CHILD PROTECTION OMBUDSMAN of COLORADO

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ISSUE BRIEF

BRIDGING THE GAPS: How current law limits the effectiveness of Colorado's child fatality reviews.

Timothy Montoya-Kloepfel thrived in the joy of others. He would do just about anything to make someone happy. If you said his Nerf gun was cool, it was yours. If you complemented his T-shirt, he would take it off and hand it to you. Timothy – Timmy to his mother and friends – reveled in painting pictures and creating items out of duct tape, all so he could give them to someone else. But as much as Timothy blossomed in the joy of others, he also wilted under the weight of the world's problems. He was overwhelmed at reports of shootings on national and local news stations. The burden of such events became so much that the then 10-year-old boy asked his mother: "What is it like to be depressed and what does that word mean?"

That question was the start, the beginning of what Timothy's mother, Elizabeth Montoya, would call a "vicious cycle." During the next two years, Timothy would cycle in and out of short-term hospitalizations, residential child care facilities and in-home services. He would be diagnosed with autism, attention deficit hyperactivity disorder and post-traumatic stress disorder. He would repeatedly threaten to harm himself, and he kept running – running away from the people and systems trying to help him.

Timothy's needs were severe and qualified him for behavioral health treatment through Medicaid and other programs. But qualifying for these programs did not guarantee Timothy was receiving the services they offered. Timothy's mother struggled to find providers with the availability and/or willingness to take on his case. Receiving services through one program, often knocked Timothy out of another. These gaps in services could last days, or they could last months. During those gaps, Elizabeth recalls doing all she could for Timothy. One day this meant holding Timothy in a bearhug on the floor next to a window. For almost an hour, the then 11-year-old would alternate between telling his mother he loved her and lunging toward the open first-floor window.

Timothy had been successful during past placements in residential child care facilities. So his mother was hopeful when he was placed in a local facility during the summer of 2020. Her hopes were quickly shattered. Just days after he was placed, Timothy ran from the unlocked facility. He was later walking on a dark road where he was hit by a car. Timothy died from his injuries. He was 12 years old.

Elizabeth does not blame the facility – or any singular entity – for her son's death. However, she knows that her son's life and death offer valuable lessons regarding how to improve the multiple systems that touched her child. But her calls to various agencies asking who was responsible for reviewing Timothy's death went unanswered. No one told her that her son's death did not qualify for review by one of two government teams in Colorado charged with reviewing the deaths of children. She was never informed why his death did not qualify.

More than one year after her son's death, no one – including state agencies that license facilities where her son was placed or provided her son services – called Elizabeth to ask what could have been done better. Had they called, Elizabeth could have calmly and clearly articulated improvements to the child protection system that she believes would have helped her son while he was alive. She would have started by discussing the need for a more structured system for connecting parents with Medicaid accepting providers – one that goes beyond the provision of a referral. Then she would have discussed the need for greater transparency regarding how residential child care facilities operate. Next, she would have discussed how the deaths of all children served by the child protection system should result in public-facing reforms and discussions. But no one called her.

"Shouldn't we all learn from this?" Elizabeth asked recently. "All I want to do is make sure something changes for other kids."[1]

SUMMARY OF THE ISSUE

When a child dies in Colorado, there is no consistent and transparent process that guarantees all systems – including law enforcement, schools and hospitals – are notified of their roles. This includes cases in which the child died of abuse and neglect. Conversely, there is no accountability mechanism for ensuring that all systems capable of preventing child maltreatment deaths are improving their practices. There are multiple entities engaged with reviewing child maltreatment deaths. There is not, however, a single entity responsible for implementing standard protocols for notifying agencies of lapses, issuing recommendations for improvements and ensuring those changes are made. Without an accountability mechanism and public monitoring system for such recommendations, there is no way to answer the question:

Why are there still so many children dying of abuse and neglect in Colorado?

