Arizona Citizen Review Panel

SEVENTH ANNUAL REPORT

DECEMBER 2005

Arizona Department of Health Services
Public Health Prevention Services
Office of Women's and Children's Health

Leadership for a Healthy Arizona

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State of Arizona

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Arizona Department of Health Services

MISSION

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EXECUTIVE SUMMARY

This Seventh Annual Citizen Review Panel Report summarizes the findings of 23 reviewed cases of severe maltreatment, including fatalities that occurred between July 2004 and October 2005.

The most prevalent family risk factors identified during the reviews were lack of parenting skills (20/23 cases) and substance abuse (18/23 cases). Methamphetamine use often creates a hazardous environment and in 30 percent of all cases reviewed, directly contributed to the child's death or near-fatal maltreatment. The Citizen Review Panel commends efforts by Child Protective Services to address the devastating impact of this drug, but also recommends additional training be provided to case managers on the assessment and management of maltreatment cases complicated by parental methamphetamine abuse.

In general, the Citizen Review Panel concluded that the intake/screening and case planning/implementation stages of the Child Protective Services (CPS) program are its strengths. There were however, concerns about the management of cases involving medically fragile children that were not always adequately assessed or monitored. While the panel found that, in most cases reviewed, activities in the safety assessment/crisis intervention stage were timely and appropriately completed, the panel determined that in six cases immediate and adequate steps were not taken to ensure the safety of the child. The panel was also concerned with the failure to complete safety assessments on all parents/custodians and to identify all safety concerns. Although case planning and implementation were appropriate and timely in the majority of cases reviewed, barriers to implementation that may be beyond the control of CPS were identified and included parental substance abuse, incarceration and refusal to obtain services.

There were a number of problems identified in the investigation stage. First, record reviews revealed that case managers did not comply with investigation policies in 10 out of the 23 cases reviewed. Policies not followed included requirements to contact known sources of pertinent information, interview all children and parents, and obtain medical, law enforcement, and court records critical to the investigation. In addition, the Citizen Review Panel disagreed with the investigation findings in 10 of the 23 cases. Disagreements included the failure to substantiate allegations and the failure to amend findings to reflect current, accurate facts within the Children's Information Library and Data Source (CHILDS) system.

In addition to the current episode of maltreatment, the Citizen Review Panel also reviewed prior CPS involvement with the family. Panels determined if appropriate steps had been taken during the past episodes of maltreatment that could have prevented the most recent episode of maltreatment. In 15 of the 23 cases reviewed by the Citizen Review Panels, CPS had investigated the families in the past. Among these 15 cases there were 54 prior reports. Panels were especially concerned about past case closures that had occurred without completion of a thorough investigation and resolution of safety concerns. Panels determined that in eight of these 15 cases, adequate steps had not been taken to ensure the safety of the child and that safety concerns were not sufficiently addressed prior to case closure.

At the conclusion of each case review, panels were asked to determine if Child Protective Services followed policies throughout the case. Although Child Protective Services has made significant efforts to improve the quality of investigations and ongoing case management through the development and enhancement of policies and procedures, panels identified only eight of the 23 cases in which policies were adequately followed. This finding suggests that there may be barriers to successful policy implementation that need to be identified. While there are many possible reasons for this failure to follow policies, the Citizen Review Panels did find that the most exemplary cases were cases in which the CPS supervisor clearly had worked closely with the case manager and demonstrated knowledge of policies. This finding suggests that closer involvement of supervisors may enhance not only compliance with established policy, but also improve the outcome for children and their families.

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CITIZEN REVIEW PANEL OVERVIEW

This is the seventh annual report from Arizona's Citizens Review Panels. Citizen Review Panels are members of the community who volunteer their time and energy to the betterment of the lives of Arizona's children. Volunteers from the community bring an array of perspectives, experiences, and expertise to these efforts.

BACKGROUND AND PURPOSE

Arizona's Citizen Review Panel Program was established in 1999 in response to the 1996 amendment to the Child Abuse Prevention and Treatment Act requiring states to develop and establish Citizen Review Panels. The purpose of citizen review is to determine whether state and local agencies are effectively discharging their child protection responsibilities. Panels develop recommendations for improvement of Child Protective Services through independent, unbiased reviews by panels composed of citizens, social service, legal, medical, education, and mental health professionals.

The creation of the Citizen Review Panel is an acknowledgment that protection of our children is the responsibility of the entire community, not a single agency. The entire community has a stake in protecting the safety of its children. While the primary focus of oversight is the Arizona Department of Economic Security/Division of Children, Youth and Families (ADES/DCYF), the Citizen Review Panel takes into consideration the impact of these other entities and assesses whether they support or hinder the state's efforts to protect children from abuse and neglect.

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

The Child Abuse Prevention and Treatment Act (SEC.106 [42 U.S.C. 5106a]) was enacted in 1974 to provide grants to states to support innovations in state child protective services and community-based preventive services, as well as research, training, data collection, and program evaluation. CAPTA requires states receiving a Basic State Grant to establish no less than three citizen review panels, composed of volunteer members who are broadly representative of their community, including members who have expertise in the prevention and treatment of child abuse and neglect. Each panel must meet at least once every three months and evaluate the extent to which the state agency is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan. In addition, panels are required to review child fatalities and near-fatalities and examine other criteria important to ensure the protection of children, such as the extent to which the state child protective service system is coordinated with the foster care and adoption programs established under title IV-E of the Social Security Act.

Section 106(c)(5)(A) of CAPTA requires states to provide each citizen review panel with access to information on cases that the panel chooses to review if the information is necessary for the panel to carry out its functions under CAPTA. Report language clarifies that Congressional intent was to direct states to provide the review panels with information that the panel determines is necessary to carry out these functions.

