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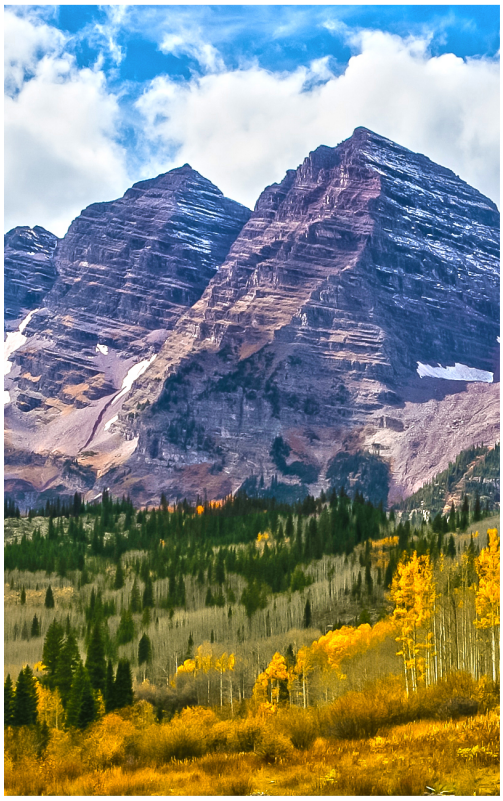
SEX OFFENDER MANAGEMENT BOARD



JUNE 2020

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DIANNE E. RAY, CPA
STATE AUDITOR

June 18, 2020

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Sex Offender Management Board (Board) within the Department of Public Safety. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government, and Section 2-7-204(5), C.R.S., which requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments for purposes of the SMART Government Act. The report presents our findings, conclusions, and recommendations, and the responses of the Board.

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REPORT HIGHLIGHTS

SEX OFFENDER MANAGEMENT BOARD

PERFORMANCE AUDIT, JUNE 2020

SEX OFFENDER MANAGEMENT BOARD
DEPARTMENT OF PUBLIC SAFETY

CONCERN

How the Sex Offender Management Board (Board) fulfills its statutory duties can affect both sex offenders in the criminal justice system and the safety of victims and potential victims. Our audit found deficiencies in how the Board has established standards of conduct for providers who serve offenders, as well as issues in how the Board approved providers and investigated complaints alleging these providers violated standards. We also found a lack of transparency and accountability in how the Board mitigates conflicts of interest among its members and documents those decisions during its meetings.

KEY FINDINGS

- Most sections of the Board Standards do not reference supporting evidence, as required by statute. Of the 381 subsections on evaluating, identifying, and treating offenders, only 18 percent of the subsections in the Adult Standards and 11 percent of the subsections in the Juvenile Standards cited supporting evidence.
- Of 18 provider applicants we reviewed who applied for Board approval to serve offenders, the Board did not verify that 13 applicants met applicable requirements related to references, competency in professional standards and ethics, clinical supervision, sex offender-specific training, example work products, and competency to serve offenders with developmental/intellectual disabilities or juvenile offenders.
- In some instances, the Board did not comply with the statutory requirement to investigate complaints and did not clearly follow the Board's complaint policy. For example, the Board took no action on two anonymous complaints submitted during the period we reviewed, and also took no action on two other complaints that met the Board's criteria requiring some investigative action.
- Nine Board members who were active during our testing period had actual conflicts or situations that created the appearance of a conflict that were not disclosed and did not prevent them from performing official actions. For example, three members of the Board's Application Review Committee were owners, directors, or officers of the same businesses that employed individuals whom the Committee approved to be providers during Calendar Year 2018.
- Both revenue and the balance of the Sex Offender Surcharge Fund have been increasing over the last 5 years, but the Board's annual allocation recommendations have not increased.

BACKGROUND

- Each of the Board's 25 members is appointed to provide expertise in sex offense-related issues and is charged with prioritizing the protection of victims and potential victims.
- The Board's primary focus is to develop standards and processes for service providers and state agencies responsible for treating and managing Colorado's 24,000 registered sex offenders. These Board standards are intended to help manage and reduce sexually abusive risk behavior and promote protective factors that help prevent offenders from reoffending.
- The Board also approves providers (e.g., mental health professionals, polygraph examiners) who serve sex offenders, investigates complaints against these providers, and develops an annual allocation plan for the Sex Offender Surcharge Fund.
- The Board conducts its work through formal voting processes during committee and full Board meetings, which are typically held monthly. It receives operational support from Department of Public Safety staff.

KEY RECOMMENDATIONS

The Board should implement policies and procedures to guide its standards revision process as well as revise standards to clearly indicate, for each standard, which is evidence-based and which lacks supporting evidence, and why.

The Board should approve only qualified providers by checking references for first-time applicants, and requiring staff and committee members to document their review of applicants' qualifications.

The Board should strengthen its complaints handling process to comply with statute, and ensure fairness and consistency by implementing written policies that address various aspects of the process.

The Board should obtain a written legal opinion from the Attorney General that clarifies how the State Code of Ethics applies to Board members, and implement written guidance to specify how the statutory provisions apply to the Board.

The Board agreed with all six recommendations.

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CHAPTER 1
OVERVIEW

In an effort to protect the public and work towards the elimination of sexual offenses, the General Assembly created the Sex Offender Management Board (Board) within the Department of Public Safety (Department). The General Assembly noted a necessity to "comprehensively evaluate, identify, treat, manage, and monitor" adult sex offenders and juveniles who have committed sexual offenses in Colorado [Section 16-11.7-101, C.R.S.], and charged the Board with developing standards, guidelines, and processes for service providers and state agencies responsible for treating and managing this population. As of 2019, Colorado had more than 24,000 registered sex offenders.

BOARD RESPONSIBILITIES

The Board's primary focus has been the creation of, and ongoing revisions to, the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* and the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (collectively known as "the Board's standards" or "Board Standards"). The Board Standards are intended to help manage and reduce sexually abusive risk behavior, promote protective factors that enable an offender's success, prevent offenders from reoffending, and "have as a priority" the protection of victims and potential victims [Sections 16-11.7-101(2) and 103(4)(a), C.R.S., and Sex Offender Management Board 2020 Annual Legislative Report].

Additionally, statutes require the Board to establish a process to approve all professionals (e.g., mental health professionals, polygraph examiners) who seek to provide services to offenders through state agencies (i.e., the Department of Corrections, Judicial Branch, Division of Criminal Justice, and Department of Human Services), and to receive and investigate complaints that allege these professionals have violated Board Standards [Sections 16-11.7-106(2) and (7)(b), C.R.S.]. The Board has included its requirements and processes for approving provider applications and investigating complaints in its standards.

BOARD ORGANIZATION AND FUNDING

The Board is housed within the Office of Domestic Violence and Sex Offender Management in the Division of Criminal Justice (Division) and is composed of 25 members, from urban and rural areas of the state, who are intended under statute to provide expertise in adult and juvenile issues related to individuals who have committed sex offenses [Section 16-11.7-103(1), C.R.S.]. The volunteer members serve 4-year terms, and as shown in EXHIBIT 1.1, are appointed by six appointing authorities: the Departments of Human Services (CDHS), Public Safety (CDPS), Education (CDOE), and Corrections (CDOC); the Chief

Justice of the Colorado Supreme Court; and the Colorado District Attorneys' Council (CDAC).

EXHIBIT 1.1. SEX OFFENDER MANAGEMENT BOARD APPOINTMENTS AND TERMS

	GROUP THE BOARD MEMBER REPRESENTS	APPOINTING AUTHORITY	EXPIRATION DATE OF CURRENT TERM
1	Private Criminal Defense Attorneys	CDPS	11/22/20
2	Licensed Mental Health Professionals–Adult	CDPS	08/26/23
3	Licensed Mental Health Professionals–Adult	CDPS	06/04/22
4	Licensed Mental Health Professionals–Juvenile	CDPS	05/06/21
5	Licensed Mental Health Professionals–Juvenile	CDPS	05/10/22
6	Sexual Abuse Victims and Victims' Rights Organizations	CDPS	01/14/23
7	Sexual Abuse Victims and Victims' Rights Organizations	CDPS	03/26/22
8	Sexual Abuse Victims and Victims' Rights Organizations	CDPS	11/02/20
9	Public Defenders	CDPS	10/17/22
10	Clinical Polygraph Examiners	CDPS	01/19/23
11	Community Corrections Boards	CDPS	09/16/20
12	Law Enforcement	CDPS	01/21/23
13	Division of Criminal Justice	CDPS	11/01/21
14	Urban County Commissioners	CDPS (in consultation with CCI)	(Vacant)
15	Rural County Commissioners	CDPS (in consultation with CCI)	05/10/22
16	County Directors of Social Services	CDPS (in consultation with CCI)	(Vacant)
17	Judicial Branch	Chief Justice of the Supreme Court	10/31/23
18	Juvenile Court Judges or Magistrates	Chief Justice of the Supreme Court	1/23/22
19	District Court Judges	Chief Justice of the Supreme Court	05/31/22
20	Out-of-Home Placement Services	CDHS	07/01/20
21	Division of Youth Services	CDHS	07/18/20
22	Department of Human Services	CDHS	01/01/23
23	Department of Corrections	CDOC	02/21/24
24	Prosecuting Attorneys	CDAC	02/22/22
25	Public School System	CDOE	10/20/21

SOURCE: Division of Criminal Justice data on board membership as of March 2020, and Section 16-11.7-103, C.R.S.

The full 25-member Board holds regular meetings (usually monthly) during which it discusses and votes on various issues, receives testimony

from stakeholders, and hears presentations on new offender treatment and assessment methods. To facilitate its work, the Board has also created a number of subcommittees and work groups, which meet on an as-needed basis and perform specific tasks, such as reviewing provider applications and investigating complaints. The Board also receives operational support from 5.6 full-time equivalent staff allocated from the Division who conduct research and provide training, guidance, and information to Board members and other stakeholders.

In Fiscal Year 2020, the Division was appropriated $262 million, and of that amount, budgeted approximately $1 million to support Board operations, which includes state general funds, state cash funds, and federal grant funds. The Board was scheduled to sunset on September 1, 2020, although in June 2020 the General Assembly enacted legislation to extend that date until September 1, 2021.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this performance audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government, and Section 2-7-204(5), C.R.S., the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act. The audit was conducted in response to a legislative request which expressed concerns related to Board Standards, provider approval, the Board's complaints process, conflicts of interest among Board members, the transparency of Board operations, and the Board's responsibilities related to the Sex Offender Surcharge Fund.

Audit work was performed from April 2019 through April 2020. We appreciate the cooperation and assistance provided by the management and staff of the Department of Public Safety and Division of Criminal Justice, and members of the Sex Offender Management Board during this audit.

We conducted this audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The key objectives of the audit were to (1) evaluate the Board's process for ensuring that Board Standards are revised, as appropriate, to be evidence-based, and contain all statutorily required content; (2) determine whether the Board approves only qualified providers; (3) determine whether the Board handles complaints against providers in accordance with statutes and Board Administrative Policies; (4) identify whether the Board has sufficient controls to ensure that its methodology for recommending Sex Offender Surcharge Fund allocations to the General Assembly is appropriate; (5) determine whether the Board complies with requirements for conducting and documenting its meetings and decision-making processes, including work done through committees; and (6) assess whether the Board has adequate controls to identify and mitigate actual or potential conflicts of interest among its members.

To accomplish our audit objectives, we performed the following audit work:

- Reviewed Colorado Revised Statutes, Board Administrative Policies, Board bylaws, Board Standards, and the *Standards for Internal Control in the Federal Government*.

- Interviewed staff at the Department of Public Safety, Judicial Branch, Attorney General's Office, Joint Budget Committee, and State Controller's Office; Board members; and stakeholder representatives.

- Reviewed and analyzed budget, vendor, and expense data in the Colorado Operations Resource Engine (CORE), the State's

accounting system; state contract documentation; and Board members' annual conflicts of interest disclosure forms.

- Reviewed and analyzed aggregate data in the Board's Access database as well as hard-copy files associated with provider approval and complaints.

- Reviewed documentation related to the Board's recommended allocations from the Sex Offender Surcharge Fund for Fiscal Years 2016 through 2020.

- Observed one meeting of the full Board, one meeting of the Application Review Committee, and one meeting of the Executive Committee in Calendar Year 2019.

- Reviewed the five most recent revisions to Board Standards, which the Board ratified between February 2018 and April 2019, along with associated Board and committee meeting minutes and materials.

- Reviewed the Board's *Lifetime Supervision of Sex Offenders Annual Report* from 2017, 2018, and 2019, as well as the Board's *Annual Legislative Report* from 2017 through 2020. We also reviewed the Sunset Reviews of the Board conducted in 2009, 2015, and 2019.

- Reviewed the entire population of anonymous complaints submitted to the Board from Calendar Years 2017 through 2019. We selected these complaints to assess how the Board reviewed and investigated anonymous complaints.

We relied on sampling techniques to support some of our audit work. Specifically, we selected the following samples:

- A non-statistical random sample of 10 complaints against Board-approved providers from the 49 complaints submitted to the Board from January 2017 through July 2019 for which the Board maintained aggregate data. We selected this sample to review the Board's process for reviewing and investigating complaints.

- A non-statistical stratified random sample of 18 providers listed on the Board's Approved Provider List as of June 2019, including nine providers who applied to serve adult sex offenders and nine who applied to serve juveniles. We selected this sample to assess compliance with relevant provider qualification and application requirements.

- A non-statistical judgmental sample of meeting minutes and agendas from five full Board meetings, minutes and agendas from five different committee meetings in Fiscal Year 2019, and minutes from 11 Application Review Committee meetings in Calendar Year 2018.

The results of our samples cannot be projected to the population. However, the sample results are valid for assessing our audit objectives related to the Board's approval and renewal of providers, review of complaints against Board-approved providers, and the transparency of Board and committee meetings, and along with the other audit work performed, provide sufficient, reliable evidence as the basis for our findings, conclusions, and recommendations.

We planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Our conclusions on the effectiveness of those controls, as well as specific details about the audit work supporting our findings, conclusions, and recommendations, are described in the remainder of this report.

A draft of this report was reviewed by the Board and Department. We have incorporated the Board's and Department's comments into the report where relevant. The written responses to the recommendations and the related implementation dates are the sole responsibility of the Board and Department.

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CHAPTER 2
PROVIDER OVERSIGHT

The Colorado Sex Offender Management Board (Board) is tasked with establishing a framework for professionals who are involved with identifying, treating, and managing sex offenders under the supervision of Colorado's justice systems. One of the Board's primary responsibilities is to establish evidence-based standards that guide the evaluation, treatment, and polygraph services that these offenders receive. Providers, such as therapists and polygraph examiners, must operate within the confines of the Board's standards and demonstrate that they are qualified to serve individuals who have committed sexual offenses. The Board enforces its standards primarily through investigation of complaints alleging that a provider has violated the Board's

standards. Our audit work found deficiencies in each aspect of the Board's provider oversight, and our recommendations are intended to improve the Board's processes for revising standards, approving providers, and investigating complaints against providers.

BOARD STANDARDS FOR EVALUATING, IDENTIFYING, AND TREATING OFFENDERS

The Board's primary purpose is to establish *evidence-based* standards for the "evaluation, identification, treatment, management, and monitoring of adult sex offenders and juveniles who have committed sexual offenses at each stage of the criminal or juvenile justice system to prevent offenders from reoffending and enhance the protection of victims and potential victims" [Section 16-11.7-101(2), C.R.S.].

In accordance with statutory requirements, the Board created the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (Adult Standards) and the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (Juvenile Standards). Collectively, we refer to the Adult Standards and Juvenile Standards as "the Board's standards" or "Board Standards." The Board Standards include hundreds of pages and multiple sections and subsections, delineating the Board's requirements and guidance on addressing various aspects of evaluating, identifying, and treating offenders. Additionally, the Board has established multiple appendices within the Board Standards, which include the Board's Administrative Policies, forms such as intake review forms for offenders who have been in prior treatment, and safety plans for disaster emergencies. Professionals who work with sex offenders (e.g., mental health professionals, polygraph examiners) are required to follow all

requirements outlined in the Board Standards [Section 16-11.7-106(1), C.R.S.].

