Senate Engrossed

~~maltreatment oversight committee; establishment~~
(now: DCS; child fatality review team)

State of Arizona
Senate
Fifty-sixth Legislature
Second Regular Session
2024

SENATE BILL 1235

AN ACT

AMENDING TITLE 8, CHAPTER 4, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 8-469; AMENDING SECTION 41-1292, ARIZONA REVISED STATUTES; RELATING TO THE DEPARTMENT OF CHILD SAFETY.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Title 8, chapter 4, article 1, Arizona Revised Statutes,
3 is amended by adding section 8-469, to read:
4 8-469. Child safety fatality and near fatality review team;
5 membership; duties; definition
6 A. THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM IS
7 ESTABLISHED IN THE DEPARTMENT OF CHILD SAFETY TO REVIEW ALL REPORTS OF
8 FATALITIES AND NEAR FATALITIES OF A CHILD MADE TO THE CHILD ABUSE HOTLINE.
9 THE TEAM SHALL:
10 1. HOLD REGULAR MULTIDISCIPLINARY TEAM MEETINGS TO REVIEW REPORTS
11 OF CHILD FATALITIES OR NEAR FATALITIES WHERE THE DEPARTMENT HAD PRIOR
12 INVOLVEMENT WITH THE CHILD, THE CHILD'S FAMILY OR THE PERPETRATOR.
13 2. IDENTIFY SYSTEMIC TRENDS THAT INFLUENCE DECISIONS AND ACTIONS
14 MADE BY THE DEPARTMENT.
15 3. RECOMMEND CHANGES TO POLICY AND PRACTICE TO IMPROVE OUTCOMES FOR
16 CHILDREN AND FAMILIES.
17 4. PROMOTE A CULTURE OF PSYCHOLOGICAL SAFETY WITHIN THE DEPARTMENT
18 BY RESPONDING TO FATALITY AND NEAR FATALITY CASES IN A MANNER THAT
19 PROMOTES LEARNING, TRANSPARENCY AND EMPLOYEE HEALTH.
20 5. PRODUCE AN ANNUAL CHILD FATALITY AND NEAR FATALITY REPORT AS
21 PRESCRIBED BY SUBSECTION E OF THIS SECTION.
22 6. SELECT CASES THAT PRESENT OPPORTUNITIES FOR SYSTEMIC LEARNING OR
23 THAT DEMONSTRATE OPPORTUNITIES FOR SYSTEMIC CHANGE AND RESPOND TO REQUESTS
24 FOR FURTHER INFORMATION BY A STANDING COMMITTEE OF THE LEGISLATURE, A
25 JOINT LEGISLATIVE OVERSIGHT COMMITTEE OR ANOTHER COMMITTEE APPOINTED BY
26 THE PRESIDENT OF THE SENATE OR THE SPEAKER OF THE HOUSE OF
27 REPRESENTATIVES.
28 B. THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM SHALL
29 HOLD REGULAR MULTIDISCIPLINARY TEAM MEETINGS TO:
30 1. REVIEW REPORTS OF CHILD FATALITIES OR NEAR FATALITIES MADE TO
31 THE CHILD ABUSE HOTLINE WHERE THE DEPARTMENT HAD INVOLVEMENT WITH THE
32 CHILD, THE CHILD'S FAMILY OR THE PERPETRATOR WITHIN THE PRIOR THREE YEARS.
33 2. SELECT CASES FOR SYSTEMIC LEARNING AND ORDER THE CHILD SAFETY
34 FATALITY AND NEAR FATALITY REVIEW TEAM TO DO A SYSTEMIC CRITICAL INCIDENT
35 REVIEW OF THOSE CASES.
36 3. RECEIVE FINDINGS FROM SYSTEMIC CRITICAL INCIDENT REVIEWS AT
37 LEAST QUARTERLY AND RECOMMEND CHANGES TO DEPARTMENT POLICY AND PRACTICE.
38 C. THE MULTIDISCIPLINARY TEAM SHALL CONSIST OF DEPARTMENT EMPLOYEES
39 DESIGNATED BY THE DIRECTOR. THE DIRECTOR SHALL ALSO APPOINT, AT A
40 MINIMUM, THE FOLLOWING PUBLIC MEMBERS WHO SHALL BE TRAINED IN SAFE SYSTEM
41 IMPROVEMENT:
42 1. A LICENSED PEDIATRICIAN WHO HAS PROFESSIONAL EXPERIENCE RELATING
43 TO CHILD ABUSE AND NEGLECT.
44 2. A PEACE OFFICER WHO HAS EXPERIENCE INVESTIGATING CHILD ABUSE AND
45 NEGLECT FATALITIES AND NEAR FATALITIES.