Section 106(d) of CAPTA requires that the citizen review panels develop annual reports and make them available to the public. These reports must be completed no later than December 31st of each year and should, at a minimum, contain a summary of the panel's activities, as well as the recommendations of the panel based upon its activities and findings.

Citizen review panel members are bound by the confidentiality restrictions in section 106(c)(4)(B)(i) of CAPTA. Specifically, members and staff of a panel may not disclose identifying information about any specific child protection case to any person or government official, and may not make public other information unless authorized by state statute to do so.

Keeping Children and Families Safe Act of 2003 amended CAPTA to include the following requirements:

1. Each panel shall examine the practices (in addition to policies and procedures) of the state and local child welfare agencies.

2. Panels shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community.

3. Each panel shall make recommendations to the state and public on improving the child protective services system.

4. The appropriate state agency is required to respond in writing no later than six months after the panel recommendations are submitted. The state agency's response must include a description of whether or how the state will incorporate the recommendations of the panel (where appropriate) to make measurable progress in improving the state child protective services system. The Arizona Department of Economic Security response to the 2004 Citizen Review Panel Report is included in Appendix A.

PROGRAM STRUCTURE

The Arizona Department of Health Services, through an interagency service agreement with the Arizona Department of Economic Security, administers Arizona's Citizen Review Panel Program. The Arizona Department of Economic Security is the state agency responsible for the provision of child protection services. During the program's planning stages, it was determined that location of this program outside the Department of Economic Security would be critical to achieve the independence necessary for an effective, objective program. Arizona Department of Health Services provides administrative support and oversees the operation of the program at the state level.

Arizona maintains three panels, which are located in Maricopa, Pima, and Yavapai counties. Appendix B lists the membership of each panel. These panels provide coverage of all counties in Arizona. Panels are responsible for review of Child Protective Service statewide policies, local procedures, pertinent data sources, and individual case records to determine compliance with CAPTA requirements and the State Plan. The State Citizen Review Panel, located in Maricopa County, serves a dual purpose of assessment of Child Protective Services and oversight of the two local panels located in Pima County and Yavapai County.

PANEL ACTIVITIES: DECEMBER 2004 THROUGH NOVEMBER 2005

CAPTA requires that citizen review panels develop annual reports and make them available to the public no later than December 31st of each year. This report reflects activities of the panel between December 1, 2004 and November 30, 2005.

PUBLIC OUTREACH

The Arizona Department of Health Services, Citizen Review Panel website solicits comments from the public on Arizona Child Protective Services. Questions regarding specific cases are directed to the appropriate agency for assistance. Public comments are considered in the development of this report.

MEETINGS

Each panel met on a more frequent basis than the quarterly requirement. The Pima County Citizen Review Panel met on eight occasions and completed eight case reviews. The Yavapai County Citizen Review Panel met on nine occasions and completed nine case reviews. The State Citizen Review Panel met on eight occasions and completed six case reviews.

Reviewed cases represented eight counties including Coconino County (1 case), Maricopa County (6 cases), Mohave County (1 case), Navajo County (2 cases), Pima County (7 cases), Pinal County (1 case), Yavapai County (4 cases), and Yuma County (1 case).

CASE RECORD REVIEWS

The Department of Economic Security provides quarterly lists of all reports that include allegations of fatalities, near-fatalities and high risk that are due to maltreatment to the Citizen Review Panel program. From this list, the program selects cases for review. In addition, the Department of Economic Security may request reviews of specific cases in need of an external review. Cases reviewed for this reporting period must have included a report investigated after July 1, 2004. Reviewed cases include those in which children remain in the family's home and those in which children have been removed by Child Protective Services. Reviewed cases are not meant to be representative of all Child Protective Services cases, but rather an examination of cases of fatalities and near-fatalities and the specific steps followed during the course of an open case. During this reporting period, Arizona Citizen Review Panels completed 23 case record reviews. Fourteen cases involved child fatalities due to maltreatment and 9 cases involved near-fatalities and other high-risk cases of maltreatment.

Case record reviews consist of the assessment of specific activities by Child Protective Services during their involvement with families. Throughout the review, the panel identifies risk factors and determines whether Child Protective Services appropriately addressed these risks when conducting the investigation. Appendix C is the case review form completed by panels to document findings from each review. Upon completion of each review, the panel is asked the key questions of whether state and federal policies were followed and whether the panel

recommends any changes in policies and procedures. The results of each review are entered into a database that is maintained by Arizona Department of Health Services.

Case reviews assess the Child Protective Service case in six stages. The stages of review include Intake and Screening, Investigation, Crisis Intervention, Investigative Finding/Determination, Case Plan Implementation, and Case Closure.

The Prior Child Protective Service History section was formally added to the review process this reporting period. Review of prior history with Child Protective Services provides a broader picture of the family and the efforts the agency has made with the family. During this portion of each review the panel assesses prior involvement to determine if safety concerns were adequately addressed and if appropriate services were offered.

The Intake and Screening Stage involves activities performed by the Child Protective Services Child Abuse Hotline. This stage includes the identification of a risk level and the type of maltreatment. The panel reviews the record to determine if the hotline accurately assigned the report and obtained sufficient, available information from the caller. The panel also determines if the hotline assigned the report to the local office in a timely manner and whether law enforcement was properly notified.

The Investigation Stage involves activities performed by Child Protective Service investigators when gathering information to assess the child's immediate safety needs and determining whether a reported or disclosed incident of maltreatment occurred. The panel reviews the record to determine if specific steps were followed during the investigation.

The Crisis Intervention and Safety Assessment Stage involves ensuring the safety of the child. The panel assesses whether or not Child Protective Services accurately assessed the child's safety and adequately responded to safety concerns. This includes assessing the decision that the child could safely remain in the home or that emergency removal was necessary.