The Board, which first established the Board Standards for adults in 1996 and juveniles in 2003, reports that it considers revisions when concerns, gaps, or opportunities are identified, including when laws change or new research becomes available. If the Board believes that any revision is necessary, the Board will assign one of its 10 committees to make recommendations, depending on the subject matter. For example, the Victim Advocacy Committee typically becomes involved with revisions related to standards that directly impact victims or potential victims of offenders. The revision process involves multiple committee meetings to obtain testimony from the general public and stakeholder groups, discuss and wordsmith proposed changes, and recommend changes to the full Board. The Board also seeks additional public comment on the proposed changes before voting to approve final revisions. Board members and staff communicate changes to providers and other stakeholders through email, word of mouth, trainings, and the Board's website.

WHAT AUDIT WORK WAS PERFORMED, WHAT WAS THE PURPOSE, AND HOW WERE THE RESULTS MEASURED?

We reviewed statutes, Board Standards, and *Standards for Internal Control in the Federal Government*, and interviewed Board members and staff within the Division of Criminal Justice (Division). Additionally, we reviewed the five most recent standards revisions, as of April 2019, which the Board ratified from February 2018 through April 2019, along with the associated Board and committee meeting materials and minutes. The revisions we reviewed changed both the Adult and Juvenile Standards and involved multiple Board committees, including the Adult Standards Revisions Committee, Juvenile Standards Revisions Committee, Victims Advocacy Committee, and Best Practices Committee.

The purpose of the audit work was to evaluate the Board's controls for complying with the following statutory requirements in setting and revising its standards.

EVIDENCE-BASED STANDARDS. The General Assembly declared in 2011, when it updated statutes through the passage of House Bill 11-1138, that to protect the public and work toward the elimination of sexual offenses, it was necessary to create the Board. Statute charges the Board with establishing "evidence-based standards for the evaluation, identification, treatment, management, and monitoring of" adults and juveniles who have committed sexual offenses [Sections 16-11.7-101(1) and (2), C.R.S.]. There are also several specific statutory provisions and other requirements related to the use of research and/or evidence-based correctional models, as follows:

- **EVALUATION AND IDENTIFICATION.** Board Standards for evaluating and identifying sex offenders must be "based upon *existing research* and shall incorporate the concepts of the risk-need-responsivity or another *evidence-based* correctional model" [Sections 16-11.7-103(4)(a)(I) and (4)(i), C.R.S.]. [Emphasis added.]

- **TREATMENT.** Board Standards for treating sex offenders must incorporate "the concepts of the risk-need-responsivity or another *evidence-based* correctional model" [Sections 16-11.7-103(4)(b)(I) and (4)(j)(I), C.R.S.]. [Emphasis added.]

According to Board members and the Board's 2019 *Annual Legislative Report*, case law and guidance published by professional organizations, combined with scientific research, provide evidence that informs the Board Standards. Both the Adult and Juvenile Standards contain footnotes citing specific sources of evidence.

QUALITY OF EVIDENCE. The Board has established an expectation that any research being considered as support for the Board Standards be assessed for the strength and reliability of the research methods used. In its 2016 *Annual Legislative Report*, the Board stated that considering the strength of research is important because not all research is

conducted according to methodologies that have the same quality and reliability and, according to the Board, using the most reliable research methods is essential in identifying interventions that are effective in reducing the risk of reoffending. The Board has adopted a hierarchy to evaluate the strength and reliability of evidence from different types of research. For example, according to the hierarchy, evidence from a systematic review or randomized control study is stronger than evidence based on an expert opinion.

REVISIONS OF BOARD STANDARDS. To facilitate the process for revising the Board Standards, the Board is required to establish a committee to make recommendations to the Board that is composed of at least 80 percent approved treatment providers [Sections 16-11.7-103(4)(b)(II) and (4)(j)(II), C.R.S.]. According to Board members and staff, the Best Practices Committee has been designated as the committee responsible for fulfilling this statutory requirement.

Additionally, the Board's written guidance, *Creating & Updating Standards & Guidelines for the Management, Treatment and Supervision of Sex Offenders*, states that once a revision has been assigned to a committee, Board staff conduct a literature review to gather research on evidence-based practices and data related to the topic of the revisions. Staff present their findings from the literature review to the committee, so that the committee may use the information to inform proposed changes. According to Division management, the research presentation sets the foundation of the revisions process and should be documented in committee meeting minutes.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND WHY DID THESE PROBLEMS OCCUR?

We could not verify that all of the Board's relevant standards are supported by evidence-based correctional models and found that the Board lacks controls to ensure that it consistently considers evidence as a basis for standards, evaluates the quality of evidence it does consider,

and accepts revision recommendations from committees with the membership composition required by statute.

MOST SECTIONS OF THE BOARD STANDARDS DO NOT REFERENCE SUPPORTING EVIDENCE. We reviewed each of the sub-sections of the Adult and Juvenile Standards on evaluating, identifying, and treating offenders to determine which standards included footnotes indicating that they were based on supporting research, case law, or guidance published by professional organizations. For example, Section 2.000 of the Adult Standards contains standards related to sex offense-specific evaluations and is made up of 16 sub-sections (excluding sub-sections related to statutory requirements, which are not based on research). We calculated the percentage of sub-sections that contained at least one citation to evidence and found that, of the 381 sub-sections on evaluating, identifying, and treating offenders, only 18 percent of the sub-sections in the Adult Standards and 11 percent of the sub-sections in the Juvenile Standards cited supporting evidence (excluding sections that contain statutes).

The Board and Division cited three primary reasons that sections of the Board Standards may not cite underlying research or evidence:

- **RESEARCH IS UNAVAILABLE OR INADEQUATE.** For example, staff reported that there is significantly less research on juveniles than on adults who have committed sexual offenses. The Board has taken the position that it is inappropriate to apply adult research to juveniles and, as a result, may not have evidence to support some juvenile standards. Similarly, the Board reported that research on victim impact is limited.

- **THE BOARD MAY CHOOSE NOT TO INCORPORATE AVAILABLE RESEARCH.** Board staff stated that even when new research becomes available that could inform changes to Board Standards, the Board may decide not to revise standards if members cannot reach consensus about the conclusiveness of the research and what aspect of the standards to change. Similarly, the Board might decide not to

incorporate new research that conflicts with other research and principles.

- **THE BOARD HAS DETERMINED THAT SOME REQUIREMENTS AND OTHER CONTENT IN STANDARDS DO NOT NEED TO CITE RESEARCH.** For example, Board members and staff told us that content that establishes procedures, and requirements that are customary for broad professional fields, such as training and continuing education requirements for providers, do not need to be evidence-based.

The Board Standards do not identify, through the use of footnotes or other explanatory information, those sections that do not require supporting evidence due to their procedural nature, or do not reflect current research and why. Without this type of explanation, stakeholders (including providers, offenders, advocacy groups, and the General Assembly) could reasonably assume that all of the Board Standards are based on research and would not have enough information to hold the Board accountable for how it developed requirements in standards.

THE BOARD LACKS DOCUMENTATION THAT ITS REVISION PROCESSES CONSISTENTLY FOLLOW STATUTORY DIRECTION AND BOARD EXPECTATIONS. We reviewed all of the documentation the Division had associated with the five standards revisions the Board ratified from February 2018 through April 2019. We identified problems in the following areas:

- **REVIEW OF EVIDENCE-BASED RESEARCH.** For two of the revisions, neither the minutes nor other documentation (i.e., materials provided to the committee for their meetings) indicated that the committees reviewed research to inform their decision-making process. According to Board and Division staff, the committees were aware of current research when discussing possible revisions, but staff agreed that the minutes should have reflected the committees' consideration of research but did not.

- **EVALUATION OF RESEARCH QUALITY.** For four of the revisions, neither the minutes nor other documentation indicated that the committees assessed the quality of the research using the Board's strength of evidence hierarchy. Board staff told us that the committees did assess the quality of the research using evaluations prepared by Division staff and discussion with staff. However, despite these assertions, the Division was unable to provide documentation to substantiate that these evaluations occurred, and the meeting minutes did not reflect any discussion of the quality of the research.

- **SELECTION OF EVIDENCE.** For four revisions, the meeting minutes did not document how the committee determined which evidence to incorporate into or exclude from the revisions. Board staff agreed that the meeting minutes should, but did not, include this information.

- **BEST PRACTICES COMMITTEE REVIEW.** For two revisions, the Division did not provide evidence that the Best Practices Committee reviewed the proposed revisions in order to demonstrate compliance with statute. According to Board staff, the Board has not required the Best Practices Committee to make recommendations or have in-depth or consistent involvement in the standards revisions process because other committees made up of subject-matter experts and stakeholders discuss, wordsmith, and reach consensus about detailed changes they want to propose. The Board believes that since, in some cases, the Best Practices Committee does make recommendations and has high-level involvement during the standards revision process, the Board is fulfilling its statutory mandate to ensure that approved treatment providers make up a majority of the committee involved with and making recommendations about revisions to standards. This process may comply with a narrow interpretation of statute but may not accomplish the intent of statute if the General Assembly meant for all revisions to be vetted by approved treatment providers and based primarily on the expertise and viewpoints of providers who have considered relevant research.

We found that, although Board staff reported that the standards revision process is a "robust research-focused" process, the Board lacks comprehensive written policies and procedures to ensure that its processes for working on revisions to the Board Standards adhere to statutory requirements. Key elements that are not addressed in any of the Board's written policies include:

1 How committees should document their deliberations on Board Standards and their determinations of what evidence to use for each relevant standard, including the extent to which meeting minutes should reflect such deliberations and decisions.

2 How committees should apply the Board's evidence hierarchy, including whether some research methods are not acceptable at all and what circumstances the committees should consider if the only available research falls on the low end of the hierarchy.

3 How committees should document that no relevant or reliable research for a standard exists and therefore the standard is not evidence-based, including the extent to which meeting minutes should reflect such determinations.

4 The extent to which meeting minutes should reflect committees' deliberations about specific wording changes to the Board Standards.

5 What types of guidance or requirements in the Board Standards are procedural and therefore do not require supporting research.

6 How the Board Standards should inform readers of which sections are not based on evidence, and why (e.g., they are procedural, no applicable evidence exists, or the Board chose not to incorporate current research).

WHY DO THESE PROBLEMS MATTER?

By not having written policies regarding how it sets and revises Board Standards, the Board is not adhering to statutory requirements designed

to ensure that it operates in a consistent, systematic, and transparent manner or internal control requirements intended to promote efficiency and effectiveness.

Without written policies on establishing or revising Board Standards, the Board does not provide clear, consistent direction to Division and Board staff and members, creating a risk that staff and committee members will not act consistently with one another or with the Board's principles. For example, according to Board staff, at times the viewpoints of Board members can influence what research is included or excluded from the standards. Without written directives on identifying and evaluating the quality of evidence, Board and committee members do not have clear parameters for weighing opinions against facts. Additionally, when there is limited evidence related to a standard or competing interests among stakeholders, written policies and procedures help ensure that the Board makes decisions consistently. The Board agreed with our concerns and provided documentation indicating that a strategic work group has begun addressing these issues.

Further, the lack of written policies and procedures about the membership of committees that recommend revisions may have contributed to the instances we reviewed where such recommendations came from committees that may not have had the statutorily required representation. Finally, written directives can help the Board demonstrate that it follows standardized, objective processes to develop and revise Board Standards that are evidence-based.

Statute enacted in 2018 recognized the importance of state boards having written directives related to their key functions. Specifically, Section 24-3.7-102, C.R.S., requires state boards to implement written policies or bylaws on understanding and operating within the limits of statutory directives and legislative intent, identifying and securing sufficient data to make informed decisions, and ensuring that members act in accordance with their roles as public representatives.

By not establishing written policies specifically requiring documentation of its processes, the Board lacks fundamental internal controls over its

process to develop and revise standards. The Office of the State Controller has directed all state agencies to follow the *Standards for Internal Control in the Federal Government*, which states that an effective internal control system includes (1) documenting key processes and decisions and (2) maintaining information that is complete, appropriate, relevant, and accessible. This information should then be used for decision-making and communicated externally, when appropriate, to help retain organizational knowledge and mitigate the risk of having certain knowledge limited to a few personnel [Principles OV4.08, 3.11, 13, 14, and 15].

Finally, not having policies that require (1) Board and committee meeting minutes to provide robust information and (2) the Board Standards to include explanatory information about which sections do not cite supporting evidence, and why, is inconsistent with the Colorado Sunshine Act, which requires that boards operate transparently and record the proceedings of their meetings in minutes [Sections 24-6-401, et seq., and 24-6-402(2)(d)(I), C.R.S.]. The public transparency contemplated by the Colorado Sunshine Act is one mechanism for holding government entities accountable to the citizens of Colorado. When citizens can see how entities operationalize their statutory duties, they are equipped to ask informed questions, which can help ensure that the entities function in conformity with statutory intent. By omitting explanations about which sections of Board Standards are not based on research, the Board limits the ability of stakeholders, such as the General Assembly, providers, and offenders and their families, to use this accountability mechanism because stakeholders likely have insufficient information to raise questions.

RECOMMENDATION 1

The Sex Offender Management Board (Board), within the Department of Public Safety, should ensure that the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (Adult Standards) and the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (Juvenile Standards) and its process to revise standards align with statutory requirements by:

A Implementing policies and procedures to guide the standards revision process, including (i) how committees should document their consideration of evidence; (ii) how committees should apply the Board's evidence hierarchy when assessing available research, including how they should document that no relevant or reliable research is available; (iii) the extent to which meeting minutes should reflect committees' deliberations about specific wording changes; (iv) which sections of the standards do not require supporting research; and (v) how the standards should inform readers of which sections are not based on evidence and why.

B Based on the policies and procedures implemented in response to PART A, revising the standards to clearly indicate, for each standard, which is evidence-based and which lacks supporting evidence, and why. Revisions could include adding footnotes, an appendix, and/or other explanatory language so readers can easily reference supporting evidence or understand why certain standards are not based on evidence.

C Requiring the Best Practices Committee to have more substantial involvement in every standards revisions process.

RESPONSE

SEX OFFENDER MANAGEMENT BOARD

A AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board wish to extend our thanks to the Office of the State Auditor (OSA) for their work on the audit. The Department and the Board appreciate and recognize the OSA's findings and recommendations, and are fully committed to implementing all of OSA's detailed recommendations. The Department and Board agree with RECOMMENDATION 1 A (i-v).

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to ensure its Standards and the revisions process align with statutory requirements by implementing: (i) how committees should document their consideration of evidence; (ii) how committees should apply the Board's evidence hierarchy when assessing available research, including how they should document that no relevant or reliable research is available; (iii) the extent to which meeting minutes should reflect committees' deliberations about specific wording changes; (iv) which sections of the standards do not require supporting research; and (v) how the standards should inform readers of which sections are not based on evidence and why. The Department has specifically developed an electronic document repository which can house information related to the evidence considered by the Board for public inspection.

B AGREE. IMPLEMENTATION DATE: JUNE 2021.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 1 B, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 1 B.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by June 2021. The Department will work with the Board to ensure its Standards and the revisions process align with statutory requirements. Based on the policies and procedures implemented in response to PART A, the Department and Board will revise the standards to clearly indicate, for each standard, which is evidence-based and which lacks supporting evidence, and why. Revisions could include adding footnotes, an appendix, and/or other explanatory language so readers can easily reference supporting evidence or understand why certain standards are not based on evidence. The Department and the Board expect to have a plan in place and address all Standards revisions prospectively within 6 months, but it is expected that it will take up to a year to retroactively implement this for all existing Standards.

