The Office of Colorado’s Child Protection Ombudsman Investigation Report  

Kit Carson County Health and Human Services  

Case ID: 11603  
June 7, 2016  

I. Introduction  
The Office of Colorado’s Child Protection Ombudsman (CPO) was created to ensure that agencies across Colorado, responsible for providing child protection services, comply with Colorado child protection policy known as Volume VII and the laws developed to protect children, known as the Colorado Children’s Code. These laws and policies were designed as a road map for child protection workers defining how to perform their duties in the best way possible to protect Colorado’s children. When these policies and laws are compromised by an employee or agency, the CPO is charged with investigating the work of the agency, identifying the compliance issues and authoring recommendations to the agency to improve practice.  

II. Complaint Summary  
On October 16, 2014, the CPO received a complaint regarding Kit Carson County Health and Human Services (KCCHHS) failure to comply with both Volume VII and the Colorado Children’s Code relating to their requirements to report third party child abuse and/or neglect to local law enforcement. The complainant stated that on two occasions, the Director of KCCHHS (Director) and a Child Welfare Supervisor (Supervisor) had been made aware of allegations of third party sexual assault on a child and had failed to report these allegations to local law enforcement for investigation.  

As part of the CPO’s initial review of the complaint, the CPO reviewed relevant rules and statutes outlined in Volume VII and the Colorado Children’s Code relating to third party abuse and/or neglect and mandated reporting. The complete statutes and rules that were explored are included in Appendix A.  

In reviewing the complaint, the CPO also took into consideration the statutory definition of sexual assault as defined in C.R.S. 18-3-405(1) which states:  

“Sexual assault on a child: any actor who knowingly subjects another not his or her spouse to any sexual contact commits sexual assault on a child if the victim is less than fifteen years of age and the actor is at least four years older than the victim.”  

In this case, it is alleged that the Director and the Supervisor of KCCHHS were made aware of a situation where a fourteen-year-old female had delivered a baby and the alleged father was twenty-one years of age.
III. Decision to Investigate

The CPO initiated a review of the allegations on October 16, 2014. During the course of the review, the CPO spoke with the District Attorney in Kit Carson County, reviewed law enforcement records, and all documentation that was located in the TRAILS database\(^1\). The CPO carefully considered the rules and statutes outlined in Appendix A, and the legislative purpose behind these rules and statutes, particularly surrounding mandatory reporting. Mandatory reporting rules and statutes were developed to guide those persons that have a high likelihood of contact with a child or children that may experience child abuse and/or neglect on what to do, what to report and whom to report to when there is a concern regarding child abuse and neglect. These rules and statutes apply to both cases of child abuse and/or neglect in which the alleged perpetrator is a family member, or in cases where the alleged perpetrator is not of any relation to the child who is alleged to being mistreated.

The evidence reviewed by the CPO staff supported the complaint that the Director and Supervisor had been made aware of allegations of child sexual assault and had failed in their duties to report such to local law enforcement as they are required under law to do. This failure to comply with child protection law and policy led the CPO to open an investigation into the concerns on October 21, 2015, at which time the Director of KCCHHS, and Executive Director Reggie Bicha of the Colorado Department of Human Services were notified. The investigation into the complaint filed with the CPO was delayed due to the criminal and legal proceedings related to this matter. Due to the pending criminal charges, as well as at the request of the District Attorney, the CPO respectfully waited for these proceedings to conclude prior to issuing a formal report as to not interfere in any way with the legal process.

IV. Investigative Summary

The CPO investigation looked into two specific reports of alleged child abuse made to the KCCHHS child welfare program. A summary of these two reports, and the actions of the KCCHHS staff in response to the reports is outlined below.

On August 6, 2014, the KCCHHS child welfare program received a report regarding a child, [redacted] (age 14), and her newborn daughter, [redacted]. The reporter notified the department that [redacted] had given birth to a child prematurely and the infant girl had been transferred to a Denver area hospital for care. The reporting party expressed concern that the young girl had hid the pregnancy and had not received any prenatal care. The report also stated concern for [redacted]’s ability to adequately parent as evidenced by her watching cartoons in the hospital while parenting education was being attempted. The reporter requested follow up

---

\(^1\) TRAILS Database: the statewide database used for documenting all calls to county/state human services agencies regarding abuse and/or neglect, as well as all of the work completed by agency staff relating to reviewing and investigating allegations of abuse and/or neglect.
by the KCCHHS to offer parenting assistance for the young mother. Further, the reporting party indicated that the mother’s boyfriend was approximately 20 years of age.