During the past 12 months, the Office of Colorado's Child Protection Ombudsman (CPO) received complaints regarding the maltreatment deaths of seven Colorado children. As with Timothy's death, a report detailing the findings and recommendations made during the review of five of those seven children's deaths will not be released to the public. A review of child maltreatment data for the past six years – 2014 through 2020 – shows that, on average, such information was not disclosed to the public in at least 39 percent of child maltreatment deaths.[2] Despite decades worth of child maltreatment reviews and recommendations, no one can explain why child abuse and neglect deaths in Colorado remain constant, nor what specific actions have been most effective in preventing such deaths. In fact, there is not a definitive number for how many children have died of abuse or neglect during the past six years. This is because the two agencies statutorily charged with reviewing child maltreatment deaths define maltreatment deaths differently.[3] Between 2014 and 2020, anywhere between 206 and 273 children died of abuse and/or neglect in Colorado.[4] The Colorado Department of Human Services' Child Fatality Review Team (CFRT) and the Colorado Department of Public Health and Environment's Child Fatality Prevention System (CFPS) review child maltreatment deaths in Colorado. While the processes and role of each review team differ, neither team has a process

[1] Elizabeth Montoya spoke with the Office of Colorado's Child Protection Ombudsman (CPO) on April 19, 2021. She provided the CPO permission to use her son's name and details of his case in this report.

[2] According to the CPO's review of the Colorado Department of Human Services' Child Fatality Review Team's public notification pages for years 2014, 2015, 2016, 2017, 2018, 2019 and 2020 last reviewed on June 11, 2021.

[3] See C.R.S. § 25-20.5-405(1)(e) and C.R.S. § 26-1-139(2)(d).

[4] According to the CPO's review of all the non-confidential child fatality/near fatality/egregious incident case-specific executive review reports published by the CFRT between January 2014 and December 2020 and CFPS annual legislative reports for correlating years.

prescribed in statute for disseminating recommendations directly to entities involved with a child prior to their death and monitoring to make sure such recommendations are implemented.

There is also no entity responsible for evaluating the effectiveness of recommendations that are implemented. The difficulty of implementing recommendations is not unique to Colorado. Nationally, child maltreatment review teams struggle to monitor and implement recommendations.[5] In Colorado, however, this problem is amplified by the fact that there are two systems issuing recommendations through very different processes.

Data presented by both teams shows neither a consistent increase nor decrease in the number of child maltreatment deaths since 2014. The numbers of child abuse deaths, however, are not the only measurement of progress, or lack thereof, to reduce child maltreatment fatalities. It is also important to look at the reviews and recommendations to see if progress has been made to improve the systems responsible for protecting Colorado children. The CPO's study of such reviews and recommendations shows years of ongoing system failures. For example, over the years, lack of coordination between law enforcement and child welfare services and failure by mandatory reporters to report child abuse were system failures noted in multiple cases reviewed by the CFRT.[6] Recommendations to address these circumstances have not been consistent and it is unclear which of these recommendations have been implemented and whether they are effective.

The CPO has heard from professionals in a variety of disciplines, including child welfare agencies, medical and health professionals and law enforcement. All have stated concerns that Colorado's current processes for reviewing child maltreatment deaths are not doing enough to prevent future deaths. The CPO's review of both systems has found that this is not a result of a lack of effort or diligence by those running these programs. Instead, the CPO has found that the structure of the programs – namely the laws that dictate their practice – are both lacking definition and are too narrow in scope.

While Colorado law inhibits the impact of each program, the gaps between the two programs also prevent the public and external stakeholders from learning and creating meaningful change. This is because neither the public nor external stakeholders have access to information that is pertinent to informing citizens and stakeholders about the circumstances of a child's life prior to their death. As a result, citizens and other child-protection-system stakeholders are substantially excluded from participating in the systems that can create change.

Colorado's bifurcated system has created a patchwork approach to reviewing child maltreatment deaths that inherently limits information about the systems that served children prior to their deaths. Often the reviews focus on the circumstances surrounding the child's death and the processes that took place after the child died – instead of the services provided to the child during their lifetime. More specifically, the bifurcated process is inconsistent in the following areas:

(1) Approach to child maltreatment death reviews;

(2) Development of recommendations;

(3) Reporting practices and transparency standards; and

(4) Monitoring implementation of recommendations.

THE COLORADO SYSTEM FOR REVIEWING CHILD MALTREATMENT DEATHS

Colorado established its first child maltreatment review processes more than 30 years ago. Since then, the state has continually attempted to improve these processes by emphasizing a multi-team, multidisciplinary approach for reviewing child maltreatment deaths and educating the public about how to prevent such fatalities. However, gaps between systems and reviews still exist.