The Department and the Board have implemented a Research-Based Decision-Making Strategic Work Group to ensure the Board's work and decision-making are supported by evidence. This Work Group will take up and ensure that all of these specific OSA recommendations have been made.

C AGREE. IMPLEMENTATION DATE: SEPTEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 1 C, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 1 C.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by September 2020. The Department will work with the Board to ensure its Standards and the revisions process align with statutory requirements. The Department and Board will require the Best Practices Committee to have more substantial involvement in every standards revisions process.

The Department and the Board have identified the Mission/Purpose Alignment Strategic Work Group to ensure that the Board's work process is in alignment with the statute. This Work Group will take up and ensure that this specific OSA recommendation has been addressed. The Work Group has made recommendations to revise the Best Practices Committee process to better align with statute, and the Committee is actively working on its standards revision review process. The process will direct future standards revisions presented to the Board to include specific recommendations from the Committee that will be provided to the Board both through Committee minutes and direct member testimony at Board meetings.

BOARD APPROVAL OF PROVIDERS

In addition to establishing written standards for assessing, evaluating, and treating sex offenders, the Board is responsible for approving all individuals (i.e., treatment providers, evaluators, and polygraph examiners) who provide sex offense-related services to juveniles or adults. Treatment providers are mental health professionals (e.g., psychiatrists, psychologists, clinical social workers, professional counselors) who provide therapy and interventions with the intent to change sexually abusive thoughts and behaviors, and evaluators who conduct systematic collection and analysis of psychological, behavioral, and social information to suggest proper treatment for offenders.

Providers approved by the Board are placed on an Approved Provider List that offenders and state agencies (i.e., the Department of Corrections, Judicial Branch, Division of Criminal Justice, and Department of Human Services) must use when seeking services from these types of providers. In general, all three types of provider applicants must meet statutory and Board requirements regarding their qualifications and credentials, including undergoing background investigations and demonstrating professional competency through assessments and trainings. Individuals apply to be listed on the Approved Provider List under three different service statuses:

- **ASSOCIATE LEVEL PROVIDER.** Providers who are applying for the first time and are still training, or have limited experience, apply at this level. Providers approved at this service status are required to have a clinical supervisor who is responsible for overseeing all clinical work they perform, which can include reviewing treatment plans developed by treatment providers, evaluations conducted by evaluators, or polygraph exams given by polygraph examiners. The initial approval as an associate level provider is good for 1 year; after they complete their first year, providers must apply for renewal every 3 years.

- **FULL OPERATING LEVEL PROVIDER.** Providers at this service status function independently and are not required to have a clinical supervisor. Providers can move up to this status from the associate level when they demonstrate that they meet all Board Standards regarding experience and training, and have the support of their clinical supervisor. Full operating level providers are required to apply for renewal every 3 years.

- **CLINICAL SUPERVISOR.** Providers approved at the full operating level may also apply to provide supervision to associate level providers. Providers apply to renew their approval as clinical supervisors at the same time they apply to renew their full operating level status.

Previously approved providers must apply to the Board if they want to function under a more advanced status or serve a population they are not already approved to serve (e.g., adults, juveniles, specific populations such as persons who have developmental and/or intellectual disabilities).

The Board has delegated responsibility for reviewing and approving provider applications to the Application Review Committee. In accordance with the Board's Administrative Policies, the Application Review Committee can deny approval if it determines that the applicant does not meet required qualifications, is not in compliance with Board Standards, fails to provide all required application materials, exhibits factors which render the applicant unable to treat clients, or fails a required background check. The Board's Administrative Policies allow applicants who are denied by the Application Review Committee to appeal that decision to the full Board.

As of June 2019, there were 300 providers approved to work with adult sex offenders and 239 providers approved to work with juveniles. Among these, 106 providers were approved to work with both populations.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed hard copy applications and electronic data associated with a stratified random sample of 18 providers who were listed on the Board's Approved Provider List as of June 2019. Our sample included nine providers who applied to serve adult sex offenders and nine providers who applied to serve juveniles. We stratified our sample to have equal representation of the three provider types (treatment providers, evaluators, and polygraph examiners). Our review focused on the most recent application submitted by each of the providers in the sample, resulting in our sample containing applications that were submitted between June 2016 and January 2019. We assessed compliance with all relevant provider qualification and application requirements. The providers in our sample included providers who were applying for the first time, renewing their approval, or changing an existing service status (e.g., providers seeking a more advanced service status or providers who serve adult offenders seeking approval to work with juveniles), as shown in EXHIBIT 2.1.

EXHIBIT 2.1. SAMPLE PROVIDER APPLICATIONS	
First-Time Applicants	4
Renewing or Changing Service Status	14
TOTAL	18

SOURCE: Office of the State Auditor analysis of hard copy files and electronic provider data provided by the Division of Criminal Justice in June 2019.

We also reviewed Board Standards, Administrative policies, and related statutes, and we interviewed Board members and staff to understand the Board's processes and controls around provider application approvals.

The purpose of the audit work was to evaluate whether the Board ensures that it approves only providers who meet all statutory and Board requirements.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED AND WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

The Board is required to develop an application and review process that allows the Board to verify applicants' qualifications and credentials, and providers to demonstrate that they are in compliance with Board Standards [Section 16-11.7-106(2)(a), C.R.S.]. We found the Board did not verify all applicable requirements had been met for 13 of the 18 applicants (72 percent), including all four first-time applicants and nine renewal/change applicants. Eight applications had more than one problem.

THE BOARD DID NOT VERIFY FIRST-TIME APPLICANTS' QUALIFICATIONS AND CREDENTIALS. Specifically, for the four first-time applicants in our sample (two treatment providers and two evaluators), the Board did not conduct checks or verification processes in the following areas:

- **REFERENCES.** The Board did not check references for any of the first-time applicants in our sample, although statute directs the Board to "obtain reference…information and recommendations that may be relevant to the applicant's fitness to provide sex-offender-specific…services…" [Section 16-11.7-106(2)(a)(III), C.R.S.] for all applicants. Division staff confirmed that the Board did not obtain or check references for these applicants.

- **COMPETENCY IN PROFESSIONAL STANDARDS AND ETHICS.** The files for these applicants contained no evidence that the Board verified that the applicants demonstrated competency, as required and according to their respective professional standards and ethics, such as those applicable to licensed psychiatrists, psychologists, clinical social workers, or professional counselors [Adult and Juvenile Standards, 4.100(C) and 4.400(B)]. Division staff told us that they verify this area by checking the Department of Regulatory Agencies' (DORA) website to determine if an applicant's license is in good standing and

whether there has been any disciplinary action against the applicant. Division staff stated that the DORA status of the four first-time applicants in our sample were verified by staff; however, the files for these applicants did not contain evidence of such checks, such as print-outs from DORA's website.

- **Clinical supervision agreements.** None of the application files for the four first-time applicants in our sample included complete supervision agreements. Board Standards require providers (i.e., treatment providers and evaluators) applying for initial placement on the Approved Provider List to provide a signed agreement with their clinical supervisor that outlines various items, including the methods the supervisor will employ to assess and develop the applicant's required competencies and the frequency of direct supervision hours the applicant will undergo (ranging from 2 to 4 hours a month). The files for these four applicants contained supervision agreements, but none addressed these requirements. Division staff confirmed that the supervision agreements should have included this information but did not.

The Board did not verify that renewal applicants demonstrated required competencies or had obtained required training. Specifically:

- **Sex offender-specific training.** The files for three of the 12 applicants in our sample who were renewing their approval and were subject to the Board's training requirements [Adult and Juvenile Standards, 4.200(D) and 4.500(C)] lacked evidence that they met all the requirements. Board Standards require treatment providers and evaluators who are applying to renew their associate level status to have completed (1) training on the standards provided by the Board, and (2) a minimum number of specialized training hours on treatment, evaluation, and monitoring of sex offenders as well as on victim impact and recovery. However, the file for one applicant lacked any evidence, such as a training certificate or attendance sheet, that they had completed the Board-provided training, and the files for two other applicants lacked evidence, such as an itemized list of

completed training hours, to indicate that they had completed the required hours of specialized training. Division staff told us that the one provider had completed the Board-provided training but was unable to provide documentation to substantiate it. Division staff agreed that the other two providers did not complete the minimum hours of required specialized training.

- **Example work products.** The files for five of the nine applicants in our sample who were subject to the Board's requirements to provide work products did not contain all of the required products. The Board requires all polygraph examiners, as well as associate level treatment providers and evaluators seeking renewal or changing of their current status, to submit samples of their work products, such as peer-reviewed polygraph exams, offense-specific treatment plans, or sex offender evaluations. For one provider, Division staff said they had submitted a work product but staff were unable to provide documentation that one was submitted with the application we reviewed. Division staff agreed that the other four applicants did not submit work products in accordance with requirements.

The Board did not verify that providers were qualified to serve specialized populations. None of the files for the five providers in our sample seeking Board approval to continue working with sex offenders with developmental/intellectual disabilities or to expand their services to juveniles contained evidence to show the Board verified that the applicants met the following requirements:

- **Competency to serve offenders with developmental/intellectual disabilities (DD/ID).** Of the four applicants in our sample who applied to continue serving offenders with DD/ID, the application files for three did not contain any evidence of the applicants' competency working with that population, as required by Board Standards. Specifically, the application files did not include assessments, narratives, or copies of polygraph exams conducted for offenders with DD/ID to demonstrate competency with the population. Additionally, two of the four applications did not include evidence that the applicants completed 10 hours of training

in serving DD/ID offenders, as required. Division staff agreed that the applicants did not submit the required documentation.

- **EXPAND APPROVED SERVICES.** We found that the Board approved one polygraph examiner in our sample to work with juveniles, even though the examiner did not submit an application. This examiner was already on the Approved Provider List to work with adult offenders, but Board Standards require all providers to submit a new application and undergo the Board's review and approval process if they wish to add services to an existing approval. The Board did not obtain evidence of the applicant's qualifications to work with juveniles, including completion of the minimum number of juvenile polygraph tests, training hours, or peer-reviewed juvenile polygraph exams, nor did the Board assess the provider's professional competency and compliance with the Juvenile Standards before approval.

WHY DID THESE PROBLEMS OCCUR?

BOARD REQUIREMENTS FOR REFERENCES FOR FIRST-TIME APPLICANTS MAY BE TOO NARROWLY WRITTEN OR APPLIED. Division management stated that first-time applicants often have limited professional experience, making it difficult for them to provide references that comply with the statutory requirement to provide references "relevant to the applicant's fitness to provide sex-offender-specific evaluation, treatment, and polygraph services…" [Section 16-11.7-106(2)(a)(III), C.R.S.]. As a result, the Division said that instead of asking first-time applicants to provide references from any source that could offer insights into the applicant's fitness (i.e., academia, professional experiences, internships), the Board disregards this requirement. In such cases, the Board has limited information to assess an applicant's fitness to provide sex offender-specific services. The Board has not considered accepting broader alternative sources as references to comply with the requirement, such as references from other types of employment, academia, or volunteer/community services.

THE BOARD DOES NOT REQUIRE STAFF TO DOCUMENT VERIFICATION THAT FIRST-TIME APPLICANTS MEET ETHICS AND COMPETENCY IN PROFESSIONAL STANDARDS REQUIREMENTS. Board staff state that they utilize DORA's website to verify that applicants are in good standing with DORA, which the Board considers sufficient evidence that the applicants are exhibiting ethics and competency in their professions. However, the Board does not require staff to document that this verification check occurred for any applicant.

THE BOARD LACKS ADEQUATE PROCESSES TO ENSURE THAT STAFF AND THE APPLICATION REVIEW COMMITTEE DOCUMENT THEIR REVIEW AND VERIFICATION OF PROVIDERS' QUALIFICATIONS BEFORE APPROVING APPLICATIONS. According to Division management, staff errors or oversights in tracking documentation that applicants needed to submit led to some of the problems we found with incomplete supervision agreements, the lack of evidence that renewal applicants had completed the minimum training hours, not having appropriate work products on file, and not having evidence that applicants are qualified to work with specific offender populations. Staff are required to document and verify these aspects of the applications and inform the Board when they cannot verify that applicants meet the requirements. However, we could not determine whether staff had checked each application for all requirements or informed the Board of unverified items. We found some evidence of staff and the Committee's review, such as checklists of required qualifications that had been reviewed and notes that cited missing documentation, but these lists did not appear in every file. It was not always clear whether Committee members or Division staff had completed the lists. With respect to the polygraph examiner the Board approved to expand their services to juveniles, Division staff said that the provider had a prior history of being a juvenile polygraph examiner, so the Board did not require an application or conduct any checks of the provider's qualifications to serve juveniles. Staff agreed that there is no provision in Board Standards to allow for this kind of "individualized approach to the provider approval process."

Furthermore, Division management indicated that in some instances the current Board Standards may not be realistic. For example, Board Standards require polygraph examiners to submit three peer-reviewed polygraph exams specific to the population they are applying to serve. However, Division management stated that requiring three exams is likely too high a bar for providers serving juveniles because polygraphs are not required and are not frequently conducted for this population. In this and other instances where applicants do not meet the Board's requirements because the requirements may be unrealistic, and if Division management feel the requirement can be modified or waived without any negative impact, it should work with the Board to modify or remove the requirement.

WHY DO THESE PROBLEMS MATTER?

The highest priority of the Board is to establish standards that maximize community safety through the effective delivery of quality evaluation, treatment, and management of sex offenders. The Board's application and review process is intended to provide assurance that all approved providers have appropriate qualifications to effectively provide services and to help prevent offenders from reoffending.

When the Board does not have a process to ensure that it documents when approved providers are qualified, offenders may not receive the quality of care they need. For example, the Board recognizes, through its standards, that it is important that providers who work with juveniles be qualified to do so, citing research indicating that the responsivity and needs of juveniles are unique from those of adults. By approving the one polygraph examiner in our sample to work with juveniles without requiring an application or checking the provider's qualifications for this population, the Board acted in a manner contradictory to its own standards and undermined its approval process. Similarly, by not verifying the references of first-time applicants who are new to their profession or have the least amount of experience working with sex offenders, there is an increased risk that the Board is approving unqualified providers to offer specialized care to help offenders avoid reoffending.

RECOMMENDATION 2

The Sex Offender Management Board (Board), within the Department of Public Safety, should ensure that it approves only qualified providers to work with sex offenders by:

A Implementing processes, and changing Board policies as needed, to request and check references for first-time applicants to help assess their fitness to provide services. This could include, for example, accepting non-professional references, such as from the applicant's educational institution or community service.

B Requiring staff to document, in the applicant's file, when they rely on work conducted by the Department of Regulatory Agencies (DORA) to satisfy the Board's requirements. As needed, the Board should modify its policies to reflect when and how staff may rely on work conducted by DORA to confirm an applicant met the Board's qualification requirements.

C Implementing processes to ensure that Division staff and the Application Review Committee review and verify applicants' qualifications, and document their completion of this review, prior to approving the applicants for inclusion on the Approved Provider List. This should include verification and documentation of required training, work product examples, evidence of work with specific populations, and completed supervision agreements.

D Implementing a process for the Board and Division to evaluate requirements that may be unrealistic and modifying or removing those requirements as needed.

RESPONSE

SEX OFFENDER MANAGEMENT BOARD

A AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 2 A, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 2 A.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to ensure it only approves qualified providers to work with sex offenders by implementing a process and revising Board policies as needed to request and check references, such as non-professional references, for first-time applicants to assess their qualifications to provide these services.

The Department and the Board have a policy to allow approval of new providers when they first began work in this field. The challenge has been to identify suitable and informative professional references for those new to the field. The Department and Board will work to identify a mechanism to check formal references in such circumstances, including the consideration of general mental health and/or educational references.

