First Regular Session
Sixty-ninth General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 13-0621.01 Jane Ritter x4342 **SENATE BILL 13-255**

SENATE SPONSORSHIP

Kefalas and Newell, Morse

HOUSE SPONSORSHIP

May and Singer,

Senate Committees
Health & Human Services
Appropriations

House Committees

A BILL FOR AN ACT

CONCERNING CHILD FATALITY REVIEW TEAMS, AND, IN CONNECTION THEREWITH, INCREASING THE CAPACITY AND RESOURCES, CLARIFYING THE RESPONSIBILITIES AND PROCESSES OF STATE AND LOCAL CHILD FATALITY REVIEW TEAMS IN THE DEPARTMENTS OF PUBLIC HEALTH AND ENVIRONMENT AND HUMAN SERVICES, AND MAKING AN APPROPRIATION.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://www.leg.state.co.us/billsummaries.)

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

Sections 1 and 4 of the bill require county or district public health agencies to establish or arrange to be established local or regional child fatality prevention review teams operating under the purview of the department of public health and environment (local or regional review team). County or district public health agencies may collaborate to form a regional child fatality prevention review team.

Section 2 revises and updates language in the legislative declaration for the Colorado department of public health and environment (CDPHE) child fatality review teams.

Section 3 adds a definition of a "local or regional review team".

Section 5 details the responsibility of local or regional review teams. The local or regional review teams are required to report case review findings to public and private agencies that have responsibilities for children and make prevention recommendations. The local and regional review teams shall also enter data into the web-based data-collection system utilized by CDPHE.

Section 6 amends the membership of CDPHE's state-level child fatality prevention review team (CDPHE state review team) to include a member from the office of Colorado's child protection ombudsman and to make numerous currently nonvoting positions into voting positions.

Section 7 of the bill tasks the CDPHE state review team with the following duties:

- To conduct an individual case-specific review of every child abuse or neglect fatality in Colorado, if a local or regional review team has not conducted such a review;
- To conduct a review of systemic child welfare issues;
- To utilize a child fatalities data-collection system;
- To collaborate with the Colorado department of human services child fatality review team (CDHS review team) to make joint recommendations for the prevention of child abuse and neglect fatalities;
- To work directly with professionals who have information regarding the cause or circumstances leading to a child's fatality;
- To administer moneys to county and district public health agencies to support local and regional review teams;
- To provide training and technical assistance to local and regional review teams regarding the facilitation of a child fatality review process, data collection, evidence-based prevention strategies, and the development of prevention recommendations, as well as strategies for convening a local or regional review team, establishing methods of notification after a child fatality, and strategies to address conflicts of interest; and
- To provide an annual data report to local and regional

review teams.

Sections 8 and 9 provide conforming amendments.

Section 10 deals with the time frame in which the CDHS review team is required to conduct a review. Currently, the CDHS review team is required to conduct an in-depth case review after an incident of egregious abuse or neglect against a child, a near fatality, or a child fatality that involves a suspicion of abuse or neglect (incident) when the child or family has had previous involvement with the state or county within the previous 2 years. The bill changes that time frame to 3 years.

The CDHS review team is given the additional duty to make annual policy recommendations that address systems involved with children and to follow up on specific system recommendations. The CDHS review team is required to make annual reports to both the public and the legislature concerning such recommendations.

Current law also requires the CDHS review team to complete a draft, confidential, case-specific review report and submit the draft to any county department of social services with previous involvement with the child or family related to the incident within 30 days. That 30-day period is extended to 55 days.

Language is added to ensure that any information released to the public by the CDHS review team is not contrary to the best interests of the child who is the subject of the report, or his or her siblings, is in the public's interest, and is consistent with the federal "Child Abuse Prevention and Treatment Reauthorization Act of 2010".

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25-1-506, **amend** (3) (b) (XIII) and (3) (b) (XIV); and **add** (3) (b) (XV) as follows:

25-1-506. County or district public health agency. (3) (b) In addition to other powers and duties, an agency shall have the following duties:

(XIII) To make necessary sanitation and health investigations and inspections, on its own initiative or in cooperation with the state department, for matters affecting public health that are within the jurisdiction and control of the agency; ~~and~~

(XIV) To collaborate with the state department and the state board

in all matters pertaining to public health, the water quality control commission in all matters pertaining to water quality, the air quality control commission and the division of administration of the state department in all matters pertaining to air pollution, and the solid and hazardous waste commission in all matters pertaining to solid and hazardous waste; AND

(XV) TO ESTABLISH OR ARRANGE FOR THE ESTABLISHMENT OF, BY JANUARY 1, 2015, AND SUBJECT TO AVAILABLE APPROPRIATIONS, A LOCAL OR REGIONAL CHILD FATALITY PREVENTION REVIEW TEAM PURSUANT TO SECTION 25-20.5-404.

SECTION 2. In Colorado Revised Statutes, **amend** 25-20.5-402 as follows:

25-20.5-402. Legislative declaration. (1) The general assembly hereby finds and declares that protection of the health and welfare of the children of this state is an important goal of the citizens of this state, and the injury and death of infants and children are serious public health concerns that require legislative action. The general assembly further finds that the prevention of ~~the~~ CHILD abuse, neglect, and ~~death of children~~ FATALITIES is a community responsibility; that professionals from disparate disciplines have responsibilities to children and have expertise that can promote the safety and well-being of children; and that multidisciplinary reviews of ~~the~~ CHILD abuse, neglect, and ~~death of children~~ FATALITIES can lead to a greater understanding of the causes of, and methods of preventing, ~~the~~ CHILD abuse, neglect, and ~~death of children~~ FATALITIES.