[5] See National Center for Fatality Review and Preventions' Child Maltreatment Fatality Reviews: Learning Together to Improve Systems that Protect Children and Prevent Maltreatment, September 2018.

[6] According to the CPO's review of all the non-confidential child fatality/near fatality/egregious incident case-specific executive review reports published by the CFRT between January 2014 and December 2020.

As stated above, there are two state agencies in Colorado tasked with studying child abuse and neglect deaths, as well as the systems capable of preventing such fatalities. While both entities share the same goal, the approach, methodology and capability of each is fundamentally different.

Colorado Department of Public Health and Environment's Child Fatality Prevention System

First, the CFPS employs a public health approach to child maltreatment reviews. This public health approach is focused on primary prevention versus specific child protection system improvements.[7] The CFPS works to identify "upstream" prevention efforts by studying aggregate data. This data has been used to develop broad policy recommendations to address issues such as providing education about safe sleep practices for infants, expanding access to quality child care and supporting polices for paid family leave. Currently, there are 43 local teams charged with reviewing every fatality of a child from birth to 17 years old caused by undetermined causes, unintentional injury, violence, motor vehicle incidents, child abuse or neglect, sudden unexpected infant death or suicide.[8] Recommendations developed by the teams are distilled into approximately half a dozen broad policy recommendations each year.

Colorado Department of Human Services' Child Fatality Review

Unlike the CFPS, the CFRT approach centers on the maltreatment deaths of children who had contact with the child welfare system three years prior to their death. This singular team identifies strengths and missteps in each case and creates recommendations based on those case-specific findings.[9] Consistently, the CFRT is the focus of media and public attention. This is because CFRT has long been considered by lawmakers, professionals and the media as the public accountability mechanism for when a child dies of abuse or neglect – despite the fact that CFPS also reviews such cases. This focus on CFRT is largely the result of the public reports issued by the team, which detail each case and the recommendations that stemmed from that review. However, the law gives them discretion to postpone or decline publication of reports in certain circumstances.[10]

Office of Colorado's Child Protection Ombudsman

There is a third entity that may review child maltreatment deaths – the CPO. The CPO was established in 2010 in response to the maltreatment deaths of 12 children in Colorado in 2007. Legislative hearings that led to the establishment of the agency revealed frustration by citizens about the lack of transparency in state child protection systems, particularly in the area of child abuse fatalities. Since the establishment of the agency, the CPO regularly gets calls from the family members of deceased children and community members who are concerned, frustrated and want to understand more about what efforts are taking place to prevent such deaths.

The CPO is required by law to review any case – including child maltreatment deaths – brought to its attention. Beginning this summer – and for the first time since the inception of the agency – the CPO will have the necessary tools to conduct its own, independent reviews of child fatalities. With the passage and implementation of House Bill 21-1272, the CPO will now be able to effectively access third-party records regarding a child's death, including law enforcement records, coroners' reports and medical records.[11] It will also have limited access to confidential documents produced by the CFPS and CFRT. The provisions of this legislation will ensure that the CPO – the state's only independent review agency for children – is able to serve as a meaningful partner in studying child deaths and formulating recommendations for system improvement.[12]

[7] This brief refers to the child protection system and child welfare services as to distinct entities. The phrase "child protection services" refers to "any public agency or any provider that receives public money that may adversely affect the safety, permanency, or well-being" of a child, as defined in C.R.S. §19-3.3-103(1)(a)(I)(A). The phrase "child welfare" refers to services provided by a county department of human services and/or the Colorado Department of Human Services.

[8] See C.R.S. §25-20.5-405(1).

[9] This report will not address the Policy Findings issued by CFRT. These findings pertain specifically to the actions of county departments in the handling of a child welfare case. While a crucial part of the CFRT's work, the CPO's concern centers on whether the CFRT is able to create change across disciplines.

[10] See C.R.S. §26-1-139(5)(i)(IV) and §26-1-139(5)(j).

[11] See House Bill 21-1272.