The Investigative Finding/Determination Stage refers to the process of classifying a report as substantiated or unsubstantiated based on information collected and analyzed during investigation. At this stage, the panel ascertains if Child Protective Services gathered sufficient information to make a final determination and if that determination is supported by case record documentation. The panel also concludes if relevant consultations and notifications were completed.

The Case Planning and Implementation Stage refers to activities by Child Protective Services to ensure families receive timely, appropriate services designed to address the reasons children entered the child protective service system. The panel has the task of determining whether the plans address both reducing the risk to children and enhancing family functioning. Plans should be based on an accurate family assessment, individualized to family circumstances, and modified as family circumstances change. The panel also explores community involvement with each case.

The Case Closure Stage should occur when the issues that led to the family's involvement with Child Protective Services, or subsequent issues identified by the agency during its involvement with the family, are resolved or significantly improved, or permanency has been achieved. The panel assesses whether risks were sufficiently identified and resolved prior to closure and if the closure was discussed with superiors.

CASE RECORD REVIEW FINDINGS

Child Protective Services received 37,657 reports of alleged maltreatment from December 1, 2004 through November 30, 2005. Of those reports, 37 were fatalities and 16 were designated as near-fatalities. Last year's report recommended that measures be taken to improve the accuracy of tracking investigations involving near-fatalities. Although this year's data shows 16 near-fatalities reported in comparison to six near-fatalities reported in the prior year, this appears to continue to be underreported. Child Protective Services substantiated 27 of the 53 reported cases of fatalities and near-fatalities. Additional reports may be substantiated at a later date as a result of the Child Protective Services appeals process.

The Citizen Review Panel reviewed 23 cases during this reporting period. Records reviewed included maltreatment reports investigated by Child Protective Services between July 2004 and October 2005. The remainder of this report presents information on Citizen Review Panel findings and recommendations to promote improvements within Arizona's child protective services agency.

Appendix D provides the detailed findings from case reviews. The following summarizes the Citizen Review Panel findings for each stage:

Prior Child Protective Service History

Fifteen reviewed cases were open with Child Protective Services prior to the investigation reviewed by the panel. Within these 15 cases there were 54 prior reports.

Panels determined that in eight cases adequate steps were not taken to ensure the safety of the child and that safety concerns were not sufficiently addressed prior to case closure. In these cases, panels identified issues such as the failure to contact relevant sources of information, failure to interview all children in the household, failure to identify and address safety concerns, and failure to obtain records pertaining to the allegations.

Intake and Screening Stage

As in previous years, record reviews identified this stage as a strength of the child protection system. Panels found that actions taken by the Child Protective Services Hotline were complete, accurate, and timely in 22 cases reviewed and disagreed in one case with the hotline's decision to not accept a call as a report.

Investigation Stage

During reviews, panel members assess numerous aspects of each investigation, identifying areas of strength and weakness within the system. Findings from this stage included:

- Records reflected that during the investigation stage, case managers did not comply with existing protocol or policies in 10 out of the 23 cases reviewed. Policies not followed included requirements to contact known sources of pertinent information, interview all children and parents, and obtain medical, law enforcement, and court records critical to the investigation.
- Other children in the home were interviewed in eight cases, but were not interviewed in six cases.
- Panels determined that of the 20 cases requiring joint investigations with law enforcement, interagency protocols were followed in 14 cases and were not followed in three cases. Panels could not determine if protocols were followed in three cases.
- In 17 of the 23 cases reviewed, Child Protective Services was thorough and accurate when investigating the existence, cause, nature, and extent of maltreatment.
- Necessary medical evaluations were completed in a timely manner in 14 of the 19 applicable cases.
- When appropriate, eight of the nine reported victims were interviewed alone, away from the alleged perpetrator.

Crisis Intervention and Safety Assessment Stage
Ensuring the child's safety is the most critical role of Child Protective Services. Overall, reviews concluded that Child Protective Services fulfilled this role. In 15 cases, panels concluded that adequate steps were taken to ensure the child's safety. In cases in which ample measures were not taken to ensure the child's safety, panels concluded that safety assessments did not identify or address all safety concerns, such as a history of domestic violence, mental illness, and substance abuse. Panels also concluded that risks to medically fragile children were not adequately assessed or monitored. In addition, safety assessments were not consistently completed on all parents or guardians.

Investigative Finding/Determination Stage
Panels concluded that Child Protective Services gathered sufficient information during the course of the investigation in 17 of the 23 cases reviewed; however agreed with the investigative finding in only 13 of the 23 cases. Concerns with this stage include disagreement with unsubstantiated findings, and failure by Child Protective Services to amend the allegation findings that reflect current, accurate facts within the Children's Information Library and Data Source (CHILDS) system. This includes failure to enter correct victim and perpetrator names and failure to enter findings to reflect deaths resulting from the alleged maltreatment that occurred after the hotline report.

Case Planning and Implementation Stage
This stage applied to 18 cases that remained open after the investigation. Panels determined that overall, case planning and ongoing case management activities were appropriate and timely. Panels determined that in 12 cases family needs were adequately addressed within the case plan. In 14 cases the case plan was developed timely and reviewed in accordance with policy, parents or guardians were involved with case planning, and appropriate services

were offered. Barriers to providing services included parental incarceration, parental substance abuse, and refusal to participate in services.

Case Closure Stage

Five cases reviewed were closed at the time of the case review. The panels agreed with the decision to close three of the cases. In one case, panel members determined that unresolved risks warranted continued involvement with the family by Child Protective Services. Panels expressed concerns about case closures from investigations that occurred prior to the report involving fatal or near-fatal maltreatment. Concerns included the failure to conduct thorough investigations and resolve safety concerns before closure.