(2) It is, therefore, the intent of the general assembly in enacting this part 4 to establish ~~a statewide~~ STATE AND LOCAL multidisciplinary,

multi-agency child fatality prevention ~~system~~ REVIEW TEAMS. The purpose of ~~the system~~ THESE TEAMS is: ~~to:~~

(a) ~~Review specified deaths of children from birth to eighteen years of age occurring in Colorado involving circumstances in which the children are receiving services from a county department or in which there has been a report of suspected abuse or neglect in order to develop a community approach to the problem of child abuse and neglect~~ FOR LOCAL OR REGIONAL REVIEW TEAMS, TO REVIEW SPECIFIC CASES OF CHILD FATALITIES IN THE TEAM'S SERVICE AREA THAT OCCUR FROM BIRTH THROUGH SEVENTEEN YEARS OF AGE AND INVOLVE UNINTENTIONAL INJURY, VIOLENCE, MOTOR VEHICLE INCIDENTS, CHILD ABUSE OR NEGLECT, SUDDEN UNEXPECTED INFANT DEATH, SUICIDE, OR UNDETERMINED CAUSES AND TO PROVIDE THE STATE WITH INDIVIDUAL CASE FINDINGS TO DEVELOP A COMMUNITY APPROACH TO THE SYSTEMIC ISSUES SURROUNDING CHILD FATALITIES;

(b) ~~Review the records of all other unexpected and unexplained deaths of children from birth to eighteen years of age occurring in Colorado in order to develop a community approach to the prevention of childhood fatalities~~ FOR THE STATE REVIEW TEAM, TO REVIEW THE INDIVIDUAL CASE FINDINGS OF THE LOCAL AND REGIONAL REVIEW TEAMS AND TO CREATE A REPORT BASED ON THOSE FINDINGS TO MAKE SPECIFIC RECOMMENDATIONS REGARDING SYSTEMIC TRENDS ACROSS THE STATE THAT MAY HELP PREVENT FUTURE CHILD FATALITIES;

(c) TO HELP THE PEOPLE OF COLORADO understand the incidence and causes of ~~childhood deaths~~ CHILD FATALITIES AND THEREFORE ENCOURAGE PUBLIC ACTION TO PREVENT FURTHER CHILD FATALITIES;

(d) TO identify services provided by public, PRIVATE, AND

NONPROFIT agencies to children and their families that are designed to prevent, ~~child abuse, neglect, or death,~~ and that are effective in preventing, child ~~abuse, neglect, or death~~ FATALITIES;

(e) TO identify ~~any~~ gaps or deficiencies that may exist in the delivery of services provided by public, PRIVATE, AND NONPROFIT agencies to children and their families that are designed to prevent child ~~abuse, neglect, or death~~ FATALITIES; and

(f) TO make recommendations for, act as a catalyst for, and implement any changes to laws, rules, and policies that will support the safe and healthy development of the children in this state and prevent FUTURE child ~~abuse, neglect, and death~~ FATALITIES.

SECTION 3. In Colorado Revised Statutes, 25-20.5-403, **amend** (2); and **repeal** (4) as follows:

25-20.5-403. Definitions. As used in this part 4, unless the context otherwise requires:

(2) "Local OR REGIONAL review team" means a local OR REGIONAL child fatality prevention review team established pursuant to section 25-20.5-404.

(4) ~~"Unexpected and unexplained death" means a death that, prior to investigation, appears to have been caused by trauma, suspicious or obscure circumstances, or child abuse or neglect. An "unexpected and unexplained death" includes, but is not limited to, death from vehicular trauma, fire, drowning, abuse, suicide, and unknown causes.~~

SECTION 4. In Colorado Revised Statutes, 25-20.5-404, **amend** (1), (2), (3) (a) introductory portion, (3) (b) introductory portion, and (4) as follows:

25-20.5-404. Local and regional review teams - creation -

membership - authority. (1) ON OR BEFORE JANUARY 1, 2015, each ~~judicial district may~~ COUNTY OR DISTRICT PUBLIC HEALTH AGENCY ESTABLISHED PURSUANT TO SECTION 25-1-506 SHALL establish, OR ARRANGE TO BE ESTABLISHED, subject to available appropriations, a local child fatality prevention review team. ~~The first meeting of a local review team shall be called by the district attorney of the judicial district in which the local review team is located.~~ COUNTY OR DISTRICT PUBLIC HEALTH AGENCIES MAY COLLABORATE TO FORM A REGIONAL CHILD FATALITY PREVENTION REVIEW TEAM TO FULFILL THE REQUIREMENTS OF THIS SECTION.

(2) Each local OR REGIONAL review team shall consist of representatives of public and nonpublic agencies in the ~~judicial district~~ COUNTY OR COUNTIES that provide services to children and their families and of other individuals who represent the community.

(3) (a) A local OR REGIONAL review ~~teams shall~~ TEAM MUST include representatives from the following entities located ~~in the judicial district~~ WITHIN THE SERVICE AREA OF THE ESTABLISHING COUNTY OR DISTRICT PUBLIC HEALTH AGENCY OR AGENCIES:

(b) A local OR REGIONAL review ~~teams~~ TEAM may include but ~~are~~ IS not limited to representatives from the following entities or groups located ~~in the judicial district~~ WITHIN THE SERVICE AREA OF THE ESTABLISHING COUNTY OR DISTRICT PUBLIC HEALTH AGENCY OR AGENCIES:

(4) Each local OR REGIONAL review team has the authority to establish committees to review specific types of ~~childhood deaths~~ CHILD FATALITIES.