B AGREE. IMPLEMENTATION DATE: SEPTEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 2 B, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 2 B.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by

September 2020. The Department will work with the Board to ensure it only approves qualified providers to work with sex offenders by requiring staff to document, in the applicant's file, when they rely on work conducted by DORA to satisfy Board requirements. The Department and Board will also modify Board policies to reflect when and how staff may rely on work conducted by DORA to confirm an applicant met Board qualification requirements.

C AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 2 C, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 2 C.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to ensure it only approves qualified providers to work with sex offenders by implementing processes to ensure that Division staff and the Application Review Committee review and verify applicants' qualifications, and document completion of this review, before approving the applicants for inclusion on the Approved Provider List. This will include verification and documentation of required training, work product, evidence of work with specific populations, and complete supervision agreements.

D AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 2 D, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 2 D.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to

ensure it only approves qualified providers to work with sex offenders by implementing a process for the Board and Division to evaluate requirements that may be unrealistic and modifying or removing those requirements as needed.

COMPLAINTS ALLEGING PROVIDER VIOLATION OF BOARD STANDARDS

The Board is directed, in Section 16-11.7-106(7)(b), C.R.S., to "review and investigate all complaints and grievances concerning compliance with its standards against individuals who [have been approved by the Board to] provide sex-offender-specific treatment, evaluation, or polygraph services." The statutes directing the Board state that while there is no way to ensure that adult offenders will not reoffend, there are "adult sex offenders who can learn to manage unhealthy patterns and learn behaviors that can lessen their risk to society in the course of ongoing treatment, management, and monitoring." As such, the Board is directed to develop and implement methods of intervention for adult sex offenders that "have as a priority the physical and psychological safety of victims and potential victims and which are appropriate to the assessed needs of the particular offender, so long as there is no reduction in the safety of victims and potential victims" [Section 16-117-103(4)(a)(I), C.R.S.]. The statutory direction to review and investigate complaints concerning individuals who provide services to sex offenders is part of the Board's broader responsibility to establish evidence-based standards that these individuals must follow, in addition to an application process they must undergo, to ensure that the services they provide have been designed to help offenders modify their past behaviors, avoid reoffending, and thereby increase protections for victims and potential victims [Section 16-11.7-101(2), C.R.S.].

The Board provides a complaint form on its website, and staff within the Division of Criminal Justice (Division) receive the completed form, which is typically submitted by the offenders but may also be submitted by any other stakeholders, such as offender advocates or other professionals working with the providers and offenders. Division staff review the information provided, and may contact the complainant to obtain additional or clarifying information. Division staff then forward

the complaint to the Board's Application Review Committee, to which the Board has provided authority to review and investigate all complaints alleging a Board-approved provider violated Board Standards. If the committee finds that an allegation has merit, under Section 16-11.7-106(7)(b), C.R.S., the Board is authorized to take any disciplinary action it deems appropriate, including removing the provider from the Board's Approved Provider List. The Board's process for receiving and reviewing complaints is intended to work as an oversight mechanism to help ensure that providers are accountable and operating in accordance with Board Standards.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed statutes, State Controller Policy, Board Administrative Policies, instructions to the public about the Board's complaint process posted on its website and included in Board Standards appendices, and the Division's agreement with the third-party investigator who investigates some complaints. According to information provided by the Board, 97 complaints against providers were filed between January 2015 and July 2019. We requested all of the aggregate data the Board maintained for complaints that were submitted for roughly the most recent 2 years of this period (specifically, between January 2017 and July 2019). This included data on 49 complaints.

We reviewed the aggregate data provided for trends in complaints submitted against specific providers. For complaints the Board received through July 2019, it recorded complaint data in a database staff created that does not include reliable information on the Board's review activities or complaint outcomes. For example, the database does not reliably differentiate between complaints that were determined to be unfounded from complaints where no determination was made, nor does it reliably differentiate between complaints that Board staff screened out through the initial administrative review and complaints that the committee reviewed and determined did not sufficiently allege a standards violation. As such, we could not assess the Board's review

and investigation process in aggregate. Instead, we selected 13 complaints, submitted from January 2017 through July 2019, and reviewed all the documentation the Board had for each. The 13 complaints included three that were submitted anonymously and 10 that we selected by random sample.

In addition, we attended one Administrative Review Committee meeting to observe the committee's handling of complaints, and we interviewed Board members and Division staff about their roles in the complaint review process. We also received feedback from stakeholders about their experiences with the Board's complaint process.

The purpose of the audit work was to evaluate whether the Board's process for handling complaints alleging violations of Board Standards complies with statutory requirements and meets standards regarding the effective design and implementation of internal controls.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

The Board must investigate complaints against providers. Statute requires the Board to "investigate *all* complaints and grievances concerning compliance with its standards against individuals who provide sex-offender-specific treatment, evaluation, or polygraph services" [Section 16-11.7-106(7)(b), C.R.S.]. [Emphasis added.]

The Board's Administrative Policies, which are included in the appendices of the Board Standards, operationalize the statutory requirement by charging the Application Review Committee with handling complaints that "sufficiently allege a Standards violation" by a provider. The policy does not define what constitutes a sufficient allegation, but Board members and Division staff stated that a complaint is sufficiently alleged if it is (1) against a Board-approved provider and (2) identifies and describes how the provider's behavior violated a specific Board Standard. The Board's policies further state that the committee may take one or more of the following actions on sufficiently alleged complaints:

- Ask the complainant and/or the provider for additional information.
- Seek resolution through an agreement between the committee and the provider.
- Request both parties to appear before the committee.
- Investigate the complaint.
- Deem a complaint unfounded and notify both parties of this disposition.

The committee should have and use quality information to make decisions. State Controller policy requires all executive branch agencies to follow the *Standards for Internal Control in the Federal Government* (Green Book). Organizations implement internal controls to help them achieve their objectives and to ensure compliance with state law [Section 24-17-102, C.R.S.]. The Board's legal responsibilities include managing complaints against providers. We applied Green Book principles related to the use of quality information in evaluating the Board's complaint processes. Green Book Principles 13.01, et seq., state that entities should:

1 Identify their information requirements.

2 Obtain quality information, which is defined as being relevant, appropriate, and complete.

3 Use quality information to make informed decisions.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND WHY DID THESE PROBLEMS OCCUR?

We found some instances in which the Board did not comply with the statutory requirement to investigate all complaints and some instances in which the Application Review Committee did not clearly follow the

Board's complaint policy. We also found that the Board lacks internal controls related to its complaint process.

THE BOARD TOOK NO ACTION ON ANONYMOUS COMPLAINTS. The Board stated that it considers complaints submitted anonymously to be unacceptable, in part because it cannot seek additional information from unidentified complainants. However, we found that two of the complaints submitted anonymously during the period we reviewed met the standards articulated to us by staff and the Board as being sufficiently alleged. Both clearly identified the Board-approved provider and described how the provider's behavior violated specific Board Standards. For example, one complaint alleged that the provider did not adequately account for an offender's developmental disability and this resulted in the offender performing poorly in treatment and the revocation of his probation. This complaint included sufficient information for the committee to have conducted follow-up work with the provider, and the offenders receiving treatment from the provider, to assess the merits of the allegation.

The Board stated that it does not accept anonymous complaints because it believes doing so could result in an increase in total submissions, making it difficult to manage the increased workload, and would likely lead to an increase in frivolous complaints. Some Board members stated that they believe there have been instances of offenders making frivolous and unsupported allegations against providers to retaliate when the offender does not like the provider or the provider's assessments about the offender's treatment needs or progress, although the Board did not provide evidence to substantiate that this occurs. However, statutes charge the Board with investigating all complaints and do not include a provision that allows the Board to require contact information from the complainant.

THE COMMITTEE DID NOT TAKE ANY OF THE COMPLAINT-RELATED ACTIONS DESCRIBED IN THE BOARD'S POLICY ON TWO COMPLAINTS. For the 10 complaints in our sample that were not anonymous, the Board took no action on two that, according to the Board, did not "sufficiently allege" a standards violation. However, we found both complaints met

the criteria described to us by the Board and staff of being (1) against a Board-approved provider and (2) describing how the provider's behavior violated a specific Board Standard. These complaints identified the complainants and their contact information, but the committee took no further action, such as requesting further information from the complainant to make the allegations more "sufficient" in the Board's estimation. Rather, the Board sent both complainants a form letter stating the complaints had been dismissed and could not be appealed because the allegation was not sufficient; however, neither letter provided any further information on what, specifically, was lacking.

The Board's policy allows committee members to dismiss a complaint that "fails to allege a Standards violation sufficiently" without conducting any further review, but does not explain what constitutes a "sufficient" allegation. The policy also does not require the committee to provide complainants information about what was missing from their complaint nor any opportunity to submit additional information about the complaint to address sufficiency issues.

THE COMMITTEE LACKED QUALITY INFORMATION TO MAKE DETERMINATIONS ON TWO COMPLAINTS. For the 10 complaints in our sample that were not anonymous, we found that two lacked quality information on which the committee could conclude. Specifically:

- One complaint alleged that a provider was often unprofessional and domineering, in violation of Board Standards that specify how a provider should conduct themselves when interacting with the offenders to whom they provide services. The complainant specified one example where the provider "snapped his fingers at me as if I were a dog" when the provider wanted the offender to sign a form. The committee dismissed the complaint without requesting any additional information from any source to gain a fuller understanding of the alleged violation and assess whether the provider's behavior aligned with standards on conduct and professionalism. Specifically, the committee never contacted the complainant to ask whether there were other instances of

unprofessional conduct, never surveyed other offenders or the provider's colleagues about their experience with the provider, and never requested or reviewed the provider's written case notes, which must include an ongoing record of the provider's interactions with, and conclusions about, the services provided to the offender.

- Another complaint alleged that a provider was "extremely unempathetic, forceful and confrontational," in violation of Board Standards that specify how a provider should conduct themselves when interacting with the offenders to whom they provide services. The complainant specified that the provider's "mannerisms and choice of words are often intimidating." The committee made one request for more information from the complainant in this case, but when the complainant did not respond, it dismissed the complaint after about 3 months without attempting to contact the complainant again. The committee cannot be held responsible if a complainant is unresponsive, but could be more thorough if it implemented a practice of making more than a single attempt to contact a complainant and pursuing other efforts to investigate complaints, such as requesting corroborating information from other offenders or speaking to the provider's colleagues.

In both of these instances, the Board appeared to have very limited information on which it based its conclusions. In contrast, for at least one other complaint about a provider's personal conduct towards an offender, we saw evidence in the complaint file that the committee obtained and considered information from both the complainant and the provider, as well as offenders other than the complainant, to inform its conclusions.

Additionally, for all 13 complaints we reviewed, the files lacked information about the rationale the committee used to reach its conclusions about the merits of the allegations. Specifically, we saw one and two-sentence notes in sections of some of the files that were hand-written by committee members, but the Board maintained no other documentation and thus had no evidence that a comprehensive review had been conducted or how the complaint determination was reached.

THE BOARD'S COMPLAINT POLICIES LACK GUIDANCE TO ENSURE THAT COMPLAINTS ARE TREATED IN A MANNER THAT IS CONSISTENT, TRANSPARENT, AND IN ALIGNMENT WITH STATUTE. We identified the following problems with the Board's policy related to complaints against providers:

- The policy requires Division staff to review all complaints, and allows staff to screen out those they determine are improper or contain insufficient information without any guidance to use in their review. Specifically, the policy provides no direction on what would be considered a complaint that has not been completed properly or what information is needed to determine if a complaint is sufficient.

- The policy does not delineate a logical sequence of activities that would help ensure that the Board adheres to its statutory mandate to review and investigate all complaints. The policy allows the committee complete discretion in handling complaints it deems "sufficiently alleged," allowing the committee to take any of a list of actions without guidance to promote consistent and equitable handling of complaints. Specifically, the policy states that the committee's "review of the complaint may take *any* [emphasis added] of the following actions" listed in the following order: (1) determine the complaint unfounded, (2) request clarifying information from the complainant and/or provider, (3) contact the provider to seek informal resolution between the provider and the Board, (4) request both the complainant and provider appear before the committee, and (5) conduct an investigation of the complaint. Board members and Division staff told us that, in practice, any of these five actions constitute an "investigation," but the written policy appears to indicate that investigation is only one of five possible steps in the process. Furthermore, the Board's written policy lacks guidance on the type and amount of information needed to make a determination on a complaint, what would prompt an investigation, and what an investigation should entail.

- The policy provision to seek informal resolution between the provider and the Board excludes the complainant from the Board's

process to identify the terms of mutual agreements. The policy states that the Board will "contact the identified provider to determine if the complaint can be resolved informally through mutual agreement between the identified provider and the ARC [Application Review Committee]." The policy goes on to say that "[t]he complainant will be notified verbally of the mutual agreement." This provision indicates that the Board does not actively engage complainants in its process until *after* the Board has already reviewed the complaint and negotiated the terms of a mutual agreement with the provider. As a result, the Board's policy creates the appearance that these agreements are based primarily on input from the provider and are not derived from a mutual process involving both the complainant and provider.

Board members and Division staff stated that, although the written policy excludes the complainant from negotiating the terms of mutual agreements, they believe that, in practice, they always include complainants in this process. However, the file for one complaint in our sample that resulted in a mutual agreement did not contain evidence that the complainants were involved with negotiating the terms of the mutual agreement. In this instance, the complaint was submitted in May 2018, and the Board's complaint file contains documentation of multiple emails and notes of conversations between the provider and a Board member and staff through the month of June. In contrast, the Board could not provide any evidence to indicate that the complainants were also contacted to discuss a potential mutual agreement or the terms of such an agreement during that time period. Rather, the Board's documentation shows that the complainants were first contacted on July 3, via an email from a Board member to the complainants to "provide an update" and summarize "what ARC [Application Review Committee] decided to do." The July 3, 2018, email from the Board member to the complainants described the agreement terms the Board and the provider had discussed. The Board member's email to the complainants asked, "Are you willing to go this route?" and one complainant responded to say they trusted the Board's decision but

that allowing the provider to potentially continue serving sex offenders was "a tough pill to swallow." The only evidence of the Board soliciting the complainants' desired outcome was on the initial complaint form, where a complainant stated that their only desire was that the provider never be allowed to provide sex offense specific services again.

The Board stated to us that it disagrees with our conclusions about the Board's involvement of the complainants in its mutual agreement process, because the Board believes that these complainants were involved in the process of negotiating the terms of the mutual agreement and had been asked to give their consent. However, in this instance the complainants' response indicated they believed the decision had already been made, which aligns with the Board's written policy stating that the Board will identify agreement terms and then notify the complainant, and there is no evidence the complainants were contacted while the committee reviewed the complaint. Not involving the complainants in the process earlier creates the perception that the Board developed the agreement based only on additional input they sought from the provider.

- The policy allows for a complaint resolved through agreement to be deemed unfounded, which seems inconsistent with the need for an agreement under which the provider will take some type of corrective action.

  The Board stated that the mutual agreement process is intended to encourage providers to voluntarily address problematic or substandard practices. According to the Board's written policy, when a provider agrees to take corrective action, the complaint "will be determined to be unfounded" and "no formal actions will appear on file" regarding the complaint. Board members stated this helps providers avoid adverse effects associated with having founded complaints on their records, such as higher insurance premiums. However, the Board's approach undermines the basic purpose of having a formal complaints process, which should allow any interested parties to easily track and understand how the Board

addresses problematic or substandard behaviors among providers. The Board acknowledged that altering its process so that the public was made aware of a provider's standards violations could make the process more transparent. To ensure that the public is fully informed of a provider's problematic behaviors, the Board could consider complaints resolved by mutual agreement to be neither founded nor unfounded, yet still develop a process to make the public aware of what violations of Board Standards were resolved through mutual agreement.

- The policy provision to ask parties to appear before the Application Review Committee includes no guidance on the circumstances under which this action would be appropriate, the purpose of such an appearance, or the procedures to be followed when the appearance occurs. The policy implies that the goal of having the parties appear is to reach some kind of agreement, but it does not specify what an agreement might contain.

