, Trails, revealed a dense log of reports dating back more than a decade. This record, in combination with the claims of stakeholders, raised concerns about the efficacy of the oversight mechanisms that were in place while El Pueblo was open and whether those mechanisms could sufficiently guarantee the safety and well-being of children living in residential child care facilities. On October 20, 2017, the CPO opened an investigation into the circumstances leading to the closure of El Pueblo.

The CPO's research was divided into three main categories:

- 1. Reports Concerning El Pueblo** – The statewide Trails database houses documentation of all referrals, assessments and findings for reports of abuse or neglect made to county departments and the CDHS. The CPO reviewed all the reports related to children and youth residing at El Pueblo during the 12 months leading up to the facility's closure. In total, there were 243 reports filed between September 26, 2016, and September 25, 2017.
- 2. Relevant Regulations and Laws** – Guidelines for the licensing and monitoring of RCCFs are in both law and rule. The CPO reviewed all applicable portions of the Colorado Children's Code, the Colorado Child Care Licensing Act and state regulations. Additionally, the CPO requested and reviewed any available operating procedures for the PSU.
- 3. Relevant Agency and Staff** – The CPO conducted interviews with staff members and managers from the PSU, formally known as the 24-Hour Licensing and Monitoring unit. These discussions covered the unit's role in the El Pueblo case and its ongoing practices with respect to other residential child care facilities in the state.

INVESTIGATION SCOPE

The CPO is acutely aware of the multiple issues affecting residential childcare facilities in Colorado. Prominent among those issues are the current discussions regarding the implementation of the new facility standards required under the federal Family First Prevention Services Act and the ongoing rate adjustment based on the actuarial analysis completed in 2018.⁷ This investigation does not duplicate efforts already underway on these two topics, nor does it address other ongoing

financial discussions happening between the CDHS, county departments and facilities.

Instead, the CPO's analysis remained narrowly focused on the assessment of reports alleging abuse or neglect within El Pueblo, and how existing laws and regulations – or lack thereof – affect the safety and well-being of children and youth. This narrow scope not only ensures the CPO is addressing the issues contained in the complaints it received, but also isolates a fundamental, systemic issue impacting residential child care facilities across Colorado.

⁷ See House Bill 17-1292 and accompanying actuarial analysis.

OVERVIEW OF CURRENT PROCESS

The CDHS is responsible for licensing and monitoring all residential child care facilities in Colorado.⁸ Per the Child Care Licensing Act, the CDHS is responsible for ensuring that the facilities licensed under the act comply with standards prescribed in state law.⁹ When facilities fail to maintain these standards, the CDHS has the sole authority to initiate appropriate sanctions up to and including closure.¹⁰

The CDHS is charged with issuing original licenses for facilities that provide 24-hour care. Once a facility has been licensed, members of the CDHS' PSU team are responsible for completing inspections deemed necessary to ensure the, "health, safety and welfare of the children being placed there are protected."¹¹ When the PSU conducts an inspection of a residential child care facility it uses statewide standards laid out in Colorado law and rule.¹² Specifically, state regulations include more than 50 pages of standards for facilities, including admissions policies, rules for the use of physical management, fire safety, seclusion policies and staff training. However, those 50 pages do not include procedures for how the PSU is to conduct their reviews, including timelines for completing reports and issuing corrective action plans. If the PSU identifies any non-compliance with these standards, the unit may work with facility administrators to address the underlying concerns. The PSU may also initiate one of several sanctions authorized by the Child Care Licensing Act.¹³

The CDHS is also responsible for developing a process for assessing reports of abuse or neglect involving children or youth while they reside in a residential child care facility. Unlike inspections focused on possible licensing violations, which begin with the PSU, assessments of possible institutional abuse or neglect start with county departments. County departments are responsible for responding to initial reports of suspected institutional abuse or neglect for facilities in their geographic jurisdiction.¹⁴ County departments receive these calls directly or through the statewide child abuse hotline. Hotline calls are forwarded to the appropriate county department, who then determines whether it will be assigned for assessment by a caseworker.

Per state regulations, all referrals alleging abuse or neglect in a home or family setting must be reviewed by a group of county department staff through the "Review, Evaluation, and Direct" (RED Team) process. During this process caseworkers and supervisors review each referral and consider a specific list of questions before deciding – as a group – whether the referral should be assigned to a caseworker. State regulations explicitly exclude reports of institutional abuse and neglect from this process.¹⁵ Effectively, the decision to screen out a call involving institutional abuse or neglect may be made by a single county department staff.

If the report is assigned to a caseworker for further assessment, the caseworker is required to visit the facility in person to interview the alleged victim.¹⁶ At the conclusion of the assessment, the caseworker will determine whether the report of institutional abuse or neglect was founded.¹⁷

⁸ See C.R.S. §26-6-104(1)(a).

⁹ See C.R.S. §26-6-106.

¹⁰ See C.R.S. §26-6-108.

¹¹ See C.R.S. §26-6-107(1)(b)(I).

¹² See Volume 7, 7.705 and 7.714 (Per Volume 7 regulations enacted on October 1, 2016.)

¹³ See C.R.S. §26-6-108.

¹⁴ See Volume 7, 7.103.21. (Per Volume 7 regulations enacted on November 1, 2015.)

¹⁵ See Volume 7, 7.103.4(A)(3). (Per Volume 7 regulations enacted on November 1, 2015.)

¹⁶ See Volume 7, 7.104.22(B)(1). (Per Volume 7 regulations enacted on November 1, 2015.)

¹⁷ Founded means, "that the abuse and/or neglect assessment established by a preponderance of the evidence that an incident(s) of abuse and/or neglect occurred." See Volume 7, 7.000.2(A).

unfounded¹⁸ or inconclusive.¹⁹ A caseworker has 60 days to complete their assessment.

Following the conclusion of the county department's assessment, the PSU will typically conduct its own investigation. The PSU monitor will work to determine whether facility staff or administration violated the statewide standards in such a way that it compromised the safety and/or well-being of children or youth. During

the PSU's investigation, PSU staff will visit the facility to review records and conduct interviews of children, youth and staff involved in the report, and, if necessary, facility administration. The PSU may also initiate an inspection at its discretion.

¹⁸ Unfounded means, "that the abuse and/or neglect assessment established that there is clear evidence that no incident of abuse and/or neglect occurred." See Volume 7, 7.000.2(A). (Per Volume 7 regulations enacted on November 1, 2015.)

¹⁹ Inconclusive means, "that the abuse and/or neglect assessment established that there was some likelihood that an incident(s) of abuse and/or neglect occurred, but assessment could not obtain the evidence necessary to make a founded finding." See Volume 7, 7.000.2(A).

CPO ANALYSIS

Finding One

Without clear guidance in state regulations, there is poor consistency and accuracy for how reports of abuse and neglect at residential facilities are handled.

The lack of a clear and robust regulatory framework has resulted in confusion between county departments and the PSU regarding responsibility for reports of institutional abuse and neglect. In total, seven county departments received 243 reports of suspected institutional abuse or neglect at El Pueblo during the year prior to the residential child care facility's closure.²⁰ The PCDSS (Pueblo County) received 90 percent of those 219 reports.²¹ The majority of the reports were screened out by PCDSS because the department did not find they contained allegations of abuse or neglect as defined in law. In many cases, PCDSS staff reported to the CPO that they believed the PSU was responsible for assessing the reports as possible licensing violations. If the PCDSS screened out a report involving El Pueblo, the report was not required to be reviewed by any entity.

The confusion in each agency's role was demonstrated in the findings of PCDSS and the PSU regarding the care provided to children and youth at El Pueblo. Repeatedly, the PCDSS determined that an allegation in a case was unfounded for abuse and neglect, while the PSU found a child's safety and well-being were severely compromised. The current framework allows for children involved in these reports to continue residing under the same conditions for weeks or months before the PSU completes a review and addresses safety concerns. In some cases, reviewed by the CPO, a youth at El Pueblo remained under the care or supervision of the same staff member who was accused of abuse or neglect.

There is disagreement among professionals regarding which entity should be responsible

for completing the first assessment when a report of institutional abuse or neglect is received. The CPO interviewed multiple county departments – including departments in rural and metro areas – regarding the current two-stage approach. Leadership in some county departments stated such departments are the entities best suited to handle such calls, as they have been trained to assess whether the allegation of abuse or neglect is founded. They also believe that because county departments are located closer to the individual facilities, it allows them to respond to reports of abuse and neglect faster than the PSU. By contrast, leadership in other county departments stated that the PSU should be responsible for the initial assessment of all institutional abuse and neglect reports, as the unit is better suited to recognize the nuances of abuse and neglect in a facility setting.

During the 12 months before El Pueblo was closed, 88 percent of the calls concerning children at the residential child care facility were not assessed.