Family Risk Factors

Throughout the review, panel members identify specific risk factors for each case. As a result of this process, panels are able to determine if Child Protective Services adequately identified and resolved risks contributing to the maltreatment. Lack of parenting skills, substance abuse, and lack of parental motivation were the most prevalent factors for reviewed fatalities, near-fatalities, and high-risk cases. Below are the risk factors identified in the reviews. The items on this list are not mutually exclusive and more than one factor may be noted for a single case.

▪ Lack of parenting skills	20
▪ Substance abuse	18
▪ Lack of motivation to provide adequate care	15
▪ Lack of physical or mental ability to provide adequate care	12
▪ Domestic violence	12
▪ Mental health problem	12
▪ Anger control problem	12
▪ Lack of resources for adequate food/shelter/medical care/childcare	10
▪ Violence by parent/guardian outside of home	6
▪ Prior substantiated reports	5
▪ Teen Parent	3
▪ Prior removals by CPS or severance of parental rights	2
▪ Prior child death	1

At the conclusion of case reviews, panels were asked to determine if state and federal policies were followed. During this reporting period, panels concluded that state and federal policies were followed in eight cases. This is a significant decrease from the last reporting period, during which panels determined that policies were followed in 17 out of the 23 cases reviewed.

Child Protective Services has made efforts to improve the quality of investigations and ongoing case management through the development and enhancement of policies and procedures. Specifically noted were policies regarding safety assessments, risk assessments, clinical reviews, peer reviews and critical thinking. The finding that policies were not followed in the majority of cases reviewed suggests there may be barriers to successful policy implementation that need to be identified.

Several cases demonstrated exceptional efforts, case management and supervisory skills. The panel concluded that the supervisor's role was critical in cases displaying exemplary work. Supervisory review and guidance were well documented in these cases. As a result, the panel decided to include acknowledgement of exceptional work by supervisors with this year's commendations. The Citizen Review Panel sent letters of commendation to case managers and supervisors of seven cases.

RECOMMENDATIONS

All findings and recommendations from the 23 cases reviewed were considered in determining the recommendations. The Citizen Review Panel respectfully submits the following recommendations to the Department of Economic Security, Division of Children, Youth, and Families (DCYF):

1. DCYF should develop policy requiring that during investigations, in which the alleged perpetrator is the non-custodial parent, a safety assessment be completed on both parents' homes and the non-custodial parent be interviewed in person.

2. Child Protective Services investigators should obtain and review relevant documents and records prior to the conclusion of the investigation. This includes the child's medical records, court documents such as protection orders and court-ordered supervised visitation, and law enforcement reports of domestic violence. DCYF should develop strategies to increase compliance with policy that currently addresses this issue.

3. Child Protective Services investigators should contact all known sources of information relevant to the investigation. DCYF should develop strategies to increase compliance with policy that currently addresses this issue.

4. DCYF should develop policy that directs staff to obtain second opinions when a physician is non-committal about the cause of a suspicious injury.

5. Preconceived assumptions as to the validity of an allegation should never be made prior to a thorough investigation. This is a particular concern when there is an appearance of a custody dispute. DCYF should include this topic within initial Child Protective Services training.

6. DCYF should implement training for Child Protective Services case managers and supervisors on assessing risks to children with special medical needs, such as children with chronic health conditions, substance-exposed infants, premature infants, and health concerns resulting from injury.

7. Local Child Protective Services offices and law enforcement should meet periodically to promote effective joint investigations.

8. The Citizen Review Panel supports the establishment of a national child abuse registry, as a tool to strengthen states' child protection efforts.

9. Ninety percent of cases reviewed by the panel involved parental or caretaker substance abuse. Methamphetamine use often creates a hazardous environment and in 30 percent of the cases reviewed, directly contributed to the child's death or near-fatal maltreatment. The Citizen Review Panel commends efforts by Child Protective Services to address the devastating impact of this drug, but also recommends additional training be provided to case managers on the assessment and management of maltreatment cases complicated by parental methamphetamine abuse.

CITIZEN REVIEW PANEL OBJECTIVES FOR 2006

The following includes the Citizen Review Panel's objectives for 2006:

1. In 2006 the Citizen Review Panel will continue to review Child Protective Services' cases involving reports of fatal and near fatal maltreatment.

2. Throughout this reporting period, the Citizen Review Panel provided informal feedback to the local Child Protective Services offices and the state administration as needed. Child Protective Services and the Citizen Review Panel program have formalized a plan for 2006 to provide feedback on concerns and trends identified during reviews to local Child Protective Services offices. This plan includes:

    a. The addition of local Child Protective Services Practice Improvement Specialists to each panel. This individual will utilize information obtained in the reviews to improve practices in their districts, as well as provide feedback to the District Program Managers within Child Protective Services.

    b. The Citizen Review Panel will provide quarterly updates to the District Program Managers and the Division of Children, Youth, and Families administration. Situations that appear to require immediate attention will be immediately addressed.

    c. The Citizen Review Panel will be invited to participate in Child Protective Services high profile staffings.

    d. The Citizen Review Panel will identify cases that are examples of both superior and problematic casework to be used for training purposes.

3. The Citizen Review Panel will examine efforts by the Department of Economic Security to improve staff retention within Child Protective Services and form recommendations to enhance these efforts.

4. The Citizen Review Panel will develop a plan with the Department of Economic Security to assist with reviews of draft policy and procedural changes.

5. In 2006 the Citizen Review Panel will assess the impact and implementation of previous years' recommendations to the Department of Economic Security.

APPENDIX A: AGENCY RESPONSE TO CITIZEN REVIEW PANEL'S 2004 RECOMMENDATIONS

Recommendation 1: During the course of an investigation, an interpreter should never be a child, a member of the family, an acquaintance of the family, or have an interest in the outcome. The Citizen Review Panel recommends development of policy regarding the use of interpreters, including selection of appropriate interpreters.

