PROPOSED

SENATE AMENDMENTS TO S.B. 1235

(Reference to printed bill)

Strike everything after the enacting clause and insert:

"Section 1. Title 8, chapter 4, article 1, Arizona Revised Statutes, is amended by adding section 8-469, to read:

8-469. Child safety fatality and near fatality review team; membership; duties; definition

A. THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM IS ESTABLISHED IN THE DEPARTMENT OF CHILD SAFETY TO REVIEW ALL REPORTS OF FATALITIES AND NEAR FATALITIES OF A CHILD MADE TO THE CHILD ABUSE HOTLINE. THE TEAM SHALL:

1. HOLD REGULAR MULTIDISCIPLINARY TEAM MEETINGS TO REVIEW REPORTS OF CHILD FATALITIES OR NEAR FATALITIES WHERE THE DEPARTMENT HAD PRIOR INVOLVEMENT WITH THE CHILD, THE CHILD'S FAMILY OR THE PERPETRATOR.

2. IDENTIFY SYSTEMIC TRENDS THAT INFLUENCE DECISIONS AND ACTIONS MADE BY THE DEPARTMENT.

3. RECOMMEND CHANGES TO POLICY AND PRACTICE TO IMPROVE OUTCOMES FOR CHILDREN AND FAMILIES.

4. PROMOTE A CULTURE OF PSYCHOLOGICAL SAFETY WITHIN THE DEPARTMENT BY RESPONDING TO FATALITY AND NEAR FATALITY CASES IN A MANNER THAT PROMOTES LEARNING, TRANSPARENCY AND EMPLOYEE HEALTH.

5. PRODUCE AN ANNUAL CHILD FATALITY AND NEAR FATALITY REPORT AS PRESCRIBED BY SUBSECTION E OF THIS SECTION.

6. 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, A JOINT

LEGISLATIVE OVERSIGHT COMMITTEE OR ANOTHER COMMITTEE APPOINTED BY THE PRESIDENT OF THE SENATE OR THE SPEAKER OF THE HOUSE OF REPRESENTATIVES.

B. THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM SHALL HOLD REGULAR MULTIDISCIPLINARY TEAM MEETINGS TO:

1. REVIEW REPORTS OF CHILD FATALITIES OR NEAR FATALITIES MADE TO THE CHILD ABUSE HOTLINE WHERE THE DEPARTMENT HAD INVOLVEMENT WITH THE CHILD, THE CHILD'S FAMILY OR THE PERPETRATOR WITHIN THE PRIOR THREE YEARS.

2. SELECT CASES FOR SYSTEMIC LEARNING AND ORDER THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM TO DO A SYSTEMIC CRITICAL INCIDENT REVIEW OF THOSE CASES.

3. RECEIVE FINDINGS FROM SYSTEMIC CRITICAL INCIDENT REVIEWS AT LEAST QUARTERLY AND RECOMMEND CHANGES TO DEPARTMENT POLICY AND PRACTICE.

C. THE MULTIDISCIPLINARY TEAM SHALL CONSIST OF DEPARTMENT EMPLOYEES DESIGNATED BY THE DIRECTOR. THE DIRECTOR SHALL ALSO APPOINT, AT A MINIMUM, THE FOLLOWING PUBLIC MEMBERS WHO SHALL BE TRAINED IN SAFE SYSTEM IMPROVEMENT:

1. A LICENSED PEDIATRICIAN WHO HAS PROFESSIONAL EXPERIENCE RELATING TO CHILD ABUSE AND NEGLECT.

2. A PEACE OFFICER WHO HAS EXPERIENCE INVESTIGATING CHILD ABUSE AND NEGLECT FATALITIES AND NEAR FATALITIES.

3. A PRACTICING SOCIAL WORKER.

4. A BEHAVIORAL HEALTH PRACTITIONER.

5. AN ATTORNEY WHO HAS PAST PROFESSIONAL EXPERIENCE REPRESENTING CHILDREN IN CHILD ABUSE AND NEGLECT CASES.

D. IN CONDUCTING CHILD FATALITY AND NEAR FATALITY REVIEWS, THE MULTIDISCIPLINARY TEAM MAY CONSULT WITH THE DEPARTMENT OF HEALTH SERVICES, THE DEPARTMENT OF ECONOMIC SECURITY, THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM OR ANY OTHER GOVERNMENTAL ENTITY THAT MAY HAVE INFORMATION PERTINENT TO A CHILD FATALITY OR NEAR FATALITY.

E. THE DEPARTMENT SHALL PRODUCE AN ANNUAL REPORT OF INFORMATION GATHERED DURING ITS REVIEW OF CHILD FATALITIES AND NEAR FATALITIES. THIS REPORT SHALL INCLUDE ALL OF THE FOLLOWING:

1. THE TOTAL NUMBER OF FATALITY AND NEAR FATALITY REPORTS IN A FISCAL YEAR, BY COUNTY.

2. THE NUMBER OF ALLEGATIONS THAT ARE SUBSTANTIATED AND UNSUBSTANTIATED.

3. THE NUMBER OF REPORTS DUE TO ABUSE AND WHETHER THE REPORTS WERE SUBSTANTIATED OR UNSUBSTANTIATED.

4. THE NUMBER OF REPORTS DUE TO NEGLECT AND WHETHER THE REPORTS WERE SUBSTANTIATED OR UNSUBSTANTIATED.

5. THE NUMBER OF REPORTS WHERE THE FAMILY HAD PREVIOUS DEPARTMENT INVOLVEMENT.

6. SYSTEMIC TRENDS THAT INFLUENCE THE PRACTICE AND DECISIONS MADE BY THE DEPARTMENT AND AREAS FOR IMPROVEMENT.

7. DETAILS OF CASES THAT PRESENT OPPORTUNITIES FOR SYSTEMIC LEARNING OR THAT DEMONSTRATE OPPORTUNITIES FOR SYSTEMIC CHANGE.

