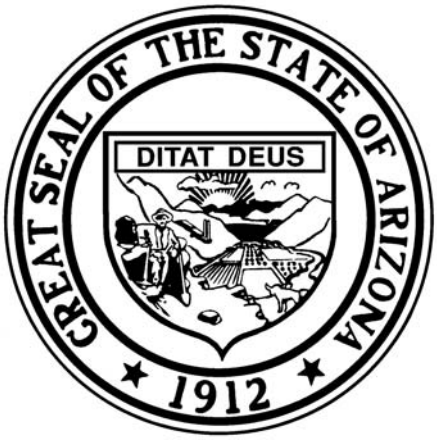
Arizona Citizen Review Panel

State Panel Report
Pima County Panel Report
Yavapai County Panel Report

NINTH ANNUAL REPORT

DECEMBER 2007

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



Leadership for a Healthy Arizona

Janet Napolitano, Governor
State of Arizona

Susan Gerard, Director
Arizona Department of Health Services

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

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EXECUTIVE SUMMARY

This Ninth Annual Citizen Review Panel Report summarizes the findings of 22 reviewed cases of severe maltreatment that occurred between September 2006 and October 2007. Ten of these cases were fatalities and 12 were near-fatalities or other high-risk cases. In the previous year's analysis (2005-06), 25 cases were reviewed, 10 of which were child fatalities. The purpose of this report is to assess and evaluate the effectiveness of Arizona's Child Protective Services (CPS) in preventing incidences of severe maltreatment of children.

The 22 cases were reviewed by one of three panels – the State Citizen Review Panel, located in Maricopa County, or by local panels located in Pima and Yavapai Counties. The State Panel serves the dual role of assessing the effectiveness of Child Protective Services while providing oversight to the two local panels. Collectively, the three panels review cases of maltreatment from all 15 counties in the state of Arizona.

As part of the assessment procedure, each panel identifies several family risk factors of child maltreatment and mortality. The most prevalent family risk factors identified during the reviews were as follows: lack of parenting skills (defined as the parent's inability to provide for a child's basic needs and their inability to guide, educate, and discipline the child in a way that facilitates positive social and emotional development) (17/22 cases), mental health problems (12/22 cases), and substance abuse (11/22 cases). Methamphetamine use continued to be the most prevalent form of drug abuse identified in case reviews; it was identified as a risk factor in nine of the 22 cases reviewed by all three panels.

The most critical role of Child Protective Services is to ensure the safety of children in the state. The Citizen Review Panels concluded that Child Protective Services has generally fulfilled this role. Child Protective Services' greatest strengths were identified to be its intake/screening and case planning/implementation processes. Panels determined that Child Protective Services Child Abuse Hotline obtained sufficient information from callers, accurately defining risk levels and types of maltreatment.

The 22 cases reviewed included 46 actual investigations (some cases had multiple investigations). Panels determined that 16 of the 46 investigations remained open in order to provide families with additional services (e.g., counseling, parenting classes, etc.), which required the development of case plans. Fifteen out of these 16 investigations had completed case plans and panels determined that appropriate services were provided to families in 13 of the 15 case plans. Panels did however express concern over Child Protective Services' lack of thorough safety assessments in at least two of the investigations reviewed.

In addition to reviewing the current incidences of child maltreatment, the Citizen Review Panels reviewed each family's previous history with the Child Protective Services system. The panels assessed whether or not Child Protective Services followed policies during prior investigations of child maltreatment. These policies include, but are not limited to, requirements to contact known sources of pertinent information, interviewing all children and parents, and obtaining medical, law enforcement, and court records critical to the investigation. Although Child Protective Services has made significant strides in improving the quality of its investigations and ongoing

case management, the panels found that policies were not adequately followed in 12 of the 22 cases reviewed.

The following is a summary of the major findings and recommendations by the state and local panels in an effort to improve the Child Protective Services system:

1. *Child maltreatment was not accurately diagnosed during treatment at hospital emergency rooms*. Children subsequently died as the result of a subsequent episode of maltreatment. Providing this feedback to hospital quality improvement committees could improve Arizona hospitals' 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 the child and in the opinion of the panel the hospital staff failed to recognize and/or report a suspicion of maltreatment of that child.

2. *Joint investigation protocol was not always followed.* This included failure to notify agencies of a qualified investigation and failure by law enforcement to act on cases of child abuse and neglect. The Joint Investigation Protocol should be followed in every applicable investigation. There should be cooperative efforts in sharing information between Child Protective Services and law enforcement agencies. These agencies should cooperate to develop strategies to improve compliance with the established protocol.

3. *Failure to substantiate allegations when there appeared to be clear evidence of child abuse and/or neglect.* The panels recommend that the Division of Children, Youth, and Families more closely review its decisions when determining investigative findings. When a finding has to be entered by state law prior to receipt and review of pertinent records, Child Protective Services should review and amend findings as warranted upon receipt of records (i.e., the death of a child).

4. *Delays in criminal court cases create impediments to Child Protective Services efforts.* The panels recommend that contacts be identified in both the County Attorney's Offices and in Child Protective Services in an effort to resolve any coordination or communication problems between the two agencies. In addition, the panels recommend that steps be taken (i.e., legislative actions or policy changes) to improve Child Protective Services' access to civil and criminal court databases, both locally and nationally.