Response: The department agrees that whenever possible, a child, family member or acquaintance should not be used as an interpreter during an investigation. The efforts to improve the ability for CPS to communicate with non-English speaking families will continue though recruitment of bilingual staff. In SFY 2004, 191 CPS employees were certified as bilingual in Spanish, Navajo, or Hopi. These individuals receive a stipend for conducting or assisting with investigations on cases involving non-English speaking families.

Additional policy and practices are in place to assist CPS staff determine when the services of an interpreter or bilingual staff may be required. DCYF policy contains guidelines to consider when preparing to respond to a report, including the need for an interpreter.

In an effort to alert CPS staff that an interpreter may be needed to assist on an investigation, Hotline staff asks all reporting sources about the family's primary language, and includes this information in the CPS report There are times when the reporting source does not have this information and a CPS Specialist is not aware**,** prior to responding to the report that an interpreter**,** will be needed. If the CPS Specialist does not speak the family's language, it may be necessary to utilize someone in the home to briefly inform the family that a CPS report has been received and make arrangements for an interpreter. The case is generally reassigned to a bilingual staff person if the CPS Specialist does not speak the family's language, or arrangements are made for an interpreter.

Recommendation 2: It is critical to consider the family's history of reports, both substantiated and unsubstantiated, when assessing the safety of children. This recommendation was made in 2001, but continues to be a concern during reviews. The Citizen Review Panel recommends that this step be emphasized in case management training and assessed during supervisory reviews or other quality assurance reviews of investigations.

Response: The department agrees that an assessment of child safety and risk of harm must include a review and consideration of the family's prior CPS history regardless of the investigation finding. The DCYF has implemented the following methods to emphasize the importance of reviewing a family's previous history of child abuse and neglect:

- Provision of training to case managers and supervisors by the Child Welfare Training Institute (CWTI) on policies for reviewing prior CPS history and the importance of considering such information in decision making.

- Requiring sufficient information to be gathered in all cases including the review of prior CPS history. When completing the Strengths and Risks Assessment**,** specific questions about prior history of child abuse and neglect are discussed with the family and this information is considered in determining a level of risk and need for continued intervention or services.
- Use of the clinical supervision process to identify cases in which there is prior CPS history and if so, if previous investigation outcomes have been reviewed to assess causes for repeated reports. This process provides an opportunity for the supervisor to provide oversight and training to their staff.

CPS Specialists are currently required to document in CHILDS when a review of prior CPS reports, medical, psychological, educational records, and police reports has been conducted. Additional documentation of the review of prior history may be explained by the case manager in written case notes.

Recent access to the CHILDS database by the Citizen Review Panels will enable the Panels to view information. Access was accomplished through a data sharing agreement which should facilitate the Panels' review of cases and provide an ability to view activities that are documented in windows as well as contacts and investigative case notes.

Recommendation 3: Complex investigations, including those involving families with numerous prior reports, may require the assistance of multidisciplinary teams. The Citizen Review Panel recommends development of multidisciplinary teams for guidance in investigations.

Response: The department agrees that during complex investigations, assistance and guidance from multidisciplinary teams as well as other existing resources is valuable. This case consultation is available through various mechanisms. Currently four multidisciplinary teams, supported by Children's Services and CAPTA funding**,** are functional within four ACYF Districts. These multidisciplinary teams are available statewide for case consultation.

CPS staffs also obtain consultation and guidance during investigations through case reviews with Child and Family Teams, staff at child advocacy centers, and, in some districts, through participation in weekly staffings with hospital social workers and physicians, and coordination with other professionals who are co-located with CPS staff including mental health professionals.

Recommendation 4: Panels noted disparities in the quality of investigations in some areas of the state that have infrequent high-risk reports. The Citizen Review Panel recommends that a consultation procedure be established to assist in the investigation of high-risk cases, particularly in areas that may have infrequent high-risk reports such as fatalities and near-fatalities.

Response: The department does not agree with the development of a statewide consultation procedure. DCYF currently has written protocol for the review of high profile cases that includes high-risk reports. Additional processes are in place to assist staff including the ability to utilize district operating procedures, multidisciplinary teams and case consultation with staff as necessary. The DCYF is exploring the option of identifying staff, with expertise

in investigating high-risk reports, being available to provide the recommended case consultation.

Recommendation 5: In order to obtain an accurate medical assessment of maltreatment, it is critical to provide available information, including history of prior injuries, medical history, and information regarding prior history of maltreatment to physicians. It is recommended that case managers routinely provide physicians with available history of prior injuries, suspected maltreatment, and medical histories.

Response: The department agrees that provision of all available information regarding a child's history to physicians is critical to assist in making an accurate medical assessment. DCYF policy directs staff to gather specific information about the child including prior history, medical information and obtaining medical examinations. DCYF will further clarify policy to ensure that all relevant information is provided to the medical provider, and this activity be documented in the case record.

Recommendation 6: During the reporting period, only six investigations by Child Protective Services were identified as cases involving near-fatalities, compared to 26 cases involving fatalities. A "near-fatality" is defined in CAPTA under section 106 (b)(4)(A) as ". . . an act that, as certified by a physician, places the child in serious or critical condition." The panel recommends that measures be taken to improve the accuracy of tracking investigations involving near-fatalities.

Response: The department agreed that staff needed to be reminded of the necessity to identify and track cases that meet the CAPTA definition of a "near-fatality" and to document such cases in CHILDS. On April 15, 2005, DCYF sent a clarification email to all CPS staff regarding this CAPTA provision, guidelines to assist in determining when a case may be a "near-fatality" and requirements for obtaining a statement from a physician.

Recommendation 7: Valid assessments of family support, resources, and risk factors are essential for effective case planning. The Citizen Review Panel recommends development of policy requiring the use of tools describing the nature of relationships among family members and between families and their communities, such as a genogram or an ecomap. Due to constraints in resources, the panel limits this recommendation to reports involving high risk maltreatment.