The majority of the 219 reports PCDSS received regarding El Pueblo involved concerns of safety and well-being for children and youth at the facility. Examples include reports of:

- Bruising and injuries to children and youth
- Inappropriate sexual contact
- Unnecessary and/or harsh physical management
- Inadequate nutrition
- Lack of appropriate supervision

²⁰ Between September 26, 2016 and September 25, 2017, The Denver County Department of Human Services, Douglas County Department of Human Services, El Paso County Department of Human Services, Jefferson County Department of Human Services, Montrose County Department of Human Services, Ouray County Department of Human Services and Pueblo County Department of Social Services each received at least one report about El Pueblo. Aggregate referral numbers for provider IDs [REDACTED] and [REDACTED] were obtained from Trails database on November 27, 2017.

²¹ For the purposes of this report, the CPO primarily focused on cases handled by the PCDSS as the department completed the majority of assessments involving children and youth at El Pueblo prior to the facility's closure.

Compared to calls involving allegations of intrafamilial abuse, these reports were almost three times more likely to be screened out without additional assessment by a PCDSS caseworker. Of the 219 calls the PCDSS received about children and youth during the year prior to El Pueblo's closure, the PCDSS assigned 26 – 12 percent – to caseworkers for further assessment.²² During the same time period, PCDSS accepted 43 percent of all other reports made to the department.²³

The CPO's review of the cases involving children and youth at El Pueblo revealed a disconnect between how the PSU and the PCDSS interpreted the issue at the center of the reports and confusion regarding which entity was responsible for handling the concern.²⁴ During interviews with the CPO, both entities acknowledge this confusion. State regulations require that the PSU receive notification of institutional abuse and neglect referrals within one working day of receiving the referral. Neither the PSU nor the PCDSS indicated that there was any process in place to ensure that such notification occurred.²⁵

The PCDSS screened out 193 reports involving children and youth at El Pueblo. For 95 percent of those reports, the PCDSS documented either a lack of information or insufficient safety concerns to meet the criteria listed in law for abuse or neglect.²⁶ The PCDSS determined the reports contained concerns about licensing violations. Calls involving possible licensing violations were screened out by the PCDSS, under the assumption that PSU had jurisdiction over the reports.²⁷ However, the PCDSS did not notify the PSU of these calls, nor did they note the possible licensing violation in Trails.²⁸

By contrast, the PSU identified several concerning incidents during its on-site visits to El Pueblo. The PSU did not review the incidents, believing they involved abuse and neglect, and thus, were within the jurisdiction of the PCDSS.²⁹ During the 12 months leading up to the closure of the facility, the PSU made seven formal reports of possible child abuse or neglect at the facility to the PCDSS. The PCDSS screened out each of the reports.³⁰ The PCDSS' decision not to assess the incidents reported by the PSU prompted the PSU to start initiating its own reviews. The PSU's findings for some of those cases were later cited in the order revoking El Pueblo's license.³¹

In one instance, PCDSS received two reports concerning the same youth. Both of the reports were screened out by the PCDSS for lack of information to meet the criteria of abuse or neglect as outlined in law.³² However, one of the reports included concerns about the frequency with which the youth was physically restrained by staff. After the PCDSS screened out the reports, the PSU initiated its own review of the youth's care at the facility.

That review revealed the youth had suffered multiple injuries as a result of assaults by other youth and the use of physical restraints by El Pueblo staff. Additionally, the PSU's review found that the youth's physical health had declined since entering the facility. Documentation obtained by the PSU detailed an incident during which the youth became escalated when staff stopped him from eating from a plate of food he pulled from a trash can. The youth stated he was upset the kitchen was not providing second servings and he was still hungry.³³ This incident is particularly concerning, given that medical documentation also showed that the youth

²² Per information obtained from the Trails database on November 27, 2017.

²³ See data available on the CDHS' Community Performance Center: https://rom.socwel.ku.edu/CO_Public/AllViews.aspx?R-VID=741

^{24, 25} Per information provided by the PSU on November 16, 2017 and November 17, 2017 and information provided by the PCDSS on January 26, 2018.

²⁶ See C.R.S. §19-1-103(1)(a) for the definition of child abuse and neglect.

^{27, 28} Per information provided by the PCDSS on January 26, 2018.

²⁹ Per information provided by the PSU on January 16, 2018.

³⁰ Per information obtained from the Trails database on November 27, 2107.

³¹ See Order of Summary Suspension: In the matter of the licensed child care facility, El Pueblo Boys & Girls Ranch, License No. [REDACTED] September 25, 2017. (Attachment A)

³² See Trials Referral ID: [REDACTED] and [REDACTED]

³³ See PSU's Report of Inspection: Complaint # [REDACTED], [REDACTED].

- who entered the facility at a healthy weight
- lost 20 pounds during his first 10 months at the facility.³⁴

The case above demonstrates the disconnect and confusion caused by the lack of structure provided by the CDHS. State regulations do not prescribe specific steps for communicating when a report of institutional abuse or neglect is screened out by a county department.³⁵ Without clear standards for how information is to be communicated between county departments and the PSU, the process is often determined by the relationship between the PSU staff and the individual county department. The PSU stated that county departments have various methods for reporting when calls involving institutional abuse and neglected are screened out. Some county departments do not report screened out calls.³⁶ Without any standard protocols or guidance to resolve the confusion, the PSU and PCDSS were left with their own interpretation of their responsibility, causing each to develop their own practice.

Since El Pueblo's license was revoked, the PSU reports that it has updated its practices to include the review of reports of institutional abuse or neglect that are screened out by county departments.³⁷ If the PSU determines a screened-out call requires additional assessment, documentation of that case, and any related violations, are housed internally with the PSU.³⁸ This practice, however, has not been memorialized in public operating procedures, state rule or state law.³⁹ There are no transparent guidelines outlining the timelines for PSU reviews, disclosure of PSU findings or standards for how the PSU conducts its reviews. Also following the closure of El Pueblo, the CDHS implemented a more in-depth training regarding the differences between intrafamilial abuse and neglect, and institutional abuse and neglect. The training uses examples and interactive processes to train county department staff. As of March 2019, roughly 80 people had completed the training.⁴⁰ The training, however,

is not mandatory and as a result, some county departments in Colorado are receiving this guidance while others are not.

When reports of abuse or neglect were reviewed, discrepancies between the PSU and PCDSS' findings delayed corrective action to improve the circumstances for the child involved in the report.

County departments are charged with assessing whether children and youth in residential treatment facilities are experiencing abuse and neglect. The PSU is tasked with determining whether the facility's treatment and care of children and youth violate state standards. While these roles are distinct, they both inherently center on ensuring the safety and well-being of children in facilities. In its review of El Pueblo, the CPO found that when both the PCDSS and the PSU completed assessments based on the same report, there were widely different determinations regarding whether a child or youth was safe. The CPO reviewed several instances in which the PCDSS determined a report of institutional abuse or neglect did not meet the standards for abuse and neglect, but the PSU's findings revealed violations of state standards so severe that they were impacting a child or youth's safety and/or well-being. The PSU's concerns – the severity of which escalated during the months prior to El Pueblo's closure – were not effectively communicated to PCDSS, nor is there any mechanism to communicate these findings with county departments across the state. According to the PSU, if a county department contacts the PSU regarding conditions or violations at a facility, PSU staff members may only state whether the facility is "in good standing."⁴¹ El Pueblo was considered "in good standing" up until the day it was closed.

During the 12 months prior to El Pueblo's closure, none of the county departments' assessments of children and youth at El Pueblo resulted in a founded finding, meaning county departments did not find sufficient evidence that the child

³⁴ See PSU's Report of Inspection: Complaint # [REDACTED], [REDACTED].

³⁵ See Volume 7, 7.104.24.

^{36, 37} Per information provided by the PSU on August 22, 2018.

³⁸ Per information provided by the PSU on November 16, 2017.

^{39, 40} Per information the CDHS provided the CPO on March 11, 2019.

⁴¹ Per information provided by the PSU to the CPO on August 22, 2018.

was being abused or neglected.⁴² Ten of the 28 assessments were closed as inconclusive – meaning there was not enough evidence to determine whether abuse or neglect occurred. Sixteen assessments were closed as unfounded for abuse or neglect.⁴³ (Two cases did not have a finding.)

PSU Findings for Cases Involving El Pueblo	
Total Assessments = 28	
Cases closed as Founded	0
Cases closed as Inconclusive	10
Cases closed as Unfounded	16
Cases without a finding	2

The PSU also completed an assessment for 26 of these cases. The PSU found violations in nine of the 10 cases in which the county departments determined the report of abuse or neglect was inconclusive. Violations were also found in nine of the 16 cases in which the county departments found the reports of institutional abuse and neglect were unfounded.