SECTION 5. In Colorado Revised Statutes, **amend** 25-20.5-405

as follows:

25-20.5-405. Local review teams - duties - authority. (1) ~~Each~~ THE local OR REGIONAL review team shall ~~review the following types of cases:~~ CONDUCT INDIVIDUAL, CASE-SPECIFIC REVIEWS OF FATALITIES OF CHILDREN FROM BIRTH THROUGH SEVENTEEN YEARS OF AGE OCCURRING IN THE JURISDICTION OF THE LOCAL OR REGIONAL REVIEW TEAM FOR THE PURPOSE OF IDENTIFYING PREVENTION RECOMMENDATIONS RELATED, AT A MINIMUM, TO THE FOLLOWING CAUSES OF CHILD FATALITY:

~~(a) A case of unexpected and unexplained death of a child eighteen years of age or younger occurring in the judicial district of the local review team;~~

(a) UNDETERMINED CAUSES;

(b) UNINTENTIONAL INJURY;

(c) VIOLENCE;

(d) MOTOR VEHICLE INCIDENTS;

(e) CHILD ABUSE OR NEGLECT AS DEFINED IN SECTION 19-1-103 (1), C.R.S., INCLUDING THE DEATH OF A CHILD WHO WAS PREVIOUSLY UNKNOWN TO THE COUNTY DEPARTMENT BUT WHOSE DEATH INCLUDED CIRCUMSTANCES RELATED TO CHILD ABUSE OR NEGLECT, REGARDLESS OF THE OFFICIAL MANNER OF DEATH;

(f) SUDDEN UNEXPECTED INFANT DEATH; OR

(g) SUICIDE.

~~(b) A case occurring in the judicial district involving the death of a child eighteen years of age or younger who was:~~

~~(I) In the custody of the department of human services or the county department at the time of death;~~

~~(II) The subject of an open child welfare case maintained by a~~

~~county department of social services; or~~

~~(III) Reported as a child involved in an investigation of suspected abuse or neglect by a county department of social services or a law enforcement agency at any time during the twelve months preceding the child's death.~~

(2) With respect to each ~~case~~ CHILD FATALITY reviewed, the local OR REGIONAL review team shall:

(a) Review the cause and manner of the ~~child's death~~ CHILD FATALITY as determined by the local coroner, pathologist, or medical examiner, and ~~attempt to~~ determine whether the local OR REGIONAL review team concurs with the coroner's, pathologist's, or medical examiner's findings. ANY INFORMATION REQUESTED FROM THE LOCAL CORONER MUST BE IN COMPLIANCE WITH SECTION 30-10-606, C.R.S.

(b) In cases in which the local OR REGIONAL review team does not concur with the cause or manner of death as determined by the local coroner, pathologist, or medical examiner, forward a report of the local OR REGIONAL review team's analysis of the cause and manner of the ~~child's death~~ CHILD FATALITY to the local coroner, pathologist, or medical examiner for his or her consideration;

(c) Evaluate means by which the ~~death~~ FATALITY might have been prevented;

(d) Report case review findings, AS APPROPRIATE, to public and private agencies that have responsibilities for children and make PREVENTION recommendations to these agencies that may help to reduce the number of child ~~deaths~~ FATALITIES;

(e) ~~Request from an agency a plan of action for improvements to prevent child deaths based upon a report submitted to the agency pursuant~~

~~to paragraph (d) of this subsection (2) when the case review involves a child in the custody of the agency at the time of death or involves identified system problems at the agency;~~

(e.5) NO LATER THAN TWO MONTHS AFTER REVIEWING A CASE, ENTER INFORMATION REGARDING THE CHILD FATALITY INTO A WEB-BASED DATA-COLLECTION SYSTEM, UTILIZED BY THE DEPARTMENT;

(f) Submit to the state review team the following information:

(I) ~~Information about each death reviewed;~~

(II) A listing of any system issues identified through the review process and recommendations to the state review team and the appropriate agencies for system improvements and needed resources, training, and information dissemination where gaps and deficiencies may exist;

(III) Any changes, positive or negative, that appear to have resulted from implementation of previous recommendations made by the local OR REGIONAL review team to the state review team and appropriate agencies; AND

(IV) Examples of services known by the local OR REGIONAL review team to be provided by public OR PRIVATE agencies to children and their families that are designed to prevent ~~child abuse, neglect, or death~~ CHILD FATALITIES and that are effective in preventing ~~child abuse, neglect, or death~~ SUCH FATALITIES. ~~and~~

(V) ~~Any additional information requested by the state review team.~~

(g) SECURE THE MOST RELIABLE INFORMATION POSSIBLE THAT IS RELATED TO A CHILD FATALITY TO PROVIDE A THOROUGH, COMPREHENSIVE REVIEW OF EACH CHILD FATALITY; AND

(h) REQUEST CAPACITY ASSISTANCE AS NECESSARY FROM THE DEPARTMENT FOR THE PURPOSE OF CONDUCTING A CHILD FATALITY REVIEW.

(3) Each local OR REGIONAL review team may, within existing appropriations and community resources, PROMOTE CONTINUING EDUCATION FOR PROFESSIONALS INVOLVED IN INVESTIGATING, TREATING, AND PREVENTING CHILD ABUSE AND NEGLECT AS A MEANS OF PREVENTING CHILD FATALITIES DUE TO ABUSE OR NEGLECT AND OTHER CHILD FATALITIES. THE LOCAL OR REGIONAL REVIEW TEAM MAY ALSO, WITHIN EXISTING RESOURCES, PROMOTE PUBLIC EDUCATION RELATED TO PREVENTING CHILD FATALITIES RELATED TO ABUSE AND NEGLECT.

~~(a) Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect as a means of preventing child deaths due to abuse or neglect; and~~

~~(b) Promote public education related to preventing unexpected and unexplained child deaths and deaths related to abuse or neglect.~~

SECTION 6. In Colorado Revised Statutes, 25-20.5-406, **amend** (2) (a) introductory portion, (2) (a) (VII), (2) (a) (VIII), (2) (b) introductory portion, (2) (c), (2) (d), and (2) (e); and **add** (2) (a) (IX) as follows:

25-20.5-406. State review team - creation - membership - vacancies. (2) (a) On or before September 1, ~~2005~~ 2013, the governor shall appoint ~~the seventeen~~ EIGHTEEN voting members of the state review team specified in this paragraph (a), as follows:

(VII) One member who represents county attorneys within the state who practice in the area of dependency and neglect; ~~and~~

(VIII) One member who represents county commissioners within

the state; AND

(IX) ONE MEMBER WHO REPRESENTS THE OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN.