- The policy does not include any requirements for staff or the Application Review Committee to document their review and decision-making processes, including the rationale for final determinations (such as to screen out or dismiss a complaint, or to remove a provider from the Approved Provider List). The Board purchased a new data management system to house all provider information, which it began using in December 2019. The Board reported that the new data system contains historical complaint information, and that the Board is now using the system to document, but not track, new complaint data. The Board reported using a Word document to document complaint information until it can fully integrate functionality to track complaint information into the new database. Additionally, the Board reported to us that in October 2019, after we noted the issue with a lack of documentation of the committee's review activities, the committee began documenting more extensive notes in the complaint files regarding its rationale for its findings. However, as of April 2020, the Board had not updated its policy to include any requirements or guidance

regarding documenting complaint review activities and decision making processes.

WHY DO THESE PROBLEMS MATTER?

Overall, the problems we identified in the Board's complaint process limit the effectiveness of the process in accomplishing its primary intent—to ensure that approved providers follow the evidence-based standards set by the Board. Weaknesses in the complaints process, in turn, undermine the Board's broader statutory purpose. According to statute, the General Assembly created the Board to establish standards that providers must follow, with the overriding goal of "prevent[ing] offenders from reoffending and enhance[ing] the protection of victims and potential victims" [Sections 16-11.7-101(1) and (2), C.R.S.].

NOT ACCEPTING ANONYMOUS COMPLAINTS COULD DISSUADE OFFENDERS AND THEIR ADVOCATES FROM BRINGING STANDARDS VIOLATIONS BEFORE THE BOARD. Choosing not to accept anonymous complaints violates the statutory mandate to investigate all complaints. Further, there is a risk that offenders with legitimate concerns about their providers' services may be reluctant to file complaints for fear of retaliation, which could prevent the Board from obtaining and assessing information to hold providers accountable to the standards it has established. Over the course of the audit, offender advocates contacted us and stated that they believe the current complaint process can leave offenders vulnerable to retaliation from providers, including, for example, that providers could falsely conclude an offender who has submitted a complaint has made poor progress in treatment, thereby affecting the offender's sentencing sanctions or parole.

In contrast, some Board members and staff stated that it would be high risk for the Board to accept anonymous complaints because doing so could provide offenders seeking to misuse the process an avenue for harassing providers they do not like, or who have made assessments the offender does not like, which could potentially push providers out of a field that Board members and staff have reported already faces shortages. Board members believe that community safety, the Board's

core priority, would not be served if the Board and its staff were required to address complaints that exhibited the patterns of misuse the Board states that it sees from certain offenders regularly. However, the Board also receives complaints from an array of stakeholders, including providers and criminal justice professionals, and these stakeholders could have legitimate reasons for relying on an anonymous complaint process. The Board could more effectively fulfill its responsibility to ensure that offenders do not receive services from a provider unless the services conform to Board Standards [Section 16-11.7-103, C.R.S.] by accepting all complaints that include sufficient information to allow investigation, rather than refusing all complaints where the complainant wishes to be anonymous.

By choosing not to investigate anonymous complaints, the Application Review Committee discounts information that might identify problematic provider behavior, thereby hindering the Board's efforts to fulfill its statutory duty to ensure that its approved providers are operating in conformance with Board Standards. Board staff noted that information from anonymous complaints could be considered grounds for a general Standards Compliance Review of the approved provider, although when we requested an example, staff told us that the Board had not yet conducted this type of review to address allegations submitted by an anonymous complainant. In addition, staff stated that these reviews are focused on the provider's overall compliance with Board Standards and would not necessarily address the anonymous complainant's concern directly. As described in RECOMMENDATION 2, the deficiencies in the Board's vetting processes for approving providers makes it all the more important that the Board leverage its complaint process to monitor, assess, and assist in ensuring that providers operate in a manner that complies with Board Standards.

UNCLEAR POLICIES CAN UNDERMINE THE EFFECTIVENESS OF THE COMPLAINTS PROCESS. When the Board does not define the standard it uses to review and investigate complaints, it risks erroneously dismissing complaints that deserve substantive review and investigation. Further, when policies are unclear, there is the significant potential that

different people will interpret and apply those policies in different ways. For example, without defining what information is needed to meet the threshold "sufficiently alleged," committee members could review complaints that provide the same amount and type of information but erroneously screen out some complaints for further review while other complaints are screened in. Our audit work identified instances that pointed to both of these problems, with the Board lacking quality information to make a determination or dismissing a complaint as not being sufficiently alleged in three of the 10 cases we reviewed.

Not requiring under policy that decision-making is documented impedes transparency of the complaint process. Because of the sparse documentation of the staff's and committee's handling of complaints (such as a brief handwritten note, and form letters dismissing complaints as insufficiently alleged without specifying what was missing, as we observed in several files we reviewed) we were unable to conclude on the extent to which the process results in sound and consistent reasoning to support decisions. The lack of specific requirements around documentation contributes to the problems we identified because it allows each staff and committee member wide leeway in determining how much or little documentation, including documentation of deliberations and thought processes, must be included in the files.

THE BOARD'S COMPLAINT PROCESS AND POLICIES MAY BE SEEN AS SUBJECTIVE. A number of the problems we found with the Board's complaint policies appear to exclude or dismiss a complainant's perspective from the process, which increases the potential for complaints to be assessed inconsistently or inequitably. Since the Board is the body responsible for dealing with complaints as part of its larger duty to ensure that approved providers follow Board Standards, policies that could be read as favoring one party to a complaint can undermine the Board's credibility. Specifically, we identified the following policies as conveying an inclination to assume that complaints are groundless, particularly when read in combination:

1 The policy to allow complaints deemed insufficient by the staff or Application Review Committee to be dismissed without any attempt to gather sufficient information.

2 The policy to consider any complaint unfounded if an agreement is reached between the provider and the Board.

3 The policy to prohibit complainants from appealing a committee decision that a complaint is insufficiently alleged.

4 The policy language that implies that dismissal is the first step in the process.

The Board and staff told us that the policies are intended to be fair and objective and the wording does not imply any bias, but a plain reading of these policies may lead to a misunderstanding of the Board's neutrality with respect to complaints. Further, the Board's dismissal of five complaints in our sample without obtaining any information beyond the complaint itself and the practice of disregarding anonymous complaints underscore the appearance of subjectivity. Additionally, to the extent that staff or the Board strictly adhere to the policies listed previously, there is an increased risk that they may treat complaints inequitably.

RECOMMENDATION 3

The Sex Offender Management Board (Board), within the Department of Public Safety, should strengthen its complaints handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to:

A Accept anonymous complaints and carry out review or investigative actions to the extent such complaints contain sufficient information to do so. Alternatively, if the Board believes that no anonymous complaints should be addressed and does not agree to change its policy to include these complaints, it should seek statutory change to exempt the Board from this responsibility.

B Define or explain what constitutes a complaint that: (i) has not been completed properly or does not contain sufficient information, to guide staff's initial review of complaints, and (ii) sufficiently alleges a standards violation, to guide the Application Review Committee in its early review process.

C In instances when a complaint is deemed to have insufficient information, notify complainants and allow them the opportunity to provide additional information prior to dismissal.

D Include guidance on the minimum type and amount of information the Application Review Committee should obtain to come to a determination on a complaint.

E Establish a clear sequence of steps the Application Review Committee must follow in managing complaints, as well as any activities the committee may take at its discretion.

F Specify (i) that all parties must be involved in negotiating the terms of a mutual agreement (i.e., the complainant, provider, and Board); (ii) the circumstances that would prompt an effort to resolve a complaint through agreement; (iii) what information mutual agreements should contain, such as the types of corrective actions

that might be suitable for an agreement; and (iv) how the public will be made aware of a provider's standards violations and the action taken to correct these violations.

G Require staff and committee members to document their activities in dealing with complaints, including the basis for decisions and actions such as dismissing a complaint, seeking a resolution through agreement, and how the terms of an agreement address a provider's lack of compliance with the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (Adult Standards) or the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (Juvenile Standards).

RESPONSE

SEX OFFENDER MANAGEMENT BOARD

A AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 3 A, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 3 A.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to strengthen its complaint handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to accept anonymous complaints and carry out review and investigative activities to the extent such complaints contact sufficient information to do so.

The Department and the Board have previously enacted a formal written policy to exclude anonymous complaints based on these complaints typically lacking sufficient information, including the potential to gather follow-up information from the complainant, to make a finding in these cases. The Department and the Board have had the option of engaging the provider in a Standards Compliance Review to verify the provider's compliance with Standards in lieu of a founded complaint. The Department and Board will change this policy, accept anonymous complaints, and identify written criteria for sufficient information to determine a founded complaint.

B AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 3 B, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 3 B (i-ii).

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to strengthen its complaint handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to define or explain what constitutes a complaint that has not been completed properly or does not contain sufficient information in order to guide staff initial review of the complaint (i), and sufficiently alleges a standard violation to guide the Application Review Committee in its early review process (ii).

C AGREE. IMPLEMENTATION DATE: SEPTEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 3 C, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 3 C.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by September 2020. The Department will work with the Board to strengthen its complaint handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to, in instances when a complaint is deemed to have insufficient information, notify complainants and allow them the opportunity to provide additional information prior to dismissal.

While the Department and Board currently takes initial steps to ensure that complainants have the opportunity to provide additional information, the written policies will be adjusted to note specific requirements for the submission of additional information and potential outcomes when no such information is provided, including the possibility of dismissal. The Department and Board will work to implement revised written policies to identify when a complaint is deemed to have insufficient information, notify complaints, and allow for the provision of additional information prior to dismissal.

D AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 3 D, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 3 D.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to strengthen its complaint handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to include guidance on the minimum type and amount of information the Committee should obtain to come to a determination on a complaint.

E AGREE. IMPLEMENTATION DATE: SEPTEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 3 E, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 3 E.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by September 2020. The Department will work with the Board to strengthen its complaint handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to establish a clear sequence of steps the Committee must follow in managing complaints as well as any activities the Committee may take at its discretion.

The Department and Board have begun implementing changes to its written policies and procedures related to the review of complaints including the steps taken in the review and investigation. While there is information contained in the Administrative Policies, it was not clear what constituted an investigation and work is being done to clarify this process. The Department will work with the Board to revise written policies and procedures for reviewing and investigating complaints to establish a clear sequence of steps the Committee must follow in managing complaints as well as any activities the Committee may take at its discretion.

F AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 3 F, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 3 F (i-iv).

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by December 2020. The Department will work with the Board to

strengthen its complaint handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to specify that all parties must be involved in negotiating the terms of a mutual agreement (i.e., the complainant, provider, and Board) (i); the circumstances that would prompt an effort to resolve a complaint through agreement (ii); what information mutual agreements should contain, such as the types of corrective actions that might be suitable for an agreement (iii); and how the public will be made aware of a provider's standards violations and the action taken to correct these violations (iv).

The Department and the Board have deployed the use of a mutual agreement resolution for a complaint in the way identified by the Recommendation (i) on a number of occasions, but recognizes and agrees the written policy needs to be revised to clearly identify this process. The Department and Board will work on this Recommendation as described.

G AGREE. IMPLEMENTATION DATE: SEPTEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 3 G, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 3 G.

The Department and the Board have begun and will continue to work on this Recommendation with full implementation by September 2020. The Department will work with the Board to strengthen its complaint handling process to comply with statute and implement adequate controls to ensure fairness and consistency by implementing revised written policies to require staff and Committee members to document their activities in dealing with complaints, seeking a resolution through agreement, and how the terms of an agreement address a provider's lack of compliance with Board Standards.

The Department has already begun to implement changes to its documentation of the Board's work related to the review of complaints including keeping written notes and outcomes of each step in the process, and more fully documenting complaint outcomes in the findings letters. The Department will work with the Board to revise written policies and procedures to require staff and Committee members to document their activities in dealing with complaints, seeking a resolution through agreement, and how the terms of an agreement address a provider's lack of compliance with Board Standards.

CHAPTER 3
TRANSPARENCY AND ACCOUNTABILITY

Given the Sex Offender Management Board's (Board) wide-ranging authority to influence how sex offenders are identified, treated, and managed, it is important that the Board operate in a manner that is transparent and accountable to the people of Colorado. Stakeholders should be able to easily understand how the Board fulfills its statutory duties, which can affect both offenders in the criminal justice system and the safety of victims and potential victims. This chapter discusses deficiencies we identified with the transparency and accountability of the Board's operations. Our recommendations are intended to improve how

the Board identifies and mitigates conflicts of interest among its members, develops recommendations for funding allocations from the Sex Offender Surcharge Fund, and documents decisions made during Board and committee meetings.

BOARD MEMBER CONFLICTS OF INTEREST

According to the General Assembly, the Board is "one of Colorado's most important resources on the treatment and management of adult sex offenders and juveniles who have committed sexual offenses," and was created with a goal of preventing offenders from reoffending and enhancing the protection of victims and potential victims [Sections 16-11.7-109(1)(a)(I) and 101, C.R.S.]. To advance this goal, statute charges the Board with several key duties, including, among others:

- Establishing evidence-based standards for the identification, evaluation, treatment, management, and monitoring of offenders, which must be followed by all individuals or entities that provide these services in Colorado [Sections 16-11.7-103(4)(a), (b), (i), (j), (k), and 106(1), C.R.S.].

- Approving individuals (i.e., treatment providers, evaluators, and polygraph examiners) who provide sex offense-related services to offenders [Section 16-11.7-106(1), C.R.S.].

- Reviewing and investigating complaints concerning compliance with standards made against individuals who provide sex offense-related services [Section 16-11.7-106(7)(b), C.R.S.].

The Board comprises 25 members who are, collectively, intended to provide a balance of expertise in adult and juvenile issues relating to persons who commit sex offenses [Section 16-11.7-103(1), C.R.S.]. The Board's membership, prescribed in statute, includes individuals who may have private interests or relationships in the arena of treating sex offenders. Specifically, the Board includes representatives of:

- Private entities that provide evaluation or treatment of sex offenders and have expertise in those areas (e.g., providers of out-of-home placement services, licensed mental health professionals, and a clinical polygraph examiner); recognized experts in the field of sexual abuse and who can represent sexual abuse victims and victims' rights organizations; and a private criminal defense attorney.

- Public entities that are responsible for overseeing the treatment of sex offenders, including representatives of state and local government agencies that deal with sex offenders (e.g., judicial, corrections, human services, youth services, criminal justice, county human or social services, county commissioners), and the judicial and law enforcement systems (e.g., district court and juvenile courts, public defender, prosecuting attorney).

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed statutes, Board bylaws, and the Board's conflicts of interest policies to determine ethical requirements that apply to Board members. In addition, we analyzed vendor and expense data in the Colorado Operations Resource Engine (CORE), the State's accounting system; state contract documentation; Board members' annual conflicts of interest disclosure forms; aggregate data on providers who serve sex offenders (e.g., mental health professionals, polygraph examiners) and complaints against approved providers; and minutes from the Board's Application Review Committee for 11 meetings that occurred during Calendar Year 2018. We also analyzed Board members' votes on the five most recent revisions to the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (Adult Standards) and the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles Who Have Committed Sexual Offenses* (Juvenile Standards). Collectively, we refer to the Adult Standards and Juvenile Standards as "the Board's standards" or "Board Standards." We analyzed votes on revisions to Board Standards ratified between

February 2018 and April 2019. Finally, we interviewed Board members and staff within the Division of Criminal Justice and Attorney General's Office.

