

Attachment I**Colorado may not be reviewing all child abuse deaths, experts say***By Jordan Steffen The Denver Post The Denver Post**Posted:*

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An unknown number of child-maltreatment deaths probably go without individual review — and in some cases are unaccounted for — by Colorado's parallel systems for investigating child abuse and neglect fatalities, national experts say.

Colorado has a unique two-tier system, with fatality reviews housed in both the Colorado Department of Human Services and the Colorado Department of Public Health and Environment. But failure to integrate parts of the two reviews is potentially stalling some efforts to implement data-driven system improvements and prevention recommendations, said Theresa Covington, executive director of the National Center for the Review and Prevention of Child Deaths.

"I don't think that it's that hard to put a fix to this," said Covington, who spoke to more than a dozen Colorado lawmakers Tuesday.

The Department of Human Services, which reviews an average of 12 deaths a year, investigates only if the child died of abuse or neglect and had had contact with the child welfare system.

The Department of Public Health reviews an average of 350 child deaths each year, but even so, deaths that could be maltreatment — such as a child who dies of an untreated medical complication — are not included. Last year, the department went from reviewing the deaths individually to examining the cases by type of death — ranging from accidental to homicide — and using that data to find trends.

"One system is so limiting that you miss the majority of your child abuse and neglect deaths," Covington said. Meanwhile, the Department of Public Health has "lost some its power" because of the broad way it examines cases.

Covington warned that useful information could be gleaned from an individual review of all child deaths.

"What we know in Colorado right now is that we don't even know how many children have died of abuse and neglect in the state, we don't know what systems worked or didn't work before the child died," said Stephanie Villafuerte, executive director of the Rocky Mountain Children's Law Center, which sponsored the presentation. "We're missing this great opportunity as a state to problem solve around these deaths to prevent future deaths."

State Rep. Jenise May, D-Aurora, said Colorado's two-tier system was designed to allow public health to look at the broad picture while human services studied how cases were handled at the county level. In considering how the two can work together, May said it is important not to overlook the value of the individual reviews.

"I think they should be integrated in what the Department of Human Services is doing and how they

can support the overarching system, which is public health," May said.

Public health tracks about 2,500 variables as it reviews child deaths, said Lindsey Myers, injury- and violence-prevention unit manager.

The Department of Human Services declined to comment on the presentation.

An investigative series by The Denver Post and 9News found that since 2007, 175 children in Colorado have died of abuse and neglect. Of those, 72 had families or caregivers who were known to human services.

The underreporting of child-maltreatment deaths is a national concern, according to a report from the U.S. Government Accountability Office. The report, released in July 2011, found that 28 states estimate there were more child abuse and neglect deaths than reported.

Inadequate data and restrictive protocols are some of the reasons Covington said it is difficult for states to accurately count the number of child maltreatment deaths.

Federal law requires human service departments to include information from their department, public health, medical examiners and law enforcement when reporting fatality data. Covington pointed to examples in other states where each agency produced a different finding.

In one case, a 4-month-old boy died sleeping on the couch while both of his parents were intoxicated. The boy's parents had an eight-year history with child protection services. After investigating the case, the medical examiner determined the boy died of natural causes; child protection services found he died of neglect; and public health said the cause of death was neglect and accidental suffocation. Law enforcement, meanwhile, had no report of the incident.

Covington made multiple recommendations during her presentation, including having all stakeholders hold ongoing "reconciliation audits" to compare findings, improving existing programs and holding the state accountable when it doesn't implement recommendations.

She also pointed to successful programs in Michigan that followed improving the state's fatality review system. One program now requires medical examiners to notify child protection services in every child death. Another works with hospitals to notify human service departments when a parent who has already had parental rights terminated has another child.

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