(b) The executive director of the department of human services shall appoint six ~~ex officio nonvoting~~ VOTING members, as follows:

(c) The executive director of the department of public health and environment shall appoint eight ~~ex officio nonvoting~~ VOTING members who represent the department of public health and environment, one of whom represents county or district public health agencies.

(d) The commissioner of education shall appoint one ~~ex officio nonvoting~~ VOTING member who represents the department of education.

(e) The executive director of the department of public safety shall appoint one ~~ex officio nonvoting~~ VOTING member who represents the department of public safety.

SECTION 7. In Colorado Revised Statutes, **amend** 25-20.5-407 as follows:

25-20.5-407. State review team - duties - definitions. (1) The state review team shall:

(a) Form committees to review ~~at a minimum, childhood deaths~~ A CHILD FATALITY CASE, IF A LOCAL OR REGIONAL CHILD FATALITY REVIEW TEAM HAS NOT CONDUCTED SUCH A REVIEW OF THE CASE, IF THE CHILD FATALITY OCCURRED in the state of Colorado AND WAS related to ONE OR MORE OF the following causes:

(I) ~~Natural~~ UNDETERMINED causes;

(II) Unintentional injury;

(III) Violence;

(IV) Motor vehicle incidents;

(V) Child abuse or neglect, ~~and~~ AS DEFINED IN SECTION 19-1-103 (1), C.R.S.;

(VI) Sudden UNEXPECTED infant death; ~~syndrome;~~ AND

(VII) SUICIDE.

(b) Outline trends and patterns of ~~childhood death~~ CHILD FATALITIES in Colorado;

(c) Identify and investigate risk factors that may lead to ~~childhood death~~ CHILD FATALITIES;

(d) Characterize groups of children who are at risk for ~~childhood death~~ A CHILD FATALITY;

(e) Evaluate the services offered and the system responses to children who are at risk of ~~childhood death~~ A CHILD FATALITY AND review recommendations of local OR REGIONAL review teams, if any; ~~and plans of action submitted by agencies for improvements to prevent childhood deaths, if any; offer recommendations for improvement to these services and system responses; and request plans of action for improvement from agencies, when necessary;~~

(e.5) CONSIDER A REVIEW OF ALL SYSTEMIC CHILD-RELATED ISSUES WHEN EVALUATING SERVICES OFFERED OR SYSTEM RESPONSES TO CHILDREN WHO ARE AT RISK OF FATALITY. FOR PURPOSES OF THIS PARAGRAPH (e.5), "SYSTEMIC CHILD-RELATED ISSUES" MEANS ANY ISSUE INVOLVING ONE OR MORE AGENCIES.

(f) Take steps to improve the quality and scope of data obtained through investigations and review of ~~childhood deaths~~ CHILD FATALITIES;

(f.5) UTILIZE A CHILD FATALITIES DATA-COLLECTION SYSTEM, USING NATIONALLY DEVELOPED PUBLIC HEALTH GUIDELINES, TO ENSURE THE PROPER IDENTIFICATION OF ALL POTENTIAL CHILD ABUSE OR NEGLECT

FATALITIES;

(g) Report to the governor and to the ~~health~~ PUBLIC HEALTH CARE and human services ~~committees~~ COMMITTEE, and the judiciary ~~committees~~ COMMITTEE of the house of representatives and the HEALTH AND HUMAN SERVICES COMMITTEE, AND THE JUDICIARY COMMITTEE OF THE senate of the Colorado general assembly, OR ANY SUCCESSOR COMMITTEES, concerning any recommendations for changes to any law, rule, or policy that the state review team has determined will promote the safety and well-being of children. The state review team shall report annually ~~within the first week of convening or reconvening the general assembly~~ ON OR BEFORE JULY 1, 2014, AND ON OR BEFORE JULY 1 EACH YEAR THEREAFTER. IN ITS REPORT, THE STATE REVIEW TEAM SHALL PROVIDE A LIST OF SYSTEM STRENGTHS AND WEAKNESSES IDENTIFIED THROUGH THE REVIEW PROCESS AND RECOMMENDATIONS FOR PREVENTIVE ACTIONS TO PROMOTE THE SAFETY AND WELL-BEING OF CHILDREN. THE ANNUAL REPORT MUST INCLUDE AN ANALYSIS OF THE STATE REVIEW TEAM'S RECOMMENDATIONS FROM THE PREVIOUS YEAR AND STATE WHAT POLICY CHANGES, IF ANY, WERE MADE TO IMPROVE CHILD SAFETY AND WELL-BEING. THE STATE REVIEW TEAM SHALL MAKE THE ANNUAL REPORT PUBLICLY AVAILABLE AND WILL CONDUCT OUTREACH EFFORTS TO EDUCATE MEMBERS OF THE CHILD PROTECTION COMMUNITY ON REPORT FINDINGS.

