



## **Why are we here?**

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 complimented 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 childcare facilities. So, his mother was hopeful when he was placed in a local facility during the summer of 2020. Her hopes were quickly shattered. Despite his history of running away, and unknown to his mother, Timothy was placed in a facility struggling to respond to youth who ran away. 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.

More than one year after her son's death, no one 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. 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."

In the spring of 2021, the Office of Colorado’s Child Protection Ombudsman (CPO) was contacted by a community member who learned about Timothy’s death and was concerned that the circumstances leading to his death would not be examined. The CPO reviewed Timothy’s case and ultimately learned that Colorado lacks a sufficient infrastructure to deter youth from running away from out-of-home placements and to ensure their well-being when they return.

In the fall of 2021, the CPO started working with members of Colorado’s General Assembly, Colorado’s residential treatment provider community and other stakeholders to draft legislation aimed at addressing youth who run away from their out-of-home placement. This work culminated in the creation of House Bill 22-1375, “*Concerning Measures To Improve Outcomes For Those Placed in Out-of-Home Placement Facilities.*” This bill established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-Of-Home Placement (Task Force).<sup>1</sup>

This critical task force is established to analyze the root causes of why children run away from out of home placement; develop a consistent, prompt, and effective response to recovering missing children and to address the safety and well-being of a child upon the child’s return to out-of-home placement.

## Overview of the Task Force

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### The Meeting Process

The Task Force will meet during the next two years and is required to produce two reports for the Colorado General Assembly. The first report is due October 1, 2023, and a final report is due October 1, 2024. The report will contain the Task Force’s findings and any systemic recommendations made by the members. The meetings will be held virtually to ensure participation from stakeholders across the state.

Each meeting will be supported and facilitated by the Keystone Policy Center (Keystone). Keystone was established in 1975 and is an independent non-profit organization. They have helped public, private and civic-sector leaders solve complex problems and advance good public policy for more than 40 years in Colorado and nationally. Keystone does not advocate for any policy position but rather works to ensure that stakeholders share decision making and work together to find mutually agreeable solutions to complex problems.

#### Meeting Dates:

All Task Force meetings will be held virtually from 8 a.m. to 11 a.m. on the following dates:

- September 28, 2022
- November 2, 2022
- January 4, 2023
- March 1, 2023
- May 3, 2023
- July 5, 2023

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<sup>1</sup> <https://leg.colorado.gov/bills/hb22-1375>

- September 6, 2023
- November 1, 2023
- January 3, 2024
- March 6, 2024
- May 1, 2024
- July 3, 2024
- September 4, 2024

### Task Force Members and the Charge

The Task Force is comprised of 24 individuals from our community. These members include young people who previously resided in the child welfare system, families whose children have run from out-of-home placements, members of law enforcement and professionals who are responsible for the care of youth in out-of-home placements including residential child-care providers, child welfare human service providers, non-profit organizations, foster parents and others.

The Task Force is required to analyze:

- The sufficiency of statewide data that measures the quantitative and qualitative experiences of children who have run away from out-of-home placements;
- The root causes of why children run away from out-of-home placements;
- The differences between runaway behavior and age-appropriate behaviors;
- The behaviors that should lead a person or facility to file a missing person report about a child;
- The relationship between children who have run away from out-of-home placement and the likelihood that the child will become a victim of crime;
- The comprehensiveness and effectiveness of existing state laws and regulations, and placement facility protocols, to respond to a child who runs from an out-of-home placement—including a review of practices related to reporting, locating, evaluating, and treating children who have run away.
- The best practices statewide and nationally for preventing and addressing runaway behavior;
- How entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors; and
- Resources to improve or facilitate communication and coordinated efforts among out-of-home placement facilities, county departments of human or social services, and law enforcement agencies.

## Support

Keystone will assist the Task Force by providing research, meeting support and assistance in generating final written reports.

The Task Force's work will also be supported by research from the Colorado Evaluation and Action Lab (Colorado Lab) at the University of Denver. This research institution will conduct focus groups with children in out-of-home placement and young adults who previously resided in the child welfare system. These focus groups will help the Task Force understand what conditions lead children to run away from out of home placement, opportunities and resources that could prevent youth from running away; and resources that youth need to ensure their safety and well-being after they return to out-of-home placement. The results of the focus groups will be provided to the Task Force to inform its finding and recommendations.

## Task Force Members Responsibilities

Task Force members are expected to attend and participate in each meeting. Each member brings an important perspective, and we are eager to hear from all of you. If you are unable to attend a meeting, please provide advance notice to the Chair and we will ensure you are provided meeting minutes and updates.

## Questions?

If you have any questions about the Task Force, please contact:

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### **ABOUT THE OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN**

The Office of Colorado's Child Protection Ombudsman (CPO) is an independent state agency committed to ensuring the state's child protection system consistently provides high quality services to every child, family and community in Colorado. The CPO studies the child protection system to ensure a better future for Colorado's children and youth. By researching and highlighting issues within Colorado's publicly funded safety nets, the CPO is working create a better child protection system now and for the future.