F. MULTIDISCIPLINARY TEAM MEETINGS ARE NOT SUBJECT TO TITLE 38, CHAPTER 3, ARTICLE 3.1.

G. THE DEPARTMENT SHALL PRESENT THE REPORT REQUIRED BY SUBSECTION E OF THIS SECTION AT A PUBLIC MEETING OF A STANDING COMMITTEE OF THE LEGISLATURE, A JOINT LEGISLATIVE OVERSIGHT COMMITTEE OR A COMMITTEE APPOINTED BY THE PRESIDENT OF THE SENATE OR THE SPEAKER OF THE HOUSE OF REPRESENTATIVES FOR THE PURPOSE OF INFORMING POLICYMAKERS ON SYSTEMIC CHANGES REQUIRED TO IMPROVE THE CHILD WELFARE SYSTEM UNLESS THE APPLICABLE COMMITTEE DEEMS IT NECESSARY TO HOLD AN EXECUTIVE SESSION TO PROTECT THE PRIVACY OR SAFETY OF INDIVIDUALS INVOLVED IN THE FATALITY OR NEAR FATALITY. INFORMATION MAY NOT BE FURTHER DISCLOSED UNLESS A COURT ORDERS THE DISCLOSURE OF THIS INFORMATION, THE INFORMATION IS DISCLOSED IN A PUBLIC OR COURT RECORD OR THE INFORMATION IS DISCLOSED IN THE COURSE OF A PUBLIC

MEETING OR COURT PROCEEDING. THE COMMITTEE MAY GO INTO EXECUTIVE SESSION TO RECEIVE CONFIDENTIAL INFORMATION.

H. THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM SHALL RESPOND TO REQUESTS FOR ADDITIONAL INFORMATION REGARDING A CHILD FATALITY OR NEAR FATALITY MADE PURSUANT SECTION 41-1292, SUBSECTION D WITHIN NINETY DAYS AFTER RECEIVING THE REQUEST.

I. EXCEPT AS PROVIDED IN SECTIONS 8-807 AND 8-807.01, INFORMATION GATHERED PURSUANT TO THIS SECTION IS CONFIDENTIAL. PUBLIC MEMBERS OF THE TEAM MAY RECEIVE CONFIDENTIAL DEPARTMENT INFORMATION BUT MAY NOT FURTHER DISCLOSE THE INFORMATION UNLESS AUTHORIZED BY LAW.

J. FOR THE PURPOSES OF THIS SECTION, "SYSTEMIC CRITICAL INCIDENT REVIEW" MEANS THE PROCESS BY WHICH THE DEPARTMENT EVALUATES FATALITIES, NEAR FATALITIES AND CRITICAL INCIDENTS TO IDENTIFY PATTERNS IN THE FACTORS THAT INFLUENCE DECISIONS AND ACTIONS AND TO IMPROVE THE QUALITY OF OUTCOMES FOR CHILDREN AND FAMILIES RECEIVING SERVICES FROM THE DEPARTMENT.

Sec. 2. Section 41-1292, Arizona Revised Statutes, is amended to read:

41-1292. Joint legislative oversight committee on the department of child safety

A. The joint legislative oversight committee on the department of child safety is established consisting of the following members:

1. The chairperson of the senate committee that addresses child safety issues.

2. The chairperson of the house of representatives committee that addresses child safety issues.

3. Two members of the senate who are appointed by the president of the senate and who are members of different political parties.

4. Two members of the house of representatives who are appointed by the speaker of the house of representatives and who are members of different political parties.

B. The chairperson of the senate committee that addresses child safety issues and the chairperson of the house of representatives committee that addresses child safety issues shall serve as cochairpersons.

C. The committee shall meet at least biannually, and a majority of the members constitutes a quorum for the transaction of business.

D. The committee shall review:

1. The department's implementation of policy and procedures and program effectiveness.

2. All reports on program outcomes released by the department to the legislature for trends and areas for statutory improvement and audits issued by the office of the auditor general related to the department.

3. Policies and procedures relating to guardianships and dependency proceedings.

4. SYSTEMIC FACTORS RELATED TO ALLEGED CHILD MALTREATMENT FATALITIES AND NEAR FATALITIES. IN REVIEWING ALLEGED CHILD MALTREATMENT FATALITIES OR NEAR FATALITIES, THE COMMITTEE MAY:

(a) 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 THE DEPARTMENT OF CHILD SAFETY, THE DEPARTMENT OF ECONOMIC SECURITY, THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM 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.

(b) REVIEW INTERAGENCY COORDINATION AND COMMUNICATION.

(c) IDENTIFY BEST PRACTICES AND SERVICES THAT MAY PREVENT FUTURE MALTREATMENT FATALITIES OR NEAR FATALITIES AND REVIEW THE RECOMMENDATIONS SUBMITTED BY THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM ESTABLISHED BY SECTION 8-469 AND THE STATE FATALITY REVIEW TEAM ESTABLISHED BY SECTION 36-3501.

(d) ENTER INTO EXECUTIVE SESSION WHEN NECESSARY TO PROMOTE THE PRIVACY AND SAFETY OF THE DECEDENT'S FAMILY OR EMPLOYEES OF THE DEPARTMENT OF CHILD SAFETY.

(e) REVIEW REPORTS PRODUCED AND PRESENTED BY THE CHILD SAFETY FATALITY AND NEAR FATALITY REVIEW TEAM ESTABLISHED BY SECTION 8-469 AND REQUEST ADDITIONAL INFORMATION AND FOLLOW UP ON DETAILS ASSOCIATED WITH A REPORT."

Amend title to conform

JANAE SHAMP

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