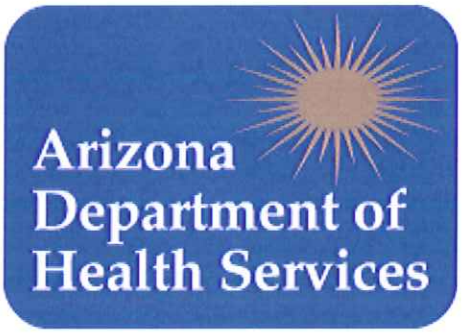
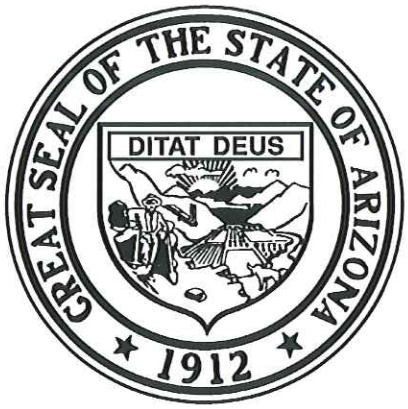
Arizona Citizen Review Panels

TENTH ANNUAL REPORT

JANUARY 2009

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

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EXECUTIVE SUMMARY

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.

The Tenth Annual Citizen Review Panel Program Report summarizes the findings of 13 reviewed cases of child maltreatment that occurred between November 1, 2007 and November 30, 2008. Nine of these cases were fatalities and four were near-fatalities or other high-risk cases. The 13 cases reviewed included 33 actual investigations (some cases had multiple investigations). In the previous year's analysis (2006-2007), 22 cases were reviewed, ten of which were child fatalities.

The 13 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.

SUMMARY OF CITIZEN REVIEW PANELS' CASE REVIEW FINDINGS

- Nine of the reviewed cases had previous involvement with Child Protective Services prior to the investigation reviewed by the panels. Within these cases, there were 29 total reports.

- The panels found that actions taken by the Child Protective Services Child Abuse Hotline were complete, accurate, and timely in all but one of the cases reviewed.

- Panels concluded that in five of the 13 cases 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 interview all relevant family members and/or reporting sources, and inadequate attempts made to locate families who were subjects of reports. The panels also noted concerns regarding inconsistent collaboration between Child Protective Services and law enforcement agencies during investigation of reports that required joint investigation.

- In nine of 13 investigations reviewed, the panels concluded that Child Protective Services adequately fulfilled its role of ensuring child safety through completion of the Child Safety Assessment tool utilized by caseworkers. The panels expressed concern about Child Protective Services' lack of thorough assessment of safety in four of the 13 investigations reviewed.

- The panels identified six of 13 investigations where documentation in the case record warranted substantiation of the allegation, in the opinion of the panels. As in prior years'

reports, the panels identified concerns regarding the failure to substantiate allegations of abuse and neglect, in spite of strong supportive evidence.

- The panels determined that 11 of 13 cases were open for Child Protective Services at the time the panels conducted the reviews. In six of 11 open cases, case planning and ongoing case management activities were appropriate and timely. Concerns included refusal by parents or guardians to participate in services, inability of Child Protective Services to enforce case plans, and failure to include all family members in case plans. Two cases did not require case plans.

- Panels concluded that five cases should not have been closed, due to failure to adequately resolve safety issues prior to closure. Concerns noted by panels included the failure of Child Protective Services to assess home environments and criminal backgrounds of parents and closure before receipt and review of pertinent records.

- As part of the review process, panels identify family risk factors of child maltreatment and mortality. The most prevalent family risk factors identified during the reviews were lack of parenting skills (n=12) and mental health issues (n=8). Substance use was noted in seven cases. Methamphetamines and marijuana were the most prevalent types of drugs identified in case reviews (n=4 each).