5. *There is a need for full home evaluations when placement and/or visitation with children is at issue.* Both parents and other adults in the home, regardless of custodial status, should undergo a full background and home evaluation including criminal history and domestic relations orders when Child Protective Services is evaluating placement and visitation issues.

6. *Utilization of services offered or provided to families by Child Protective Services and their providers.* Decisions regarding whether or not children remain with or return to parents with substance abuse or related problems should be dependent upon the parents'

commitment to participate in substance abuse treatment and related services (including monitoring) that are identified to ensure the safety of the child.

7. *There is a lack of assessment and referral of children for appropriate educational services*. There was also concern that these children are not receiving an adequate education because their parents have not enrolled them in any schools. The panel members are aware of the educational system's responsibilities to evaluate the appropriateness of educational services. The panel recommended that the Arizona Department of Education reexamine its policies regarding the educational assessment of children whose educational progress is not currently being assessed.

The report that follows presents the background and purpose of the Citizen Review Panel in Arizona, which is followed by the findings of the State Panel, the Pima County Panel, and the Yavapai County Panel. Each panel sets forth its own recommendations on how to improve the Child Protective Services system. The report concludes with the 2008 objectives of the Citizen Review Panel.

CITIZEN REVIEW PANEL OVERVIEW

This is the ninth annual report from Arizona's Citizens Review Panel. Citizen Review Panel participants 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 31 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 2006 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.

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.

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 Child Protective Services on or after July 1, 2006. 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 22 case record reviews. Ten cases involved child fatalities due to maltreatment and 12 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 its 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.

STATE PANEL ACTIVITIES: NOVEMBER 2006 THROUGH OCTOBER 2007

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, 2006 and October 31, 2007.

STATE PANEL MEETINGS

The State Citizen Review Panels met more frequently than the quarterly requirement. The State Panel met on eight occasions and completed seven case reviews. Reviewed cases included five cases from Maricopa County and two cases from Pima County.

STATE PANEL CASE RECORD REVIEW FINDINGS

This section of the report presents information on the State Citizen Review Panel findings and recommendations to promote improvements within Arizona's Child Protective Services.

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

Prior Child Protective Service History
Five reviewed cases had previous involvement with Child Protective Services prior to the investigation reviewed by the panel. Within these cases, there were 21 prior reports.

Intake and Screening Stage
As in previous years, record reviews identified this stage as a strength of the child protection system. The panel found that actions taken by the Child Protective Services Hotline were complete, accurate, and timely in all but one of the cases reviewed. In that case, the panel felt that concerns noted in the narrative were not accurately addressed in the allegations.

Investigation Stage
The panel reviewed 12 investigations within seven cases. During reviews, panel members assess numerous aspects of each investigation, identifying areas of strength and weakness within the system. The panel determined this stage to be an area of weakness. Panel members concluded that in only four of the 12 investigations reviewed, activities necessary for a thorough investigation were completed. Concerns noted included failure to obtain medical and police records, failure to obtain medical exams, failure to address allegations of injuries as stated in the report, failure to address signs of drug use, inconsistent collaboration with law enforcement, and inadequate attempts made to locate families who were subjects of reports.

Crisis Intervention and Safety Assessment Stage
In seven out of 12 investigations reviewed, the panel concluded that Child Protective Services adequately fulfilled its role of ensuring child safety. The panel expressed concerns about Child Protective Services' lack of thorough assessment of safety in two of the 12 investigations reviewed. The panel is aware that Child Protective Services recently implemented a new process to assess the safety of children and will further assess this area in the coming year.

Investigative Finding/Determination Stage
The panel concluded that the documentation did not support the investigative findings in seven of the 12 investigations reviewed. As in prior years' reports, the panel identified concerns regarding the failure to substantiate allegations of abuse and neglect, in spite of strong supportive evidence. In one case that was not substantiated, the parent actually admitted to abusing the child to a Child Protective Services investigator. However, the case was not substantiated because there was no evidence of physical injury. In another case, there was evidence of prenatal exposure to substance abuse, but still no allegations of neglect were substantiated. The panel acknowledges that the inability to substantiate neglect in these cases could be related to how child abuse and neglect are defined by state statutes, which places emphasis on documented physical injuries and evidence of substantial risk of harm to a child. The panel also concluded that Child Protective Services failed to amend findings so that current, accurate findings were included within the Children's Information Library and Data Source (CHILDS) system.

Case Planning and Implementation Stage
This stage only applied to five cases that remained open after investigations. The panel determined that in four of the five cases, case planning and ongoing case management activities were appropriate and timely. Concerns included refusal by parents or guardians to participate in services and inability of Child Protective Services to enforce case plans and failure to include all family members in case plans.

Foster Family Section
There were no reviews of foster family home cases this reporting period.

Case Closure Stage
The majority of the cases remained open at the time of review by the panel. The panel reviewed three cases that had been closed. Panel members concluded that two cases should not have been closed, due to failure to adequately resolve safety issues prior to closure. Concerns noted by panel members included the failure of Child Protective Services to assess the home environment and criminal backgrounds of non-custodial parents, closure with investigative findings that had been determined prior to receipt and review of pertinent records, and the closure of a case in spite of evidence that parental drug use affected the ability to parent.

Family Risk Factors
Throughout the review, panel members identify specific risk factors for each case. Because of this process, the panel is able to determine if Child Protective Services adequately identified and resolved risks contributing to the maltreatment. Lack of parenting skills (7), mental health problems (5), substance abuse (4), and anger control (4) 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.