Response: The department does not agree with implementing the use of these tools at this time due to recent implementation of the Child Safety Assessment and Strengths and Risks Assessment tools. The Family -Centered Strengths and Risks Interview Guide and Documentation Guide requires staff to gather information about the various domains of a family's life including the parent's relationship with various family members and their community. As the use of tools such as genograms or ecomaps may be helpful in gathering additional information about the relationships among family members and their community, DCYF will review existing contracts with direct service providers such as Family to Family and Family Preservation to include the completion of such tools by the service provider.

Recommendation 8: When there is a violation of a safety plan, a case should remain open until there is adequate assurance that the safety plan is followed. Safety plans that have been violated should be revised following a new safety assessment taking into account the nature and severity of the violation, as well as the likelihood of compliance.

Response: The department agrees with this recommendation**,** and the recommendation supports current policy to conduct a Child Safety Assessment whenever evidence or circumstances suggest that a child's safety may be in danger. This includes a violation of a Safety Plan. State policy requires staff to offer/provide services to ensure the child's safety. The case remains open during service provision. The department will send a "policy clarification" email to CPS reminding staff to ensure that children are safe prior to closing a case and reminding staff of the statutory requirement to offer/provide services in these cases. The department will also ensure that this policy requirement is re-enforced through Case Manager CORE curriculum.

Recommendation 9: When investigations involve a relative that assumes custody of a child, the relative's needs should be thoroughly addressed, particularly the need for grief therapy when there is a death.

Response: The department agrees with this recommendation and has implemented Kinship Care policy that is consistent with current statues requiring the provision (through existing means or referrals) specified non-financial services to Kinship Care providers. Relatives who assume custody are involved in case planning and are assisted in obtaining the following services:

- Family assessment, case management, child day care, housing search and relocation, parenting skills training, supportive intervention and guidance counseling, transportation, emergency services, parent aid services, respite services, and additional services that the department determines are necessary to meet the needs of the child and family which would include grief therapy when identified as a needed service.

Recommendation 10: Risk assessments should be completed before closure of Family Preservation services. When Family Preservation identifies additional needs or safety concerns, these should be included in their plan, rather than addressing only initially identified needs.

Response: This recommendation has been implemented. Family Preservation providers are trained on the department's revised Child Safety Assessment**,** and Family-Centered Strengths and Risks Assessment tools and protocols. These tools are currently utilized to identify safety or risks concerns to be addressed during the provision of services to the family and at the closure of a case. These assessments are to be provided to CPS for inclusion in the case record.

Recommendation 11: Panels identified cases in which child maltreatment was not accurately diagnosed during treatment at hospital emergency rooms and the children subsequently died as the result of maltreatment. Providing this feedback to hospital quality improvement committees could improve hospital response to maltreatment.

The Citizen Review Panel recommends development of a mechanism to notify hospitals that a child has died due to maltreatment, if the hospital was known to have previously provided care for possible maltreatment to that child.

Response: DCYF will meet with members of the state Citizen Review Panel to explore possible methods to assist the Citizen Review Panel accomplish this recommendation. The Citizen Review Panel requires the department's involvement as the Panel does not have the statutory authority to release CPS information about a child fatality to hospital review committees that could be essential in educating hospital staff.

APPENDIX B: PANEL MEMBERS

STATE CITIZEN REVIEW PANEL

Chair:

Mary Ellen Rimsza, M.D. FAAP, Chairperson
Center for Health Information and Research
L Wm Seidman Research Institute
W.P. Carey School of Business
Arizona State University

Members:

Cindy Copp
ADES/Administration for Children, Youth & Families

Dyanne Greer, J.D.
U. S. Attorney's Office

Dave Graham
ADES/Administration for Children, Youth & Families

Linda Johnson
ADES/Administration for Children, Youth & Families

Simon Kottoor
Sunshine Group Home

William N. Marshall Jr., M.D.
University of Arizona College of Medicine
Department of Pediatrics

Nancy Logan
Attorney General's Office

Evelyn Roanhorse
Bureau of Indian Affairs

Beth Rosenberg
Children's Action Alliance

Rebecca Ruffner
Prevent Child Abuse, Inc.

Ivy Sandifer, M.D.
Physician

Ellen Stenson
Ombudsman's Office

Katrina Taylor
Public Representative

Chuck Teegarden
Pinal County Attorney's Office

Roy Teramoto, M.D.
Indian Health Services

Natalie Miles Thompson
Crisis Nursery

Princess Lucas-Wilson
ADES/Division of Developmental Disabilities

Staff:

Susan Newberry, Manager

Therese Neal, Local Team Manager

Teresa Garlington, Administrative Secretary

PIMA COUNTY CITIZEN REVIEW PANEL

Chair:
William N. Marshall, Jr., M.D.
University of Arizona
College of Medicine, Department of Pediatrics

Coordinator:
Zoe Rowe

Members:

Michelle Araneta
Pima County Attorney's Office

Jill Baumann
CASA, Pima County Juvenile Court

David Braun
Office of the Attorney General

Diane Calahan
SO Arizona Children's Advocacy Center

Christopher Corman
Foster Care Review Board
Arizona Supreme Court

Lori Groenewold, M.S.W.
Children's Clinics for Rehabilitation Services

Patrice Herberholz, RN, BA
Never Shake a Baby Arizona
Prevent Child Abuse Arizona

Karen Ives
Wee Care Baby Proofing

Karen Kelsch
Pilot Parents of Southern Arizona

Linda Luke
Pima County Attorney's Office

Joan Mendelson
Attorney

Carol Punske, M.S.W.
ADES/Administration for Children, Youth & Families

YAVAPAI COUNTY CITIZEN REVIEW PANEL

Chair:
Rebecca Ruffner
Prevent Child Abuse Arizona

Members:

Bill Hobbs
Yavapai County Attorney's Office

Michael James
Court Appointed Special Advocate

P. J. Janik
Prescott Valley Police Department

Dawn Kimsey
ADES/Administration for Children, Youth & Families

Rodney Lewis
ADES/Administration for Children, Youth & Families

Bonnie Mari
Yavapai Regional Medical Center

Shane Reed
Yavapai County Attorney's Office

Mary Ellen Sandeen
Yavapai Regional Medical Center

APPENDIX C: CITIZEN REVIEW PANEL DATA FORM

CASE ID #_____ **DATE OF REVIEW _____**

FAMILY MEMBERS

Relationship	DOB	Gender	Race	Role	Residence Type	County/State

REPORT HISTORY:

# of CPS Reports on Family _____; Number of prior substantiated reports on family _____
Date of initial report: _____; Date of most recent report: _____;

Report Date	Perpetrator	Victim	Allegation	Risk	Finding

Allegations:_____

_____

_____

_____

_____

PRIOR CPS HISTORY

Were there previous reports investigated by CPS? ☐Yes ☐No (If yes, answer remaining questions on this page.)

1. Were adequate steps taken to ensure the safety of the child(ren) during previous investigations? ☐Yes ☐No

   Comments:_____

   _____

   _____

   _____

   _____

2. Was a safety assessment done and acted upon during previous assessments? ☐Yes ☐No

   Comments:_____

   _____

   _____

   _____

   _____

3. Were safety concerns adequately identified and addressed prior to case closures?

   ☐Yes ☐No

   Comments:_____

   _____

   _____

   _____

   _____

4. Were appropriate services offered previously? ☐Yes ☐No

   Comments:_____

   _____

   _____

   _____

   _____

STAGE 1: INTAKE AND INITIAL SCREENING

Recommendations/Comments on Intake/Initial Screening

Consider Hotline's response to report, including accuracy and timeliness.

_____

_____

_____

STAGE 2: INVESTIGATION

1. Were interagency protocols followed? ☐Yes ☐No ☐N/A ☐Unk
2. Thoroughness and accuracy of the investigation;
   A. Did the investigation address the required areas of:
      i. The existence, cause, nature and extent of child maltreatment? ☐Yes ☐No ☐Unk
      ii. The existence of previous injuries? ☐Yes ☐No ☐N/A ☐Unk
      iii. Identity of the person responsible for the maltreatment? ☐Yes ☐No ☐N/A ☐Unk
      iv. Names and conditions of other children in the home? ☐Yes ☐No ☐N/A ☐Unk
      v. The environment where the child resides? ☐Yes ☐No ☐N/A ☐Unk
   B. Were necessary medical evaluations completed in a timely manner?
      ☐Yes ☐No ☐N/A ☐Unk
   C. Were necessary psychological evaluations completed in a timely manner?
      ☐Yes ☐No ☐N/A ☐Unk
   D. Completion and thoroughness of interviews:
      i. Were parents, caregivers and the alleged abusive person interviewed?
         ☐Yes ☐No ☐N/A ☐Unk
      ii. Was the alleged victim interviewed alone, away from the presence of the alleged abusive person? ☐Yes ☐No ☐N/A ☐Unk
      iii. Were other children in the home interviewed? ☐Yes ☐No ☐N/A ☐Unk
      iv. Does the case record reflect compliance with policy? ☐Yes ☐No ☐Unk
      v. Was the reporting source or others with knowledge of the maltreatment contacted and interviewed by the investigator? ☐Yes ☐No ☐N/A ☐Unk
3. Recommendations/Comments on Investigation Stage:

   _____

   _____

STAGE 3: CRISIS INTERVENTION AND SAFETY ASSESSMENT

1. Were immediate and adequate steps taken to ensure the safety of the child(ren)?
   ☐ Yes ☐No ☐N/A ☐Unk
2. Did the safety assessment adequately address all safety concerns? ☐Yes ☐No ☐N/A ☐Unk
3. Was the safety assessment acted upon? ☐Yes ☐No ☐N/A ☐Unk
4. Was prior involvement by CPS with the family adequately considered?
   ☐Yes ☐No ☐N/A ☐Unk
5. Was a risk assessment completed? ☐Yes ☐No ☐N/A ☐Unk
6. Comments on Crisis Intervention, Safety Assessment:

   _____

   _____

   _____

STAGE 4: INVESTIGATION FINDINGS/ DETERMINATION

1. Was sufficient information gathered to make a final determination of the finding?
   ☐Yes ☐No ☐N/A ☐Unk
2. Did the case record document support the finding (for example: substantiated, proposed substantiation or unsubstantiated)? ☐Yes ☐No ☐N/A ☐Unk
3. Comments on Report Findings/Determination Stage:

   _____

   _____

   _____

STAGE 5: CASE PLANNING AND CASE PLAN IMPLEMENTATION

1. Was the case plan developed timely and reviewed periodically in accordance with ACYF policy? ☐Yes ☐No ☐N/A ☐Unk
2. Were the following persons involved with the planning process:
   A. Parents/guardians? ☐Yes ☐No ☐N/A ☐Unk
   B. Child(ren)? ☐Yes ☐No ☐N/A ☐Unk
   C. Other relatives? ☐Yes ☐No ☐N/A ☐Unk
   D. Other team members? ☐Yes ☐No ☐N/A ☐Unk

3. Were needs of the family adequately identified and addressed in the case plan, including modifications to reflect progress or other changes in needs? ☐Yes ☐No ☐N/A ☐Unk
4. Was a range of services offered to the family to promote reunification or permanent placement outside the home? ☐Yes ☐No ☐N/A ☐Unk
5. Were there barriers to obtaining services? ☐Yes ☐No ☐N/A ☐Unk
6. Were timely, meaningful contacts made with the child(ren) and parent(s)?

