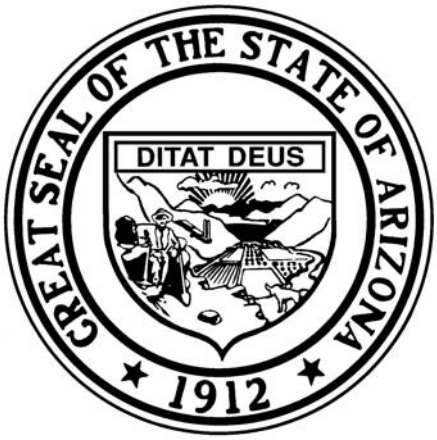
Arizona Citizen Review Panel

EIGHTH ANNUAL REPORT

DECEMBER 2006

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



Leadership for a Healthy Arizona

Janet Napolitano, Governor
State of Arizona

Susan Gerard, Director
Arizona Department of Health Services

MISSION

Setting the standard for personal and community health through direct care delivery, science, public policy and leadership.

Arizona Department of Health Services
Public Health Prevention Services
Office of Women's and Children's Health
Child Fatality Review Unit
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007
(602) 542-1875

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).

EXECUTIVE SUMMARY

This Eighth Annual Citizen Review Panel Report summarizes the findings of 25 reviewed cases of severe maltreatment, including fatalities that occurred between September 2005 and October 2006.

The most prevalent family risk factors identified during the reviews were lack of parenting skills (19/25 cases) and substance abuse (18/25 cases). Methamphetamine continues as the most prevalent substance used and was identified in 14 of the 25 cases reviewed, which is an increase from 30 percent in 2005 to 56 percent in 2006. The Citizen Review Panel is aware of the nationwide epidemic associated with methamphetamine abuse and commends CPS for their efforts to combat the problem.

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.

Citizen Review Panels noted that in some cases, risk assessments, safety assessments, and case plans did not adequately address the increased vulnerability of infants and children with special needs, including premature infants, children with chronic illnesses, and mental or physical disabilities. Panels also concluded that caregivers in some out of home placements may not have adequate knowledge, experience and/or training to provide care for children with special needs. The Panel recommends that training and resources be made available to CPS staff and licensed foster homes to adequately identify and address the increased risks of children with special needs.

Citizen Review Panels determined that CPS significantly increased compliance with investigation policies from the prior year. In 2005, CPS was in compliance with investigative policy in only 13 of 23 cases. During this reporting period, CPS complied with policy in 23 of the 25 cases reviewed

At the conclusion of each case review, panels were asked to determine if Child Protective Services followed policies throughout the case. Panels concluded that state and federal policies were followed in 15 cases. This is a significant increase from the last reporting period, during which Panels determined that policies were followed in only eight out of the 23 cases reviewed.

Three cases reviewed involved the death of children while placed in foster care homes. The Foster Family section was formally added to the review process during this reporting period to assist with documenting these specific reviews. The Panel noted several concerns regarding the process of licensing and monitoring of foster homes. These concerns include the lack of identification of risk factors within foster care families and the lack of resolution when issues were identified. Concerns were also noted regarding the abilities of foster parents in relation to the number of children for which they are licensed to care. The Panel recommends that DCYF conduct a study to reevaluate their process for determining individual foster home capacity.

Citizen Review Panels noted that the CPS training academy does not include a component on safe sleep environments for infants. The Panel recommends that, during the course of investigations or ongoing case management duties, CPS assess for and promote infant safe sleep practices as recommended by the American Academy of Pediatrics.

TABLE OF CONTENTS

CITIZEN REVIEW PANEL OVERVIEW

This is the eighth annual report from Arizona's Citizens Review Panel. Citizen Review Panel 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 2005 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: NOVEMBER 2005 THROUGH OCTOBER 2006

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 November 1, 2005 and October 31, 2006.

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 of the Citizen Review Panels met on a more frequent basis than the quarterly requirement. The Pima County Citizen Review Panel met on twelve occasions and completed eleven case reviews. The Yavapai County Citizen Review Panel met on nine occasions and completed nine case reviews. The State Citizen Review Panel met on seven occasions and completed five case reviews.