Risk Factor	*Frequency*
Lack of parenting skills*	7
Mental health problem	5
Substance abuse	4
Anger control problem	4
Lack of motivation to provide adequate care	3
Domestic violence	3
Lack of resources for adequate food/shelter/medical care/childcare	2
Violence by parent/guardian outside of home	2

*Parenting skills should demonstrate an ability to provide for a child's basic needs and the capability to guide, educate, and discipline in a way that facilitates a child's positive social and emotional development.

Substance abuse continues to be a high risk factor with families involved with Child Protective Services. The three most commonly used substances in order of frequency were methamphetamines, alcohol, and marijuana.

At the conclusion of case reviews, panel members were asked to determine if state and federal policies were followed. During this reporting period, the panel concluded that state and federal policies were only followed in two of the seven cases. In cases where policies were not followed, the panel identified the failure to obtain pertinent records during the investigation in two cases and failure to complete a joint investigation in one case. Failure to obtain medical and forensic exams was identified in one case and failure to have contact with children in accordance with policy timelines were noted in three cases. The panel concluded that two cases with clear evidence of abuse were not substantiated in accordance with the Division of Children, Youth, and Families' policy.

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, the panel continued to express concerns regarding review of unsubstantiated report findings and the completion of safety and risk assessments. The panel is aware of Child Protective Services implementation of a new safety assessment, risk assessment, and case plan process and will monitor progress in this area.

STATE PANEL RECOMMENDATIONS

All findings and panel recommendations from the seven cases reviewed by the State Panel 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:

1. The panel 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 a subsequent episode of maltreatment. Providing this feedback to hospital quality improvement committees could improve Arizona hospitals' 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 the child and in the opinion of the panel the hospital staff failed to recognize and/or report a suspicion of maltreatment of that child.

2. The panel recommends that steps be taken (e.g., legislative actions, policy changes) to improve Child Protective Services' access to civil and criminal court databases, both in the state and nationally. This access could provide timely and more complete information on criminal history of parents and others living in a child's household as well as timely information regarding current parental custody of children who are the subjects of investigations.

3. Reviews completed by the panel resulted in concerns surrounding the failure to substantiate allegations when there appeared to be clear evidence of abuse and/or neglect. The panel recommends that the Division of Children, Youth, and Families more closely review its decisions to unsubstantiate reports. When a finding has to be entered by state law prior to receipt and review of pertinent records, Child Protective Services should review and amend findings as warranted upon receipt of records.

4. Panel reviews also resulted in concerns surrounding the completion of investigations, services offered or provided, and investigation outcomes. These issues are summarized as follows:

    - Parental failure to participate in substance abuse services (including monitoring) that are identified to promote the child's safety should impact decisions regarding children remaining with or returning to parents.

    - The panel continued to have concerns that 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. Efforts should be made by Child Protective Services and law enforcement agencies to enforce compliance with protocol.

    - Both parents and other adults in the home, regardless of custodial status, should undergo a full background and home evaluation including criminal history and domestic relations orders when Child Protective Services is evaluating placement and visitation issues.

5. In cases where policies were not followed, the panel identified the failure to obtain medical and forensic exams vital to the investigation. The panel recommends that the Division of Children, Youth, and Families develop a policy regarding forensic

evaluations that would include both when these evaluations are indicated and the content of these evaluations.

6. The panel acknowledges the updates made by Child Protective Services in response to the previous year's recommendations made to the Division of Children, Youth, and Families. The panel would further recommend that a formal process be implemented to update the Citizen Review Panel regularly on Child Protective Services' progress in implementing the Citizen Review Panel's recommendations as well to update the panel on policy changes.

PIMA COUNTY PANEL ACTIVITIES: NOVEMBER 2006 THROUGH OCTOBER 2007

PIMA COUNTY PANEL MEETINGS

The Pima County Citizen Review Panel met on eight occasions and completed seven case reviews. Reviewed cases represented four counties including Cochise County (one case), Gila County (one case), Pima County (four cases), and Pinal County (one case).

PIMA COUNTY PANEL CASE RECORD REVIEW FINDINGS

This section of the report presents information on the Pima Citizen Review Panel findings and recommendations to promote improvements within Arizona's child protective services agency.

The following summarizes the Citizen Review Panel findings:

Prior Child Protective Service History
Only two of the cases reviewed had previous involvement with Child Protective Services prior to the investigation reviewed by the panel. Within these cases, there were seven prior reports.

Intake and Screening Stage
The panel continued to identify this stage as a strength of the child protection system. The panel found that actions taken by the Child Protective Services Hotline were over all complete, accurate, and timely. The panel did express concern that a call made to the hotline alleging an injury was not taken as a report to be investigated by Child Protective Services.

Investigation Stage
During reviews, panel members assess numerous aspects of each investigation, identifying areas of strength and weakness within the system. Within the seven cases reviewed there were ten investigations. Panels concluded that six investigations were appropriate and comprehensive. Concerns were noted in two of the investigations examined during the reviews. These concerns included failure to obtain medical records or police records and failure to obtain medical exams. The panel further noted concerns regarding the failure to interview children and parents as required by policy. In two investigations, the panel was unable to determine if activities were appropriate due to lack of documentation.

Crisis Intervention and Safety Assessment Stage
Overall, reviews concluded that Child Protective Services continues to ensure child safety. The panel expressed some concerns about Child Protective Services' lack of a thorough assessment of safety in two of the investigations reviewed. The panel is aware that Child Protective Services recently implemented a new process to assess the safety of children and will further assess this area in the coming year.