On August 7, 2014, KCCHHS employees, including the Supervisor and three others, reviewed the report and after evaluation did not believe there was concern for abuse and neglect and did not provide any further action or investigation into the concerns reported. In the documentation completed by department staff, it is noted that the agency’s next step was to report the concerns to local law enforcement. A note that was also entered by the Supervisor states that the referral was staffed with the Director and that she concurred with the decision not to assign the referral for further follow up by the Department. The note did state that the Director thought the family should be referred to the Nurse Family Partnership program due to the extended family’s prior negative history and perception of the child welfare program. The Director expressed concern that the family’s prior negative experience may have an impact on the mother agreeing to participate in services through the Nurse Family Partnership. The CPO found that although department staff identified the need to notify law enforcement, this did not occur.

On August 11, 2014, KCCHHS received a second referral concerning Alexandra Reed and her newborn child. The report was similar to the first in that it was stated that Alexandra was 14 years of age and she had just given birth to a premature baby. The reporter indicated that Alexandra’s boyfriend was 20 years old and that Alexandra had been residing with her boyfriend. The reporter expressed concern for Alexandra’s ability to adequately care for a newborn child based off her knowledge of the young mother having received special education services while she was enrolled in school. This report was again brought for RED Team with four agency staff including the Supervisor and Director involved in this complaint. The decision to not investigate these concerns any further was made based on the finding by the team that this was an allegation of third party abuse, and it was noted that this should be referred to local law enforcement. Further notations were made that the parents of Alexandra were to be contacted and advised of KCCHHS legal obligation to notify law enforcement. The team once again noted that it would be beneficial to the family to offer voluntary services; however, the CPO found no evidence to support that the KCCHHS spoke with Alexandra or any member of her family regarding voluntary services as reported to the CPO by the Director.

In speaking with the Kit Carson District Attorney, as well as reviewing law enforcement records, the CPO identified that KCCHHS failed to report the allegations of third party sexual abuse to local law enforcement in an immediate fashion as defined in statute, and further failed to cooperate with the investigation by local law enforcement into the sexual assault allegations. Kit Carson Sheriff’s Department became aware of the alleged sexual assault on a child on August 12, 2014, after receiving a report from a local victim’s advocate. Kit Carson Sheriff’s Department contacted the KCCHHS Supervisor and spoke with her about the reports. The Supervisor acknowledged that two reports had been made; however, she advised that KCCHHS did not believe it to be their jurisdiction due to the lack of allegations of abuse and/or neglect.
by a family member. The Supervisor also expressed concern that should law enforcement become involved, the family may not cooperate with services and the mother may be separated unnecessarily from the alleged perpetrator and father of her child. Kit Carson Sheriff’s Department requested a copy of the email that was sent to KCCHHS reporting the alleged sexual assault, as well as any other reports received relating to the issue. The Supervisor agreed and although she complied with sending portions of the referrals to the investigating officer, she did not include all that had been requested. Kit Carson Sheriff’s Department obtained a search warrant for KCCHHS records after attempts to have the reports handed over in full failed. The search warrant was issued and executed on August 14, 2014.

As part of the investigation, the CPO staff also interviewed the Director and Supervisor regarding the reported concerns of their failing to report child sexual assault to law enforcement. The Director was interviewed on October 29, 2015 and the Supervisor was interviewed on November 11, 2015. In speaking with both the Director and Supervisor, both parties advised that they had spoken with their former county child welfare attorney regarding the allegations of sexual abuse and the need to report to law enforcement and had been advised that they were not required to report. Both parties were resistant in answering questions and demonstrated a lack of understanding of the law which defines sexual assault on a child, as well as a lack of understanding on their legal responsibility to report any allegations of third party child abuse to local law enforcement. This lack of understanding was also demonstrated in the police report interviews with witnesses that attested they had spoken with the Director regarding the report and had been advised that it was not the jurisdiction of the child welfare program. Neither party accepted responsibility for failing to report and further defended their decision as being in the best interest of [Redacted] and her newborn.