1 3. A PRACTICING SOCIAL WORKER.
2 4. A BEHAVIORAL HEALTH PRACTITIONER.
3 5. AN ATTORNEY WHO HAS PAST PROFESSIONAL EXPERIENCE REPRESENTING
4 CHILDREN IN CHILD ABUSE AND NEGLECT CASES.
5 D. IN CONDUCTING CHILD FATALITY AND NEAR FATALITY REVIEWS, THE
6 MULTIDISCIPLINARY TEAM MAY CONSULT WITH THE DEPARTMENT OF HEALTH SERVICES,
7 THE DEPARTMENT OF ECONOMIC SECURITY, THE ARIZONA HEALTH CARE COST
8 CONTAINMENT SYSTEM OR ANY OTHER GOVERNMENTAL ENTITY THAT MAY HAVE
9 INFORMATION PERTINENT TO A CHILD FATALITY OR NEAR FATALITY.
10 E. THE DEPARTMENT SHALL PRODUCE AN ANNUAL REPORT OF INFORMATION
11 GATHERED DURING ITS REVIEW OF CHILD FATALITIES AND NEAR FATALITIES. THIS
12 REPORT SHALL INCLUDE ALL OF THE FOLLOWING:
13 1. THE TOTAL NUMBER OF FATALITY AND NEAR FATALITY REPORTS IN A
14 FISCAL YEAR, BY COUNTY.
15 2. THE NUMBER OF ALLEGATIONS THAT ARE SUBSTANTIATED AND
16 UNSUBSTANTIATED.
17 3. THE NUMBER OF REPORTS DUE TO ABUSE AND WHETHER THE REPORTS WERE
18 SUBSTANTIATED OR UNSUBSTANTIATED.
19 4. THE NUMBER OF REPORTS DUE TO NEGLECT AND WHETHER THE REPORTS
20 WERE SUBSTANTIATED OR UNSUBSTANTIATED.
21 5. THE NUMBER OF REPORTS WHERE THE FAMILY HAD PREVIOUS DEPARTMENT
22 INVOLVEMENT.
23 6. SYSTEMIC TRENDS THAT INFLUENCE THE PRACTICE AND DECISIONS MADE
24 BY THE DEPARTMENT AND AREAS FOR IMPROVEMENT.
25 7. DETAILS OF CASES THAT PRESENT OPPORTUNITIES FOR SYSTEMIC
26 LEARNING OR THAT DEMONSTRATE OPPORTUNITIES FOR SYSTEMIC CHANGE.
27 F. MULTIDISCIPLINARY TEAM MEETINGS ARE NOT SUBJECT TO TITLE 38,
28 CHAPTER 3, ARTICLE 3.1.
29 G. THE DEPARTMENT SHALL PRESENT THE REPORT REQUIRED BY SUBSECTION E
30 OF THIS SECTION AT A PUBLIC MEETING OF A STANDING COMMITTEE OF THE
31 LEGISLATURE, A JOINT LEGISLATIVE OVERSIGHT COMMITTEE OR A COMMITTEE
32 APPOINTED BY THE PRESIDENT OF THE SENATE OR THE SPEAKER OF THE HOUSE OF
33 REPRESENTATIVES FOR THE PURPOSE OF INFORMING POLICYMAKERS ON SYSTEMIC
34 CHANGES REQUIRED TO IMPROVE THE CHILD WELFARE SYSTEM UNLESS THE APPLICABLE
35 COMMITTEE DEEMS IT NECESSARY TO HOLD AN EXECUTIVE SESSION TO PROTECT THE
36 PRIVACY OR SAFETY OF INDIVIDUALS INVOLVED IN THE FATALITY OR NEAR
37 FATALITY. INFORMATION MAY NOT BE FURTHER DISCLOSED UNLESS A COURT ORDERS
38 THE DISCLOSURE OF THIS INFORMATION, THE INFORMATION IS DISCLOSED IN A
39 PUBLIC OR COURT RECORD OR THE INFORMATION IS DISCLOSED IN THE COURSE OF A
40 PUBLIC MEETING OR COURT PROCEEDING. THE COMMITTEE MAY GO INTO EXECUTIVE
41 SESSION TO RECEIVE CONFIDENTIAL INFORMATION.
42 H. THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM SHALL
43 RESPOND TO REQUESTS FOR ADDITIONAL INFORMATION REGARDING A CHILD FATALITY
44 OR NEAR FATALITY MADE PURSUANT TO SECTION 41-1292, SUBSECTION D WITHIN
45 NINETY DAYS AFTER RECEIVING THE REQUEST.