Investigative Finding/Determination Stage
The panel concluded that Child Protective Services did adequately complete activities within this stage in the majority of the cases reviewed and agreed that documentation supported the investigative findings in six of the investigations reviewed. In one investigation, the panel identified concerns regarding failure to complete and document interviews with all parents and siblings. The panel identified concerns in one investigation regarding the failure to obtain and review required documents before determining allegations to be either substantiated or unsubstantiated.

Case Planning and Implementation Stage
This stage only applies to those cases that remained open after the investigation. The panel determined that case planning was completed as required in six cases, but identified concerns with the development and implementation of the plans in two cases. Panel members noted the failure to complete developed plans and concerns that the plans do not adequately address the needs of the family.

Foster Family Section
There were no reviews of foster family home cases this reporting period.

Case Closure Stage
The majority of the cases remained open at the time of review by the panel. Of the three cases that were closed, panel members determined that safety issues were not adequately resolved prior to closure in two of the cases. In one case, panel members determined that Child Protective Services failed to assess the child's safety throughout the investigation and prior to closure.

Family Risk Factors
Throughout the review, panel members identify specific risk factors for each case. As a result of this process, the panel is able to determine if Child Protective Services adequately identified and resolved risks contributing to the maltreatment. Lack of parenting skills (4), mental health problems (3), substance abuse (3), and anger control (3) 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 in the list below (see next page) are not mutually exclusive and more than one factor may be noted for a single case.

Risk Factor	*Frequency*
Lack of parenting skills	4
Mental health problem	3
Substance abuse	3
Anger control problem	3
Lack of motivation to provide adequate care	3
Domestic violence	3
Lack of resources for adequate food/shelter/medical care/childcare	2
Violence by parent/guardian outside of home	2
Lack of physical or mental ability to provide adequate care	2
Teen Parent	2

Substance abuse continues to be a high risk factor with families involved with Child Protective Services. The three most commonly used substances in order of frequency were methamphetamines, alcohol, and marijuana.

At the conclusion of case reviews, the panel members were asked to determine if state and federal policies were followed. During this reporting period, the panel concluded that state and federal policies were followed in four of the seven cases. Problems noted in three cases included poor documentation, failure to obtain pertinent records, failure to interview professionals with relevant information, failure to see parents/children in a timely manner, and failure to obtain medical examinations.

PIMA COUNTY PANEL RECOMMENDATIONS

The Pima County Citizen Review Panel respectfully submits the following recommendations to the Department of Economic Security, Division of Children, Youth, and Families:

1. The panel continues to have a concern that joint investigation protocol is not always followed. Joint investigation protocol should be followed in every applicable investigation. Child Protective Services and law enforcement agencies should develop a strategy to improve compliance with the established protocol.

2. The panel expressed concerns in one case that delays in criminal cases may create problems with Child Protective Services efforts. The panel recommended that contacts with the County Attorney's Office and Child Protective Service be identified to resolve coordination or communication problems with either agency.

YAVAPAI COUNTY PANEL ACTIVITIES: NOVEMBER 2006 THROUGH OCTOBER 2007

YAVAPAI COUNTY PANEL MEETINGS

The Yavapai County Citizen Review Panel met on eight occasions and completed eight case reviews. Reviewed cases represented three counties including Mohave County (one case), Yavapai County (four cases) and Yuma County (three cases).

YAVAPAI COUNTY PANEL CASE RECORD REVIEW FINDINGS

This section of the report presents information on the Yavapai Citizen Review Panel findings and recommendations to promote improvements within Arizona's child protective services agency.

The following summarizes the Citizen Review Panel findings:

Prior Child Protective Service History
Five reviewed cases had previous involvement with Child Protective Services prior to the investigation reviewed by the panel. Within these five cases, there were 18 prior reports.

Intake and Screening Stage
The panel continued to identify this stage as a strength of the child protection system. The panel found that actions taken by the Child Protective Services Hotline were complete, accurate, and timely in all but one of the cases reviewed.

Investigation Stage
During reviews, panel members assess numerous aspects of each investigation, identifying areas of strength and weakness within the system. The panel determined the investigation stage to be an overall strength for this area of the state noting that investigations were thoroughly completed. The panel identified a concern regarding a hospital emergency department's failure to identify abuse and subsequently, released the child in one case. The panel also noted concerns regarding Child Protective Services' failure to gather appropriate medical records or police records necessary to complete an investigation in one case.

Crisis Intervention and Safety Assessment Stage
Overall, reviews concluded that Child Protective Services continues to ensure child safety. The panel expressed some concerns about Child Protective Services' lack of a thorough assessment of safety, in two of the investigations reviewed. The panel is aware that Child Protective Services recently implemented a new process to assess the safety of children and will further assess this area in the coming year.

Investigative Finding/Determination Stage
The panel concluded that Child Protective Services did adequately complete activities within this stage in the majority of the cases reviewed. The panel identified concerns regarding inadequate attempts made to locate families who are subject of a report prior to entering findings.

Case Planning and Implementation Stage
This stage only applies to those cases that remained open after the investigation. The panel determined that case planning was completed as required in seven of nine cases. Concerns with the development and implementation of the plans included three cases that did not have current case plans in the case file, and in two cases, the parents refused to participate in services provided. In the majority of cases, the panel noted that the case plans thoroughly addressed the needs of the families and provided appropriate services to meet these needs.