[12] The CPO reviewed the statutes of other states' child protection ombudsman agencies to identify those that are statutorily provided access to child fatality information. The CPO found 80 percent of similarly structured agencies are proactively involved in reviewing child maltreatment fatalities in their states.

SCOPE AND METHODOLOGY

The CPO has closely monitored the work of the CFRT and CFPS for more than four years. This work was done not only to access the extremely valuable information produced by each team, but to also monitor the impact of each team's recommendations on the child protection system.

As such, the CPO has reviewed and cataloged approximately 100 CFRT case-specific reports, as well as nearly a dozen aggregate and annual reports produced by both teams.[13] The CPO monitored these systems using ***only*** public-facing information and documents. Because the CFPS is not required to publish any findings or recommendations made by local teams regarding individual case reviews, these documents were not reviewed by the CPO.

This approach allowed the CPO to better appreciate the challenges the public face while interacting with these reviews. Since becoming an independent agency, the CPO has routinely heard from citizens, legislators and members of the media seeking information and clarity regarding the process for reviewing child maltreatment deaths. Such inquires have also come from parents and family members of children whose deaths were reviewed by the CFPS, CFRT or both. The public has repeatedly reported feeling confused and disconnected from the reviews, and this has led to frustration by those attempting to utilize the reports to make meaningful change.

In addition to the insights described above, the CPO's long-term study of these reviews captured changes in how information is presented, what information is published and outside initiatives – particularly by the CFRT. The CPO cites several case examples from CFRT reports in this brief, many of them predating changes to the CFRT's public reports. Regardless of the changes made by the CFRT in its internal processes over time, the CPO finds that such anecdotes demonstrate the long-standing and ongoing challenges facing child fatality reviews in Colorado.

While the CPO reviewed all available public reports, the CPO limited the data presented in this brief to child maltreatment deaths that took place between 2014 and 2020. This was done to accommodate the legislative amendments made to the teams' authorizing statutes in 2013.

ANALYSIS

Less than a decade ago, the enabling statutes for the CFRT and CFPS were amended in an attempt to strengthen review processes. The amendments were aimed at incorporating local perspectives into the reviews, strengthening the multidisciplinary aspects of each process and requiring that the two teams coordinate each year to develop joint recommendations to prevent future child maltreatment deaths.[14] None of these legislative amendments, however, created a standard practice for how either team will ensure the recommendations they issue are disseminated or implemented, nor is there any requirement that the teams should monitor whether their efforts are effective in decreasing the number of such deaths. In short, these changes asked more of both teams, but failed to provide additional resources or meaningful guidance as to how to ensure change is taking place.

Colorado needs to ensure that every review of a child maltreatment death provides equal opportunities to improve services that could help prevent future child maltreatment deaths. Currently, some deaths yield more change than others. Some high-profile child maltreatment deaths spur outrage, prompt discussions about policies and practice and, in some cases, bring about tangible change. But most cases do not.

[13] The CPO focused its research for this brief solely on the CFRT's case-specific reports involving child fatalities. It did not include reports detailing near fatal or egregious incidents.

[14] See C.R.S. §25-20.5-407(1)(i).

The public only has access to some of the findings and recommendations developed during the review of individual child maltreatment deaths

The distinct roles of the CFPS and CFRT create a significant gap in the collection and dissemination of key information about child abuse and neglect deaths in Colorado. Currently, the public and external stakeholders only have access to case-specific findings and reviews for roughly half of all child maltreatment deaths in Colorado.

Local CFPS teams review all qualifying child deaths assigned to them by the CFPS state team. These local reviews – whose deliberations and findings are not available to the public or external stakeholders – study the death and issue case-specific recommendations. Local CFPS teams reviewed 232 child fatalities – including non-maltreatment deaths – in 2019. Those teams made nearly 500 prevention recommendations.[15] By law, those recommendations are not made available to the public. Instead, the recommendations are scrubbed of any identifying information and submitted to the CFPS state team. The aggregate data is entered into a federal reporting system and used by the state team to develop broad recommendations. It should be noted that not all 500 recommendations concern child maltreatment deaths.