PSU Findings for Cases Involving El Pueblo	
Total Cases Reviewed = 26	
County Department Conclusion	PSU Conclusion
10 cases = Inconclusive for abuse/neglect	9 cases = Violations found
16 cases = Unfounded for abuse/neglect	9 cases = Violations found

Of the 18 cases in which the PSU found violations, all but one case involved violations that impacted the safety and well-being of children and youth. According to the PSU reports, the violations directly impacted care and safety of the children at El Pueblo.

Each of the violations identified by the PSU fell into one of four categories:

1. Lack of appropriate and/or required supervision.
2. Improper physical management of children and youth.
3. Untrained and unqualified staff.
4. Failing to utilize de-escalation techniques and failure to refrain from harsh treatment of children and youth.

Below are summaries of cases that demonstrate how the violations identified by the PSU directly impacted the safety and well-being of children at El Pueblo.

Lack of Appropriate and/or Required Supervision

Case Example – The PCDSS received a report that two youth engaged in sexual contact after leaving their cottages without permission. One youth initially reported the contact as an assault. The county department closed the case as unfounded. However, the PSU cited the facility for multiple violations, including failure to provide adequate supervision for the youth based on their needs. One of the citations noted that El Pueblo staff marked the youth as being asleep in their beds during the time when the youth were off campus.⁴⁴

Improper Physical Management of Children and Youth

Case Example – An allegation that a staff member placed a non-verbal youth with autism in an improper arm hold was closed as “inconclusive” by the PCDSS. The PSU cited the facility for multiple violations. According to the PSU’s report, the staff involved in the incident admitted knowing the arm hold was not approved and stated that they had used the hold multiple times before. One of the violations listed by the PSU found that staff had not been properly trained as to the needs of the youth.⁴⁵

^{42, 43} Per information obtained from the Trails database on November 27, 2017.

⁴⁴ See Trails Assessment ID: [REDACTED].

Untrained and/or Unqualified Staff

Case Example – The PCDSS received a report regarding a youth with autism and low communication skills. According to the report, the El Pueblo staff member assigned to the youth slapped the youth after he accidentally bumped into his teacher. The PCDSS closed the case as inconclusive. The PSU, however, found several violations, chief among them was the fact that the staff member was not properly trained regarding the needs of the youth. According to the PSU's report, the staff member admitted they were not properly trained for the one-on-one care the youth required and they were not provided adequate information about the youth's needs.⁴⁶

Case Example – The PCDSS was contacted after a staff member at El Pueblo twisted a youth's arm behind the youth's back in a "police arm band method" and only released the youth after another staff member told him to. The PCDSS closed the assessment as "inconclusive." PSU cited the facility for seven violations, including failing to provide training to staff. The staff involved in the incident was also involved in a previous incident that required a corrective action plan for using improper physical management on youth. The staff was placed on temporary leave and upon his return was encouraged to look up the facility's policies as guidance for how to engage with youth. The staff was provided no additional training before returning to work.⁴⁷

Failing to Utilize De-escalation Techniques and Failure to Refrain from Harsh Treatment of Children and Youth

Case Example – A youth at El Pueblo reported that a staff member was belittling and harassing them. The PCDSS closed the case as unfounded, but the PSU found that staff violated state regulations for failing to

document any de-escalation techniques and for using inappropriate use of force techniques.⁴⁸

Case Example – A youth stated that the bump on his head was the result of a fight with other youths that El Pueblo staff allowed to happen. The PCDSS closed the assessment as "unfounded." According to the PSU's report, however, the staff member working with the youth was not qualified nor trained to handle the youth's needs. The staff member violated state regulations when they utilized harsh treatment techniques. Additionally, El Pueblo was cited for placing a non-verbal youth in the same cottage as youth with conduct disorders.⁴⁹

The disconnect between the PCDSS' assessments and the PSU's reviews prolonged El Pueblo's ability to remain open, despite repeat violations and actions by staff that impacted the safety and well-being of children and youth at the facility. There was a significant lag between when county departments received the report of suspected institutional abuse or neglect, and when members of PSU arrived at the facility to complete their own investigation.⁵⁰ In all but one case, there was a one to three-month gap between when the call was received by the county department and when the PSU arrived to conduct their own review. The CPO recognizes county departments have a 60-day window to complete assessments. Given the severity of the PSU's findings, however, such a time gap allowed children to remain in the care of staff members that the PSU would later find unqualified, untrained and who acted inappropriately.

According to the PSU, a determination by the county department that the report of institutional abuse was founded is "almost essential" for the PSU to take any adverse licensing action. Without such a finding, the PSU finds it difficult to show imminent harm is present at the facility.⁵¹ Imminent harm is required for the PSU suspend a facility's license.

⁴⁴ See Trails Assessment ID: [REDACTED].

⁴⁵ See Trails Assessment ID: [REDACTED].

⁴⁶ See Trails Assessment ID: [REDACTED].

⁴⁷ See Trails Assessment ID: [REDACTED].

⁴⁸ See Trails Assessment ID: [REDACTED].

⁴⁹ See Trails Assessment ID: [REDACTED].

⁵⁰ Per information obtained from the Trails database on November 27, 2017.

⁵¹ According to information provided by the PSU in November 2017.

CPO Recommendation: The CDHS should review and revise the current system for handling reports of institutional abuse to ensure that concerns are addressed in a timely and effective manner. This review should include a consideration of the following:

- a. Whether county departments are the best entities to investigate allegations of institutional abuse in residential child care facilities.
- b. Whether the current two-stage investigation process is effective in ensuring the safety and well-being of children in residential child care facilities.
- c. Whether state regulations provide adequate guidance surrounding the screening, assessment, and disposition of allegations of institutional abuse.
- d. Whether state regulations provide adequate guidance surrounding the identification, investigation, and communication of substantiated licensing violations.

CDHS-OCYF Response: The Department agrees to review and revise, if necessary, the current policies and guidance for screening and responding to allegations of institutional abuse and/or neglect to ensure that concerns are addressed in a timely and effective manner.

1.a. The Department believes county departments are the best entities to receive, screen, assess, and investigate allegations of institutional abuse in RCCFs. As such, the Department agrees to review policies and guidance provided to county departments regarding the receipt, screening and assessment of allegations of institutional abuse in RCCFs. Colorado is a state supervised, county administered system and as such, CDHS/DCW regularly reviews processes and practice guidance to ensure that policies are aligned with best practices and current knowledge in the field of child welfare. When a facility is located within a county's jurisdiction, a county department assesses allegations of institutional abuse and/or neglect to determine if an individual employed by an RCCF is a person responsible for abuse or neglect (PRAN) against a child/youth who is placed at the facility. County staff are ultimately the persons responsible for accepting and screening the referrals for assessment and have been trained through the Child Welfare Training System (CWTS). Completed assessments are reviewed by a multidisciplinary committee and the committee provides feedback to the assessing county, the placing county and to the provider. This process is currently being reviewed to determine if there are opportunities for process improvement.

CDHS has reviewed current training offered by the CWTS and has developed learning activities to promote consistency in the completion of institutional abuse and/or neglect assessments. Learning activities implemented since the closure of El Pueblo have included a web-based ECHO training, face-to-face site visits by the Institutional Assessment Specialist with DCW to provide TA to county staff and a review of processes with the Institutional Assessment Review Team (IART). Following the implementation of a learning activity, DCW reviews outcomes and practices to determine if behavior changes have occurred.

Currently, there is an assessment screen out process that the ARD completes by randomly selecting a sample of screened out institutional abuse and/or neglect referrals to ensure counties are appropriately screening out referrals when they do not meet the statutory requirement and to bring to the attention of the PSU any concerning referrals that contain potential licensing violations. ARD utilizes a standardized tool to evaluate the referrals and the screening decisions.

1.b. The Department believes the current two-stage assessment and investigation process is effective in ensuring the safety and well-being of children in RCCFs. As such, the Department agrees to utilize a continuous quality improvement process to review the current two-stage assessment and investigation process to determine if there are areas that need to be modified or enhanced.

The use of a two stage assessment/investigation process allows for a distinction between assessing allegations of abuse and neglect and investigating for licensing violations to determine agency/facility culpability. These are separate, yet related, processes and allows for checks and balances within the child welfare system.

It is the role and responsibility of child welfare caseworkers and supervisors within county departments of human or social services to assess for child abuse and/or neglect in an assessment of institutional abuse or neglect, also referred to as the Stage I. Both caseworkers and supervisors are trained and certified through the CWTS to provide this function statewide through the state supervised, county administered child welfare system.

It is the role and responsibility of the PSU to supervise and monitor the business practices of an agency/facility who has applied and been licensed to do business in the state of Colorado as an RCCF. If an agency doing business as an RCCF in Colorado is alleged to have violated the state statutes and/or Code of Colorado Regulations required of the business, the PSU will initiate an investigation of the entity to determine if the business' practices/policies, or lack thereof, contributed to the abuse/neglect of a child/youth placed in the facility. This is also referred to as the Stage II. If it is determined that a business' practices/policies did contribute to the abuse/neglect of a child/youth placed in the facility, this may result in adverse action, by the PSU, against an entity's business license if it meets statutory requirements.