The purpose of the audit work was to evaluate whether the Board has adequate processes and controls to identify and mitigate actual or perceived conflicts of interest among Board members.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Overall, we assessed the extent to which the Board adheres to ethical standards intended to help ensure Board members fulfill the public trust placed in them and carry out their duties for the benefit of the people of the state. Specifically, we evaluated Board members' compliance with expectations that they avoid taking official action in situations where they have conflicts of interest. These expectations are reflected in the following statutory and policy provisions:

- Section 24-18-108.5(2), C.R.S., prohibits members of uncompensated boards, including members of the Sex Offender Management Board, from performing official acts that could have a direct economic benefit on a business or other undertaking in which they have a direct or substantial financial interest. Statute defines "official act" or "official action" as "any vote, decision, recommendation, approval, disapproval, or other action…which involves the use of discretionary authority" [Section 24-18-102(7), C.R.S.] and "financial interest" as including ownership, directorship, or officership in a business, or employment or prospective employment [Sections 24-18-102(4)(a), (c), and (f), C.R.S.].

- The Board's bylaws in place during the period reviewed by the audit required Board members to disclose conflicts or appearances of conflict during meetings, and abstain from discussing, making a motion, seconding a motion, or voting on issues with which they had a conflict.

In September 2019, the Board adopted an expanded conflict of interest policy and disclosure form based on recommendations from an external consultant. The new policy and disclosure form emphasize the expectation that Board members discharge their duties with integrity, honesty, and in keeping with the ethical standards in the State Constitution and statutes. The policy states that its purpose includes: (1) ensuring that the activities of the Board are transparent to the public and (2) protecting the public's interest when the Board contemplates actions that would benefit the private interest of a Board member. It also contains language indicating that Board members should consider the risk of conflicts not only for themselves, but also for their spouses and household members, and that a conflict might exist when the member has privileged information that might influence, or might be reasonably perceived by the public as influencing, their conduct [Section V(1)]. The new policy also specifies that Board members should recuse themselves when any matter with which they have a conflict is to be considered by the Board.

We took into account the bylaws and policies that were in effect during the period we reviewed (February 2018 through June 2019), as well as the new policy implemented in September 2019.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND WHY DO THESE PROBLEMS MATTER?

We could not fully conclude on the extent to which Board members adhered to the expectation that they operate in a manner that fulfills the public trust and benefits the people of the state due to lack of documentation of some of their actions. However, we found indications that nine Board members who were active during our testing period had actual conflicts or situations that created the appearance of a conflict that were not disclosed and did not prevent them from performing official Board actions, as follows:

VOTING TO APPROVE PROVIDERS. Three of the eight Board members who served on the Application Review Committee were owners, directors, or officers of the same businesses that employed individuals whom the Committee approved to be providers during meetings at which the three members were present. The meeting minutes clearly showed that the providers were approved, but the minutes lacked evidence indicating whether these three members disclosed their conflicts, which members were present during each vote, and whether the three members with conflicts abstained from making or seconding motions or voting to approve the providers. Board staff asserted that these three committee members abstained from voting, but they did not provide documentation of any abstentions. As such, we could not definitively confirm which members approved or denied each decision. The lack of documentation regarding individual members' voting positions violates statutory and Board requirements related to open meetings, which we discuss further in RECOMMENDATION 6.

A fourth Board member who served on the Application Review Committee worked for a state agency and was present at meetings when the committee approved providers employed by the same agency. This scenario creates the appearance of a conflict since the statutory definition of "financial interest" also includes employment [Section 24-18-102(4)(c), C.R.S.].

VOTING TO REVISE BOARD STANDARDS. Any Board member who is also an approved sex offender provider may have a conflict when voting on changes to Board Standards, because the standards apply to providers. As of December 2019, eight of the 25 Board members were approved providers and, therefore, had potential conflicts that would have needed to be disclosed and mitigated. Seven of the eight Board members were owners or directors of entities that collectively had millions of dollars in contracts to provide sex offense-related services through state agencies from July 2014 through June 2019. The employment positions of these seven members and the applicable statutory definition of financial interest for each member are shown below in EXHIBIT 3.1. For example, one member is the director of a private counseling agency that

had a $3.5 million contract with the Department of Corrections to provide mental health therapy to adult sex offenders, while another member is the director of a non-profit organization that had a $1 million contract with the Judicial Branch to provide evaluation and mental health treatment services to offenders on probation.

EXHIBIT 3.1. BOARD MEMBERS WITH STATE CONTRACTS

MEMBER	EMPLOYMENT POSITION	APPLICABLE STATUTORY DEFINITION OF FINANCIAL INTEREST[1]
1	Owner of a polygraph business	Ownership interest in a business
2	Owner and president of a polygraph business[2]	Ownership interest in a business
3	Independent contractor who provides counseling services	Ownership interest in a business
4	Executive Director of a non-profit organization that provides therapeutic treatment to children and their families	Directorship or officership in a business[3]
5	Director of a counseling business	Directorship or officership in a business
6	Clinical Director of a business that provides sex offense-related evaluation and treatment services	Directorship or officership in a business
7	Director of a business that provides sex offense-related evaluation and treatment services	Directorship or officership in a business

SOURCE: Office of the State Auditor analysis of Colorado Revised Statutes; contract documentation provided by the Judicial Branch and Departments of Corrections, Human Services, and Public Safety; and websites of the Board members' employing organizations.
[1] Section 24-18-102(4), C.R.S., states that "financial interest" means a substantial interest held by an individual which is: (a) an ownership interest in a business, (b) a creditor interest in an insolvent business, (c) an employment or a prospective employment for which negotiations have begun, (d) an ownership interest in real or personal property, (e) a loan or any other debtor interest, or (f) a directorship or officership in a business.
[2] Section 16-11.7-103(1)(d)(VIII), C.R.S., provides that one clinical polygraph examiner serve on the Board at a given time. Board member No. 2's term began after Board member No. 1 resigned from the Board.
[3] Section 24-18-102(1), C.R.S., defines a "business" as any corporation, limited liability company, partnership, sole proprietorship, trust or foundation, or other individual or organization carrying on a business, whether or not operated for profit.

Between February 2018 and April 2019, the seven Board members who were owners or directors of entities with state contracts voted on changes to Board Standards that could have affected their private financial interests.

- We reviewed minutes of meetings at which 17 votes on standards revisions occurred and found that, for 15 of the 17 votes we reviewed, none of those seven Board members disclosed that they

held state contracts, and they did not abstain from voting on revisions that apply to the types of services they provide. For the other two votes, meeting minutes showed that a Board member with a potential conflict abstained from voting on a standards revision that applied to the type of services they provide. Since the minutes did not include any narrative detail for those two instances, we could not determine why the members abstained from the votes, nor could we confirm whether the members took these voting positions to mitigate conflicts associated with their state contracts.

When members vote on Board Standards that directly affect how they do business as private citizens, there is a risk of their private financial interests (which include ownerships or directorships of businesses, as defined in statute) outweighing their duty to the Board and State. For example, the Board sets standards for how frequently a sex offender must undergo polygraph examinations. If the Board was considering revising the standards to increase the number or frequency of required examinations, Board members who are approved polygraph providers could realize a financial benefit.

OFFICIAL ACTIONS TO INVESTIGATE COMPLAINTS AND TAKE DISCIPLINARY ACTION AGAINST PROVIDERS. Of the eight Board members who serve on the Application Review Committee, six were owners, directors, officers, or employees of the same organizations as 53 providers who were on the Board's Approved Provider List as of June 2019. Conflicts could exist if these Board members take official actions involving providers who work for the same employer. These actions could be perceived as beneficial to the employer, such as voting to renew a provider's approval or to dismiss a complaint against a provider. Conversely, Board members might be more inclined to vote to take action on a complaint against a competing provider, if they both served the same client base. Minutes from committee meetings did not contain evidence that Board members disclosed these conflicts. The Board's complaint data showed that complaints were filed against two of these 53 providers during Calendar Year 2018. However, we could not determine if the Board members with conflicts took official action on

these complaints due to a lack of documentation regarding how the committee handled them. Minutes showed that the Application Review Committee decided one complaint was unfounded, but the committee did not formally ratify this decision through a vote because it lacked a quorum. The Board's database indicated that the other complaint was outside of the Board's purview, and none of the Calendar Year 2018 committee meeting minutes referenced any discussion of the complaint. EXHIBIT 3.2 lists the number of approved providers who work for the same organization as each Board member.

EXHIBIT 3.2. APPLICATION REVIEW COMMITTEE MEMBERS

BOARD MEMBER	NUMBER OF APPROVED PROVIDERS EMPLOYED BY THE SAME ORGANIZATION
1	19
2	16
3	10
4	6
5	1
6	1

SOURCE: Office of the State Auditor analysis of the Board's approved provider data, as of June 2019.

Because Board members are active professionals who reflect a collective balance of expertise in adult and juvenile issues relating to persons who commit sex offenses, it is expected that they may have business connections that are affected by the Board's official acts. Thus, without robust policies and processes around conflicts of interest, members risk acting in a manner that is not fully consistent with ethical requirements. Further, even the appearance of conflicts can affect the credibility of the Board, undermining the value of its work in establishing how the State evaluates, identifies, treats, manages, and monitors sex offenders to prevent recidivism and enhance the protection of victims and potential victims [Section 16-11.7-101, C.R.S.].

WHY DID THESE PROBLEMS OCCUR?

We identified several factors that appear to contribute to the examples we found of Board members taking formal actions when they had a conflict or an appearance of a conflict of interest.

Lack of clarity in some areas of the new policy. We identified areas in which the new policy the Board implemented in September 2019 may be confusing due to a lack of specificity or conflicts with the bylaws, as follows:

- The policy states that Board members are to conform their conduct to the "applicable" requirements of the ethics standards in the State Constitution and statutes, but does not identify which requirements the Board considers applicable to its members. Statute itself more narrowly specifies certain ethics laws that apply to members of state boards. The policy defines an "official act" as any vote, decision, recommendation, approval, disapproval, or other action, including inaction, which involves the use of discretionary authority, but does not define "discretionary authority."

- The policy defines a "conflict of interest" as a situation where a Board member's official action may have an economic benefit on a business or other undertaking in which the member has a financial interest, but does not provide any guidance on what other types of undertakings members should consider.

- The policy defines a "direct economic benefit" as occurring when a Board member or their spouse has a financial interest in any entity which may be affected in a direct and substantial way by the actions of the Board, but does not define "direct" or "substantial." Further, this definition does not fully align with another section of the policy which (1) requires each member to disclose not only financial interests held by them or their spouses, but also by their household members and (2) appears to require a broader disclosure of an interest which might conflict with their duties. Additionally, the policy provides no clarifying guidance to help members identify conflicts that can arise when an entity in which they have a financial interest—not the Board members themselves—might receive an economic benefit from Board actions.

- The bylaws require Board members to abstain from voting when they have a conflict of interest, or *appearance* of a conflict of interest

[Article 6.4], whereas the policy allows members to decide, in their own discretion, whether to recuse themselves when the appearance of a conflict exists [Section VII]. Until December 2019, the bylaws allowed members to answer questions of the Board during discussions regarding topics with which they had a conflict [Article 7.1], while the policy requires Board members to leave the room when recusals occur during deliberations [Section VII]. Clarifying how members should handle participation in Board deliberations and official acts is important because about one-third of the Board members (eight of the 25) are approved providers with expertise intended to inform Board decision-making, yet at the same time those members also have conflicts that need to be appropriately mitigated. In December 2019, the Board revised its bylaws and removed the provisions that conflicted with its policy.

The policy does not reflect the Board's practical interpretation of statutory requirements. The Board disagreed that the examples we found constituted actual or potential conflicts, because their interpretation of definitions referenced in statute and Board policy differ from a plain reading of those concepts. Specifically, although statute and the policy define "financial interest" to include a substantial interest held by an individual such as a directorship or officer position in a business, the Board does not believe this definition applies, for example, to a member who is the Executive Director of an organization that serves sex offenders. Similarly, the Board does not consider votes that change Board Standards to be official acts that members with a conflict should avoid, even though statute and Board policy both specify that "any vote" involving the use of discretionary authority is an official act. Board and Division representatives told us that since the General Assembly specifically mandated that the Board include approved providers in its membership, they believe applying ethics requirements in a manner that would exclude those individuals from participating in the Board's decision-making processes is not what the General Assembly intended. Specifically, Board members cited the statutory requirement that approved treatment providers compose at least 80

> percent of the committee that recommends standards revisions to the Board [Section 16-11.7-103(4)(j)(II), C.R.S.]. Board and Division representatives base this understanding, in part, on the verbal guidance they have received from legal counsel. However, this perspective contradicts the Board's own policy, which requires Board members to conform their conduct to requirements in the Constitution and Code of Ethics, and references the same legal provisions that we cited in our analyses.

The Board has not sought written legal guidance on how to balance fulfilling its statutory duties while also adhering to ethics provisions that apply to its members. For example, the Board has not obtained a written opinion from the Attorney General that addresses which definitions and provisions in the State Code of Ethics apply (or do not apply) to Board members as part of fulfilling their legislatively proscribed duties. In addition, Board members and Division staff told us that they believe a supervisory relationship has to exist in order for a member of the Application Review Committee to have a potential conflict when approving providers or reviewing complaints involving providers who work for the same organization. However, statute is silent about this issue, and the Board's policy does not reflect this interpretation, so additional legal clarification is needed for the Board to ensure that its policies and practices are consistent with statutory expectations.

Lack of documented processes to enforce conflict of interest requirements. The Board's bylaws specify that the Board Chair is responsible for "enforcing ethics and conflicts of interest provisions" specified in the bylaws [Articles 3.4, 6.4], and the new policy states that the Chair will provide copies of all annual disclosure statements to the Division. However, neither the bylaws nor the conflict of interest policy establish processes for enforcing the conflict of interest requirements. The problems we found with members taking official action when they have a conflict or the appearance of a conflict, and the gaps we identified in the new policy, suggest a need for the Board to establish clear, written enforcement procedures. For example, the Board currently has no documented procedures that establish responsibilities

or procedures for ensuring that members submit their annual disclosure forms, communicating disclosures reported in annual disclosure forms to the entire Board, or reminding members at each meeting about disclosing any conflicts and avoiding official actions (e.g., abstaining from voting on matters with which they have a conflict). These processes are necessary to help Board members stay informed and to hold each other accountable for compliance with conflicts of interest requirements.

We also found problems with the Board's bylaws and conflict of interest disclosure form in place during the period we reviewed. First, they narrowly defined an "interest," stating "a member of the Board shall be considered to have a personal, private, or financial interest…if the passage of [sic] failure of [a] motion or vote will result in the member deriving a direct financial…benefit *that is greater than any such benefit derived by or shared by other persons in the member's profession, occupation, industry, or regions*." [Emphasis added.] Second, they did not require members to make a routine, written disclosure of potential conflicts of interest; the conflict of interest form that Board members were asked to sign and submit beginning in April 2019 only asked Board members to attest to their understanding of the Board's conflict of interest policy, not to disclose their conflicts. The Board's new conflict of interest policy, adopted in September 2019, addressed both of these problems by more broadly defining a conflict of interest and requiring members to make an annual disclosure of any interests that may give rise to a conflict of interest.

RECOMMENDATION 4

The Sex Offender Management Board (Board), within the Department of Public Safety, should improve its controls over the identification and management of conflicts of interest among its members by:

A Obtaining a written legal opinion from the Attorney General that clarifies how the State Code of Ethics applies to Board members, including (i) what types of official actions constitute use of the Board's discretionary authority, (ii) employment situations that create financial interests for members, (iii) whether a supervisory relationship must exist for Board members to have a conflict involving providers who work for the same organization, and (iv) whether Board members who are state employees have financial interests that could create conflicts.

B Based on the legal opinion obtained in response to PART A, implementing written guidance that provides specific examples of how statutory definitions and provisions apply to the Board (e.g., official acts, direct economic benefits, businesses or other undertakings, and financial interests) to help members identify when they have conflicts, or the potential appearance of conflicts, that should be disclosed.