Pursuant to the CFPS' enabling statute, the local teams are not required to produce a report detailing the individual case, findings and recommendations. However, without such reports, the public has no insight as to how the local teams are collecting data or even categorizing deaths. For example, the CFPS acknowledged in its 2021 annual report that one local team may determine a child died of abuse or neglect, while a different local team might determine a different cause of death.[16] In short, anyone who does not participate in the review has no way of knowing what circumstances were present, what details the team relied on when making its findings and how the recommendations may address any issues identified.

By contrast, the CFRT does publish a case-specific summary report for the majority of child maltreatment deaths it reviews.[17] However, the CFRT only reviews child maltreatment deaths when the child and/or their family had contact with child welfare services within three years of the child's death.[18] As a result, 39 percent of the maltreatment deaths identified by the CFRT between 2014 and 2020 – 78 deaths – were not reviewed.[19]

Different review approaches do not ensure lessons from each child maltreatment death are disseminated to the community, nor do they ensure that recommendations are implemented

The CPO's analysis of Colorado's current processes for reviewing child maltreatment deaths focused largely on the juxtaposition between the laws' intent to utilize interagency perspectives to educate the public regarding these cases, and the actual results achieved by the reviews. How the differences between the intent of the law and the implementation of the law impact the prevention of future maltreatment deaths is detailed below.

CFPS local teams maintain significant discretion in reviews and house valuable information

In amending the CFPS's law to include local teams, legislators and child-protection professionals recognized the invaluable perspective that such teams bring to the review of child deaths.[20] Colorado's population is as diverse as its landscapes and recognizing the unique circumstances in each case is invaluable to the public health approach of the CFPS. However, the diversity of the 43 local teams also creates a vulnerability to inconsistency. Local teams are provided training regarding how to review child deaths and develop recommendations, and they are consistently monitored to ensure all cases are reviewed and data is entered correctly. Still, local teams maintain significant discretion in how they approach

[15] See Colorado Department of Public Health & Environment, Child Fatality Prevention System: 2021 Annual Legislative Report, July 1, 2021.

[16] See Colorado Department of Public Health & Environment, Child Fatality Prevention System: 2021 Annual Legislative Report, July 1, 2021.

[17] See C.R.S. §26-1-139(5)(j).

[18] See C.R.S. §26-1-139(1)(c).

[19] According to data provided on the CFRT's public notification page, as reviewed on June 11, 2021.

[20] See C.R.S. §25-20.5-402(2)(a).

each case. As stated above, one local team may find that a child died of abuse, while a different team may determine the cause of death to be accidental. Because each child's identifying information is removed before being entered into the state database, there is no way for any outside entity to question or review the information independently.

Again, anonymity is key to the public health approach because it allows the CFPS teams to review data and determine trends, rather than focus on issues in singular cases. However, because CFPS is the only program in Colorado that reviews all child maltreatment deaths, maintaining the integrity of the data this way also results in the loss of crucial information for remedying specific problems in the child protection system. Such information includes:

- A list of systems reviewed, issues identified and recommendations for improvements.[21]
- A list of needed resources, training and recommendations for how to improve information sharing among agencies.[22]
- Information on changes that have resulted from recommendations that were issued by local teams and implemented.[23]
- Examples of services provided by private or public agencies in the community that are designed to prevent child fatalities or have been effective in preventing child fatalities.[24]

CFRT reviews remain centered on the actions of child welfare services

Routinely, the public response and discourse about child maltreatment deaths centers on the actions and services of child welfare agencies across Colorado. However, child-protection professionals across all disciplines have long acknowledged the fact that, in most child maltreatment deaths, a child and their caregivers are involved with not one, not two, but more than three public entities prior to their deaths.

While the law guiding the CFRT acknowledges the broad responsibility for studying and preventing these deaths, it also creates one of the largest obstacles in ensuring that all child maltreatment deaths have the potential to drive tangible, timely improvements across entities. The law emphasizes the importance of incorporating diverse agencies and disciplines in the review and prevention of child maltreatment deaths.

However, while the composition of the CFRT team is prescribed in statute, it is unclear how non-child-welfare professionals not appointed to the team are incorporated into each review. This includes non-child-welfare entities involved in individual cases. Currently, there is no requirement that such professionals participate.