Reviewed cases represented eight counties including Cochise County (1 case), Greenlee County (1 case), Maricopa County (5 cases), Mohave County (3 case), Navajo County (1 cases), Pima County (8 cases), Pinal County (1 case), Yavapai County (5 cases).

CASE RECORD REVIEWS

The Department of Economic Security provides quarterly lists of all investigative 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 by CPS after July 1, 2005. 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 25 case record reviews. Ten cases involved child fatalities due to maltreatment and 15 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. An additional section is completed on cases involving investigations of licensed foster homes.

The Prior Child Protective Service History section involves a review of a family's prior history with Child Protective Services. Review of this information 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.

The Foster Family section was formally added to the review process during this reporting period. This section is completed when Panels review cases with allegations involving the foster family placement. Special attention is given in this section to review the families licensing history and the steps taken by the department to complete and maintain the license.

CASE RECORD REVIEW FINDINGS

The Citizen Review Panel reviewed 25 cases during this reporting period. Records reviewed included maltreatment reports investigated by Child Protective Services between July 2005 and October 2006. The remainder of this report presents information on Citizen Review Panel findings and recommendations to promote improvements within Arizona's child protective services agency.

The following summarizes the Citizen Review Panel findings for each stage:

Prior Child Protective Service History

Twenty reviewed cases had previous involvement with Child Protective Services prior to the investigation reviewed by the panel. Within these 20 cases, there were 61 prior reports.

Panels determined that in eleven 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 24 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 complied with existing protocol or policies in 20 out of the 25 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 eleven cases and not interviewed in three cases. In four cases, Panels were unable to determine from the records reviewed whether other children in the home were interviewed .
- Panels determined that of the 23 cases requiring joint investigations with law enforcement, interagency protocols were followed in 19 cases and not followed in two cases. Panels could not determine if protocols were followed in two cases.
- In 21 of the 25 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 21 of the 23 applicable cases.

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 16 cases, Panels concluded that safety assessments adequately addressed all safety concerns. In the cases that did not meet the child's safety needs, 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 23 of the 25 cases reviewed and agreed with the investigative finding in 20 of the 25 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 23 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 19 cases family needs were adequately addressed within the case plan. In 22 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.

Foster Family Section
Three cases reviewed involved the death of children while placed in foster care homes. The Panel noted several concerns regarding the process of licensing and monitoring foster homes. These concerns include the lack of identification of risk factors within families and the lack

of resolution to the concerns identified. Concerns were also noted regarding the abilities of foster parents in relation to the number of children for which they are licensed to care.

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 these three cases, panel members determined that unresolved risks warranted continued involvement with the family by Child Protective Services. Panels expressed concerns about case closures when safety concerns regarding substance abuse, domestic violence and parental custody were not resolved adequately 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, domestic violence and mental health problems 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	19
▪ Substance abuse	18
▪ Domestic violence	16
▪ Mental health problem	16
▪ Lack of motivation to provide adequate care	15
▪ Anger control problem	13
▪ Lack of resources for adequate food/shelter/medical care/childcare	7
▪ Violence by parent/guardian outside of home	6
▪ Teen Parent	6
▪ Prior child death	2
▪ Lack of physical or mental ability to provide adequate care	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 15 cases. This is a significant increase from the last reporting period, during which Panels determined that policies were followed in only eight 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; however, Panels continue to express concerns regarding the completion of safety and risk assessments and review of unsubstantiated report findings.

Several cases demonstrated exceptional efforts, case management and supervisory skills. The Panel noted several cases where the case aide provided exceptional efforts as well. As a result, the Panel decided to include acknowledgement of exceptional work by case aides with this year's commendations. The Citizen Review Panel sent letters of commendation to case aides, case managers, and supervisors of five cases.