On October 29, 2015 and again on November 11, 2015, the CPO verbally requested of the Director and the Supervisor copies of the agency’s Memorandum of Understanding with local law enforcement, any emails sent from the Supervisor to Kit Carson Sheriff’s Department concerning the reports of alleged sexual assault and any attachments, the anonymous fax which precipitated the second contact with the KCCHHS on August 11, 2014 and the facsimile from the hospital regarding the initial referral on August 6, 2014. As the documents were never forwarded to the CPO, a written request was made on November 18, 2015. The documents were received by the CPO on November 20, 2015; however, the attachments to the emails sent to the Kit Carson Sheriff’s Department via email from the Supervisor were not included.

During conversations with the Director regarding the ongoing services reportedly being provided to [Redacted] and her child, to ensure that the child is safe and [Redacted] has parenting supports, the Director acknowledged that a referral had been made to the Nurse Family Partnership program and that the KCCHHS child welfare department was monitoring [Redacted] and her baby closely. CPO staff inquired as to documentation of this monitoring and was advised that the KCCHHS was under no obligation to provide that to the CPO as the family was not working with the KCCHHS under an open child welfare case. The CPO advised the
Director of the statute\(^2\) which entitles the CPO to these documents; however, the Director refused to comply. The CPO did obtain a copy of a referral for [REDACTED] to receive services through the Nurse-Family Partnership program. The referral was made by the hospital staff, and not by KCCHHS as was reported by the Director.

On October 3, 2014, the Director and Supervisor were charged with a Class 3 misdemeanor of “Child Abuse-Fail to report suspected”. The Director and Supervisor were engaged in a lengthy legal process which resolved on October 14, 2015. The Kit Carson District Attorney’s Office notified the CPO that all charges against the Supervisor had been dropped as it was determined that she was acting at the direction of the KCCHHS Director.

On October 14, 2015, the Director pleaded guilty to Failure to Report Child Abuse or Neglect, C.R.S. 19-3-304(I), a class 3 misdemeanor and received a one year Deferred Judgment and Sentence with all terms and conditions, including determination of supervision, open to the Court. The following conditions were made as terms of the plea agreement:

A. The defendant (KCCHHS Director) will allocute in open court;
B. The defendant will participate in a joint training of mandatory Reporting requirements with the District Attorney’s Office and employees of the Kit Carson Department of Human Services; and
C. The defendant will participate in additional training of Mandatory Reporting requirements with the District Attorney’s Office for the benefit of the DHS of Yuma, Phillips, Sedgwick, Logan, Morgan and Washington counties, if requested by the District Attorney’s Office.

The Director received 40 hours of community service as a condition of her deferred judgment. At the conclusion of the criminal proceedings, the KCCHHS Director resigned from her position with the Department.

On March 4, 2016, the CPO received documentation from the acting director of KCCHHS, outlining two new policies developed to ensure that the compliance issue relating to mandatory reporting does not happen again. The policies as sent to the CPO state:

- **Policy-Child Welfare Reporting to the Office of the District Attorney**

  All child welfare referrals shall be forwarded to the Office of the District Attorney of the respective judicial district of suspected jurisdiction in writing utilizing the Kit Carson County DA Reporting form. Written forms shall be faxed with a copy of successful transmission retained.

---

\(^2\) **19-3.3-103(I)(A)** In investigating a complaint, the Ombudsman shall have the authority to request and review any information, records, or documents, including records of third parties, that the ombudsman deems necessary to conduct a thorough and independent review of a complaint so long as either the state department or a county department would be entitled to access or receive such information, records, or documents.
• **Policy-Child Welfare Reporting to Law Enforcement**

All child welfare referrals shall be forwarded to the suspected jurisdictional law enforcement agency within 24 hours of receipt of the referral. Referrals made verbally shall be followed up with a written referral. All reporting of child welfare referrals shall coincide with the KCCHHS and law enforcement memorandum of understanding.

As a result of the plea agreement, all staff of KCCHHS (34 total members) participated in a Mandatory Reporting Training delivered by the Kit Carson District Attorney’s Office. This training was completed on November 24, 2015 and was reported and confirmed to the CPO on March 16, 2016. The CPO obtained a copy of the sign in sheet for the training to verify compliance and attendance. The Director’s name was not present on the sign-in sheet; however, the District Attorney verified her attendance and her refusal to sign in for the training. Further, on March 16, 2016, the CPO was advised by the Kit Carson District Attorney’s Office that the relationships between the DA’s Office and KCCHHS were much more open and they anticipated that these relationships will only strengthen with the hiring of a new agency director. The CPO was advised that the Director and the Supervisor are no longer employed by KCCHHS and a new director with experience in law enforcement had been hired to be the agency’s new director.