A review of approximately 100 case-specific public reports did not indicate the presence of educators, medical professionals and others – who are not sitting members of the CFRT – that were involved with the child and/or family during the case-specific review. For example, the CFRT reviewed a case in 2015 and noted concerns that the father of the child – who was actively parenting the child – was non-compliant with the substance monitoring requirements of his parole. The public report noted concerns that the father's parole officer had not notified child welfare services of this fact and articulated that this was a "systemic issue around the state." The report did not state whether the specific parole officer or a representative of the Colorado Department of Corrections' Division of Adult Parole was invited or attended the review.[25]

[21] See C.R.S. §25-20.5-405(2)(f)(II).

[22] See C.R.S. §25-20.5-405(2)(f)(II).

[23] See C.R.S. §25-20.5-405(2)(f)(III).

[24] See C.R.S. §25-20.5-405(2)(f)(IV).

[25] See Colorado Department of Human Services Child Fatality/Near Fatality/Egregious Incident Case Specific Executive Review Report, NON-CONFIDENTIAL, Case ID: 14-085.

The only provision in the CFRT statute to address this issue is concerning. Specifically, for the purpose of a case-specific review:

> (1) Representatives of other agencies involved with the child or the family may be included in the review. However, only CFRT members from the CDHS or county departments may appoint "additional members" to participate in specific case reviews.[26]
>
> (2) Only entities involved with the family during the year prior to the child's death – not three years prior – may be appointed for the purpose of a specific case reviews.[27]

Such restrictions unnecessarily limit the diversity of those participating in these reviews and ultimately hinder the breadth and impact of the recommendations developed.

Limitations to the type of maltreatment deaths reviewed, restricting participation in reviews and failing to notify the entities involved with a child or their family of findings can stall the momentum needed to implement systemic changes.

CFRT statute narrows the team's analysis and recommendations to the actions of child welfare services

The inclusivity issues articulated above parlay into issues regarding how recommendations are formed, to whom they are provided and the timing with which they are released. Such issues are, in part, caused by the law outlining CFRT. Specifically, the same law that establishes a diverse review team and requires recommendations for all disciplines, also artificially restricts the analysis that is completed during the review. The law simultaneously identifies the need for a multidisciplinary review and recommendations, while also placing child welfare services at the center of the review. This focus is reflected by the fact that only maltreatment deaths of children who have had previous contact with child welfare services are reviewed. State law also requires the CFRT to review specific actions of child welfare services, including:

- The services provided by any child welfare agency prior to the child's death.[28]
- Whether child welfare agencies were compliant with "statute, regulations and relevant policies and procedures" that are connected to the child's death.[29]
- Any services or supports provided to the child's family by the child welfare services agency after the child's death.[30]

The law does not mandate similar scrutiny of any other agency who may have had contact with the child or their family.

The CFRT must also determine the county department's compliance with law, regulations and other policies in the handling of the case. No one disputes that the services delivered by child welfare agencies should be critically reviewed. However, the reviews' emphasis on child welfare's actions results in discussions and solutions that are inherently focused on the actions of one discipline. Not the collective impact all agencies had on a child in the case. There is no clear guidance in statute regarding how CFRT should produce or issue recommendations to non-child-welfare entities.

No other public system – such as hospitals, schools, or law enforcement – is required to review and submit documentation detailing how it provided services to the child or family prior to the child's death. This disproportional scrutiny and the flow of information to the CFRT inevitably keeps the focus of these reviews on child welfare services, and repeatedly results in missed opportunities to address gaps and deficiencies in other systems.

[26] See C.R.S. §26-1-139(6)(e).

[27] See C.R.S. §26-1-139(6)(e).

[28] See C.R.S. §26-1-139(4)(b).

[29] See C.R.S. §26-1-139(3)(d).

[30] See C.R.S. §26-1-139(3)(g).