Foster Family Section
There were no reviews of foster family home cases this reporting period.

Case Closure Stage
Eight of the investigations had been closed at the time of review by the panel. In one case, panel members determined that safety concerns were not adequately resolved prior to closure. A concern noted by panel members includes the closure of one case when appropriate attempts to locate the family were not completed by Child Protective Services.

Family Risk Factors
Throughout the review, panel members identify specific risk factors for each case. As a result of this process, the panel is able to determine if Child Protective Services adequately identified and resolved risks contributing to the maltreatment. Lack of parenting skills (6), substance abuse (4), mental health problems (4), and lack of motivation to provide adequate care (4) 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.

Risk Factor	*Frequency*
Lack of parenting skills	6
Substance abuse	4
Mental health problem	4
Lack of motivation to provide adequate care	4
Anger control problem	3
Lack of resources for adequate food/shelter/medical care/childcare	3
Domestic violence	2
Lack of physical or mental ability to provide adequate care	2
Violence by parent/guardian outside of home	1
Teen Parent	1

Substance abuse continues to be a high risk factor with families involved with Child Protective Services. The three most commonly used substances in order of frequency were methamphetamines, alcohol, and marijuana.

At the conclusion of case reviews, the panel members were asked to determine if state and federal policies were followed. During this reporting period, the panel concluded that state and federal policies were followed in five of the eight cases. In one case, the panel was unable to determine if policies were followed. In the two cases where policies were not followed, the panel determined that case documentation did not comply with policy and prior report findings were not appropriately considered during current investigations.

YAVAPAI COUNTY PANEL RECOMMENDATIONS

The Yavapai Citizen Review Panel respectfully submits the following recommendations to the Department of Economic Security, Division of Children, Youth, and Families:

1. The Citizen Review Panel noted a lack of assessment and referral of children for appropriate educational services. There was also concern that these children are not receiving an adequate education because their parents have not enrolled them in any schools. The panel members are aware of the educational system's responsibilities to evaluate the appropriateness of educational services. The panel recommended that the Arizona Department of Education reexamine its policies regarding the educational assessment of children whose educational progress is not currently being assessed.

2. Reviews completed by the panel resulted in concerns regarding the entering of appropriate after-investigation findings in the CHILDS reporting system. Findings of a death of a child or other abuse/neglect findings that are determined only at the end of an investigation were not consistently updated and entered into the reporting system. The panel recommends that DCYF more closely review cases to verify that accurate findings are reported in CHILDS.

CITIZEN REVIEW PANEL OBJECTIVES FOR 2008

The Citizen Review Panel has the following objectives for 2008:

1. Continue to review Child Protective Services' cases involving reports of fatal and near fatal maltreatment.

2. Identify cases that are examples of both exemplary, in accordance with state and federal policies, and unsatisfactory casework to be used for training purposes.

3. Continue efforts to provide feedback on concerns and trends identified during reviews to local Child Protective Services offices. These efforts will include collaboration with Child Protective Services 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. 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. Continue to be invited to participate in Child Protective Services high profile staffings and assess the ability of the panel to complete these reviews for Child Protective Services.

6. Develop a plan with the Department of Economic Security to assist with reviews of draft policy and procedural changes.

7. 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 members' satisfaction with the program.

APPENDIX A: AGENCY RESPONSE TO CITIZEN REVIEW PANEL'S 2006 RECOMMENDATIONS

Recommendation 1: The 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

Response: The Department agrees with this recommendation. By August 31, 2007, the Division's Child Welfare Training Institute (CWTI) will ensure that the CPS Specialists and Supervisors receive information on infant safe sleeping arrangements. By August 31, 2007 the Division's Policy Unit will develop and disseminate to CPS staff a brochure for caregivers of infants that encourage safe sleeping arrangements for infants.

By August 31, 2007, the Division's Policy Unit will review and revise as applicable the child safety assessment (CSA) and strengths and risks assessment (SRA) tools to ensure that safe sleeping arrangements for infants is addressed.

Recommendation 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 six 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.

Response: The Department agrees with this recommendation. The Division's revised child safety assessment (CSA) and strengths and risks assessment (SRA) and case planning process directs staff to clearly gather information about the child's special needs and ensure that these needs are considered in the overall assessment and case planning process. Statewide implementation of this revised CSA, SRA and case planning process is projected for June 30, 2007. All staff are currently being trained on the enhanced process.

By August 31, 2007, the Division's Child Welfare Training Institute (CWTI) will review and revise as applicable the basic core curriculum for CPS Specialists and Supervisors to ensure that the risks to children with special needs are identified and addressed. The

CWTI will continue to enhance staff knowledge and skills through training opportunities that focus on the needs of infants and children with special needs such as co-sponsorship of the Pre-Conference Institute on Infants and Toddles in the Courts and the Infant Toddler Mental Health Coalition of Arizona Conference set for August 2007.

As of November 2006, the Division now requires all newly licensed foster parents to complete the nationally recognized, standardized curriculum (PS-MAPP) which includes preparation, selection and training program for foster parents. PS-MAPP (Partnering for Safety and Permanence—Model Approach to Partnerships in Parenting) curriculum is designed to present information about the special needs of children entering out-of-home care and requires prospective foster parents to assess their abilities to meet the needs of this population.