In addition to Stage II investigations, other processes the PSU has in place to ensure the safety and well-being of children in RCCFs includes the following: annual audits by licensing, complaint investigations, screened out investigations, assessment of critical incident reports, monitoring, and increased monitoring. Furthermore, once a agency/facility has been submitted for adverse action, licensing and monitoring are required to visit a minimum of one time per month. The current standard operating procedures also require quarterly visits for new facilities. The PSU is in the process of developing a new monitoring team to focus on outcomes which research suggests is a better indicator of assessing child safety in agencies and facilities.

1.c. See 1.a. above. The Department agrees to review state regulations to determine if they provide adequate guidance surrounding the screening, assessment, and disposition of allegations of institutional abuse. In addition, a state and county foster care work group appointed by Sub-PAC is currently reviewing all screening, disposition, and assessment processes across all out of home placements. The work group will make recommendations and once received, will be considered and policy changes may occur through the formal rule-making process.

1.d. See 2.b. through 2.f. below. DCW is currently in the process of reviewing whether state regulations provide adequate guidance surrounding the identification, investigation, and communication of substantiated licensing violations. This work is being done in collaboration with CDHS legal, the Attorney General's Office, the Office of Early Childhood (OEC) and the OBH.

CPO Recommendation: The CDHS should develop standard operating procedures for the monitoring of licensed residential child care facilities. These policies should be available to the public and, at a minimum, include:

- a. Standard protocols, including standard timeframes, for receiving and reviewing complaints and concerns about licensed facilities. Such standards should address both:
 - a. Reports received as referrals through the statewide Child Abuse and Neglect Hotline.
 - b. Complaints and concerns received through other mechanisms, including those made directly to CDHS staff.
- b. Standards for determining whether there are any licensing violations.
- c. Standard protocols for the finalization, formatting and distribution of reports regarding facility monitoring.
- d. Standards for handling repeat licensing violations.
- e. Standards for creating and enforcing corrective action plans for licensed facilities.
- f. Standards for implementing negative licensing action against licensed facilities.
- g. Standards governing communication about substantiated licensing violations with county departments and the public.

CDHS-OCYF Response: The Department agrees to continue to review and revise, if necessary, the standard operating procedures for the monitoring of licensed RCCFs. The Department agrees these policies should be available to the public.

2.a. Standard protocols, including standard timeframes, for receiving and reviewing complaints and concerns about licensed facilities exist. When complaints and concerns are reported to CDHS regarding RCCFs, they are managed by CDHS Client Services in coordination with the DCW. In 2018, a continuous quality improvement (CQI) process was conducted to review the CDHS formal complaint process. The CQI process determined that the complaint process with regard to RCCFs was aligned with statute and rule. As a result there were no recommendations for changes to that process. There is an agreed upon process between the ARD and DCW where ARD sends the PSU 24-Hour Monitoring Team supervisor a report that identifies alleged licensing violations. These alleged licensing violations are entered into the Colorado Child Care Licensing System (CCCLS) and assigned for investigation. When the PSU is contacted directly regarding concerns or complaints, the PSU 24-Hour Monitoring Supervisor enters the information directly into the CCCLS upon receipt and assigns them for investigation.

The ARD pulls a random sample monthly, of institutional abuse and/or neglect referrals which were screened out. If ARD identifies a referral that meets the criteria for screening in, they send the referral to a second level review. If the second level reviewer agrees that the referral met the criteria for assignment, the county and the Institutional Abuse Specialist is notified and the referral is re-screened. If there is imminent danger or harm identified at the time of the review, the county is contacted and an immediate response to the allegation is required by the county department. The results of all reviews are shared on a quarterly basis with the Institutional Abuse Specialist at DCW.

2.b. through 2.f. The review and revision of these standards is currently in progress in coordination with the CDHS legal team and the Attorney General's Office. Revisions are being made to the procedures to ensure alignment with the OEC and OBH.

2.g. All Stage II investigations completed by DCW's PSU's 24-Hour Monitoring Team are documented directly in Trails. This information is available to counties, the DYS, and anyone who has the appropriate profile access to Trails. The public can request this information through the Colorado Open Records Act.

Finding Two

The lack of standard and public operating procedures lessens the PSU's ability to sufficiently and consistently monitor residential facilities and enforce corrective action plans.

El Pueblo remained open even after reviews by the PSU found multiple repeat violations – sometimes involving the same staff member. While the PSU was repeatedly identifying violations of state regulations, El Pueblo's compliance with the PSU's corrective action plans appeared sporadic. There are no standards or guidance regarding when the PSU should implement adverse licensing action against a facility. The PSU relied heavily on El Pueblo staff to self-report incidents at the facility. The CPO's review of the circumstances at the facility found that not all incidents were reported by El Pueblo staff. In short, the CPO's analysis of the cases opened by the PSU found that, currently, the PSU is not effectively monitoring residential child care facilities to ensure issues are identified and remedied in a timely manner. In the case of El Pueblo, this was most clearly demonstrated through the following:

1. Reliance on El Pueblo to self-report incidents.
2. Failure to publicly report or effectively track repeat violations at El Pueblo.
3. Inability to enforce timely compliance with corrective action plans issued by the PSU.

The PSU relied on El Pueblo staff to self-report all issues and incidents, but not all concerns were reported.

During the 12 months leading to El Pueblo's closure, 64 percent of the 243 reports concerning children and youth at El Pueblo were made by staff at the facility. Of the 28 cases that were opened for assessment by county departments, 16 were reported by non-El Pueblo staff. Nine of those calls resulted in the PSU finding at least one violation of state standards.

The CPO reviewed audio recordings of all available reports made by El Pueblo staff to the

PCDSS during the 12 months before the facility was closed.⁵² The reporting party was often the same employee. That employee was tasked by facility management to report incidents to PCDSS on behalf of all staff. In reporting the incidents to PCDSS, the El Pueblo employee was routinely dismissive of the incident and/or demeaning of the children and youth involved. This was particularly concerning to the CPO as this employee's rendition of the incident informed the PCDSS' first impression of the report. This concern was heightened by the fact that there appears to be no mechanism or policy in place that would have ensured El Pueblo staff reported all required incidents to the PCDSS. In fact, one case reviewed by the CPO demonstrates why such a policy may be necessary to ensure the safety and well-being of children in facilities.

Case Example – On July 20, 2017 – two months before the facility was closed – an anonymous complaint was filed directly to the PSU. The complaint detailed an incident that took place three months earlier.⁵³ The complaint contained a video recording of a senior administrator at El Pueblo placing a 10-year-old boy into a physical hold. An incident report completed by El Pueblo staff was also included in the complaint. The incident report stated that the El Pueblo administrator placed the child in a supine position after he hit the administrator. The video, however, shows the administrator placing the child in the hold before the child swung at him, according to the PSU's report. When the PSU requested a copy of the video directly from El Pueblo, they were informed by the facility that it had accidentally been deleted.

Ultimately, the PSU cited El Pueblo for multiple violations of state regulations, including failing to use appropriate de-escalation techniques, failure to complete accurate case documentation and using physical management when there was no evidence such tactics were necessary. The PSU released its findings three days before

^{52, 53} Per information obtained from the Trails database on November 27, 2017.

El Pueblo was closed – five months after the incident took place. The administrator involved in the incident maintained his employment at the facility until it was closed.⁵⁴

The PSU did not efficiently or effectively track or respond to repeat findings.

By the time the CDHS issued the summary suspension order to close El Pueblo, conditions at the facility presented, “a substantial danger to the public health, safety, and welfare requiring emergency action.”⁵⁵ But the dangers and conditions cited by the CDHS did not demonstrate circumstances that were new, or even recently developed. The order cited a series of 40 repeat violations that took place during the 12 months leading up to the facility’s closure. While the order cited a series of concerning reports made during the same month El Pueblo was closed, the PSU was aware of and had closed dozens of cases – with similar concerns and findings – well before the order was issued.

The CPO’s review of the 243 reports involving children and youth at El Pueblo revealed that many of the concerning conditions which the CDHS cited as reasons necessitating “emergency action” existed as early as six months before the facility was closed. By March 2017, the PSU had closed six cases, each with repeat violations, including:

- Four violations for failure to use appropriate discipline
- Four violations for failure to document the use of physical management
- Two violations for failure to supervise children and youth based on their needs
- Three violations for failure to use appropriate de-escalation techniques

In the majority of cases that included repeat findings by the PSU, the presence of repeat violations appeared to have little impact on the corrective action plan issued by the PSU.