The CPO's review of approximately six years of recommendations produced by the CFRT demonstrate the consistent and persistent omission of non-child-welfare entities. For example, a report released in 2020 detailed the death of a 7-year-old boy who was unaccounted for several months before his body was found by law enforcement. The report noted that the child's school did not collect any information about the home-schooling program his parents said they would provide him when he was disenrolled. However, the report did not include any recommendations to education professionals regarding the information gap.[31] In a different case, the CFRT found that a medical professional had failed to diagnose a skull fracture shortly before a child's death. The team did not make a recommendation to that medical professional specifically, nor did it make a recommendation to the medical community broadly.[32] In two additional cases, the CFRT noted poor coordination between child welfare services and local coroners during fatality investigations. A recommendation to coroners was not issued in either case.[33]

No standard practice for providing family members with notice of review, findings or recommendations

Neither the CFPS nor the CFRT are required to provide interested family members – immediate or extended – with the findings or recommendations developed as a result of a specific child's review. Additionally, there is no prescribed method in law for inviting family members – when appropriate – to participate in either the CFPS local team review or the CFRT review.

Often, family members who contact the CPO regarding the death of a child in their family are surprised to learn that there are two teams required by law to review that child's death. For the families that are aware of either process, many are confused and frustrated that they do not have direct and timely access to information produced by either the CFRT or the CFPS local team that reviewed their loved one's death.

The CPO recognizes there are circumstances in which a family member's participation in a review may be inappropriate or unallowable, including situations in which that family member is a party in ongoing criminal proceedings regarding the child's death. However, there are several other circumstances in which the family of a child who was killed by abuse or neglect may serve as one of the most effective advocates for change. The ability of family members to act as such advocates is stifled when they do not have consistent access to information about a child's death or a meaningful opportunity to provide insight regarding that child and their family.

CFPS and CFRT enabling statutes create inconsistent transparency and publishing practices

The circumstances of Timothy's death were recently featured in a series of media reports.[34] However, had it not been for those reports, it is likely that the public would have no knowledge of his death and the issues his death exposed. Improving transparency in how child fatalities are reviewed and the findings and recommendations produced by those reviews is not a challenge unique to Colorado. In fact, at the time of publication there is federal legislation under consideration designed to strengthen how teams share this information with federal authorities and to standardize how states review child abuse and neglect fatalities. [35]

Currently, there are no standards for how recommendations developed by CFPS local teams are disseminated into the community. Presumably, agencies who participate in the reviews will receive the recommendations, but there is no standard process for delivering these recommendations to entities not present during reviews. Without access to these recommendations, the public and

[31] See Colorado Department of Human Services Child Fatality/Near Fatality/Egregious Incident Case Specific Executive Review Report, NON-CONFIDENTIAL, Case ID: 18-104

[32] See Colorado Department of Human Services Child Fatality/Near Fatality/Egregious Incident Case Specific Executive Review Report, NON-CONFIDENTIAL, Case ID: 16-013

[33] See Colorado Department of Human Services Child Fatality/Near Fatality/Egregious Incident Case Specific Executive Review Report, NON-CONFIDENTIAL, Case ID: 17-094 and See Colorado Department of Human Services Child Fatality/Near Fatality/Egregious Incident Case Specific Executive Review Report, NON-CONFIDENTIAL, Case ID: 17-049d

[34] See articles published in The Colorado Sun and 9News in May of 2021.

[35] See the Child Abuse Death Disclosure Act

legislature are unable to know if agencies received them and monitor the implementation of recommendations.

Additionally, without access to any information about the local teams' findings in individual cases, the public and external stakeholders have no ability to monitor if the CFPS's findings and recommendations differ from those of the CFRT.

The enabling statutes for both the CFRT and the CFPS acknowledge the importance of transparency in reviewing child maltreatment deaths. However, both statutes also prevent each team from being able to fulfill this charge in earnest. Currently, child welfare services are the only entity whose actions must be presented in a public case-specific report. While the involvement of other agencies is noted in reports, the public currently does not have any comparable insight to the involvement of other agencies as it does child welfare services.

Since becoming an independent agency, the CPO has consistently received inquiries from the public regarding the process for reviewing child maltreatment deaths. Such inquires have also come from parents and family members of children whose death were reviewed by either the CFRT or CFPS. Many are confused and frustrated to learn that the state does not produce an individual report for every child who dies of maltreatment in Colorado. This frustration is especially overwhelming for families of children who died of maltreatment but did not qualify for review by CFRT.

