CHILD PROTECTION OMBUDSMAN of COLORADO

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EXECUTIVE SUMMARY

INVESTIGATION: EL PUEBLO BOYS AND GIRLS RANCH

By the time El Pueblo Boys and Girls Ranch (El Pueblo) was closed only 37 of the facility's 65 beds were full. The facility, which was licensed by the Colorado Department of Human Services (CDHS) 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 month. In revoking the facility's license, the CDHS cited a list of concerning incidents and more than a dozen repeat violations of state regulations regarding the use of physical restraints, inappropriate discipline and a lack of supervision.

Following the facility's closure, a concerned citizen contacted the Office of Colorado's Child Protection Ombudsman (CPO) and asked: Why did it take so long to close a facility that was failing to keep children and youth safe? The CPO opened an investigation and spent more than a year studying the complex system and multiple actors tasked with ensuring the well-being and safety of children and youth in residential child care facilities such as El Pueblo. In addition to a thorough legal and regulatory analysis, the CPO reviewed the 243 reports related to children and youth residing in El Pueblo during the 12 months that preceded its closure.

Through its investigation, the CPO found that a lack of regulation, resources and transparency surrounding residential child care facilities has the potential to perpetuate the circumstances that plagued El Pueblo. Primarily, the CPO identified three issues that 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. The three issues are:

- **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.**
- **The lack of standard and public operating procedures weakens the CDHS' ability to sufficiently and consistently monitor residential child care facilities and enforce corrective action plans.**
- **Without a public reporting process to capture the CDHS's findings regarding the safety and care of children and youth, 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.**

CPO's RECOMMENDATIONS

Based on its investigation, the CPO issued four recommendations to the CDHS, which is the state agency responsible for developing procedures to address allegations of abuse and neglect inside residential child care facilities it licenses.

RECOMMENDATION 1

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.

RECOMMENDATION 2

The CDHS should develop standard operating procedures for the monitoring of licensed residential child care facilities. These policies should be available to the public.

RECOMMENDATION 3

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

RECOMMENDATION 4

The CDHS should develop systems to improve transparency surrounding conditions, services and outcomes in residential child care facilities. At a minimum, such mechanisms should include, a method for storing information so it may be easily accessed by county departments and a public reporting function to share appropriate information about facility monitoring.

The CPO monitors the implementation of all of its recommendations. Public updates regarding this process may be found on the CPO's website: www.coloradocpo.org.

To view a complete copy of the CPO's report visit, www.coloradocpo.org.