C Revising the bylaws and/or conflicts of interest policy to ensure that both contain clear, precise, and consistent direction related to (i) which provisions of the State Constitution and statutes apply to Board members, (ii) what types of actions are considered to be the exercise of "discretionary authority," (iii) what types of situations are considered other undertakings that members should consider when identifying conflicts, (iv) what is meant by the terms "direct" and "substantial" when referring to direct economic benefits, (v) whether members are required to abstain from voting when the appearance of a conflict exists, and (vi) whether Board members can be present and answer questions during discussions of matters with which they have conflicts.

D Expanding the bylaws or policy to identify responsible parties and processes for (i) ensuring that Board members submit the required annual disclosures, (ii) communicating the annual disclosures to the entire Board, and (iii) reminding Board members during meetings to disclose their conflicts.

RESPONSE

SEX OFFENDER MANAGEMENT BOARD

A AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 4 A, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 4 A (i-iv).

The Department and the Board will work on this Recommendation with full implementation by December 2020. The Department and the Board will improve its controls over the identification and management of conflicts of interest among its members by obtaining a written legal opinion from the Attorney General that clarifies how the State Code of Ethics applies to Board members, including what types of official actions constitute use of the Board's discretionary authority (i), employment situations that create financial interests for members (ii), whether a supervisory relationship must exist for Board members to have a conflict involving providers who work for the same organization (iii), and whether Board members who are state employees have financial interests that could create conflicts (iv).

The Department/Board take very seriously their responsibilities related to identification and management of conflicts of interests. The Department and Board have taken the following steps to address this issue: obtaining verbal legal guidance and an external review of the Board's decision making process including conflict of

interest. The Department/Board have implemented guidance received to date and will initiate this request within 30 days.

B AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 4 B, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 4 B.

The Department and the Board will work on this Recommendation and make the request within 30 days of the audit hearing, with full implementation of this Recommendation by December 2020, or earlier depending upon the timing of receiving the written legal opinion. The Department and the Board will improve its controls over the identification and management of conflicts of interest among its members by, based on the legal opinion obtained in response to Recommendation 4 A, implementing written guidance that provides specific examples of how statutory definitions and provisions apply to the Board (e.g., official acts, direct economic benefits, businesses or other undertakings, and financial interests) to help members identify when they have conflicts, or the potential appearance of conflicts, that should be disclosed.

C AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 4 C, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 4 C.

The Department and the Board will work on this Recommendation by making the written legal opinion request within 30 days of the audit hearing, with full implementation by December 2020 or sooner depending upon when the written legal opinion is received. The Department and the Board will improve its controls over the identification and management of conflicts of interest among its members by revising the bylaws and/or conflicts of interest policy to ensure that both contain clear, precise,

and consistent direction related to which provisions of the State Constitution and statutes apply to Board members (i); what types of actions are considered to be the exercise of "discretionary authority" (ii); what types of situations are considered other undertakings that members should consider when identifying conflicts (iii); what is meant by the terms "direct" and "substantial" when referring to direct economic benefits (iv); whether members are required to abstain from voting when the appearance of a conflict exists (v); and whether Board members can be present and answer questions during discussions of matters with which they have conflicts (vi).

D AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 4 D, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 4 D (i-iii).

The Department and the Board will work on this Recommendation with full implementation by December 2020. The Department and the Board will improve its controls over the identification and management of conflicts of interest among its members by expanding the bylaws or policy to identify responsible parties and processes for ensuring Board members submit the required annual disclosures (i); communicating the annual disclosures to the entire Board (ii); and reminding Board members during meetings to disclose their conflicts (iii).

ALLOCATION OF SEX OFFENDER SURCHARGE FUNDS

The Board is responsible for recommending annual allocations of money from the Sex Offender Surcharge Fund (Surcharge Fund) to four state agencies: the Judicial Branch, the Departments of Corrections and Human Services, and the Division of Criminal Justice (Division) within the Department of Public Safety [Section 16-11.7-103(4)(c), C.R.S.]. Revenue for the Surcharge Fund comes from court fees paid by persons convicted of sex offenses or persons who receive a deferred sentence for sex offenses, and the funds should be used to cover the direct and indirect costs associated with the evaluation, identification, and treatment and continued monitoring of sex offenders [Sections 18-21-103(2)(b) and (3), C.R.S.].

Each year, the Board's Allocation Committee, which is made up of Board members who represent the four recipient agencies, proposes allocation amounts for the full Board's consideration and approval. The Board prepares an annual allocation plan with its final allocation recommendations and submits it to the General Assembly, which ultimately decides how much to appropriate from the Surcharge Fund to each agency.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed data from CORE, preliminary allocation recommendations from the Allocation Committee and the Board's final allocation recommendations for Fiscal Years 2016 through 2020, and the Long Bill and supplemental appropriations bills for Fiscal Years 2017 through 2019. Additionally, we interviewed staff at the Division, Judicial Branch, Joint Budget Committee, and Office of the State

Controller. We also interviewed four of the five members of the Board's Allocation Committee. Finally, we reviewed statutes.

The purpose of the audit work was to evaluate the Board's controls to ensure that its recommendations for Surcharge Fund allocations align with statute.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Statutes direct that, in developing the annual allocation plan for the Surcharge Fund, the General Assembly intended the Board to consider the four entities' funding needs to carry out their responsibilities to evaluate, identify, treat, and monitor sex offenders, as well as the various funding sources available to each for these activities. This intent is reflected in the following two statutory provisions:

- The monies appropriated to these entities from the Surcharge Fund, after consideration of the Board's plan, are intended to be used to cover the direct and indirect costs associated with the evaluation, identification, and treatment and the continued monitoring of sex offenders [Section 18-21-103(3), C.R.S.].

- The Board is required to coordinate the expenditure of monies from the Surcharge Fund with any other monies expended by the recipient agencies to identify, evaluate, and treat adult sex offenders and juveniles who have committed sexual offenses [Section 16-11.7-103(4)(c), C.R.S.]. Since it is not practical for the Board to direct the expenditure of funds that have been appropriated to other departments, and based on our interviews with Board staff, it is reasonable to construe this provision as meaning that the Board should take into account any other monies these entities have for identification, evaluation, treatment, and monitoring of sex offenders when developing its annual allocation plan.

Statute [Sections 24-3.7-102(1)(a) and (g), C.R.S.] also requires the Board to implement written policies or bylaws related to (1) understanding and

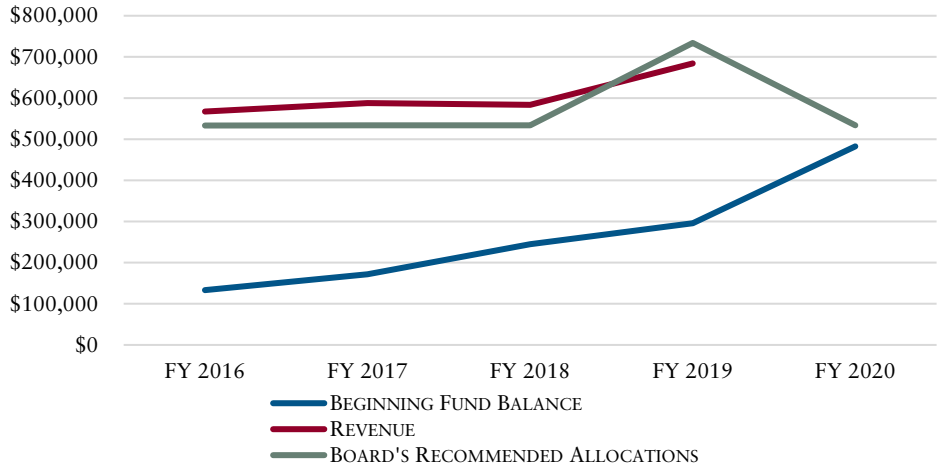
operating within the limits of statutory directives and any specific directions or laws related to the Board's powers and duties and (2) identifying and securing sufficient data to make informed decisions.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

Our audit work found indications that the Board is not developing its annual allocation plan for the Surcharge Fund based on consideration of specific funding needs at each agency and consideration of any other funding sources the agencies have for evaluating, identifying, treating, and monitoring sex offenders.

First, both revenue and the fund balance have been increasing over the last 5 years. However, the Board's annual allocation recommendations have not increased, except for a one-time recommended allocation for a single department, as shown in EXHIBITS 3.3 and 3.4, respectively.

EXHIBIT 3.3. SEX OFFENDER SURCHARGE FUND
FISCAL YEARS 2016 THROUGH 2020



SOURCE: Office of the State Auditor analysis of CORE data and Fiscal Years 2016 through 2020 Board recommendations for allocations from the Surcharge Fund.
NOTES: (1) For Fiscal Year 2019, the Board recommended the same allocation amount as it had in prior years ($533,900). However, the Board later recommended an additional, one-time allocation of $200,000 to help fund a provider data system that the Division of Criminal Justice is responsible for developing per statute.
(2) Since Fiscal Year 2020 was still in progress when audit work was completed, revenue data for that year was not available.

EXHIBIT 3.4. SEX OFFENDER MANAGEMENT BOARD RECOMMENDED ALLOCATIONS FROM THE SEX OFFENDER SURCHARGE FUND FISCAL YEARS 2017 THROUGH 2020				
DEPARTMENT	2017	2018	2019	2020
Corrections	$30,000	$30,000	$30,000	$30,000
Human Services	38,300	38,300	38,300	38,300
Public Safety	163,600	163,600	363,600[1]	163,600
Judicial	302,000	302,000	302,000	302,000
TOTAL	$533,900	$533,900	$733,900	$533,900

SOURCE: Office of the State Auditor analysis of the Board's Fiscal Years 2017 through 2020 "Recommendations for Expenditures" from the Sex Offender Surcharge Fund letters.
[1] Includes a one-time allocation of $200,000 to help fund a provider data system that the Division of Criminal Justice is responsible for developing per statute.

Second, our analysis of budget data found that all four recipient agencies reverted a portion of their appropriations back to the Surcharge Fund in Fiscal Years 2015 through 2018, as seen in EXHIBIT 3.5. This data suggests that there is misalignment between the Board's recommended allocations and how much money the recipient agencies actually need or can spend on sex offender-related expenses.

EXHIBIT 3.5. SEX OFFENDER MANAGEMENT BOARD BUDGET REVERSIONS TO SEX OFFENDER SURCHARGE FUND FROM RECIPIENT AGENCIES FISCAL YEARS 2015 THROUGH 2018				
DEPARTMENT	2015	2016	2017	2018
Corrections	$1,200	$1,200	$500	$0
Human Services	5,600	4,700	0	300
Public Safety	3,000	12,400	27,800	17,400
Judicial	0	0	0	500
TOTAL	$9,800	$18,300	$28,300	$18,200

SOURCE: Office of the State Auditor analysis of recipient agencies' budget requests for Fiscal Years 2018 through 2020 (which contained data for the years shown in the table) and data reported by the Judicial Branch.

WHY DID THIS PROBLEM OCCUR?

The Board has not implemented a process to fully inform its decision making in developing its annual allocation plan.

THE BOARD DOES NOT USE READILY AVAILABLE INFORMATION TO MONITOR AND ANALYZE SURCHARGE FUND ACTIVITY. Although several Board members reported that the Allocation Committee reviews

financial data related to the Surcharge Fund, such as revenue and fund balance trends, the committee does not appear to use other financial data to inform its proposed allocations to the full Board, such as past expense and budget reversion data for each recipient agency. EXHIBIT 3.5 shows that all four recipient entities did not use their full allocations from Fiscal Years 2015 through 2018, but there was no evidence in meeting minutes or other documentation that the committee researched those trends or considered reasons for past reversions when developing each year's allocation recommendations. In fact, the Allocation Committee proposed *higher* allocations for all four agencies in Fiscal Years 2017 through 2019, indicating that the committee believed the departments needed more funding than they had been receiving. EXHIBIT 3.6 shows the allocations proposed by the committee, as well as the amounts the Board recommended in its allocation plans to the General Assembly, for Fiscal Years 2017 through 2019.

EXHIBIT 3.6. SEX OFFENDER SURCHARGE FUND
COMPARISON OF ALLOCATION COMMITTEE AND SEX OFFENDER MANAGEMENT BOARD RECOMMENDED ALLOCATIONS
FISCAL YEARS 2017 THROUGH 2019

	2017		2018		2019	
DEPARTMENT	ALLOCATION COMMITTEE	FULL BOARD	ALLOCATION COMMITTEE	FULL BOARD	ALLOCATION COMMITTEE	FULL BOARD
Judicial	$347,300	$302,000	$362,400	$302,000	$362,400	$302,000
Public Safety	188,100	163,600	196,300	163,600	196,300	363,600[1]
Human Services	44,000	38,300	45,900	38,300	45,900	38,300
Corrections	33,700	30,000	35,200	30,000	35,200	30,000
Total	$613,100	$533,900	$639,800	$533,900	$639,800	$733,900

SOURCE: Office of the State Auditor analysis of the Fiscal Years 2017 through 2019 Allocation Committee recommendations and the Board's "Recommendations for Expenditures" from the Sex Offender Surcharge Fund.
[1] Includes a one-time allocation of $200,000 to help fund a provider data system the Division of Criminal Justice is responsible for developing per statute.

In spite of the Allocation Committee's proposals, the Board did not increase its recommended allocations in these years. The Board told us this is not because the full Board was aware of the reversions, or had other information about the agencies' needs, but because the Board believes the recipient agencies are reluctant to request increased spending authority from the General Assembly for additional funding. However, according to Joint Budget Committee (JBC) staff, a request for increased spending authority based on the Board's

recommendations should be fairly simple; the recipient agencies would only need to align their funding requests with the Board's recommended allocation amounts as justification for any requested increases. At the time of our audit, Division staff had not sought similar insight from the JBC in order to inform the Board's allocation process and help guide recipient agencies about how they can leverage additional funding from the Surcharge Fund as part of the State's budgeting process.

Board members and Division staff also told us that they are unclear about their ability to monitor the Surcharge Fund and evaluate the funding needs of other departments to develop its allocation plan. One reason staff cited was that the Office of the State Controller (OSC) assigned responsibility for administering the Surcharge Fund to the Judicial Branch, since its staff receive and enter revenue data for the fund in CORE. However, according to the OSC, Division staff with access to CORE should be able to access all accounting data about the Surcharge Fund, including annual reversion amounts, which the Board could use to help it analyze the fund as part of its decision-making process.

THE BOARD DOES NOT HAVE A CONSISTENT PROCESS TO DETERMINE THE RECIPIENT AGENCIES' FUNDING NEEDS. Although the Allocation Committee is composed of representatives from each of the four entities who are expected to express their agency's needs for funding, the committee does not have a method to ensure that it is considering full and consistent information about each agency when developing its proposals. For example, the committee does not ask agencies to (1) submit a written request or statement of need, (2) provide any historical expenditure information, (3) offer a rationale for the amount of funds needed, or (4) send budget representatives from each agency to discuss their funding requests during full Board meetings.

THE BOARD HAS NOT DEFINED A TARGET BALANCE FOR THE SURCHARGE FUND. Although Board members told us that they review fund balance information, they have not established a target amount that they believe should be reserved in the fund, which could help the Board evaluate whether it can support increased allocations.

WHY DOES THIS PROBLEM MATTER?

When the Board does not have a process to fully inform its decision making in developing its annual allocation plan for the Surcharge Fund, it may not be helping the State maximize available funds to evaluate and treat sex offenders, and may indirectly contribute to funds intended for other uses being redirected to sex offenders. We identified an example of this with respect to the Judicial Branch. Because its allocation from the Surcharge Fund remained at the same level each year from Fiscal Years 2016 through 2018, the Judicial Branch used an increasing amount of funding from its Offender Services Fund to pay for the rising costs of sex offender evaluations, as shown in EXHIBIT 3.7. According to the Judicial Branch, it redirected funds from its Offender Services Fund, which are intended to be used for probation services, to pay for evaluations of sex offenders who are unable to cover those costs themselves. Completing timely sex offender evaluations helps prevent case processing delays and reduces overall costs to the State by ensuring that offenders are not returned to court for revocation based on non-payment, which can lead to more expensive sentences with the Department of Corrections.