By November 30, 2007, the Division's Policy Unit will review the PS-MAPP (Foster Parent Preparation and Selection, and Training) and ensure that it adequately addresses the risks and needs of children with special needs. The Division will monitor existing contracts for home recruitment, study and supervision (HRSS) to ensure that providers fully implement PS-MAPP consistently statewide. In addition to PS-MAPP, licensed foster parents, who receive medically fragile children, will complete advanced pre-service training prior to accepting placement of children with special needs.

Recommendation 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.

Response: This recommendation was forwarded to the Department's Office of License, Certification and Regulations (OLCR) for consideration.

The Department contracts with child placing agencies to study an applicant's strengths and risk factors. Based on the contractor's assessment of the home, a written home study report is submitted to the OLCR that includes their recommendation to license the home or deny the application. The OLCR reviews the information provided by the contractor to ensure compliance with all licensing requirements and may require additional information from the applicant to resolve potential risk factors prior to the issuance of a license.

As of November 2006, the Division now requires all newly licensed foster parents to complete PS-MAPP which includes preparation and selection and training for foster parents. PS-MAPP (Partnering for Safety and Permanence—Model Approach to Partnerships in Parenting) program requires families to identify and assess the strengths and risks or needs within their own family and family of origin as they may impact the family's ability to meet the needs of children placed in their care.

By November 30, 2007, the Division's Policy Unit will monitor existing contracts for home recruitment, study and supervision (HRSS) to ensure that providers fully implement PS-MAPP consistently statewide.

The rules that govern the licensing of family foster homes are currently under review and revision. The issue of licensing capacity in relation to number of small children placed simultaneously in the same home is being addressed in these rules. In preparation for this rule review and revision, OLCR staff completed an exhaustive review of other states' foster home licensing rules. Information gathered during this review was considered by OLCR.

The Division will continue to work with the provider community to utilize congregate care when appropriate to meet the child's individualized assessed placement needs.

Recommendation 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 unsubstantiated reports.

Response: The Department agrees with this recommendation. The Protective Services Review Team (PSRT) Manager holds a case conference with the CPS Supervisor to review any action to "over-turn" a proposed substantiated finding. The purpose of the conference is to ensure that the CPS Specialist and Supervisor clearly understand the required evidence to support a substantiated finding.

By November 30, 2007, the Division's Practice Improvement Unit will develop a process to conduct periodic reviews of random selection of cases in which the CPS Specialist and Supervisor did not substantiate child abuse or neglect to assess whether evidence gathered during the investigation was sufficient to support a finding of child abuse and/or neglect. Information gathered during these reviews will be used to direct case consultation and training including monthly "tips" regarding the evidence required to substantiate child abuse and neglect.

Additionally, the Division's current initiative to improve case record documentation will include direction regarding evidence required to substantiate child abuse and neglect.

Recommendation 5: Panel reviews also resulted in numerous concerns surrounding the completion of investigations, 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.

  Response: The Department agrees with this recommendation. A child, who has suffered a serious non-accidental injury, should not be returned to the home until a safety plan is developed and implemented. Current policy requires that the safety plan be sufficient to control and manage the safety threat, and monitored to ensure the child's continued safety. Department policy also requires the case to remain open until the safety threat is eliminated.

  Implementation of the Division's revised child safety assessment (CSA) and strengths and risks assessment (SRA) and case planning process will address this recommendation as it directs the child safety assessment and safety planning process. All staff are currently being trained on the enhanced process. Statewide implementation is projected for June 30, 2007.

- 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.

  Response: The Department agrees with this recommendation. By September 30, 2007, the Division's Policy Unit will review (and revise as warranted) current policy to ensure that staff refer a young pregnant teen for prenatal care. By September 30, 2007, this recommendation will be reviewed with CPS staff, who provide specialized services to this population.

- Failure to comply with substance abuse treatment plans, including screening, should impact decisions regarding children remaining with or return to parents.

Response: The Department agrees with this recommendation. The Division's revised child safety assessment (CSA) and strengths and risks assessment (SRA) and case planning process directs staff to clearly gather information about the parent's overall functioning including use (or continued use) of substances and its direct impact on the parent's ability to ensure child safety. The revised case planning process requires staff to develop behaviorally-based case plans that clearly describe how the parent's behavior must change to ensure child safety. Decisions regarding the permanency plan for the child will be determined based on the parent's ability to make the identified behavioral change.

Assessment and re-assessment of child safety and risk of harm include an assessment of the parent's use of substances and occur at intervals specified in the case plan. Statewide implementation of this revised CSA, SRA and case planning process is projected for June 30, 2007. All staff are currently being trained on the enhanced process.

In addition to the above activities, the Division's Program Services Administration staff have actively sought to increase CPS staff knowledge and skills to better assess the impact of substance abuse on child safety. Such efforts include:

- *statewide training on methamphetamine by experts was completed in June 2006. Twenty–five sessions were held with a total of 1,011 CPS staff and other stakeholders attending. This training has been instrumental in increasing awareness of the consequences of methamphetamine abuse in addition to building skills in engaging and providing interventions for these seemingly difficult clients. Sixteen additional trainings are planned for July 2007 to June 2008.*
- *convening and leading a task force examining the methamphetamine impact on child welfare to improve the child welfare response to family's impacted by methamphetamine in order to ensure child safety and improve well being. The task force includes experts from substance abuse organizations, behavioral health agencies, universities and others. The efforts and recommendations of this task force resulted in the following:*
- *updated Child Welfare Training Institute (CWTI) training curriculum on substance abuse to include a train-the-trainer component completed January 30, 2007;*
- *partnership with Department of Health Services to identify a screening tool to enhance CPS Specialists identification of substance abuse related issues (disseminated to field staff with in-service training in April 2007);*
- *development of informational publications targeted at CPS staff to ensure staff are properly informed on the impact of methamphetamine; The informational series includes practice points on topics such as family-centered practice, methamphetamines and child maltreatment, effective treatment, safety, and engagement and are currently being disseminated to field staff with in-service training.*
- *development of Risk Domains and Six Fundamental Safety Questions for Methamphetamine Abuse matrix to assist CPS Specialists to explore maltreatment in the context of methamphetamine abuse. This tool was disseminated to the field with an in-service training in April 2007.*