Summary of Citizen Review Panels' Case Review Recommendations

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

1. The Citizen Review Panels recommend that Child Protective Services and law enforcement agencies develop strategies to improve compliance with the established joint investigative protocols for all applicable cases. Particular attention should be paid to enhancing prompt communication and information sharing between Child Protective Services and law enforcement agencies. A similar recommendation was made in the 2007 annual report, and Child Protective Services has addressed these concerns through enhanced monitoring processes and measures (see Appendix A). Also, in 2008, legislation was passed to strengthen and clarify the development of joint investigation protocol procedures (HB 2455). The effects of these actions will be applicable to panel case reviews beginning with the 2009 annual report.

2. The Citizen Review Panels recommend that Child Protective Services more closely review its decisions when determining investigative findings. In cases where additional information has been received after a finding has been made to comply with statutory timeframes, Child Protective Services should review and amend the finding as necessary. A similar recommendation was made in the 2007 annual report, and Child Protective Services has addressed these concerns through improved quality assurance processes and measures (see Appendix A). The effects of these actions will be applicable to panel case reviews beginning with the 2009 annual report.

3. The Citizen Review Panels recommend that Child Protective Services caseworkers be more diligent in consistently documenting all steps of their investigations.

4. The Citizen Review Panels recommend that Child Protective Services develop protocols to identify, assess, and intervene in cases of chronic neglect. Cases of chronic neglect can extend over many years and involve multiple caregivers. These cases require complex strategies and a high level of coordination among many agencies and stakeholders.

5. The Citizen Review Panels recommend that Child Protective Services develop strategies to address complex, interconnected families. These strategies should address staff communication and consistent decision making. Due to the increasing complexity of family relationships (e.g. kin placements, divorces, remarriages, live-in significant others, extended families), Child Protective Services caseworkers need the ability to better assess and address child safety when an adult or child is involved in more than one case, household, or family.

The report that follows presents the background and purpose of the Citizen Review Panel Program in Arizona, followed by the findings and recommendations of the Citizen Review Panels.

CITIZEN REVIEW PANEL OVERVIEW

This is the tenth annual report from Arizona's Citizen Review Panel Program. 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 (CAPTA) 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 Program 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 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

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 services 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 necessary to carry out these functions.

Section 106(d) of CAPTA requires that Citizen Review Panels develop annual reports which are made available to the public. These reports should contain a summary of the panel's activities, as well as the recommendations of the panels based upon their activities and findings.

Citizen Review Panel members are bound by the confidentiality restrictions in section 106(c)(4)(B)(i) of CAPTA. Specifically, members 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.

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

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 2007 Citizen Review Panel Report is included in Appendix A.

CITIZEN REVIEW PANEL 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 Program 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. Forums were also held to solicit feedback from the public regarding the impact of current procedures and practices upon children and families in the community. Summaries of these forums are included in this report.

CASE 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 external review. Reviewed cases in this reporting period 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 open cases. During this reporting period, Arizona Citizen Review Panels completed 13 case record reviews. Nine cases involved child fatalities due to maltreatment and four 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 reviews, the panels identify risk factors and determine whether Child Protective Services appropriately addressed these risks when conducting investigations. Appendix C is the case review form completed by panels to document findings from each review. Upon completion of each review, the panels ask the key questions of whether state and federal policies were followed and whether the panels recommend any changes in policies and procedures. The results of each review are entered into a database 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 panels assess 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 panels review the record to determine if the Hotline accurately assigned the report and obtained sufficient, available information from the caller. The panels also determine

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 panels review 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 panels assess 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 panels ascertain if Child Protective Services gathered sufficient information to make a final determination and if that determination is supported by case record documentation. The panels also conclude 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 panels have 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 plans should be modified as family circumstances change. The panels also explore 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 panels assess whether risks were sufficiently identified and resolved prior to closure and if the closure was discussed with superiors.

The Foster Family section was added to the review process during the 2007 reporting period. This section is completed when panels review cases with allegations involving foster family placement. In this section, special attention is given to the family's licensing history and the steps taken to complete and maintain the license.