(h) ~~Subject to available appropriations and community resources, distribute information to the public concerning risks to children and recommendations for promoting the safety and well-being of children~~ PROVIDE AN ANNUAL SUMMARY TO THE DEPARTMENT OF HUMAN SERVICES OUTLINING THE TRENDS AND PATTERNS OF CHILD ABUSE AND

NEGLECT FATALITIES, INCLUDING INFORMATION REGARDING THE FINDINGS FROM CASES KNOWN AND UNKNOWN TO THE COUNTY DEPARTMENTS OF SOCIAL SERVICES;

(i) ~~Serve as a link with child death review teams throughout the country and participate in national child death review team activities; and~~ COLLABORATE WITH THE DEPARTMENT OF HUMAN SERVICES CHILD FATALITY REVIEW TEAM, CREATED PURSUANT TO SECTION 26-1-139, C.R.S., TO MAKE JOINT RECOMMENDATIONS FOR THE PREVENTION OF CHILD FATALITIES;

(j) ~~Perform any other functions necessary to enhance the capability of the state of Colorado to reduce and prevent childhood injuries and death;~~

(k) SUBJECT TO AVAILABLE APPROPRIATIONS, ADMINISTER MONEYS TO COUNTY OR DISTRICT PUBLIC HEALTH AGENCIES TO SUPPORT LOCAL OR REGIONAL REVIEW TEAM ACTIVITIES;

(l) PROVIDE TRAINING AND TECHNICAL ASSISTANCE TO LOCAL OR REGIONAL REVIEW TEAMS REGARDING THE FACILITATION OF A CHILD FATALITY REVIEW PROCESS, DATA COLLECTION, EVIDENCE-BASED PREVENTION STRATEGIES, AND THE DEVELOPMENT OF PREVENTION RECOMMENDATIONS. THE TRAINING AND TECHNICAL ASSISTANCE FOR LOCAL OR REGIONAL REVIEW TEAMS MUST BE PROVIDED THROUGH FEDERALLY FUNDED TRAINING PROGRAMS FOR IMPROVING EFFECTIVENESS IN CONDUCTING CHILD FATALITY REVIEWS; EXCEPT THAT, IF SUCH FEDERALLY FUNDED PROGRAMS ARE UNAVAILABLE, THE STATE, SUBJECT TO AVAILABLE APPROPRIATIONS, MAY PROVIDE THE TRAINING AND TECHNICAL ASSISTANCE. THE TRAINING AND TECHNICAL ASSISTANCE MAY ALSO INCLUDE, BUT NEED NOT BE LIMITED TO:

(I) STRATEGIES OR ASSISTANCE WITH CONVENING AND FACILITATING LOCAL AND REGIONAL REVIEW TEAMS;

(II) ESTABLISHING METHODS OF NOTIFICATION AFTER A CHILD FATALITY HAS OCCURRED; AND

(III) STRATEGIES FOR MEMBERS OF STATE, LOCAL, OR REGIONAL REVIEW TEAMS TO ADDRESS A CONFLICT OF INTEREST IN A CHILD FATALITY REVIEW;

(m) PROVIDE AN ANNUAL DATA REPORT TO EACH LOCAL OR REGIONAL REVIEW TEAM SUMMARIZING ITS LOCAL OR REGIONAL REVIEW DATA ENTERED INTO THE WEB-BASED DATA-COLLECTION SYSTEM;

(n) SUBJECT TO AVAILABLE APPROPRIATIONS AND COMMUNITY RESOURCES, DISTRIBUTE INFORMATION TO THE PUBLIC CONCERNING RISKS TO CHILDREN AND RECOMMENDATIONS FOR PROMOTING THE SAFETY AND WELL-BEING OF CHILDREN;

(o) SERVE AS A LINK WITH CHILD FATALITY REVIEW TEAMS THROUGHOUT THE COUNTRY AND PARTICIPATE IN NATIONAL CHILD FATALITY REVIEW TEAM ACTIVITIES; AND

(p) PERFORM ANY OTHER FUNCTIONS NECESSARY TO ENHANCE THE CAPABILITY OF THE STATE OF COLORADO TO REDUCE AND PREVENT CHILDHOOD INJURIES AND FATALITIES.

SECTION 8. In Colorado Revised Statutes, **amend** 25-20.5-408 as follows:

25-20.5-408. Access to records. (1) **Review team access to records.** (a) Notwithstanding any other state law to the contrary but subject to the requirements of applicable provisions of federal law, the state review team and the local OR REGIONAL review teams shall have access to all records and information in the possession of the department

of human services and the county departments of social services that are relevant to the review of a child ~~death~~ FATALITY, including records and information related to previous reports and investigations of suspected child abuse or neglect.

(b) Except as otherwise provided in paragraph (c) of this subsection (1), notwithstanding any other state law to the contrary, but subject to the requirements of applicable provisions of federal law, the state review team and the local OR REGIONAL review teams shall have access to all other records and information that are relevant to a review of a child ~~death~~ FATALITY and that are in the possession of a state or local governmental agency. These records include, but are not limited to, birth certificates, records of coroner or medical examiner investigations, and records of the department of corrections.

(c) Mental health and substance abuse treatment records may be accessed only with the written consent of appropriate parties in accordance with applicable federal and state law.

(2) **Public access to records and information.** (a) **Open meetings.** Meetings of the state review team and local OR REGIONAL review teams shall be subject to the provisions of section 24-6-402, C.R.S.

(b) **Confidentiality.** Each member of the state review team, each member of a local OR REGIONAL review team, and each invited participant at a meeting shall sign a statement indicating an understanding of and adherence to confidentiality requirements. A person who knowingly violates confidentiality requirements commits a class 3 misdemeanor and, upon conviction, shall be punished as provided in section 18-1.3-501, C.R.S.

(c) **Release of information.** (I) Members of the state review team, members of the local OR REGIONAL review teams, a person who attends a review team meeting, and a person who presents information to a review team may release information to governmental agencies as necessary to fulfill the requirements of this part 4.

(II) Members of the state review team, members of the local OR REGIONAL review teams, a person who attends a review team meeting, and a person who presents information to a review team shall not be subject to examination, in any civil or criminal proceeding, concerning information presented to members of the review team or opinions formed by the review team based on that information. A person may, however, be examined concerning information reviewed by the state review team or a local OR REGIONAL review team that is otherwise available to the public or that is required to be revealed by that person in another official capacity.

(III) Information, documents, and records of the state review team and the local OR REGIONAL review teams shall not be subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding; except that information, documents, and records that would otherwise be available from a person serving on the state review team or a local OR REGIONAL review team or that would otherwise be required to be revealed by law shall not be immune from subpoena, discovery, or introduction into evidence solely because the information was presented at or became available due to a proceeding of the state review team or a local OR REGIONAL review team.