RECOMMENDATIONS

All findings and Panel recommendations from the 25 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. Citizen Review Panels noted that the CPS training academy does not include a component on safe sleep environments for infants, including recommendations from the American Academy of Pediatrics regarding safe sleep environments for infants. The Panel recommends that DCYF develop and implement training for CPS workers on recommendations from the American Academy of Pediatrics. The Panel further recommends that during the course of investigations or ongoing case management duties, that CPS promote infant safe sleep practices as recommended by the American Academy of Pediatrics. This should include assessment of the infant's sleep environments and discussions with parent/guardians. DCYF should consider distribution of safe sleep campaign literature to families with infants. Information on safe sleep recommendations can be found at http://www.cdc.gov/SIDS/sleepenvirnoment.htm.

2. Citizen Review Panels noted that in some cases, risk assessments, safety assessments, and case plans did not adequately address the increased vulnerability of infants and children with special needs, including premature infants, children with chronic illnesses, and mental or physical disabilities. Panels also concluded that caregivers in some out of home placements may not have adequate knowledge, experience and/or training to provide care for children with special needs. The Panel recommends that training and resources be made available to CPS staff and licensed foster homes to adequately identify and address the increased risks of children with special needs. These children include infants less than 6 months old or weighing less than 14 pounds, and infants, children or adolescents who have chronic illnesses, mental or physical disabilities, failure to thrive, and those prenatally exposed to substances.

3. During this reporting period, Panels reviewed three cases of deaths of children in foster care. The Citizen Review Panel recommends the following to address concerns identified during these reviews:

    - During the course of initial foster home licensing, all risk factors should be thoroughly assessed and necessary actions taken to ensure the safety of children prior to the issuance of the foster home license. Licensing agencies and CPS should work together to assess any risk factors that may be identified and resolve any concerns regarding these risk factors to ensure the safety of children in the foster home. Examples of factors requiring assessment include:
        - A history of domestic violence,
        - Past history of abuse within the foster family or within the foster parent's family of origin,
        - Mental health concerns,
        - Financial instability,
        - Lack of parenting experience, and

- Changes in family composition.

- DCYF should conduct a study to reevaluate the license capacity of an individual foster home. The study should consider the following.
  - More stringent limits on the number of infants and toddlers in a foster home.
  - The number of children in a foster home should reflect the capabilities of the foster parents, the support systems in place, and the total number of children living in the foster family's home. This includes the foster parents' own children and other children living in the home.
  - Increases in the number of children a family is licensed to care for should be gradual and closely monitored following each increase.
  - The Panel recommends that, although there is a shift from congregate to foster care, DCYF explore how congregate care can effectively be utilized.

4. Reviews completed by the Panels resulted in numerous concerns surrounding the failure to substantiate allegations when there appeared to be clear evidence of abuse and/or neglect. Panels recommend that DCYF more closely review decisions to unsubstantiate reports.

5. Panel reviews also resulted in numerous concerns surrounding the completion of investigatons, services offered or provided and investigation outcomes. The Panel has the following recommendations.

   - If no perpetrator is identified in the investigation of a serious non-accidental injury to a child, CPS should not return the child to the parents/guardians unless evidence conclusively demonstrates the child will be safe in their care.
   - Investigations that involve young, pregnant teens should trigger referrals to community and public health agencies to help ensure a healthy outcome of the teen's pregnancy.
   - Failure to comply with substance abuse treatment plans, including screening, should impact decisions regarding children remaining with or return to parents.
   - Decisions regarding outcomes of investigations should not solely depend upon Medical Examiner or physician findings, if there is inconsistent evidence and/or CPS has reason to doubt the Medical Examiner or physician findings. Since not all physicians or medical examiners have had substantial experience in the diagnosis of abuse, CPS should encourage staff to seek out consultants with expertise in abuse whenever there is inconsistent evidence or doubts regarding the findings.
   - Joint investigation protocol is not always followed. This includes failure to notify agencies of a qualified investigation and failure by law enforcement to assign a case for investigation. The Governor's Office Division for Children should periodically publish reports from counties/law enforcement jurisdictions on compliance with joint investigation requirements. Reports should be standard throughout the state to allow for informed comparisons.
   - Both parents, regardless of their custodial status, should always be interviewed and notified of allegations.

CITIZEN REVIEW PANEL OBJECTIVES FOR 2007

The following includes the Citizen Review Panel's objectives for 2007:

1. In 2007, the Citizen Review Panel will continue to review Child Protective Services' cases involving reports of fatal and near fatal maltreatment.