**V. Findings and Recommendations**

In conclusion, the CPO found that the KCCHHS Director and Child Welfare Supervisor, failed to comply with the mandatory reporting rules as defined in Volume VII and mandatory reporting laws as outlined in the Colorado Children’s Code (Appendix A). The Director and Supervisor demonstrated a significant lack of understanding both of the laws surrounding child sexual abuse, as well as their responsibility to protect children within their community by reporting suspected criminal child abuse to the local authorities for investigation.

This complaint was found to be an act of omission by the KCCHHS employees. Because of this, the CPO is unable to fully assess the potential number of instances in which allegations of child abuse and/or neglect and criminal acts against children have gone unreported to law enforcement without a complainant stepping forward.

This report concludes the investigation into the complaint concerning KCCHHS with a finding of Agency/Caseworker Non-Compliance with Policy and Law. This investigation was unique to the CPO in that the complaint was received after action had been taken by the Kit Carson District Attorney. Due to the ongoing criminal proceedings, and KCCHHS staff unwillingness to speak with the CPO until the criminal case was resolved, the CPO was unable to work with the KCCHHS staff on necessary changes to improve practice for a significant amount of time. As a result of the criminal case, the KCCHHS acting director implemented new policies to ensure that reporting of potential criminal acts towards children were reported to the District Attorney and
to Law Enforcement. The CPO supports the policies that were instituted in KCCHHS to address the reporting issues; however, also finds that the duty and responsibility to report suspected child abuse and/or neglect immediately is crucial in ensuring that the children within our communities are protected. In order to do so, mandatory reporters must be adequately trained on their duties and responsibilities, and understand their mandates under Colorado law. In an effort to ensure this, the CPO recommends the following:

1. Kit Carson County Health and Human Services meet quarterly with the District Attorney’s Office and the Sheriff’s Department to ensure that all parties remain in compliance with the mandatory reporting policies as developed by KCCHHS.
2. Kit Carson County Health and Human Services ensure that all new staff hired complete the CDHS Mandatory Reporter Online Training.
3. Kit Carson County Health and Human Services ensure that all staff, on an annual basis, complete the CDHS Mandatory Reporter Online Training.

The Child Protection Ombudsman Office of Colorado will be following annually the progress of Kit Carson County Health and Human Services to ensure ongoing compliance with training and reporting mandates.
VI. Agency Response

BOARD OF COUNTY COMMISSIONERS

Aug. 26, 2016

The Kit Carson County Board of County Commissioners has reviewed your report dated June 13, 2016. The Board appreciates the time and effort that you invested in your investigation. Fortunately, many of the concerns that you identified had already been addressed by the Board by the time your report was provided.

First and foremost, the Board hired a new Kit Carson County Health and Human Services Director on April 1, 2016. The Board believes that the new Director’s strong organizational skills coupled with her understanding of and value for collaborating with stakeholders will serve the citizens of Kit Carson County well. As reflected in your report, the new Director’s law enforcement experience has already improved the relationship with the District Attorney’s Office which will “only strengthen” in time. The Board agrees with this assessment.

The Board also hired a new special county attorney on June 1, 2016. The new law firm brings a multidisciplinary approach with nearly three decades of experience in the child welfare field including a strong understanding of the State Department of Human Services rules and regulations. These new additions to the Health and Human Services Department deserve particular note because the allegations which you investigated occurred nearly two years ago under the direction of individuals no longer associated with Kit Carson County. Further, the Kit Carson County Health and Human Services Department hired two new caseworkers in the Spring of 2016. Both of these individuals have completed the Child Welfare Training Academy including training on mandatory reporters.

Finally, the Health and Human Services Department has already begun formalizing reporting policies, collaborating with community partners regarding mandatory reporter requirements, and drafting memorandums of understanding with law enforcement agencies and other stakeholders. We anticipate that these will be finalized in the near future.

In conclusion, the Board of County Commissioners takes the health and safety of the citizens of Kit Carson County seriously and is continuously assessing the quality of services provided and implementing improvements where necessary.

Sincerely,
The Board of County Commissioners for Kit Carson County, Colorado
Appendix A

1. Defining “third party” abuse and/or neglect

Volume VII and the Colorado Children’s Code both clearly define third party abuse/neglect as follows:

7.000.2

“Third-party abuse and/or neglect means a situation where a child is subjected to abuse and/or neglect by any person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent, or any other person not included in the definition of intrafamilial abuse or institutional abuse.”