The CDHS has not provided the PSU with any guidance regarding how repeat violations should be handled and the PSU does not have any internal policies guiding this practice. Essentially, the CPO could find no standards for ensuring repeat violations are clearly identified, addressed by the facility and corrected in a timely manner. The prominence of repeat violations in these cases also impacted the safety and well-being of children at El Pueblo. Of particular concern were cases in which specific staff members were involved in multiple cases which included the same violations.

For example, in one case reviewed by the CPO, two El Pueblo staff members were involved in two incidents in which the PSU found violations of state regulations. A youth at El Pueblo reported that he was drug across the carpet by staff. The youth had a 2-inch rugburn near his temple and a 1-inch rug burn along his jaw. The PSU reviewed the case and found that both staff members involved in this incident, were also involved in a previous case with similar abuse allegations roughly one month before.⁵⁶

In that case, the PSU discussed its concerns about the two staff members with El Pueblo administration. Specifically, the PSU cited one man’s “excessive use of physical management.” The PSU cited multiple violations in the case, including failure to use appropriate de-escalation techniques and failing to use appropriate discipline. According to the PSU report, El Pueblo took no “progressive action against” either employee following the closure of the first case. Both staff members remained employed at El Pueblo.

Roughly a month after the PSU closed the first case involving the employees, the same employees were involved in the incident with the youth who had rugburns on his face. Both men remained employed for roughly a month after the second incident, but both men resigned prior to the PSU’s arrival to investigate the case. El Pueblo was cited with at least seven repeat violations in this case.

⁵⁴ See PSU Report of Inspection, Complaint [REDACTED], [REDACTED].

⁵⁵ See Order of Summary Suspension: In the matter of the licensed child care facility, El Pueblo Boys & Girls Ranch, License No. [REDACTED], September 25, 2017. (Attachment A)

⁵⁶ See PSU Report of Inspection, Referral ID [REDACTED], [REDACTED].

The PSU could not ensure timely compliance – if there was compliance at all – with the corrective action plans it was issuing to El Pueblo.

The CPO's review also found several cases in which El Pueblo disagreed with the PSU's findings and/or failed to adequately address issues in a timely manner – if at all. In such cases, the practice or issue at the center of the violation was allowed to continue for months.

In one case, nearly six months passed between when the incident was reported, and when El Pueblo submitted an acceptable response to the PSU's corrective action plan. In that case, the PCDSS received a report on November 30, 2016, regarding a 13-year-old girl who stated she was sexually assaulted by another youth after the two left the El Pueblo campus without permission. Both youths reported being gone for approximately two hours, but the PSU found that El Pueblo staff marked each youth as being in their beds during that time.⁵⁷ During the PSU's investigation, El Pueblo staff could not account for the discrepancy, nor could they confirm which staff members were assigned to the youths' cottages. The PSU cited El Pueblo for violating a state regulation that require staff supervise youth according to their needs – a repeat violation.

The corrective action plan required El Pueblo to submit "written verification to CDHS as to future compliance of the regulations" by March 2, 2017.⁵⁸ On March 14, 2017, El Pueblo provided

the PSU with a response that stated it disagreed with the repeat violation and claimed that staff exceeded required ratios. However, El Pueblo also acknowledged they would be adding additional staff to address the concern and would implement an electronic documenting system to assist staff completing rounds. The next day, the PSU informed El Pueblo that their response did not sufficiently address the minimum requirements of the corrective action plan and extended the deadline to March 22, 2017. El Pueblo responded to the PSU on the new due date. Again, El Pueblo stated they exceeded required staffing ratios and claimed they complied with state regulations to the "extent possible" because youth left the premises. They disagreed with the repeat finding and said they would attempt to add staff and implement an electronic documenting system for rounds. Again, the PSU said this response did not sufficiently address the minimum requirements of the corrective action plan and extended the deadline to May 19, 2017. On May 2, 2017, El Pueblo acknowledged that they were not able to obtain additional staff, and the facility was still "transitioning" to a new electronic documenting system for rounds.⁵⁹

Six months after the report was made, El Pueblo had not implemented any of the practices it said would address the issues identified by the PSU. The final response submitted by El Pueblo effectively marked the end of the discussion between El Pueblo and the PSU regarding this case and the corrective action plan.

^{57, 58, 59} See PSU Report of Inspection, Referral ID [REDACTED], [REDACTED].

CPO Recommendation: The CDHS should request and allocate additional staff and funding to monitor conditions and services in licensed residential child care facilities.

CDHS-OCYF Response: The Department agrees to submit a request for additional funding to support additional FTEs to monitor conditions and services in licensed RCCFs. The Department cannot commit to obtaining additional staff if a budget request is not approved through the State of Colorado Office of Strategic Planning and Budget and/or if the Colorado Joint Budget Committee does not appropriate funds to the Department for this purpose.

Finding Three

Without a public reporting process to capture the PSU's findings, county departments, parents and advocates cannot make fully informed decisions about the care, safety and well-being of children and youth placed in residential facilities.

Unlike other entities licensed and monitored by the PSU – such as daycare facilities – there is no public reporting system to communicate PSU findings for reviews of residential child care facilities. As such, there is no meaningful way for citizens and agencies to monitor whether facilities like El Pueblo are effectively providing children and youth the care they need. Additionally, the lack of transparency makes it difficult to hold the CDHS accountable for monitoring facilities and taking negative licensing action when necessary. For example, following El Pueblo's closure, the CDHS closed two other residential child care facilities in the state.⁶⁰ On its face, these closures signaled the CDHS was taking swift action against facilities that failed to ensure children were safe and receiving appropriate care. However, such action by the CDHS is rare and provides the public a narrow view of the facility's performance. In the case of El Pueblo, the summary suspension order detailed incidents at the facility that occurred during its last two months of operation. The order did not capture the systemic issues at the facility – information that could have been used by county departments and families making decisions about whether to place children at the residential child care facility prior to its closure.

Whether a county department placing a child at a residential child care facility is provided timely and appropriate information about the care that child is receiving depends heavily on individual relationships between county department staff and PSU staff. Access to such information is not consistent across the state and several county departments reported that they are not provided timely information when licensing violations impact the conditions and care children are receiving. Additionally, there is no streamlined system for accessing PSU findings and corrective action plans by residential child care facility. To obtain information about conditions at residential child care facilities, county departments must often

rely on information contained in individual cases – if available – and other county departments. Effectively, some county departments have more information than others when deciding where to place children.

County departments and citizens had limited means of accessing information about El Pueblo and ensuring the CDHS was properly monitoring the facility.

Currently, there are no standards regarding how the PSU tracks and discloses when a facility has complied with its corrective action plans. Without any public reporting or standardized tracking, there is no way for entities other than the PSU and the facilities to know if issues that led to violations – and impacted the safety and well-being of children – have been adequately addressed.

Without the ability to monitor or track when a facility has violated standards – and whether the facility has corrected those issues – the public, county departments and agencies such as the CPO have no mechanism to account for the work of the PSU nor the quality of services being provided by residential childcare facilities. The county department's findings for all institutional abuse assessments are reviewed through the Institutional Abuse Review Team (IART). This is a voluntary process during which a group of stakeholders may review the county department's findings. This group does not review calls that were screened out and not assessed by county departments. A similar process to review PSU's findings does not exist.

Additionally, there is minimal information provided to the public regarding the CDHS' decisions to close facilities. The case detailed above also presents the question of why the PSU did not implement any adverse action against

⁶⁰ See Order of Summary Suspension: In the matter of the licensed child care center, Betty K. Marler Youth Services Center, Inc., License No. [REDACTED], July 16, 2018 and Order of Summary Suspension: In the matter of the licensed secure residential treatment center, Robert E. Denier Youth Services Center, License No. [REDACTED], August 22, 2018.

El Pueblo. The PSU granted El Pueblo three extensions, totaling two months. In a different case, the PSU granted El Pueblo two extensions to comply with its corrective action plan. Again, the facility was given two months to comply. During these periods, staff actions continued to create situations in which the PSU would later find repeat violations at the facility. In fact, the PSU stated to the CPO that it was increasingly concerned about conditions at El Pueblo.⁶¹ The PSU adjusted staff schedules to be on site more frequently, and PSU investigators started initiating more investigations. Still, during this period, the PSU chose not to utilize any of the adverse licensing actions available to it under Colorado law.

Under the Child Care Licensing Act, the PSU may suspend, revoke or make probationary the license of any facility it oversees.⁶² It may take any of these steps for various reasons, including failure to maintain standards prescribed and published by the CDHS and failure by a facility to “maintain, equip and keep safe and sanitary condition any premises.” While the PSU ultimately implemented the harshest option – summary suspension – it could have addressed the issues at El Pueblo sooner by using one of the lesser options. This trend does not appear to be isolated to PSU’s handling of El Pueblo. Between July 2015 and July 2017, the PSU implemented adverse licensing action nine times. In two instances the PSU placed a license on suspension, in one case they revoked a

license and in three cases – including El Pueblo – the PSU suspended facilities’ licenses. (The two other summary suspensions took place after El Pueblo was closed.)⁶³

While Colorado law provides the various adverse actions options for PSU, there are currently no standards in state regulations, nor does the PSU have any internal policies, regarding when to utilize adverse licensing action. In the case of El Pueblo, the use of summary suspension resulted in an immediate closure of the facility. Without transparent standards regarding when the PSU seeks adverse licensing action, it is unclear what factors or decisions played a role in closing some facilities versus others.