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

3. Citizen Review Panel program will continue efforts to provide feedback on concerns and trends identified during reviews to local Child Protective Services offices. These efforts will include collaboration with CPS to define the role of the Child Protective Services Practice Improvement Specialists during panel meetings and formalization of a protocol for the specialists to return information to their districts.

4. 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.

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

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

7. In 2007, the Citizen Review Panel will assess the impact and implementation of previous years' recommendations to the Department of Economic Security. Program staff will assist the Citizen Review Panels with an effectiveness evaluation of the program including member's satisfaction with the program.

APPENDIX A: AGENCY RESPONSE TO CITIZEN REVIEW PANEL'S 2005 RECOMMENDATIONS

Recommendation 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 parent's homes and non-custodial parent to be interviewed in person.

> **Response:** The Department agrees that all parties subject to the report should be interviewed as required by DCYF policy. The Department has included this recommendation in the current policy revisions which will be available to staff online when the policy manual is deployed in July. The Department will also communicate this clarification CPS staff via administrative directive and integrate the change into the Case Manger CORE curriculum.

Recommendation 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.

> **Response**: The Department agrees with this recommendation. Current policy requires all records relevant to the investigation be gathered and considered during the investigation and prior to closure.
>
> Frequently, the CPS Specialist conducting an investigation is also responsible for obtaining and reviewing all relevant documents. Some records are readily available, while others such as orders of protection, court orders for supervised visitation, autopsy reports, and medical or psychological records are more difficult to obtain in a timely manner. The recent addition of trained case aides who are able to assist in gathering this information is helping relieve case managers of this task.
>
> The Department has also been working to develop and enhance partnerships with domestic violence advocates who will be able to provide information regarding the family's domestic violence issues. The Department will explore the feasibility of establishing a pilot protocol with a County Superior Court that will facilitate access to Domestic Relations court records by local CPS Office staff.

Recommendation 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.

> **Response:** The Department agrees with this recommendation which is supported by current policy. Department policy directs the CPS Specialist to contact all persons including the reporting source who may have information concerning the family circumstances and current allegations. Frequently, the source is anonymous or does not provide contact information. In reports where the source contact information is known, case managers should make every effort to contact the source.

While this policy and the importance of this policy is integrated in the Case Manager CORE training and administrative and clinical supervision functions, the Department, in consultation with field staff (District Program Managers, CPS Supervisors/Specialists, and Practice Improvement Specialists) will develop additional strategies to improve compliance with this policy.

Recommendation 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.

Response: The Department's current policy requires staff to review all conflicting medical opinions within 48 hours with a Multidisciplinary Team (including a physician), or to base intervention on the most serious diagnosis if a Multidisciplinary Team is not available. The Department agrees to review (and augment) this policy with a focus on efficacy in resolving cases involving suspicious injury. If this policy is found to be inadequate, the Department will explore the feasibility of contracting with a medical provider, who is recognized as an expert in the diagnosis of child abuse and neglect, to provide a second opinion in these relatively few cases and to make this expertise available to field staff.

Recommendation 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.

Response: The Department agrees with this recommendation and will review its current curricula to ensure that this topic is sufficiently covered. The Department agrees that every report of child abuse and neglect should be thoroughly investigated and the outcome of the investigation reviewed by the supervisor prior to a decision regarding an investigative finding. The investigation should also include a comprehensive family centered assessment of strengths and risks that place the child at risk of harm.

Case Manager and Supervisor CORE training focuses on thorough assessments, and the use of the Child Safety Assessments and the Strengths and Risks Assessment. Staff are also instructed regarding the impact of their personal biases, personal values and personal opinions on case decisions. Specifically, trainees are instructed to gather sufficient information upon which to make a decision regarding the validity of the report and, if information is unknown, to continue to gather information to accurately assess the needs and strengths of each family.

Custody issues receive special emphasis in the Hotline Criteria curriculum. It is stressed that, although some families may use CPS for retaliation and make false reports, case managers must use their interview and assessment skills to obtain information to accurately assess the needs and strengths of the family and to determine the validity of the allegation.