C.R.S. 19-1-103(108)

“Third-party abuse as used in part 3 of article 3 of this title, means a case in which a child is subjected to abuse, as defined in subsection (1) of this section, by a person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent, as defined in subsection (101) of this section, or any other person not included in the definition of intrafamilial abuse, as defined in subsection (67) of this section.”

2. Mandatory Reporting requirements:

7.104.31(A)

“When the referral alleges abuse and/or neglect by a third-party ten (10) years of age or older, the county department shall immediately forward the referral to the appropriate law enforcement agency for screening and investigation.”

7.103.5(A)(6)

“County departments may determine that a referral does not require further action and screen it out for the following reasons:

The person alleged to be responsible for the abuse and/or neglect is a third(3rd) party and ten (10) years of age or older. In this circumstance, the county department shall send the referral to the appropriate law enforcement agency.”

7.104.32

“County departments shall attempt to obtain a copy of the report summarizing any investigation that was conducted by law enforcement. If the report is obtained, it shall be the basis upon which the county department enters a
founded finding of abuse and/or neglect into the state automated case management system.”

C.R.S. 19-3-304(1)

“Any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions that would reasonably result in abuse or neglect shall immediately upon receiving such information report or cause a report to be made of such fact to the county department, the local law enforcement agency, or through the child abuse reporting hotline system as set forth in 26-5-111, C.R.S.”

3 C.R.S. 19-3-304 outlines those persons required to report child abuse or neglect. Section (II)(cc) identifies any worker in the state department of human services and a mandated reporter under statute.
February 14, 2019

Stephanie Villafuerte, State of Colorado Child Protection Ombudsman

Regarding: Case ID 11603, Kit Carson County Health and Human Services

Dear Ms. Villafuerte,

My name is Kindra Mulch. I am a former director (1998 to 2015) of Kit Carson County Health and Human Services (KCCHHS). I was the director referenced in this case, it was a clear misunderstanding of the statute requiring the Human Services Departments (KCCHHS) to refer all cases of child abuse reports to law enforcement immediately. Never was there intent to avoid or hinder any reporting to law enforcement. The statutory requirement for immediate reporting to law enforcement was the practice of KCCHHS when a child was in imminent danger. During cases where there was no immediate threat to any child this small division of: one supervisor, two caseworkers and one case aid completed RED team assessments, as prescribed in statute, and consulted Department legal counsel as indicated by the circumstances. As the Director, I was often included in communications with legal counsel as well as apprised of cases of unusual reports. That is indeed what happened in this case.

The CPO prepared the report dated June 7, 2016 which outlined concerns regarding practices within the child welfare program of KCCHHS. It is not my intent to request reopening of any investigation but solely to clarify mischaracterizations. I was always professional and communicated as openly as I was able with the Ombudsman, given the legal pending action. I agree that the legal action made some dialogue challenging, but it was respectful and congenial on my part. I also recall staff sending requested reports and written records to the Ombudsman upon request. This report was released and made public months after my retirement from 35 years of service to KCCHHS.

I was not noticed of the release of the report in either June of 2016 or when the report was made public. I certainly never would have thought that the findings would be so disturbing. I was under the assumption due to assurances provided by the Ombudsman I spoke with in 2014 facts and conclusions would include summary reflecting the clear miscommunication between KCCHHS/Child Welfare program and law enforcement. It was also to include the fact that I nor anyone who ever worked for me ever acted out of malice but rather was awaiting consult from Department legal counsel over a five-day period that included a weekend. Additionally, the accurate fact is that no child was ever in imminent danger during the five days from time of initial referral to reporting to law enforcement.

After reading the report last month, I immediately reached out to your office. I find it imperative to provide clarification and information not contained within the report. In the fall of 2014, I spoke with the Ombudsman and advised that I indeed was accepting responsibility for failing to immediately report this referral to law enforcement. I furthermore shared the following sequence of events:

• Day 1): I received information from one of my employees that a mandatory reporter at the hospital had called in a mandatory report of a young minor who resides in the county who had just given birth. According to the reporter, there was a young adult male visiting the female at the hospital when the minor’s mother was not there, and that he looked “older”. The reporting party did not know the male’s name, age or whether he was potentially the
father of the child. The caller was not concerned about immediate or impending safety of
the mother or infant at the time of the call. The reporter stated that mother and infant
would remain in the hospital for a few days.