Strategies have also been implemented to enhance CPS expertise and resources related to substance abuse. These include substance abuse treatment provider participation in family drug court, Team Decision Making meetings and dependency hearings, and co-location of substance abuse staff in CPS offices to improve levels of engagement and provide CPS staff with expertise in the area of substance abuse, while ensuring immediate access to needed treatment services.

- 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.

  Response: The Department agrees with this recommendation. Current policy directs staff to review all conflicting medical evidence with a multidisciplinary team including a physician with expertise in child maltreatment diagnosis and treatment, or to base intervention on the most serious diagnosis if a multidisciplinary team is not available. Clearly, the intent is that staff seek out "specialists" to assist in determining the appropriate course of action.

  By September 30, 2007, the Division's Policy Unit, in consultation with the District Program Managers, will:
  - *review available resources to ensure that CPS staff have access to consultants with expertise and experience in the diagnosis and treatment of child maltreatment;*
  - *ensure that staff understand when expert consultation should occur; and*
  - *ensure that the Division's Medical Director of the Comprehensive Medical and Dental Program takes a more active role in the resolution of these rare case specific situations.*

- 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.

  Response: The Department agrees with this recommendation. To improve compliance with this statutory requirement, the Division completed a review of a random sample of cases meeting the joint investigation criteria. Based on this review, the Division took the following corrective actions to improve performance in this area:
  - *modifications to CHILDS to enhance identification and accurate documentation of reports that required joint investigation with law enforcement; written clarification to field staff about the importance of and when a joint investigation with law enforcement is required and what constitutes a joint investigation;*
  - *integration of the requirements for a joint investigation in the revised child safety assessment, and documentation requirements; and*

- *development of management information reports to monitor compliance with joint investigation.*

By June 30, 2007, the Division's Policy Unit will provide follow-up written clarification and "reminders" to field staff regarding the statutory requirement to conduct joint investigations, the importance of joint investigations, and how such investigations should be documented in CHILDS.

- Both parents, regardless of their custodial status, should always be interviewed and notified of allegations.

Response: The Department agrees with the intent of this recommendation. By September 30, 2007, the Division's Policy Unit will revise policy to direct the CPS Specialist to interview the non-custodial parent when the identity and whereabouts can be reasonably determined, or when such contact would not be likely to endanger the life or safety of any person or compromise the integrity of a criminal investigation or the CPS investigation.

Policy currently requires the CPS Specialist to interview all persons who have information about the allegations or about the risk of future maltreatment to the child. Policy also requires the CPS Specialist to consult with the Supervisor when the Specialist's determines that it is not necessary to interview the parent or other adult who does not reside in the home.

Additionally, the revised child safety assessment (CSA) and strengths and risks assessment (SRA) directs the CPS Specialist to make contact with the custodial and non-custodial parent in order to gather information about their overall functioning.

APPENDIX B: PANEL MEMBERS

STATE CITIZEN REVIEW PANEL

Chair:
Mary Ellen Rimsza, M.D. FAAP
American Academy of Pediatrics
University of Arizona College of Medicine

Members:

Cindy Copp
ADES/Administration for Children, Youth & Families

Frank DiModica
Phoenix Police Department

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

Linda Johnson
ADES/Administration for Children, Youth & Families

Simon Kottoor
Sunshine Group Home

Rebecca Lowry
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

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, Citizen Review Panel Program Manager

Teresa Garlington, Administrative Secretary

PIMA COUNTY CITIZEN REVIEW PANEL

Chair:
Amy Gomez
Victim Witness Program
Pima County Attorney's Office

Coordinator:
Rebecca Lowry

Members:

Jill Baumann
CASA, Pima County Juvenile Court

Diane Calahan
SO Arizona Children's Advocacy Center

Christopher Corman
Arizona Supreme Court
Foster Care Review Board

Sandy Guizzetti
Arizona Supreme Court
Foster Care Review Board

Penelope Jacks
Children's Acton Alliance of Southern Arizona

Lynn Kallis
Pilot Parents of Southern Arizona

Christie Kroger
ADES/Administration for Children, Youth & Families

Joan Mendelson
Attorney

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

Barbra Quade
Jewish Family Services

Laurie San Angelo
Office of the Attorney General

Jane Schorzman, M.A.
Arizona Child Abuse Information Center

Christine Trueblood
CODAC, Health Families

Angela Tuzzolino
ADES/Administration for Children, Youth & Families

Lisa Watkins
ADES/Administration for Children, Youth & Families

Consultant: Anna Binkiewicz, M.D.