The lack of public reporting regarding the PSU’s findings for residential child care facilities sits in stark contrast to other reporting mechanisms developed by the CDHS. One example is the CDHS’ implementation of C-Stat. County departments submit data every month to the CDHS to help identify, “positive trends, and opportunities for improvement.”⁶⁴ Each division within the Office of Behavioral Health, Children, Youth and Families, Early Childhood, Economic Security and Community Access and Independence collect and analyze data, which is made available in a variety of ways, including online dashboards and reoccurring reports. No such system exists regarding residential childcare facilities which are licensed and monitored by the CDHS.

⁶¹ Per information provided by the PSU on November 16, 2017.

⁶² See C.R.S. §26-6-108(2).

⁶³ According to data provided by the PSU on July 6, 2018.

⁶⁴ See information about C-Stat at: <https://www.colorado.gov/pacific/cdhs/c-stat>

CPO Recommendation: The CDHS should develop systems to improve transparency surrounding conditions, services and outcomes in residential child care facilities. At minimum, such mechanisms should include the following:

- a. A mechanism for storing information about licensing violations that can be easily accessed by county departments to inform placement and contract decisions.
- b. A mechanism for reporting appropriate information about facility monitoring to the public.

CDHS-OCYF Response: The Department agrees that systems should be developed to improve transparency surrounding conditions, services and outcomes in RCCFs. Currently and historically, all Stage II investigations are entered into Trails with the exception of the agency/facility response. Additionally, other information and documents such as complaints, critical incident report investigations, referrals screened out by county departments of human/social services but may contain potential licensing violations, and licensing and monitoring visits are not easily accessed in Trails as they are entered into other systems.

Through the Trails Modernization project, a mechanism is being developed to store information about licensing violations that can be easily accessed by county departments to inform placement and contract decisions. A mechanism for reporting appropriate information about facility monitoring to the public is available through the Colorado Open Records Act. Additionally, statute requires “due process,” providing a reasonable opportunity to comply. Therefore, the facility’s license remains in good standing until negative licensing action takes place. Disclosing information about a facility, prior to that facility being provided the opportunity to comply with all lawful requirements, interferes with the legal process. The Department agrees to review the possibility and efficacy of posting licensing history for 24 hour facilities in a manner similar to OEC.

C.R.S. 19-1-103 (66) defines “Institutional abuse” as any case of abuse (as defined in C.R.S. 19-1-103 (1)) that occurs in any public or private facility in the state that provides child care out of the home, supervision, or maintenance. It further defines “facility” as a RCCF, specialized group facility, foster care home, family child care home, or any other facility subject to the Colorado “Child Care Licensing Act”. The inclusion of foster parents and kinship providers in this current definition complicates the balance of transparency and confidentiality for these particular out of home placement providers. Efforts are currently underway to explore separating the definition of “facility” into classifications such as “family-like settings” and “institutional settings”. Such a separation could impact how RCCF monitoring information is relayed to the public.

CONCLUSION

The conditions at El Pueblo, and the circumstances surrounding the residential child care facility's closure, serve as a case example of the issues impacting the CDHS' ability to regulate such facilities. While the CPO's review centered on the conditions at one residential child care facility, the issues revealed by that study revealed significant gaps in how the CDHS ensures the safety and well-being of children and youth at residential child care facilities. El Pueblo's doors are closed, but the issues identified in this report continue. El Pueblo represents a worst-case scenario for children and youth. If the issues in this report remain unaddressed, that scenario has the potential to repeat itself.

The CPO would like to thank all of the stakeholders who shared their time and expertise during this investigation. Specifically, the CPO would like to thank the Colorado Department of Human Services and the Pueblo County Department of Social Services for their cooperation and willingness to share their knowledge and insight.

Pursuant to C.R.S. 19-3.3-103(2), the CPO respectfully submits this report to the citizens of Colorado, the General Assembly and the Colorado Department of Human Services Executive Director, Michelle Barnes.

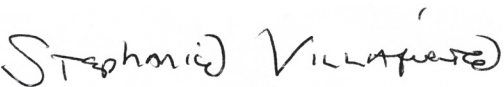
Respectfully submitted by:



Caroline Parker
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Jordan Steffen
Deputy Ombudsman
Office of Colorado's Child Protection Ombudsman



Stephanie Villafuerte
Ombudsman
Office of Colorado's Child Protection Ombudsman

Attachment **A**

BEFORE THE DEPARTMENT OF HUMAN SERVICES
STATE OF COLORADO

ORDER OF SUMMARY SUSPENSION

IN THE MATTER OF THE LICENSED RESIDENTIAL CHILD CARE FACILITY,
EL PUEBLO BOYS & GIRLS RANCH, LICENSE NO. [REDACTED]

THE PEOPLE OF THE STATE OF COLORADO

TO: El Pueblo Boys & Girls Ranch

[REDACTED]
One El Pueblo Ranch Way
Pueblo, Colorado 81006

The Colorado Department of Human Services (Department), pursuant to §§ 24-4-104(4) and 26-6-108(2), C.R.S. (2017), and upon information obtained from inspections, investigations and other reports concerning the matter referenced below, finds:

1. The Department has jurisdiction over the license, persons, and subject matter in this document.
2. The Department issued permanent license no. [REDACTED] to El Pueblo Boys & Girls Ranch ("El Pueblo") to operate as a residential child care facility at One El Pueblo Ranch Way, Pueblo, Colorado 81006. The license has an effective date of January 1, 1995, with the most recent continuation notice received on or about March 17, 2017.
3. The permanent child care license issued authorizes the care of 166 children of the ages 5 years 0 months to 18 years 0 months. El Pueblo is also authorized to accept individuals who are 18 to 21 years old if they are placed by court order prior to their eighteenth birthday.
4. On or about July [REDACTED] 2017, the Department received a complaint alleging that the current Chief Executive Officer of El Pueblo inappropriately restrained a child. The Department reviewed video of the incident, and determined the situation was not an emergency that would justify use of a physical restraint. Additionally, the Chief Executive Officer also submitted false and misleading documentation to the Department regarding the restraint.

5. On or about August [REDACTED] 2017, it was reported that a child ran from El Pueblo, and rode a train from Pueblo to [REDACTED]. The child rode in the back of the train unsupervised, with their legs hanging off the side, for the [REDACTED] hour ride. The child stated they ran because of bullying, kids stealing each other's food because they were hungry, lack of medical attention, and staff not intervening in peer fights, instead telling the children to take the fight out of camera view at El Pueblo.

6. On or about September [REDACTED] 2017, it was reported that a high needs child placed at El Pueblo did not receive all prescribed medications during the child's stay, and left the facility with an unexplained burn on the child's body.

7. On or about September [REDACTED] 2017, a report was made stating that a [REDACTED] child who functions at the level of a [REDACTED] year old, and who was supposed to be under on a one-to-one staff supervision plan, escaped out of a window in their room. The child was out of staff sight for more than an hour before being found. The child had crossed two streets to [REDACTED] where the child was finally located.

8. On or about [REDACTED], [REDACTED] children at El Pueblo attempted suicide. One of the children was returned to El Pueblo under one-to-one staff supervision; yet the following evening, the one staff member assigned to the one-to-one was supervising five other children along with that child.

9. On or about September [REDACTED] 2017, a report was made stating that approximately [REDACTED] prior, El Pueblo staff physically abused a child. Staff pulled the child's hair, scratched the child, and elbowed and kned the child's body. Staff also punched the same child in the mouth around that same time. The reporting party stated that staff hit children in areas of the facility where there are no cameras.

10. On or about September [REDACTED] 2017, a report was made alleging that on [REDACTED], a child with significant disabilities was rolling around the floor and banging their head on the floor. Staff present during the incident reported they had to obtain permission from an administrator before they could initiate a restraint on the child; the administrator denied this request. Staff watched as the child continuously engaged in self-abuse including biting their own arms and legs, resulting in bleeding wounds. The child pulled off their own skin, and was chewing and eating it. This behavior occurred for approximately 25 minutes. Staff again requested permission to intervene; the request was denied. Staff attempted to call additional administrative staff, but that administrator did not return the call for an hour. Staff cleaned and bandaged the wounds.