CITIZEN REVIEW PANEL ACTIVITIES: NOVEMBER 2007 THROUGH NOVEMBER 2008

CAPTA requires that Citizen Review Panels develop annual reports and make them available to the public. This report reflects activities of the panels between November 1, 2007 and November 30, 2008 and includes case review findings, recommendations, and a summary of feedback from public forums. This report combines the reviews of the three panels that operate

in Arizona. The reports from the three panels were combined because of the small number of total reviewed cases this year.

Citizen Review Panel Meetings

The Citizen Review Panels met more frequently than the quarterly requirement. The State Panel met on six occasions and completed five case reviews. The Pima County Panel reviewed four cases and held six meetings. The Yavapai County Panel reviewed four cases in four meetings.

Citizen Review Panels' Case Review Findings

The following summarizes the Citizen Review Panels' findings for each stage:

Prior Child Protective Service History
Nine of the reviewed cases had previous involvement with Child Protective Services prior to the investigation reviewed by the panel. Within these cases, there were 29 total reports.

Intake and Screening Stage
As in previous years, panels identified this stage as a strength of the child protection system. The panels found that actions taken by the Child Protective Services Child Abuse 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 panels determined this stage to be an area of weakness. Panels concluded that in five of the 13 cases reviewed, activities necessary for a thorough investigation were completed. Concerns included failure to obtain medical and police records, failure to obtain medical exams, failure to interview all relevant family members and/or reporting sources, and inadequate attempts made to locate families who were subjects of reports. The panels also noted concern regarding inconsistent collaboration between Child Protective Services and law enforcement agencies during the investigation of reports that required joint investigation.

Crisis Intervention and Safety Assessment Stage
In nine of 13 investigations reviewed, the panels concluded that Child Protective Services adequately fulfilled its role of ensuring child safety through completion of the Child Safety Assessment tool utilized by caseworkers. The panels expressed concerns about Child Protective Services' lack of thorough assessment of safety in four of the 13 investigations reviewed.

Investigative Finding/Determination Stage
The panels identified six of 13 investigations where documentation in the case record warranted substantiation of the allegation, in the opinion of the panels. As in prior years' reports, the panels identified concerns regarding the failure to substantiate allegations of abuse and neglect, in spite of strong supportive evidence. In several cases, there was

evidence of prenatal exposure to substance abuse, but still no allegations of neglect were substantiated.

Case Planning and Implementation Stage
The panels determined that 11 of 13 cases were open for Child Protective Services at the time the panels conducted the reviews. In six of 11 open cases, case planning and ongoing case management activities were appropriate and timely. Concerns included refusal by parents or guardians to participate in services, inability of Child Protective Services to enforce case plans, and failure to include all family members in case plans. Two cases did not require case plans.

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

Case Closure Stage
Panels concluded that five cases should not have been closed, due to failure to adequately resolve safety issues prior to closure. Concerns noted by panels included the failure of Child Protective Services to assess home environments and criminal backgrounds of parents and closure before receipt and review of pertinent records.

Family Risk Factors
Throughout the reviews, panels identify specific risk factors for each case. Because of this process, the panels are able to determine if Child Protective Services adequately identified and resolved risks contributing to the maltreatment. Lack of parenting skills (n=12), mental health problems (n=8), substance abuse (n=7), lack of anger control (n=5), and domestic violence (n=5) were the most prevalent family risk factors for reviewed fatalities, near-fatalities, and high-risk cases. Below are the risk factors identified in the reviews. More than one factor may have been identified in a single case.

Risk Factor	*Frequency*
Lack of parenting skills*	12
Mental health problem	8
Substance abuse	7
Anger control problem	5
Domestic violence	5
Lack of motivation to provide adequate care	4
Lack of resources for adequate food/shelter/medical care/childcare	4
Teen parent	4

*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 common risk factor with families involved with Child Protective Services. The three most commonly identified substances in order of frequency were methamphetamines (n=4), alcohol (n=4), and marijuana (n=3).