(IV) Information received by the state review team or a local OR REGIONAL review team that contains information exculpatory to a person

charged with a criminal offense shall be subject to release pursuant to the rules of criminal procedure.

SECTION 9. In Colorado Revised Statutes, 25-20.5-409, **amend** (1) and (2) as follows:

25-20.5-409. Administration - funding - cash fund. (1) To the extent ~~funds~~ MONEYS are available, the state review team and the local OR REGIONAL review teams may hire staff or consultants to assist them in completing their duties.

(2) Staff and consultants of the state review team or the local OR REGIONAL review teams shall receive reimbursement for travel and expenses to offset the costs incurred in fulfilling their duties, which shall be paid from moneys appropriated to implement this part 4 and within the limits of those moneys.

SECTION 10. In Colorado Revised Statutes, 26-1-139, **amend** (1), (2) (c), (3) (a), (4) (b), (4) (c), (4) (i) (I), (5) (a), (5) (b), (5) (c), (5) (e), (5) (l), and (6) (f); and **add** (6.5) as follows:

26-1-139. Child fatality and near fatality prevention - legislative declaration - process - department of human services child fatality review team - reporting - rules. (1) The general assembly hereby finds and declares that:

(a) It is of the utmost importance and a community responsibility to mitigate the incidents of egregious abuse or neglect, near ~~deaths~~ FATALITIES, or ~~deaths~~ FATALITIES of children in the state due to abuse or neglect. Professionals from disparate disciplines share responsibilities for the safety and well-being of children as well as expertise that can promote that safety and well-being. Multidisciplinary reviews of the incidents of egregious abuse or neglect, near ~~deaths~~ FATALITIES, or ~~deaths~~ FATALITIES

of children due to abuse or neglect can lead to a better understanding of the causes of such tragedies and, more importantly, methods of mitigating future incidents of egregious abuse or neglect, near ~~deaths~~ FATALITIES, or ~~deaths~~ FATALITIES.

(b) There is a need for agency transparency and accountability to the public regarding an incident of egregious abuse or neglect against a child, a near fatality, or a child fatality that involves a suspicion of abuse or neglect when the child or family has had previous involvement, AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, with the state or county. ~~that was directly related to the incident~~ WITHIN THREE YEARS PRIOR TO THE INCIDENT.

(c) There is a need for a multidisciplinary team to conduct in-depth case reviews after an incident of egregious abuse or neglect against a child, a near fatality, or a child fatality that involves a suspicion of abuse or neglect and when the child or family has had previous involvement, ~~that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality, with a county department~~ AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, within ~~two~~ THREE years prior to the incident. The multidisciplinary ~~review~~ REVIEWS would complement that of the review conducted by the Colorado state child fatality prevention review team in the department of public health and environment pursuant to article 20.5 of title 25, C.R.S. The goal of the multidisciplinary review shall not be to affix blame, but rather to improve understanding of why the incidents of egregious abuse or neglect against a child, near fatalities, or fatalities OF A CHILD DUE TO ABUSE OR NEGLECT occur, TO IDENTIFY AND UNDERSTAND WHERE IMPROVEMENTS CAN BE MADE IN THE ___ DELIVERY OF CHILD

WELFARE SERVICES, __ and TO develop recommendations for mitigation of future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities OF A CHILD DUE TO ABUSE OR NEGLECT.

(d) It is the intent of the general assembly to codify the department of human services child fatality review team as well as modify certain aspects of its processes to promote an understanding of the causes of each ~~child's death or near death~~ incident OF EGREGIOUS ABUSE OR NEGLECT, NEAR FATALITY, OR FATALITY OF A CHILD due to abuse or neglect, identify systemic deficiencies in the delivery of services and supports to children and families, and recommend changes to help mitigate future incidents of egregious abuse or neglect against a child, near fatalities, or ~~child deaths~~ FATALITIES OF CHILDREN DUE TO ABUSE OR NEGLECT.

(e) It is further the intent of the general assembly to comply with the federal ~~"Child Abuse Prevention and Treatment Act", 42 U.S.C. sec. 5101 et seq.~~ "CHILD ABUSE PREVENTION AND TREATMENT REAUTHORIZATION ACT OF 2010", P.L. 111-320, which requires states to allow for public disclosure of the findings or information about a case of child abuse or neglect that resulted in a child fatality or near fatality, AND TO INCLUDE IN THE DISCLOSURE THE AGE, GENDER, AND RACE OR ETHNICITY OF THE CHILD TO BETTER UNDERSTAND TRENDS AND PATTERNS OF CHILD FATALITIES IN COLORADO AS THEY RELATE TO AGE, GENDER, AND RACE OR ETHNICITY.

(2) As used in this section, unless the context otherwise requires:

(c) "Previous involvement" means a situation in which the county department has received a referral, responded to a report, opened an assessment, provided services, or opened a case in the Colorado TRAILS system THAT IS RELATED TO THE PROVISION OF CHILD WELFARE SERVICES.