11. A child arrived at El Pueblo in [REDACTED] 2016 weighing [REDACTED] pounds, and left the facility less than ten months later, weighing [REDACTED] pounds. El Pueblo had

no explanation for the child's significant weight loss; the child was not morbidly obese at the time of admission. The child also suffered excessive bruising. Children at El Pueblo have consistently expressed that they are hungry; through numerous interviews occurring February 2017 through September 2017, and eight completed grievances by youth, children have stated that the facility does not provide them with adequate food. Child abuse and neglect referrals and staff interviews raised concerns that the children's hunger resulted in frustration and often escalated into aggression.

12. In the past year, during licensing Stage II investigations of child abuse and neglect referrals, the facility has had eleven repeat violations regarding use of physical restraints, six repeat violations regarding inappropriate discipline, eighteen repeat violations of children's rights, and five repeat lack of supervision violations.

13. The Department has reasonable grounds to believe and finds that the operation of this residential child care facility presents a substantial danger to the public health, safety, and welfare requiring emergency action, as indicated by the following:

- (a) El Pueblo consistently fails to maintain standards prescribed and published by the Department, in violation of § 26-6-108(2)(d), C.R.S. (2017);
- (b) El Pueblo furnished or made misleading or false statements or reports to the Department, in violation of § 26-6-108(2)(e), C.R.S. (2017);
- (c) El Pueblo fails to provide safe conditions for the children, in violation of § 26-6-108(2)(h), C.R.S. (2017); and
- (d) Substantial evidence exists that persons employed by El Pueblo have committed acts of child abuse, as defined in section 19-1-103(1), C.R.S. (2017), in violation of § 26-6-108(2)(i), C.R.S. (2017).

THEREFORE, the Department is authorized to summarily suspend this license pursuant to §§ 24-4-104(4) and 26-6-108(2), C.R.S. (2017).

ACCORDINGLY, IT IS ORDERED that license number [REDACTED] issued to El Pueblo Boys & Girls Ranch, is summarily suspended pending proceedings to determine whether that license should be further suspended or revoked. El Pueblo shall immediately surrender license number [REDACTED] to the Department pending the conclusion of the administrative proceedings herein.

FURTHERMORE, IT IS ORDERED:

1. That the Notice of Charges be promptly prepared and sent to El Pueblo.
2. That administrative proceedings be instituted and determined promptly.
3. That El Pueblo shall immediately desist and refrain from any further act for which a child care license is required by the State of Colorado.
4. That El Pueblo shall immediately surrender license no. [REDACTED] to the Department pending the conclusion of the administrative proceedings herein.

DONE this 25th day of September, 2017.

COLORADO DEPARTMENT OF HUMAN
SERVICES

A handwritten signature in dark ink, appearing to read "Robert Werthwein", is written over a horizontal line.

Robert Werthwein, Director
Office of Children, Youth & Families

Attachment **B**



COLORADO

**Office of Children,
Youth & Families**

Division of Child Welfare

Ann M. Rosales, MSW, Director

Ms. Stephanie Villafuerte
Office of Colorado's Child Protection
Ombudsman
1300 Broadway, Suite 430
Denver, CO 80203

July 19, 2019

Dear Ms. Villafuerte,

Below please find the Colorado Department of Human Services' (CDHS) responses to the Child Protection Ombudsman's (CPO) investigation report in regard to the circumstances surrounding the closure of the El Pueblo Boys and Girls Ranch (El Pueblo). This document contains the Department's general response to the overall report as well as responses to the four recommendations made by the CPO.

General Response to the Report

The investigation report outlines concerns about the closure of El Pueblo, specifically asking, "If conditions at El Pueblo were so severe, why did it take the CDHS so long to order the closure of the facility?" The Department believes that the conclusion by the CPO that it took too long for the Department to close El Pueblo does not take into consideration El Pueblo's right to due process and the rights of El Pueblo as a licensed facility doing business in the state of Colorado. The Department must build a well documented case against a facility in order to proceed with an adverse licensing action. In the case of El Pueblo, the lack of founded cases of child abuse and neglect complicated the Department's ability to build a strong case for adverse action.

Beginning in September 2016, the assigned Placement Services Unit (PSU) Monitoring Specialist began to notice a pattern of screened out institutional abuse referrals that were indicative of abuse and neglect, regarding one child in care at El Pueblo. These concerns were brought to the attention of Pueblo County, who was responsible to complete institutional investigations on El Pueblo. As time progressed, the PSU Monitoring Specialist began to observe several repeat screened out referrals and critical incident reports pertaining to many youth. These screened out referrals were turned into complaints and the PSU collectively investigated the related incidents due to concerns about the severity and frequency. PSU conducted multiple investigations and discussed violations and concerns with El Pueblo administration. In an effort to help the facility make improvements and become trauma informed, the Department awarded a \$20,000 grant to El Pueblo to hire staff from Limbic Legacy to train El Pueblo on implementing a trauma-informed treatment model. In April 2017, due to the willful and deliberate actions of El Pueblo and the continued number of allegations of abuse and neglect, the adverse licensing action process was initiated. PSU staff increased monitoring efforts to ensure compliance and the safety of the youth in the facility by visiting the facility a minimum of one time weekly and often two to three days a week, on evenings, weekends and during sleeping hours, until the program closed in September 2017. These visits were conducted concurrent to the adverse licensing process that was taking place with the Attorney General's Office and the facility's attorneys.



The responsibility for ensuring facility compliance lies with multiple entities. Additionally these entities impose standards of care on a facility and provide oversight in accordance with those standards. All residential child care facilities (RCCFs) are held to standards by multiple entities, such as the Colorado Department of Public Health and Environment (CDPHE), local zoning, Colorado Department of Education (CDE), the Administrative Review Division (ARD), the Office of Behavioral Health (OBH), Division of Child Welfare (DCW), Division of Youth Services (DYS), guardians ad Litem (GALs), magistrates, and county departments, to include contract administration, ongoing caseworkers and institutional abuse assessment case workers. Each licensed facility is often held accountable to multiple county contracts at one time. Most often, these various entities collaborate during times that facilities struggle to maintain standards of care, such as the case for El Pueblo. More specifically, the PSU, CDE and OBH had increased their oversight due to ongoing, repeat violations of their standards and were in regular attendance at the facility to provide oversight and technical assistance (TA). PSU maintains strong partnerships and meets with these entities regularly. PSU is open to further strengthening those relationships and defining processes.

The Department was proactive in its approach with El Pueblo by determining that there was a pattern of screened out institutional abuse referrals, increasing oversight at the facility in response, engaging other oversight entities for assistance, and providing significant TA directed at improving the performance of the facility. When the PSU determined that the TA was not changing practice and El Pueblo's actions were willful and deliberate, the Department moved to issue the order of summary of suspension.

Responses to Recommendations

Recommendation 1	ID: 2017-2736-F1(R1)	Agency: CDHS
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CPO Recommendation: The CDHS should review and revise the current system for handling reports of institutional abuse to ensure that concerns are addressed in a timely and effective manner. This review should include a consideration of the following:

- a. Whether county departments are the best entities to investigate allegations of institutional abuse in residential child care facilities.
- b. Whether the current two-stage investigation process is effective in ensuring the safety and well-being of children in residential child care facilities.
- c. Whether state regulations provide adequate guidance surrounding the screening, assessment, and disposition of allegations of institutional abuse.
- d. Whether state regulations provide adequate guidance surrounding the identification, investigation, and communication of substantiated licensing violations.

CDHS Response: The Department agrees to review and revise, if necessary, the current policies and guidance for screening and responding to allegations of institutional abuse and/or neglect to ensure that concerns are addressed in a timely and effective manner.

1.a. The Department believes county departments are the best entities to receive, screen, assess, and investigate allegations of institutional abuse in RCCFs. As such, the Department agrees to review policies and guidance provided to county departments regarding the receipt, screening and assessment of allegations of institutional abuse in RCCFs. Colorado is a state supervised, county administered system and as such, CDHS/DCW regularly reviews processes and practice guidance to ensure that policies are aligned with best practices and current knowledge in the field of child welfare. When a facility is located within a county's jurisdiction, a county department assesses allegations of institutional abuse and/or neglect to determine if an individual employed by an RCCF is a person responsible for abuse or neglect (PRAN) against a child/youth who is placed at the facility. County staff are ultimately the persons responsible for accepting and screening the referrals for assessment and have been



trained through the Child Welfare Training System (CWTS). Completed assessments are reviewed by a multidisciplinary committee and the committee provides feedback to the assessing county, the placing county and to the provider. This process is currently being reviewed to determine if there are opportunities for process improvement.

CDHS has reviewed current training offered by the CWTS and has developed learning activities to promote consistency in the completion of institutional abuse and/or neglect assessments. Learning activities implemented since the closure of El Pueblo have included a web-based ECHO training, face-to-face site visits by the Institutional Assessment Specialist with DCW to provide TA to county staff and a review of processes with the Institutional Assessment Review Team (IART). Following the implementation of a learning activity, DCW reviews outcomes and practices to determine if behavior changes have occurred.