   ☐Yes ☐No ☐N/A ☐Unk
7. Was the content/purpose of the contact or visit reflected in the records?

   ☐Yes ☐No ☐N/A ☐Unk
8. Comments on Case Planning Stage:

   _____

   _____

   _____

STAGE 6: CASE CLOSURE (Answer if the case was closed at the time of review.)

1. Were issues identified in the risk and safety assessment sufficiently resolved prior to case closure? ☐Yes ☐No ☐N/A ☐Unk If no, answer A and B.

   A. List risks/safety issues:_____

   B. Were these issues severe enough to warrant further involvement with CPS?

      ☐Yes ☐No ☐N/A ☐Unk
2. Did the Panel agree with the decision to close the case? ☐Yes ☐No ☐N/A ☐Unk
3. Comments on Case Closure Stage: (In addition to the above questions, consider if prior to closure this decision was discussed with the family, and if clear instructions were provided to family members on any follow-up issues or actions to take if safety concerns return?)

   _____

   _____

   _____

   _____

   _____

   _____

   _____

FAMILY RISK FACTORS:

☐ Substance abuse

☐ Mental health problems

☐ Domestic violence

☐ History of violence outside of home

☐Lack of physical or mental ability to provide adequate care

☐ Lack of anger control

☐ Lack of parenting skills

☐ Lack of resources for adequate food/shelter/medical care/childcare

☐ Teen Parent

☐ Prior child death

☐ Lack of motivation to provide adequate care

☐ Prior removals by CPS or severance of parental rights

☐ Prior substantiated reports

☐ Other

_____

_____

CASE REVIEW FINDINGS:

1. Were State/Federal policies followed? ☐Yes ☐No

Comments:_____

_____

_____

_____

_____

_____

_____

2. Based upon this review, does the panel recommend any changes in policies and procedures?

   ☐Yes ☐No

Comments:_____

_____

_____

_____

_____

_____

_____

APPENDIX D: CASE REVIEW FINDINGS

Prior CPS History	Yes	No	Unknown	N/A
1. Were there previous reports investigated by CPS?	14	9	0	0
2. Were adequate steps taken to ensure the safety of the child(ren) during previous investigations?	6	8	0	0
3. Was a safety assessment done and acted upon during previous assessments	6	8	0	0
4. Were safety concerns adequately identified and addressed prior to case closures?	8	6	0	0
5. Were appropriate services offered previously?	9	5	0	0
Stage 2: Investigation	**Yes**	**No**	**Unknown**	**N/A**
1. Were interagency protocols followed?	14	3	3	3
2. Thoroughness and accuracy of the investigation				
A. Did the investigation address the required areas of:				
The existence, cause, nature and extent of child maltreatment?	17	6	0	0
The existence of previous injuries?	11	3	2	7
Identity of the person responsible for the maltreatment?	20	3	0	0
Names and conditions of other children in the home?	13	5	0	5
The environment where the child resides?	15	6	1	1
B. Were necessary medical evaluations completed in a timely manner?	14	3	2	4
C. Were necessary psychological evaluations completed in a timely manner?	7	7	5	4
D. Completion and thoroughness of interviews:				
Were parents, caregivers and the alleged abusive person interviewed?	17	4	1	1
Was the alleged victim interviewed alone, away from the presence of the alleged abusive person?	8	1	0	14
Were other children in the home interviewed?	8	6	0	9
Does the case record reflect compliance with the protocol or policy?	13	10	0	0
Was the reporting source or others with knowledge of the maltreatment contacted and interviewed by the investigator?	16	5	2	0

Stage 3: Crisis Intervention, Safety Assessment	**Yes**	**No**	**Unknown**	**N/A**
1. Were immediate and adequate steps taken to ensure the safety of the child(ren)?	15	6	0	2
2. Did the safety assessment adequately address all safety concerns?	14	5	2	2
3. Was the safety assessment acted upon?	14	3	1	5
4. Was prior involvement by CPS with the family adequately considered?	11	2	2	8
5. Was a risk assessment completed?	18	4	0	1
Stage 4: Investigation Findings/Determination	**Yes**	**No**	**Unknown**	**N/A**
1. Was sufficient information gathered to make a final determination of the finding?	17	6	0	0
2. Did the case record document support the finding?	13	9	1	0
Stage 5: Case Planning, Case Plan Implementation	**Yes**	**No**	**Unknown**	**N/A**
1. Was the case plan developed timely and reviewed periodically in accordance with ACYF policy?	14	4	0	0
2. Were the following persons involved with the planning process?				
A. Parents/guardians	14	1	2	1
B. Children	3	1	2	12
C. Other relatives	11	2	3	2
D. Other team members	9	2	2	5
3. Were needs of the family adequately identified and addressed in the case plan, including modifications to reflect progress or other changes in needs?	12	4	1	1
4. Was a range of services offered to the family to promote reunification or permanent placement outside the home?	14	2	2	0
5. Were there barriers to obtaining services?	7	9	2	0
6. Were timely, meaningful contacts made with the children and parents?	11	5	2	0
7. Was the content/purpose of the contact or visit reflected in the records?	12	5	1	0
Stage 6: Case Closure	**Yes**	**No**	**Unknown**	**N/A**
1. Were identified risks sufficiently resolved prior to case closure?	4	1	0	0
A. If yes were these risks severe enough to warrant further involvement with CPS?	1	0	0	0
2. Did the Panel agree with the decision to close the case?	3	2	0	0

To obtain further information, contact:

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Information about the Arizona Citizen Review Panel may be found on the Internet through the Arizona Department of Health Services at:
http://www.azdhs.gov/phs/owch/crp.htm

This publication can be made available in alternative format. Please contact the Child Fatality Review Unit at (602) 542-1875 (voice) or call 1-800-367-8939 (TDD).

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