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SB 1235: DCS; child fatality review team
Sponsor: Senator Shamp, LD 29
Transmitted to the Governor

Overview

Establishes the Child Safety Fatality and Near Fatality Review Team (DCS Review Team) under the Arizona Department of Child Safety (DCS) and outlines duties of the DCS Review Team. Requires the Joint Legislative Oversight Committee on DCS (Joint DCS Oversight Committee) to review systemic factors related to alleged child maltreatment fatalities and near fatalities.

History

Arizona Department of Child Safety

The primary purpose of DCS is to protect children. To achieve this DCS will do and focus equally on: 1) investigating reports of abuse and neglect; 2) assessing, promoting and supporting the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse and neglect; 3) cooperating with law enforcement regarding reports that include allegations of criminal conduct; and 4) coordinating services to achieve and maintain permanency for the child, strengthen the family and provide prevention, intervention and treatment services without compromising the child's safety (A.R.S. § 8-451).

Joint Legislative Oversight Committee on DCS

Laws 2017, Chapter 282 created the Joint DCS Oversight Committee which consists of six members. The Committee reviews the following: 1) DCS's implementation of policy and procedures and program effectiveness; 2) all reports on program outcomes released by DCS to the Legislature for trends and areas for statutory improvement and audits issued by the Office of the Auditor General related to DCS; and 3) policies and procedures relating to guardianships and dependency proceedings. The committee meets at least biannually.

State Child Fatality Review Team

The State Child Fatality Review (CFR) Team is established in the Arizona Department of Health Services (DHS). The CFR program was created to review all possible factors surrounding a child's death and identify ways of reducing preventable fatalities. Its duties include encouraging and assisting in the development of local review teams, conducting an annual statistical report on the incidence and causes of child fatalities in Arizona and evaluating the incidence and causes of maternal fatalities associated with pregnancy in Arizona. The State CFR Team consists of the head, or designee, of 11 various state offices and entities, as well as 10 additional members appointed by the DHS Director who serve staggered 3-year terms (CFR Report 2023 and A.R.S. § 36-3501).

Provisions

DCS Review Team

1. Creates the DCS Review Team to review all reports of fatalities and near fatalities of a child made to the child abuse hotline. (Sec. 1)

2. Directs the DCS Review Team to:
   a) hold regular multidisciplinary team meetings to review reports of child fatalities or near fatalities where DCS had prior involvement with the child, the child's family or the perpetrator;
   b) identify systemic trends that influence decisions and actions made by DCS;
   c) recommend changes to policy and practice to improve outcomes for children and families;
   d) promote a culture of psychological safety within DCS by responding to fatality and near fatality cases in a manner that promotes learning, transparency and employee health;
   e) produce an annual child fatality and near fatality report; and
   f) select cases that present opportunities for systemic learning or that demonstrate opportunities for systemic change and respond to requests for further information by a standing committee of the Legislature, joint legislative oversight committee or another committee appointed by the President of the Senate and the Speaker of the House of Representatives. (Sec. 1)

3. Requires the DCS Review Team to hold regular multidisciplinary team meetings to:
   a) review reports of child fatalities or near fatalities made to the child abuse hotline where DCS has involvement with the child, the child's family or the perpetrator within the prior three years;
   b) select cases for systemic learning and order the DCS Review Team to do a systemic critical incident review of those cases; and
   c) receive findings from systemic critical incident reviews at least quarterly and recommend changes to DCS policy and practice. (Sec. 1)

4. Requires the multidisciplinary team to consist of DCS employees designated by the DCS Director. (Sec. 1)

5. Instructs the DCS Director to appoint, at a minimum, the following public members who must be trained in safe system improvement:
   a) a licensed pediatrician who has professional experience relating to child abuse and neglect;
   b) a peace officer who has experience investigating child abuse and neglect fatalities and near fatalities;
   c) a practicing social worker;
   d) a behavioral health practitioner; and
   e) an attorney who has past professional experience representing children in child abuse and neglect cases. (Sec. 1)

6. Permits the multidisciplinary team to consult with the Department of Health Services (DHS), the Department of Economic Security (DES), the Arizona Health Cost Containment System (AHCCCS) or any other governmental entity that may have

information pertinent to a child fatality or near fatality when conducting child fatality and near fatality reviews. (Sec. 1)

7. Requires DCS to produce an annual report of information gathered during its review of child fatalities and near fatalities and include the following:
   a) the total number of fatality and near fatality reports in a fiscal year, by county;
   b) the number of allegations that are substantiated and unsubstantiated;
   c) the number of reports due to abuse and whether they were substantiated or unsubstantiated;
   d) the number of reports due to neglect and whether they were substantiated or unsubstantiated;
   e) the number of reports where the family had previous DCS involvement;
   f) systemic trends that influence the practice and decisions made by DCS and areas for improvement; and
   g) details of cases that present opportunities for systemic learning or that demonstrate opportunities for systemic change. (Sec. 1)
8. States the multidisciplinary team meetings are not subject to open meeting laws. (Sec. 1)
9. Requires DCS to present the annual report to the following at a public meeting in order to inform policymakers on systemic changes required to improve the child welfare system:
   a) a standing committee of the Legislature;
   b) a joint legislative oversight committee; or
   c) a committee appointed by the President of the Senate or the Speaker of the House of Representatives. (Sec. 1)
10. Allows the applicable committee, if deemed necessary, to hold an executive session to protect the privacy or safety of individuals involved in the fatality or near fatality or to receive confidential information. (Sec. 1)
11. Specifies that the information on the report cannot be further disclosed unless:
   a) a court orders the disclosure of this information;
   b) the information is disclosed in a public or court record; or
   c) the information is disclosed in the course of a public meeting or court proceeding. (Sec. 1)
12. Requires the DCS Review Team to respond to requests for additional information regarding a child fatality or near child fatality made pursuant to the Joint DCS Oversight Committee withing 90 days after receiving the request. (Sec. 1)
13. States that the information gathered is confidential. (Sec. 1)
14. Permits public members of the DCS Review Team to receive confidential DCS information but prohibits further disclosure unless authorized by law. (Sec. 1)

Joint Legislative Oversight Committee on DCS

15. Expands the duties of the Joint DCS Oversight Committee systemic to include reviewing factors related to alleged child maltreatment fatalities and near fatalities. (Sec. 2)
16. Permits the Joint DCS Oversight Committee, in reviewing alleged child maltreatment fatalities and near fatalities, to:
   a) review interagency coordination and communication;
   b) enter into executive session when necessary to promote the privacy and safety of the decedent's family or employees of DCS;

c) critically analyze the systemic factors that may have contributed to an alleged child maltreatment fatality or near fatality, including the laws, policies and practices of DCS, DES, AHCCCS and any other state agency that may have been involved in the safety and welfare of the child or with the child's family and the perpetrator, including any economic, health, social services, supports and resources, to identify improvements that could mitigate future child maltreatment fatalities or near fatalities;
d) identify best practices and services that may prevent future maltreatment fatalities or near fatalities and review the recommendations submitted by the DCS Review Team and the State Fatality Review Team; and
e) review reports produced and presented by the DCS Review Team and request additional information and follow up on details associated with a report. (Sec. 2)

17. Defines *systemic critical incident review* (Sec. 1)