The CPO finds these discussions to be telling about the general public's access to, and understanding of, information and recommendations gleaned from reviewing child maltreatment deaths. Many of whom are seeking to use information by both teams to help implement change

Robust and public monitoring about the implementation of recommendations is needed to help determine which efforts are effective at preventing child maltreatment deaths

Nationally, child maltreatment death review programs struggle to determine whether the recommendations they issue are being effectively implemented. It is extremely difficult for any entity to find a definitive correlation between a recommendation and positive change. Colorado is no different. That difficulty, however, is heightened because of the inconsistency between how the CFPS and CFRT report their recommendations and monitor their implementation.

The CFPS publishes its broad, policy recommendations annually in a report addressed to the Colorado General Assembly. For example, in July 2021 the CFPS recommended supporting policies "that expand access to stable, quality, and affordable child care, especially for infants and young children."[36] Such work is crucial for implementing long-term changes that may help prevent future fatalities. However, the implementation of such large-scale policies can take years and often require significant political capital and resources. The CFPS' annual report contains detailed updates regarding the progress of the policy recommendations made during previous years. There is not, however, a public record of the hundreds of recommendations made by the local teams.

The CFRT also issues an annual report which includes a chart with each recommendation. Updates regarding the status of a recommendation are not as detailed as the CFPS. The three most common updates are: In Progress, Complete or Considered and Not Implemented. These reports do not provide details for all the CFRT's systemic recommendations. Missing details include what agencies were consulted, what practices were changed and why certain recommendations were rejected.

In 2020, the CDHS formed the CFRT Recommendation Steering Committee, which is designed to "ensure each CFRT recommendation is prioritized, acted upon, and implemented in a timely manner to address known systemic gaps and prevent future child deaths."[37] The CPO is aware of and monitoring these efforts. However, this 11-member committee is comprised of representatives from four CDHS offices, representatives from two county human services

[36] See Colorado Department of Public Health & Environment, Child Fatality Prevention System: 2021 Annual Legislative Report, July 1, 2021

[37] See Colorado Department of Human Services, Division of Quality Assurance & Quality Improvement: 2020 Child Maltreatment Fatality Annual Report, July 1, 2021.

departments and one representative from the CDPHE's Child Maltreatment Prevention Unit.[38] As this brief demonstrates, there must be a larger, multidisciplinary approach to addressing the issues identified in this brief, including the implementation of recommendations made by each team that reviews child maltreatment fatalities. This process must be transparent – open to public input and scrutiny – and involve individuals and communities not previously involved in such conversations.

It is imperative that new perspectives and new voices be integrated into the child fatality review process, otherwise we will continue to be unable to answer the question:

Why are there still so many children dying of abuse and neglect in Colorado?

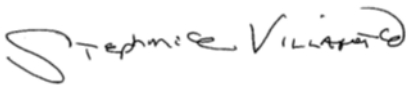
CONCLUSION AND RECOMMENDATION

As demonstrated by this brief, the systems in place for reviewing child maltreatment deaths in Colorado are complex. Comprised of multiple entities, formed by decades of work and operating under the pall of countless tragedies, the processes for reviewing a child's death – particularly one caused by abuse and neglect – has long held the attention of Colorado citizens and agencies such as the CPO. These systems should remain at the forefront of our minds. Just as these systems must consistently adapt, they must also be consistently studied and improved.

Today, the CPO is launching its independent process for reviewing child maltreatment deaths. Aided by recent legislation, the CPO's process will increase the multidisciplinary approach of existing child fatality reviews, engage families when appropriate, increase public engagement and bring accountability to the recommendations set forth from each review. The CPO's first case will be an independent review of the services provided to Timothy Montoya-Kloepfel and the circumstances of his death. Timothy's life and death offer valuable lessons for how we may improve systems serving children. Those lessons, however, may only serve the public if they are available to the public. The CPO anticipates releasing a public report later this year.

Pursuant to C.R.S. 19-3.3-103(2), the CPO respectfully submits this report to the citizens of Colorado, child protection stakeholders and the Colorado General Assembly.

Jordan Steffen
Deputy Ombudsman



Stephanie Villafuerte
Child Protection Ombudsman

[38] See Colorado Department of Human Services, Division of Quality Assurance & Quality Improvement: 2020 Child Maltreatment Fatality Annual Report, July 1, 2021.