

PROPOSED
SENATE AMENDMENTS TO S.B. 1235
(Reference to printed bill)

1 Strike everything after the enacting clause and insert:

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 OF
11 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 PROMOTES
19 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 JOINT

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

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

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

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

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

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

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

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

21 3. A PRACTICING SOCIAL WORKER.

22 4. A BEHAVIORAL HEALTH PRACTITIONER.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 41-1292. Joint legislative oversight committee on the
19 department of child safety

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

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

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

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

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

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

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

6 D. The committee shall review:

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

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

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

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

17 (a) CRITICALLY ANALYZE THE SYSTEMIC FACTORS THAT MAY HAVE
18 CONTRIBUTED TO AN ALLEGED CHILD MALTREATMENT FATALITY OR NEAR FATALITY,
19 INCLUDING THE LAWS, POLICIES AND PRACTICES OF THE DEPARTMENT OF CHILD
20 SAFETY, THE DEPARTMENT OF ECONOMIC SECURITY, THE ARIZONA HEALTH CARE COST
21 CONTAINMENT SYSTEM AND ANY OTHER STATE AGENCY THAT MAY HAVE BEEN INVOLVED
22 IN THE SAFETY AND WELFARE OF THE CHILD OR WITH THE CHILD'S FAMILY AND THE
23 PERPETRATOR, INCLUDING ANY ECONOMIC, HEALTH, SOCIAL SERVICES, SUPPORTS AND
24 RESOURCES, TO IDENTIFY IMPROVEMENTS THAT COULD MITIGATE FUTURE CHILD
25 MALTREATMENT FATALITIES OR NEAR FATALITIES.

26 (b) REVIEW INTERAGENCY COORDINATION AND COMMUNICATION.

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

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

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

8 Amend title to conform

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