FOR THE PURPOSES OF THIS SECTION, "CHILD WELFARE SERVICES" MEANS A SPECIALIZED SET OF SERVICES THAT ARE INTENDED TO STRENGTHEN THE ABILITY OF FAMILIES TO PROTECT AND CARE FOR THEIR OWN CHILDREN, MINIMIZE HARM TO CHILDREN AND YOUTH, AND ENSURE PERMANENCY PLANNING. ~~except that the following situations shall not be considered to be "previous involvement":~~

~~(I) The situation did not involve abuse or neglect;~~

~~(II) The situation occurred when the parent was seventeen years of age or younger and before he or she was the parent of the deceased child; or~~

~~(III) The situation occurred with a different family composition and a different alleged perpetrator.~~

(3) There is hereby established in the state department the department of human services child fatality review team. The team shall have the following objectives:

(a) To assess the records of each case in which a suspicious incident of egregious abuse or neglect against a child, near fatality, or child fatality DUE TO ABUSE OR NEGLECT occurred and the child or family had previous involvement, ~~with a county department that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality~~ AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, within ~~two~~ THREE years prior to the incident of egregious abuse or neglect against a child, near fatality, or fatality OF A CHILD DUE TO ABUSE OR NEGLECT;

(4) The team shall have the following duties:

(b) To review the services provided to the child, the child's family, and the perpetrator by the county department for any county with which

the family has had previous involvement, ~~that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality in the two~~ AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, WITHIN THREE years prior to the incident of egregious abuse or neglect against a child, near fatality, or fatality OF A CHILD DUE TO ABUSE OR NEGLECT;

(c) To review records and interview individuals, as deemed necessary and not otherwise prohibited by law, involved with or having knowledge of the facts of the incident of egregious abuse or neglect against a child, near fatality, or fatality OF A CHILD DUE TO ABUSE OR NEGLECT, including but not limited to all other state and local agencies having previous involvement, ~~with the child or family that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality~~ AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, within ~~two~~ THREE years prior to the incident of egregious abuse or neglect against a child, near fatality, or fatality OF A CHILD DUE TO ABUSE OR NEGLECT;

(i) To develop and distribute the following reports, the content of which shall be determined by rules promulgated by the state department pursuant to subsection (7) of this section:

(I) On or before ~~April 30, 2013~~ JULY 1, 2014, and ON OR BEFORE each ~~April 30~~ JULY 1 thereafter, an annual child fatality and near fatality review report, absent confidential information, summarizing the reviews required by subsection (5) of this section conducted by the team during the previous year. THE REPORT MUST ALSO INCLUDE ANNUAL POLICY RECOMMENDATIONS BASED ON THE COLLECTION OF REVIEWS REQUIRED BY SUBSECTION (5) OF THIS SECTION. THE RECOMMENDATIONS MUST ADDRESS

ALL SYSTEMS INVOLVED WITH CHILDREN AND FOLLOW UP ON SPECIFIC SYSTEM RECOMMENDATIONS FROM PRIOR REPORTS THAT ADDRESS THE STRENGTHS AND WEAKNESSES OF CHILD PROTECTION SYSTEMS IN COLORADO. The team shall post the annual child fatality and near fatality review report on the state department's web site and distribute it to the Colorado state child fatality prevention review team established in the department of public health and environment pursuant to section 25-20.5-406, C.R.S., the governor, the health and human services committee of the senate, and the ~~health and environment~~ PUBLIC HEALTH CARE AND HUMAN SERVICES committee of the house of representatives, or any successor committees. The annual child fatality and near fatality review report ~~shall~~ MUST be prepared within existing resources.

(5) (a) Each county department shall report to the state department any suspicious incident of egregious abuse or neglect against a child, near fatality, or fatality of a child DUE TO ABUSE OR NEGLECT within twenty-four hours OF BECOMING AWARE of the incident of egregious abuse or neglect against a child, near fatality, or fatality OF A CHILD DUE TO ABUSE OR NEGLECT. If the county department has had previous involvement, ~~that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or child fatality~~ AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, within ~~two~~ THREE years prior to the incident of egregious abuse or neglect against a child, near fatality, or fatality OF A CHILD DUE TO ABUSE OR NEGLECT, the county department shall provide the state department with all relevant reports and documentation regarding its previous involvement with the child within sixty calendar days after BECOMING AWARE OF the incident of egregious abuse or neglect against a child, near fatality, or fatality OF A CHILD DUE

TO ABUSE OR NEGLECT. The state department may grant, at its discretion, an extension to a county department for delays outside of the county department's control regarding the receipt of all relevant reports and information critical to an effective review, including but not limited to the final autopsy and law enforcement reports, until such documents can be made available for review by the team.

(b) Within three business days after receiving FROM A COUNTY DEPARTMENT the information provided under paragraph (a) of this subsection (5), the department shall disclose to the public that information has been received, whether the department is conducting a review of the incident, whether the child was in his or her own home or in foster care, as defined in section 19-1-103 (51.3), C.R.S., and the child's gender and age. The department may disclose the scope of the review.

(c) The team shall complete its review of each incident of egregious abuse or neglect, near fatality, or fatality OF A CHILD DUE TO ABUSE OR NEGLECT, draft a confidential, case-specific review report, and submit the draft report to any county department with previous involvement, AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, within ~~thirty~~ FIFTY-FIVE calendar days after the review team meeting. Any county department with previous involvement, ~~shall have~~ AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, HAS thirty calendar days after the completion of the draft confidential, case-specific review report to review the draft confidential, case-specific review report and provide a written response to be included in the final confidential, case-specific review report. A confidential, case-specific review report ~~shall~~ MUST be finalized and submitted pursuant to paragraph (e) of this subsection (5) no more than thirty calendar days

after the county department's response is received by the team or upon confirmation in writing from the county department that a written response will not be provided.

(e) The TEAM SHALL PROVIDE THE final confidential, case-specific review report ~~shall be provided~~ to the executive director, the director for any county or community agency referenced in the report, the county ~~commissioners~~ BOARD OF HUMAN SERVICES of any county department with previous involvement, AS DEFINED IN PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION, the legislative members of the team appointed pursuant to paragraph (f) of subsection (6) of this section, and the department of public health and environment.

(l) The state department or any county department may release to the public any information at any time to correct any inaccurate information reported in the news media, so long as the information released by the state department or county department is not explicitly in conflict with federal law, IS NOT CONTRARY TO THE BEST INTEREST OF THE CHILD WHO IS THE SUBJECT OF THE REPORT, OR HIS OR HER SIBLINGS, IS IN THE PUBLIC'S BEST INTEREST, AND IS CONSISTENT WITH THE FEDERAL "CHILD ABUSE PREVENTION AND TREATMENT REAUTHORIZATION ACT OF 2010", P.L. 111-320.