Currently, there is an assessment screen out process that the ARD completes by randomly selecting a sample of screened out institutional abuse and/or neglect referrals to ensure counties are appropriately screening out referrals when they do not meet the statutory requirement and to bring to the attention of the PSU any concerning referrals that contain potential licensing violations. ARD utilizes a standardized tool to evaluate the referrals and the screening decisions.

1.b. The Department believes the current two-stage assessment and investigation process is effective in ensuring the safety and well-being of children in RCCFs. As such, the Department agrees to utilize a continuous quality improvement process to review the current two-stage assessment and investigation process to determine if there are areas that need to be modified or enhanced.

The use of a two stage assessment/investigation process allows for a distinction between assessing allegations of abuse and neglect and investigating for licensing violations to determine agency/facility culpability. These are separate, yet related, processes and allows for checks and balances within the child welfare system.

It is the role and responsibility of child welfare caseworkers and supervisors within county departments of human or social services to assess for child abuse and/or neglect in an assessment of institutional abuse or neglect, also referred to as the Stage I. Both caseworkers and supervisors are trained and certified through the CWTS to provide this function statewide through the state supervised, county administered child welfare system.

It is the role and responsibility of the PSU to supervise and monitor the business practices of an agency/facility who has applied and been licensed to do business in the state of Colorado as an RCCF. If an agency doing business as an RCCF in Colorado is alleged to have violated the state statutes and/or Code of Colorado Regulations required of the business, the PSU will initiate an investigation of the entity to determine if the business' practices/policies, or lack thereof, contributed to the abuse/neglect of a child/youth placed in the facility. This is also referred to as the Stage II. If it is determined that a business' practices/policies did contribute to the abuse/neglect of a child/youth placed in the facility, this may result in adverse action, by the PSU, against an entity's business license if it meets statutory requirements.

In addition to Stage II investigations, other processes the PSU has in place to ensure the safety and well-being of children in RCCFs includes the following: annual audits by licensing, complaint investigations, screened out investigations, assessment of critical incident reports, monitoring, and increased monitoring. Furthermore, once a agency/facility has been submitted for adverse action, licensing and monitoring are required to visit a minimum of one time per month. The current standard operating procedures also require quarterly visits for new facilities. The PSU is in the process of developing a new monitoring team to focus on outcomes which research suggests is a better indicator of assessing child safety in agencies and facilities.

1.c. See 1.a. above. The Department agrees to review state regulations to determine if they provide adequate guidance surrounding the screening, assessment, and disposition of allegations of institutional abuse. In addition, a state and county foster care work group appointed by Sub-PAC is currently reviewing all screening, disposition,



and assessment processes across all out of home placements. The work group will make recommendations and once received, will be considered and policy changes may occur through the formal rule-making process.

1.d. See 2.b. through 2.f. below. DCW is currently in the process of reviewing whether state regulations provide adequate guidance surrounding the identification, investigation, and communication of substantiated licensing violations. This work is being done in collaboration with CDHS legal, the Attorney General's Office, the Office of Early Childhood (OEC) and the OBH.

Recommendation 2	ID: 2017-2736-F1(R2)	Agency: CDHS
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CPO Recommendation: The CDHS should develop standard operating procedures for the monitoring of licensed residential child care facilities. These policies should be available to the public and, at a minimum, include:

- a. Standard protocols, including standard timeframes, for receiving and reviewing complaints and concerns about licensed facilities. Such standards should address both:
 - a. Reports received as referrals through the statewide Child Abuse and Neglect Hotline.
 - b. Complaints and concerns received through other mechanisms, including those made directly to CDHS staff.
- b. Standards for determining whether there are any licensing violations.
- c. Standard protocols for the finalization, formatting and distribution of reports regarding facility monitoring.
- d. Standards for handling repeat licensing violations.
- e. Standards for creating and enforcing corrective action plans for licensed facilities.
- f. Standards for implementing negative licensing action against licensed facilities.
- g. Standards governing communication about substantiated licensing violations with county departments and the public.

Agency Response: The Department agrees to continue to review and revise, if necessary, the standard operating procedures for the monitoring of licensed RCCFs. The Department agrees these policies should be available to the public.

2.a. Standard protocols, including standard timeframes, for receiving and reviewing complaints and concerns about licensed facilities exist. When complaints and concerns are reported to CDHS regarding RCCFs, they are managed by CDHS Client Services in coordination with the DCW. In 2018, a continuous quality improvement (CQI) process was conducted to review the CDHS formal complaint process. The CQI process determined that the complaint process with regard to RCCFs was aligned with statute and rule. As a result there were no recommendations for changes to that process. There is an agreed upon process between the ARD and DCW where ARD sends the PSU 24-Hour Monitoring Team supervisor a report that identifies alleged licensing violations. These alleged licensing violations are entered into the Colorado Child Care Licensing System (CCCLS) and assigned for investigation. When the PSU is contacted directly regarding concerns or complaints, the PSU 24-Hour Monitoring Supervisor enters the information directly into the CCCLS upon receipt and assigns them for investigation.

The ARD pulls a random sample monthly, of institutional abuse and/or neglect referrals which were screened out. If ARD identifies a referral that meets the criteria for screening in, they send the referral to a second level review. If the second level reviewer agrees that the referral met the criteria for assignment, the county and the Institutional Abuse Specialist is notified and the referral is re-screened. If there is imminent danger or harm identified at the time of the review, the county is contacted and an immediate response to the allegation is required by the county department. The results of all reviews are shared on a quarterly basis with the Institutional Abuse Specialist at DCW.



2.b. through 2.f. The review and revision of these standards is currently in progress in coordination with the CDHS legal team and the Attorney General's Office. Revisions are being made to the procedures to ensure alignment with the OEC and OBH.

2.g. All Stage II investigations completed by DCW's PSU's 24-Hour Monitoring Team are documented directly in Trails. This information is available to counties, the DYS, and anyone who has the appropriate profile access to Trails. The public can request this information through the Colorado Open Records Act.

Recommendation 3	ID: 2017-2736-F3(R1)	Agency: CDHS
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CPO Recommendation: The CDHS should request and allocate additional staff and funding to monitor conditions and services in licensed residential child care facilities.

Agency Response: The Department agrees to submit a request for additional funding to support additional FTEs to monitor conditions and services in licensed RCCFs. The Department cannot commit to obtaining additional staff if a budget request is not approved through the State of Colorado Office of Strategic Planning and Budget and/or if the Colorado Joint Budget Committee does not appropriate funds to the Department for this purpose.

Recommendation 4	ID: 2017-2736-F3(R1)	Agency: CDHS
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CPO Recommendation: The CDHS should develop systems to improve transparency surrounding conditions, services and outcomes in residential child care facilities. At minimum, such mechanisms should include the following:

- a. A mechanism for storing information about licensing violations that can be easily accessed by county departments to inform placement and contract decisions.
- b. A mechanism for reporting appropriate information about facility monitoring to the public.

Agency Response: The Department agrees that systems should be developed to improve transparency surrounding conditions, services and outcomes in RCCFs. Currently and historically, all Stage II investigations are entered into Trails with the exception of the agency/facility response. Additionally, other information and documents such as complaints, critical incident report investigations, referrals screened out by county departments of human/social services but may contain potential licensing violations, and licensing and monitoring visits are not easily accessed in Trails as they are entered into other systems.

Through the Trails Modernization project, a mechanism is being developed to store information about licensing violations that can be easily accessed by county departments to inform placement and contract decisions. A mechanism for reporting appropriate information about facility monitoring to the public is available through the Colorado Open Records Act. Additionally, statute requires "due process," providing a reasonable opportunity to comply. Therefore, the facility's license remains in good standing until negative licensing action takes place. Disclosing information about a facility, prior to that facility being provided the opportunity to comply with all lawful requirements, interferes with the legal process. The Department agrees to review the possibility and efficacy of posting licensing history for 24 hour facilities in a manner similar to OEC.

C.R.S. 19-1-103 (66) defines "Institutional abuse" as any case of abuse (as defined in C.R.S. 19-1-103 (1)) that occurs in any public or private facility in the state that provides child care out of the home, supervision, or maintenance. It further defines "facility" as a RCCF, specialized group facility, foster care home, family child care home, or any other facility subject to the Colorado "Child Care Licensing Act". The inclusion of foster parents and kinship providers in this current definition complicates the balance of transparency and confidentiality for these



particular out of home placement providers. Efforts are currently underway to explore separating the definition of "facility" into classifications such as "family-like settings" and "institutional settings". Such a separation could impact how RCCF monitoring information is relayed to the public.

The Department values the work of the CPO and appreciates the time dedicated to this investigation. I hope you find this information to be helpful and responsive to your request. Please do not hesitate to contact me if you have any other questions. Thank you.

Respectfully,



Minna Castillo Cohen, M.ED
Director, Office of Children, Youth and Families
Colorado Department of Human Services