- Day 2: RED team determined that the facts didn’t appear to support an immediate
  response but requested further information and staffing with the director. I was contacted
  by the supervisor and it was determined that a call to the department attorney would be
  prudent. A call was placed to the attorney, but a message had to be left. The details
  included that the infant was transferred to Denver hospital and the mother was going to
  Denver with her parents to be with the infant. One of my public health nurses visited the
  minor female in the hospital, but the girl refused to provide any information about the
  baby’s father and claimed that she did not know she was pregnant until she went into labor.
  My office’s primary concern was the health and well-being of the minor female and her
  infant child.
    - It was part of my job duties to determine whether issues should be reported to law
      enforcement. In this situation, I was concerned that my employee had no
      information that this young adult male was the father of this baby, or that the minor
      mother and young adult male had an intra-familial relationship or had been
      engaged in a sexual relationship. I did not know whether these facts constituted
      suspected child abuse. Balancing the lack of information available to us and our duty
to report, I consulted with the county attorney for my office for guidance on
whether to forward the report. As a result, I indicated to the supervisor (RED Team
Leader) that she did not have to make a report to law enforcement based upon the
legal advice I was given.

- Day 3 and 4) weekend: The supervisor was in contact with the Denver hospital and
  assurance was secured that the infant and mother were at the hospital and the infant would
  not be discharged for several days.

- Day 5): An anonymous report was received that included additional concerns regarding this
  referral. The message was relayed to the child welfare supervisor late in the afternoon.
  Again, the supervisor made assurances that the parties remained in Denver at the hospital.
  The nurses at the hospital didn’t report concerns for the mother or infant safety. The
department’s attorney was again contacted and apprised of the updates. The attorney’s
assistant was relaying information. The response from the assistant to the Department
included that the attorney would follow up the next day and if everyone was safe, time
allowed for thorough review of the facts.

- Day 6): I received a call from the department attorney at approximately 5:30 pm. The
  attorney recommended that a referral to law enforcement was in order. At approximately,
  8:00 pm the Supervisor sent the referral to local law enforcement that included the two
  referrals; noting that the first referral had been screened out by our RED Team.

The Ombudsman indicated that the report would include this sequence of events. The
Ombudsman regretted that due to the litigation and the request of the District Attorney it was not
possible to complete the investigation or file a report at this time.

Charges were filed in 2014 against me and other personnel regarding this matter for failing to
immediately report this referral to the District Attorney. My personal attorney, retained for purposes of
these charges, and I tried repeatedly to discuss the case with the District Attorney to no avail. The case was continually delayed; initially no judge in the district would hear the case (several recused themselves) and then we awaited assignment of a retired judge. Scheduling conflicts of others involved also delayed the process. The case would have gone to trial had I not plead to a deferred judgement that included the dismissal of the child welfare supervisor from all involvement. The plea offer was not made until September of 2015. This Supervisor was exemplary in her work and her passion for child welfare. This highly qualified, experienced, compassionate supervisor was considering leaving the practice of child welfare due to the stress of this unnecessary upheaval. I wanted to protect this supervisor from further turmoil, and I accepted full responsibility for the decisions made. This case ultimately ended with a final order of the court to dismiss the deferred judgement and sentence.

As previously stated, it is not my desire to line item the mischaracterizations in the report, however, I do want it known that on no occasion have I ever intentionally failed to sign an attendance registration. I never blatantly avoided any parties to this investigation or case. My behavior remained and remains professional.

Of important note, my status with Kit Carson County was and remains eligible for rehire. I was, in fact, hired by Kit Carson County again in November 2018.

I accept responsibility for my failures including not addressing this report sooner. My character and credibility have been harmed by statements made in this report that are wrong or taken out of context I appreciate your kind offer of allowing inclusion of my account of the events. My career is filled with numerous achievements to support my integrity, morals, commitment to children, families and all vulnerable people. I have contributions to give in the arena of prevention and early intervention for children and families. I sincerely appreciate the opportunity provided by CPO to set the record straight. I look forward to working with you to further the support of your role as a “neutral problem solver that helps citizens navigate a complex child protection system in an expert and timely manner”.

I remain forever committed to doing the right thing and supporting the advancement of Child Welfare practice in order that no child is ever abused, neglected nor endangered but rather that all children have opportunity for living in safe, secure, loving families.

Kind Regards,

Kindra Mulch