EXHIBIT 3.7. SOURCES OF FUNDING FOR JUDICIAL BRANCH EVALUATIONS OF SEX OFFENDERS, FISCAL YEARS 2016 THROUGH 2018

	2016		2017		2018	
	AMOUNT	PERCENTAGE OF TOTAL	AMOUNT	PERCENTAGE OF TOTAL	AMOUNT	PERCENTAGE OF TOTAL
Sex Offender Surcharge Fund	$302,000	23%	$302,000	24%	$302,000	21%
Offender Services Fund	995,000	77%	973,000	76%	1,123,000	79%
TOTAL	$1,297,000	100%	$1,275,000	100%	$1,425,000	100%

SOURCE: Office of the State Auditor analysis of data in the 2018 *Annual Report on the Lifetime Supervision of Sex Offenders*.

By not asking each agency to provide consistent information to the Allocation Committee, the Board is lacking a control to (1) ensure that it can make informed decisions, (2) help justify its recommended allocation amounts, and (3) increase the transparency of its processes. Finally, by not setting a reserve fund balance target and tracking the

fund balance against the target, the Board is hindered in determining when there are sufficient funds to recommend increases in allocations.

RECOMMENDATION 5

The Sex Offender Management Board (Board), within the Department of Public Safety, should ensure that it has effective controls over the funding allocations it recommends from the Sex Offender Surcharge Fund (Surcharge Fund) by:

A Implementing processes for the Allocation Committee to use more comprehensive financial information to inform its proposed allocations, such as by asking agencies to submit written requests or statements related to their need for allocations, provide some historical expenditure information, and offer a rationale for the amount of funds needed.

B Seeking guidance from Joint Budget Committee staff about the process to request increased spending authority, and sharing that guidance with agencies that receive money from the Surcharge Fund to help ensure that their annual budget requests align with the Board's recommended allocation amounts.

C Directing staff to seek guidance from the Office of the State Controller on accessing accounting data about the Surcharge Fund, including annual reversion amounts, and provide that information to the Board and/or Allocation Committee. The Board should then use that information for analysis as part of the Board's annual decision-making process.

D Establishing a target fund balance in writing and tracking against that benchmark.

RESPONSE

SEX OFFENDER MANAGEMENT BOARD

A AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 5 A, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 5 A.

The Department and the Board will work on this Recommendation with full implementation by December 2020. The Department and the Board will ensure that it has effective controls over the funding allocations it recommends from the Sex Offender Surcharge Fund (Surcharge Fund) by implementing processes for the Allocation Committee to use more comprehensive financial information to inform its proposed allocations, such as by asking departments to submit written requests or statements related to their need for allocations, provide some historical expenditure information, and offer a rationale for the amount of funds needed.

B AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 5 B, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 5 B.

The Department and the Board will begin work on this Recommendation with JBC staff within 30 days following the audit hearing, with full implementation by December 2020 once the JBC staff guidance is received. The Department and the Board will ensure that it has effective controls over the funding allocations it recommends from the Sex Offender Surcharge Fund (Surcharge Fund) by seeking guidance from Joint Budget Committee staff about the process to request increased spending authority, and sharing that

guidance with agencies that receive money from the Surcharge Fund to help ensure that their annual budget requests align with the Board's recommended allocation amounts.

C AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 5 C, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 5 C.

The Department and the Board will work on this Recommendation with full implementation by December 2020. The Department and the Board will ensure that it has effective controls over the funding allocations it recommends from the Sex Offender Surcharge Fund (Surcharge Fund) by directing staff to seek guidance from the Office of the State Controller on accessing accounting data about the Surcharge Fund, including annual reversion amounts, and provide that information to the Board and/or Allocation Committee. The Board will then use that information for analysis as part of the Board's annual decision-making process.

D AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 5 D, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 5 D.

The Department and the Board will work on this Recommendation with full implementation by December 2020. The Department and the Board will ensure that it has effective controls over the funding allocations it recommends from the Sex Offender Surcharge Fund (Surcharge Fund) by establishing a target fund balance in writing and tracking against that benchmark.

The Department along with the Board and other impacted state agencies identified an informal target fund balance of the 16.5%

cash fund balance minimum in 2006-2008, and tracked against that benchmark during that time when the fund balance was close to that level. However, the Board and Department did not formalize this fund balance in policy or procedure, and have not tracked against this balance more recently. The Department and the Board will ensure it establishes a target fund balance in writing and track against that benchmark.

MEETING TRANSPARENCY

The full 25-member Board holds regular meetings (usually monthly) during which it discusses and votes on various policy issues, such as what revisions to adopt in its Board Standards. It also hears presentations on new treatment and assessment methods, and receives testimony from various stakeholders, including groups advocating for offenders' rights and groups that support victims' rights.

The Board has also delegated some of its work to committees, which meet on an as-needed basis and perform specific tasks such as reviewing applications from professionals seeking Board approval to provide sex offense-related services, assessing complaints against Board-approved providers, and creating plans for allocating funds from the Sex Offender Surcharge Fund. As of December 6, 2019, the Board had six standing committees, five of which are advisory, that make recommendations to the full Board that must be ratified by a majority of Board members to take effect. The sixth committee, the Application Review Committee, has been delegated decision-making authority by the Board related to approving new and re-applications from providers interested in offering services to sex offenders, reviewing complaints against providers, and completing Standards Compliance Reviews of providers, among other things [Board bylaws, Article 9]. For both types of committees, as with the full Board meetings, members conduct business and move recommendations and decisions forward through a formal vote. The full Board and all committee voting is recorded in written meeting minutes.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

We reviewed documentation associated with a sample of 10 meetings that occurred during Fiscal Year 2019, from November 2018 through May 2019, including five full Board meetings and meetings of five different committees, one of which has been delegated decision-making

authority by the full Board. During these 10 meetings, the Board and committees recorded a total of 54 distinct votes, 53 of which occurred at either a meeting of the full Board or a meeting of the committee that has been delegated decision-making authority by the full Board. We reviewed meeting minutes and agendas; observed one committee meeting in person, at which an additional six votes were taken; interviewed Board members and Division staff; and reviewed statutes and Board bylaws.

The purpose of our audit work was to determine if Board and committee meetings operate in alignment with open meetings laws and Board bylaws.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

As a state public body, the Board must adhere to the Colorado Sunshine Act, which includes open meetings laws that require meetings to be conducted transparently and in an accessible manner for the public [Section 24-6-401, et seq., C.R.S.]. Specifically, under statute, the Board is:

- Prohibited from adopting "any proposed policy, position, resolution, rule, or regulation or tak[ing] formal action by secret ballot," which is defined as "a vote cast in such a way that the identity of the person voting or the position taken in such vote is withheld from the public" [Section 24-6-402(2)(d)(IV), C.R.S.].

- Required to take and retain minutes of all meetings.

In combination, these statutory provisions establish an expectation that any state public body, such as the Board, take and record official actions, such as votes, in their minutes so that the identity and voting position of each Board member are apparent to the public [Section 24-6-402(2)(d)(IV), C.R.S.].

The Board's bylaws [Articles 4.8, 4.9, and 8.1] recognize that committee meetings are subject to the Open Meetings Law [Section 24-6-402(2)(d)(I), C.R.S.].

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

THE BOARD AND ITS COMMITTEES DID NOT RECORD MEMBERS' VOTES IN A WAY THAT DEMONSTRATED COMPLIANCE WITH STATUTORY REQUIREMENTS. We found the following problems:

- **INDIVIDUAL MEMBER VOTES.** Minutes for two of the six committee meetings we reviewed, including one we observed, indicated that members voted 33 times on various issues, including whether to approve applications from professionals seeking Board authorization to work with sex offenders (e.g., therapists, polygraph examiners) and determinations about complaints filed against service providers. However, the minutes for both meetings noted only the final decision (e.g., that a provider's application to serve sex offenders was approved), but did not specify how many members approved or denied each decision, or abstained from voting, nor did the minutes reference the voting positions of individual members who were present.

  In addition, the minutes for all five of the full Board meetings we reviewed recorded member votes on 26 formal actions in such a way that the public could not determine the identity of each person voting or taking a position. Specifically, for these meetings and votes, the minutes listed members' names alongside the numbers "1," "2," or "3," rather than words clearly articulating a voting position. When we asked the Board about these, they told us a "1" indicated a "yes" vote, a "2" indicated a "no" vote, and a "3" indicated an abstention, but the minutes did not contain a key explaining which number corresponded to which voting position.

- **MEMBERS PRESENT DURING VOTES.** Minutes of all five full Board meetings we reviewed did not reflect votes associated with all Board

members who were listed as having been present at the meetings. For the five meetings, there were a total of 26 votes taken, during each of which anywhere from one to seven of the members listed as present were not recorded as having voted. As a result, there was no way to determine if or how all members voted, including whether some abstained from voting due to conflicts of interest. Division staff reported that members were absent during these votes (e.g., to attend to business outside of the meeting room), but we could not verify that assertion since the minutes did not record when Board members entered or exited the meeting.

WHY DID THESE PROBLEMS OCCUR?

Division staff told us that someone who wants to see how individual members vote can attend meetings in person and observe which members cast votes by raising their hands to vote in favor or against a motion. Division staff further stated, "There is no mandate to record the way in which Board members vote," and indicated that their usage of the numerical coding system in full Board meeting minutes provides detail on individual members' votes as "a courtesy to our minute reading audience." Regarding committee meeting votes, Division staff cited a provision in Board bylaws Article 6.1 that states, "The Board and committees will work to develop consensus on issues under consideration by the Board." Staff stated that since committees seek consensus in their decision making, and if the consensus decision is noted in the minutes, then there was no need to record final vote tallies or individual committee members' voting positions. However, the meeting minutes we reviewed did not indicate when decisions were made by consensus.

Although the Board provided examples of minutes from other meetings that did indicate when committees made consensus decisions, the Board did not provide clear evidence that it consistently records this voting information in the minutes for all of its meetings. In addition, the bylaws also acknowledge that there may be instances when reaching consensus is not possible, in which case "a majority vote of the Board or [c]ommittee members…shall be the official decision of the Board or

[c]ommittee." Further, Division staff's perspective does not take into account that the official documented record of every full Board and committee meeting (i.e., the minutes) must be available for public inspection and should therefore stand alone in demonstrating compliance with statutory voting requirements. In addition, it is likely not feasible for all individuals around the state who are interested in the Board's proceedings to travel to the Denver metropolitan area to observe each Board and committee meeting in person.

Prior to our audit, the Board had not included a key in the minutes of full Board meetings to help members of the public understand the numerical coding that indicates how each member voted (i.e., whether a "1," "2," or "3" represents a "yes" vote, "no" vote, or an abstention). After we brought this issue to their attention in August 2019, the Board began including a voting key in the full Board's meeting minutes. Regarding committee meeting votes, as of December 2019, Division staff began recording the overall outcome of votes (e.g., the total number of members who approved, opposed, or abstained from a vote), but the minutes do not show the votes of each individual member. Board staff also reported that they were awaiting the OSA's recommendations before addressing the other statutory compliance and transparency issues the audit identified.

At this time, the Board's bylaws do not establish responsibility for any Division staff or Board members to ensure that meeting minutes contain all required voting information or that the Board complies with open meetings laws and provides the public transparent records of its policy recommendations and decisions.

WHY DO THESE PROBLEMS MATTER?

WHEN THE BOARD DOES NOT RECORD VOTES IN A WAY THAT IS CLEAR AND READILY UNDERSTANDABLE TO THE PUBLIC, THE BOARD DOES NOT OPERATE TRANSPARENTLY. The Colorado Sunshine Act, which includes open meetings laws, establishes a clear legislative intent that the public be able to understand how entities, such as the Board, formulate and determine policy decisions. By omitting information that is essential to

deciphering its formal actions, such as clearly indicating (1) how each Board member voted, (2) how to interpret numbers that are used to reflect members' voting positions, and (3) which members were not present for a vote, the Board reduces the transparency of its decision-making process. Maintaining complete and transparent records of committee proceedings is particularly important for committees that have been delegated authority to make decisions on the Board's behalf. For example, the Application Review Committee is responsible for determining which providers should be approved to serve sex offenders and how to respond to complaints against providers [Board bylaws, Article 9], both of which are among the Board's primary statutory responsibilities [Sections 16-11.7-106 (2) and (7), C.R.S.].

Maintaining complete and transparent voting records is also important for the Board to clearly demonstrate and monitor how it identifies and manages actual and potential conflicts of interest among Board and committee members. If voting records do not clearly delineate how individual members vote on each decision, including which members abstain from voting, there is no way for the Board or the general public to verify that members abstained from voting on decisions with which they had an actual or potential conflict. As described in RECOMMENDATION 4, we found instances where Board members had actual or potential conflicts, but we could not verify that those members abstained from voting due to the lack of detail about voting positions contained in meeting minutes. Being able to demonstrate appropriate identification and response to conflicts of interest is particularly important in light of the problems our audit identified in this area.

WHEN THE BOARD CANNOT DEMONSTRATE ADHERENCE TO OPEN MEETINGS LAWS, THERE IS A RISK THAT ITS OFFICIAL DECISIONS COULD BE CONSIDERED INVALID. Section 24-6-402(8), C.R.S., establishes that "no resolution, rule, regulation, ordinance, or formal action of a state or local public body shall be valid unless taken or made at a meeting that meets the requirements of" the Open Meetings Law. The Board's practice of not clearly documenting details about each member's vote prevents the Board from clearly demonstrating compliance with open

meetings requirements, which could result in the votes being invalid. Given that the Board is an important resource to the State, tasked with setting State policies regarding the treatment and management of juveniles and adults who have committed sexual offenses [Board bylaws, Article 1], it is important that the Board operates in a transparent manner that ensures its decisions are binding.

RECOMMENDATION 6

The Sex Offender Management Board (Board), within the Department of Public Safety, should ensure that it documents all formal votes regarding public policy recommendations and decisions regarding sex offenders in a manner that is transparent to the public and complies with open meetings laws by:

A Revising and implementing the Board's bylaws to specify that tallies of individual votes and clear references to the specific voting positions of individual members present, rather than only final decisions, must appear in full Board and committee meeting minutes.

B Revising and implementing the Board's bylaws to specify which Division staff or Board members are responsible for ensuring all minutes from full Board and committee meetings contain complete voting information and provide the public a transparent record of its policy recommendations and decisions.

RESPONSE

SEX OFFENDER MANAGEMENT BOARD

A AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 6 A, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 6 A.

The Department and the Board will work on this Recommendation with full implementation by December 2020. The Department and the Board will ensure that it documents all formal votes regarding public policy recommendations and decisions regarding sex offenders in a manner that is transparent to the public and complies with open meetings laws by revising and implementing the Board's

bylaws to specify that tallies of individual votes and clear references to the specific voting positions of individual members present, rather than only final decisions, must appear in full Board and committee meeting minutes.

In recognition of the importance of this Recommendation, the Department and the Board enacted an electronic vote recording tool for Board meetings several years ago, and reported the results of this recording in Board minutes. When it was identified during the Audit that there was no voting key in the minutes, the Department and the Board began including the key. The Department and the Board are committed to fully implementing this Recommendation at both the Board and Committee level.

B AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department and the Board appreciate and recognize the OSA's findings and recommendations related to RECOMMENDATION 6 B, and are fully committed to implementing this Recommendation. The Department and Board agree with RECOMMENDATION 6 B.

The Department and the Board will work on this Recommendation with full implementation by December 2020. The Department and the Board will ensure that it documents all formal votes regarding public policy recommendations and decisions regarding sex offenders in a manner that is transparent to the public and complies with open meetings laws by revising and implementing the Board's bylaws to specify which Division staff or Board members are responsible for ensuring all minutes from full Board and committee meetings contain complete voting information and provide the public a transparent record of its policy recommendations and decisions.

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