Continued training in family centered assessments, application of critical decision making at management and unit meetings, and the use of supervision circles are being deployed to

enhance the quality of CPS investigations and critical decision making during the investigation and throughout the life of the case.

Recommendation 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.

Response: The Department agrees that advanced training in risk assessments of children with special needs should be included in the Department's overall case manager/supervisor training.

The Child Welfare Training Institute (CWTI) will consult with DDD trainers regarding curriculum on the assessment of the special medial needs of vulnerable children in the case manager CORE training.

CWTI will contact CMDP to identify local, specialized medical practitioners who may be able to provide information or advanced training on safety and risk issues for this group of children.

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

Response: The Department agrees that collaboration and communication is essential in the investigation and prosecution of child abuse and neglect. CPS staff welcome and will continue to see out opportunities to collaborate with law enforcement.

The Counties have used the recommendations developed by the Arizona Children's Justice Task Force (CJTF) for Multidisciplinary Protocol is the development of their protocols for joint investigations. The CJTF did not address periodic meetings between law enforcement and Child Protective Services; however, to ensure ongoing communication and collaboration between law enforcement and CPS, the Counties did incorporate CJTF recommendations for ongoing notification of case status across agencies and sharing of information in their protocols.

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

Response: While not directed towards the Department, the Department clearly supports this recommendation. A national registry of child abuse and neglect would enable states to immediately access information that could be critical to an investigation. Information available through such a registry would aid our efforts to protect and treat child abuse and neglect.

Recommendation 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.

Response: The Department agrees with this recommendation. During the past year, the Department has been proactive in encouraging staff to participate in substance abuse/use trainings, teleconferences and workgroups that include experts in this area. Some of the trainings and related opportunities include:

Methamphetamine Task Force
The Department facilitated a task force that is examining the methamphetamine impact on the Arizona child welfare. A panel of experts from substance abuse organizations, behavioral health agencies, universities and others has been convened to improve the child welfare response to families impacted by methamphetamine. Documents from this group will make improvements to the child welfare training, and policy and practice. The Task Force expects to present specific research based models for providing services to methamphetamine involved families when the family remains in tact together and for those cases where removal of a child.

Statewide training on Methamphetamine
The Department is providing leadership and coordination in statewide training on methamphetamine by experts in the field. Training in multiple locations (25) across the state commenced in March and is expected to further develop and strengthen our CPS response. This training will be instrumental in increasing our awareness of the consequences of methamphetamine abuse in addition to building our skills in engaging and providing intervention for these seemingly difficult clients.

Arizona Methamphetamine Conference – *A Call to Action Addressing the Meth Crisis in Arizona,* held February 13th and 14th was sponsored by both the Governor and Office of the Attorney General. The Conference was attended by 35 Department staff.

The purpose of the multidisciplinary program was to bring together experts in order to address the meth crisis from a public policy and community action perspective. Effective prevention, prosecution and treatment efforts were highlighted. In addition to general session attendees, 22 community coalitions were convened to assist local communities develop the most effective environmental prevention strategies.

By the end of this training, participants were able to:

- Describe patterns of methamphetamine use, abuse, and dependence;
- Describe the impact of methamphetamine use on children and families;
- Describe appropriate responses by child safety workers to methamphetamine use;
- Demonstrate confidence and ability to intervene effectively in situations where methamphetamine dependence is suspected or discovered, and
- Demonstrate confidence and ability to monitor and participate in a family's recovery process.

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 Ann 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

☐ 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:_____

_____

_____

_____

_____

_____

_____

To obtain further information, contact:

Therese Neal
Child Fatality Review
Office of Women's and Children's Health
150 N. 18th Avenue, Suite 320
Phoenix, AZ 85017-3242
Phone: (602) 542-1875
Fax: (602) 542-1843
E-mail: nealt@azdhs.gov

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).

ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH PREVENTION SERVICES
OFFICE OF WOMEN AND CHILDREN'S HEALTH
CHILD FATALITY REVIEW PROGRAM
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007
(602) 542-1875

Printed on Recycled Paper