1 I. EXCEPT AS PROVIDED IN SECTIONS 8-807 AND 8-807.01, INFORMATION
2 GATHERED PURSUANT TO THIS SECTION IS CONFIDENTIAL. PUBLIC MEMBERS OF THE
3 TEAM MAY RECEIVE CONFIDENTIAL DEPARTMENT INFORMATION BUT MAY NOT FURTHER
4 DISCLOSE THE INFORMATION UNLESS AUTHORIZED BY LAW.
5 J. FOR THE PURPOSES OF THIS SECTION, "SYSTEMIC CRITICAL INCIDENT
6 REVIEW" MEANS THE PROCESS BY WHICH THE DEPARTMENT EVALUATES FATALITIES,
7 NEAR FATALITIES AND CRITICAL INCIDENTS TO IDENTIFY PATTERNS IN THE FACTORS
8 THAT INFLUENCE DECISIONS AND ACTIONS AND TO IMPROVE THE QUALITY OF
9 OUTCOMES FOR CHILDREN AND FAMILIES RECEIVING SERVICES FROM THE DEPARTMENT.
10 Sec. 2. Section 41-1292, Arizona Revised Statutes, is amended to
11 read:
12 41-1292. Joint legislative oversight committee on the
13 department of child safety
14 A. The joint legislative oversight committee on the department of
15 child safety is established consisting of the following members:
16 1. The chairperson of the senate committee that addresses child
17 safety issues.
18 2. The chairperson of the house of representatives committee that
19 addresses child safety issues.
20 3. Two members of the senate who are appointed by the president of
21 the senate and who are members of different political parties.
22 4. Two members of the house of representatives who are appointed by
23 the speaker of the house of representatives and who are members of
24 different political parties.
25 B. The chairperson of the senate committee that addresses child
26 safety issues and the chairperson of the house of representatives
27 committee that addresses child safety issues shall serve as
28 cochairpersons.
29 C. The committee shall meet at least biannually, and a majority of
30 the members constitutes a quorum for the transaction of business.
31 D. The committee shall review:
32 1. The department's implementation of policy and procedures and
33 program effectiveness.
34 2. All reports on program outcomes released by the department to
35 the legislature for trends and areas for statutory improvement and audits
36 issued by the office of the auditor general related to the department.
37 3. Policies and procedures relating to guardianships and dependency
38 proceedings.
39 4. SYSTEMIC FACTORS RELATED TO ALLEGED CHILD MALTREATMENT
40 FATALITIES AND NEAR FATALITIES. IN REVIEWING ALLEGED CHILD MALTREATMENT
41 FATALITIES OR NEAR FATALITIES, THE COMMITTEE MAY:
42 (a) CRITICALLY ANALYZE THE SYSTEMIC FACTORS THAT MAY HAVE
43 CONTRIBUTED TO AN ALLEGED CHILD MALTREATMENT FATALITY OR NEAR FATALITY,
44 INCLUDING THE LAWS, POLICIES AND PRACTICES OF THE DEPARTMENT OF CHILD
45 SAFETY, THE DEPARTMENT OF ECONOMIC SECURITY, THE ARIZONA HEALTH CARE COST

1 CONTAINMENT SYSTEM AND ANY OTHER STATE AGENCY THAT MAY HAVE BEEN INVOLVED
2 IN THE SAFETY AND WELFARE OF THE CHILD OR WITH THE CHILD'S FAMILY AND THE
3 PERPETRATOR, INCLUDING ANY ECONOMIC, HEALTH, SOCIAL SERVICES, SUPPORTS AND
4 RESOURCES, TO IDENTIFY IMPROVEMENTS THAT COULD MITIGATE FUTURE CHILD
5 MALTREATMENT FATALITIES OR NEAR FATALITIES.
6 (b) REVIEW INTERAGENCY COORDINATION AND COMMUNICATION.
7 (c) IDENTIFY BEST PRACTICES AND SERVICES THAT MAY PREVENT FUTURE
8 MALTREATMENT FATALITIES OR NEAR FATALITIES AND REVIEW THE RECOMMENDATIONS
9 SUBMITTED BY THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM
10 ESTABLISHED BY SECTION 8-469 AND THE STATE FATALITY REVIEW TEAM
11 ESTABLISHED BY SECTION 36-3501.
12 (d) ENTER INTO EXECUTIVE SESSION WHEN NECESSARY TO PROMOTE THE
13 PRIVACY AND SAFETY OF THE DECEDENT'S FAMILY OR EMPLOYEES OF THE DEPARTMENT
14 OF CHILD SAFETY.
15 (e) REVIEW REPORTS PRODUCED AND PRESENTED BY THE CHILD SAFETY
16 FATALITY AND NEAR FATALITY REVIEW TEAM ESTABLISHED BY SECTION 8-469 AND
17 REQUEST ADDITIONAL INFORMATION AND FOLLOW UP ON DETAILS ASSOCIATED WITH A
18 REPORT.