(6) The team consists of up to twenty members, appointed on or before September 30, 2011, as follows:

(f) ~~One member from the health and environment committee of the house of representatives or any successor committee, to be appointed by the speaker of the house of representatives, and one member from the health and human services committee of the senate or any successor committee, to be appointed by the president of the senate.~~ TWO MEMBERS

OF THE GENERAL ASSEMBLY, ONE APPOINTED BY THE MAJORITY LEADER OF THE SENATE AND ONE APPOINTED BY THE MAJORITY LEADER OF THE HOUSE OF REPRESENTATIVES; EXCEPT THAT, IF THE MAJORITY LEADERS ARE FROM THE SAME POLITICAL PARTY, THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT THE SECOND MEMBER. The members appointed pursuant to this paragraph (f) are nonvoting members and are not required to be present at any meeting of the team.

(6.5) MEMBERS OF THE TEAM SERVE THREE-YEAR TERMS AND ARE ELIGIBLE FOR REAPPOINTMENT UPON THE EXPIRATION OF THE TERMS. VACANCIES SHALL BE FILLED IN A MANNER AND WITHIN A TIME FRAME TO BE DETERMINED BY RULES PROMULGATED BY THE STATE DEPARTMENT PURSUANT TO SUBSECTION (7) OF THIS SECTION; EXCEPT THAT ANY VACANCY OF A MEMBER APPOINTED PURSUANT TO PARAGRAPH (f) OF SUBSECTION (6) OF THIS SECTION SHALL BE FILLED BY THE APPOINTING AUTHORITY.

SECTION 11. In Colorado Revised Statutes, 26-1-139, **repeal and reenact, with amendments,** (5) (g) and (5) (h) as follows:

26-1-139. Child fatality and near fatality prevention - legislative declaration - process - department of human services child fatality review team - reporting - rules. (5) (g) THE CASE-SPECIFIC EXECUTIVE SUMMARY FOR A CHILD WHO WAS NOT IN FOSTER CARE, AS DEFINED IN SECTION 19-1-103 (51.3), C.R.S., AT THE TIME OF THE FATALITY MUST INCLUDE:

(I) THE CHILD'S NAME, DATE OF BIRTH, AND DATE OF FATALITY;

(II) THE AGE, GENDER, AND RACE OR ETHNICITY OF THE CHILD AND A DESCRIPTION OF THE CHILD'S FAMILY, INCLUDING THE BIRTH ORDER OF THE CHILD WHOSE DEATH IS BEING REVIEWED;

(III) A STATEMENT OF ANY CHILD WELFARE SERVICES, AS DEFINED IN SECTION 26-5-101 (3), AND ANY OTHER GOVERNMENT ASSISTANCE OR SERVICES THAT WERE BEING PROVIDED TO THE CHILD, ANY MEMBER OF THE CHILD'S FAMILY, OR THE PERSON SUSPECTED OF THE ABUSE OR NEGLECT;

(IV) THE DATE OF THE LAST CONTACT BETWEEN THE AGENCY PROVIDING ANY CHILD WELFARE SERVICE AND THE CHILD, THE CHILD'S FAMILY, OR THE PERSON SUSPECTED OF THE ABUSE OR NEGLECT; __

(V) THE AGE, INCOME LEVEL, AND EDUCATION LEVEL OF THE LEGAL CARETAKER AT THE TIME OF THE FATALITY;

(VI) INFORMATION ON THE PERSON OR PERSONS CARING FOR THE CHILD AT THE TIME OF THE FATALITY; AND

(VII) ANY OTHER INFORMATION REQUIRED BY RULES PROMULGATED BY THE STATE DEPARTMENT PURSUANT TO SUBSECTION (7) OF THIS SECTION.

(h) THE CASE-SPECIFIC EXECUTIVE SUMMARY FOR A CHILD WHO WAS IN FOSTER CARE, AS DEFINED IN SECTION 19-1-103 (51.3), C.R.S., AT THE TIME OF THE INCIDENT MUST INCLUDE:

(I) THE CHILD'S NAME, DATE OF BIRTH, AND DATE OF FATALITY;

(II) THE AGE, GENDER, AND RACE OR ETHNICITY OF THE CHILD;

(III) A DESCRIPTION OF THE FOSTER CARE PLACEMENT;

(IV) THE LICENSING HISTORY OF THE FOSTER CARE PLACEMENT;

(V) A STATEMENT OF ANY CHILD WELFARE SERVICES, AS DEFINED IN SECTION 26-5-101 (3), AND ANY OTHER GOVERNMENT ASSISTANCE OR SERVICES THAT WERE BEING PROVIDED TO THE CHILD, ANY MEMBER OF THE CHILD'S FAMILY, OR THE PERSON SUSPECTED OF THE ABUSE OR NEGLECT;

(VI) THE DATE OF THE LAST CONTACT BETWEEN THE AGENCY PROVIDING ANY CHILD WELFARE SERVICE AND THE CHILD, THE CHILD'S FAMILY, OR THE PERSON SUSPECTED OF THE ABUSE OR NEGLECT; AND

(VII) ANY OTHER INFORMATION REQUIRED BY RULES PROMULGATED BY THE STATE DEPARTMENT PURSUANT TO SUBSECTION (7) OF THIS SECTION.

SECTION 12. Appropriation. (1) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of public health and environment, for the fiscal year beginning July 1, 2013, the sum of $456,966 and 4.0 FTE, or so much thereof as may be necessary, for allocation to the prevention services division, for the child fatality prevention line item for costs related to the implementation of this act.

(2) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of human services, for the fiscal year beginning July 1, 2013, the sum of $63,755 and 1.0 FTE, or so much thereof as may be necessary, for allocation to the executive director's office, special purpose subdivision for the administrative review unit for costs related to the implementation of this act.

SECTION 13. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.