YAVAPAI COUNTY CITIZEN REVIEW PANEL

Chair/Coordinator:
Rebecca Ruffner (Former)
Prevent Child Abuse Arizona
Barbara Jorgensen, R.N., M.S.N. (Current)
Yavapai County Health Department

Members:

Bill Hobbs
Yavapai County Attorney's Office

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

Mary Ellen Sandeen
Yavapai Regional Medical Center

CPS CASE HISTORY REVIEW

(Complete one "CPS Case History Review" for each CPS report.)

CRP CASE ID # _____ - _____ - _____

DATE OF REVIEW_____

TOTAL NUMBER OF REPORTS MADE TO CPS:_____

DATE OF CPS REPORT MADE TO CPS: _____
(Enter the date reported to CPS for the investigation reviewed on this form. If more than one report made to CPS, complete an additional form for each report.)

STAGE 1: INTAKE AND INITIAL SCREENING

1. Were Hotline activities associated with this report satisfactory? ☐Yes ☐No

2. Recommendations/Comments on Intake/Initial Screening
Consider: Hotline's response to report, including accuracy and timeliness.

_____

_____

_____

_____

STAGE 2: INVESTIGATION OR ASSESSMENT

1. Were activities that were necessary for a thorough investigation completed? ☐Yes ☐No
   Consider: Coordination with law enforcement; adherence to interagency protocols; investigation initiated in a timely fashion; interviews of all applicable persons including the source if appropriate; interviews or observations of all children; location/environment of interviews; completion of medical evaluations; assessment of alleged maltreatment; and compliance with policy.
2. Provide comments regarding investigation.

_____

_____

_____

_____

_____

_____

STAGE 3: CRISIS INTERVENTION, SAFETY ASSESSMENT, EMERGENCY PLACEMENT, AND FAMILY STABILIZATION

1. Were adequate measures taken to ensure the safety of the child(ren)? ☐Yes ☐No
Consider: Immediacy of measures; adequate consideration of prior involvement by CPS with the family; adequacy of actions taken; services provided; monitoring of safety.

2. Comment on the adequacy of measures taken.

_____

_____

_____

3. Was a safety assessment completed? ☐Yes ☐No

4. Provide comments on the quality of the safety assessment. *Consider: Inclusion of all safety concerns; plans to address safety concerns; timeliness of safety assessment; revision of safety plans when needed.*

_____

_____

_____

STAGE 4: INVESTIGATION FINDINGS/ DETERMINATION

1. Did the documentation support the finding *(For example: substantiated, proposed substantiation, unsubstantiated or unable to locate)*? ☐Yes ☐No

2. Provide comments on investigation findings:

_____

_____

_____

_____

STAGE 5: CASE PLANNING/CASE PLAN IMPLEMENTATION

1. Was a case plan developed following this investigation? ☐Yes ☐No

2. Describe completion and implementation of case plan: *Consider: Absence of needed case plans; timeliness of case plan; adequate identification of family needs; adequacy of plan to meet identified needs; consideration of medical needs; consideration of success/failure of services previously received modifications that reflect changes in family needs. Note whether a completed case plan agreement is located in the case file.*

_____

_____

_____

_____

3. Provide comments regarding on-going case management activities.
Consider: Sufficiency of contacts with child(ren), all family members, foster parents, providers; appropriate visits among family members, with out-of-home placements; case record documentation; compliance with court-orders; compliance with policy.

_____

_____

_____

_____

_____

4. Did the services provided adequately address the needs of the family? ☐Yes ☐No

5. Comment on the services provided to the family. *Consider: All services including, but not limited to, child care, mental health treatment and assessment, medical, educational, transportation, substance abuse treatment and assessment, and parent-aid services. Comment on issues such as the periodic review of quality, continued need, and appropriateness of services; progress toward treatment goals; effectiveness of providers; and participation by family members in services provided.*

_____

_____

_____

_____

_____

STAGE 6: CASE CLOSURE

1. Were safety concerns adequately resolved prior to case closure? ☐Yes ☐No ☐N/A

2. Did the panel agree with the decision to close the case? ☐Yes ☐No

3. Comment on case closure: *(In addition to the above questions, consider if prior to closure this decision was discussed with the family, team members, and providers. Were clear instructions provided to family members on any follow-up issues or actions to take if safety concerns return?)*

_____

_____

_____

_____

FAMILY FOSTER HOME CASES

1. Date of foster home licensing_____

2. Family composition (Members and their ages)

_____

_____

_____

_____

3. Was a critical review of the foster family's background, qualifications and stressors completed?

☐Yes ☐No ☐N/A ☐Unk

_____

_____

_____

_____

4. Were concerns adequately identified and addressed?

_____

_____

_____

_____

5. What initial training, ongoing training and support was provided to the foster family? *(include monitoring)*

_____

_____

_____

_____

6. Were licensing policies followed? ☐Yes ☐No ☐N/A ☐Unk If no:

_____

_____

_____

_____

FAMILY RISK FACTORS:

☐ Substance abuse
- ☐Alcohol
- ☐Methamphetamines
- ☐Cocaine
- ☐Marijuana
- ☐Opiates
- ☐Barbiturates
- ☐Other _____

☐ 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
2. Comment on policies followed or not followed:

_____

_____

_____

_____

_____

3. Commendation recommended? ☐Yes ☐No If yes, identify individuals/titles -

_____

_____

_____

_____

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

☐Yes ☐No

5. Comments:_____

_____

_____

_____

_____

To obtain further information, contact:

Therese Neal
Child Fatality Review Section
Bureau 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 Section at (602) 542-1875 (voice) or call 1-800-367-8939 (TDD).

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

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