Conclusion of Case Reviews

At the conclusion of case reviews, panel members determine if state and federal policies were followed. During this reporting period, the panels concluded that state and federal policies were followed in seven of the 13 cases. In cases where policies were not followed, the panels identified the failure to obtain pertinent records during the investigation in four cases and failure to complete a joint investigation in three cases.

CITIZEN REVIEW PANELS' CASE REVIEW RECOMMENDATIONS

All findings and panel recommendations from the 13 cases reviewed by the Citizen Review Panels were considered in determining recommendations. The Citizen Review Panel Program respectfully submits the following recommendations to the Department of Economic Security, Division of Children, Youth, and Families:

1. The Citizen Review Panels recommend that Child Protective Services and law enforcement agencies develop strategies to improve compliance with the established joint investigative protocols for all applicable cases. Particular attention should be paid to enhancing prompt communication and information sharing between Child Protective Services and law enforcement agencies. A similar recommendation was made in the 2007 annual report, and Child Protective Services has addressed these concerns through enhanced monitoring processes and measures (see Appendix A). Also, in 2008, legislation was passed to strengthen and clarify the development of joint investigation protocol procedures (HB 2455). The effects of these actions will be applicable to panel case reviews beginning with the 2009 annual report.

2. The Citizen Review Panels recommend that Child Protective Services more closely review its decisions when determining investigative findings. In cases where additional information has been received after a finding has been made to comply with statutory timeframes, Child Protective Services should review and amend the finding as necessary. A similar recommendation was made in the 2007 annual report, and Child Protective Services has addressed these concerns through improved quality assurance processes and measures (see Appendix A). The effects of these actions will be applicable to panel case reviews beginning with the 2009 annual report.

3. The Citizen Review Panels recommend that Child Protective Services caseworkers be more diligent in consistently documenting all steps of their investigations. The panels recognize that large caseloads and staff turnover affect Child Protective Services caseworkers' ability to document consistently all investigative activities.

4. The Citizen Review Panels recommend that Child Protective Services develop protocols to identify, assess, and intervene in cases of chronic neglect. Cases of chronic neglect

can extend over many years and involve multiple caregivers. These cases require complex strategies and a high level of coordination among many agencies and stakeholders.

5. The Citizen Review Panels recommend that Child Protective Services develop strategies to address complex, interconnected families. These strategies should address staff communication and consistent decision-making. Due to the increasing complexity of family relationships (e.g. kin placements, divorces, remarriages, live-in significant others, extended families), Child Protective Services caseworkers need the ability to better assess and address child safety when an adult or child is involved in more than one case, household, or family.

ARIZONA DEPARTMENT OF PUBLIC HEALTH SERVICES PUBLIC FORUMS

CAPTA requires that Citizen Review Panel Programs provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community. Arizona fulfilled this requirement in 2008 by organizing three public forums. These forums were organized by the program staff at the Arizona Department of Health Services to fulfill contractual requirements with the Department of Economic Security. Each public forum was held in a different region of the state, with events in Phoenix (central region), Flagstaff (northern region), and Sierra Vista (southern region).

Forums were publicized to the best extent possible, and all community members were welcome. Members of the Arizona Citizen Review Panels and representatives from the Department of Economic Security Division of Youth, Children, and Families were also invited.

At the Phoenix Forum, held on August 20, 2008, no members of the public or members of the Citizen Review Panels attended. Five staff members from the Department of Economic Security Division of Children, Youth, and Families were present. The Sierra Vista forum was held on September 29, 2008, and three members of the public attended. There were ten participants at the forum held in Flagstaff on October 2, 2008. No representatives from the Arizona Citizen Review Panels or the Department of Economic Security attended the Sierra Vista or Flagstaff events.

The 13 community members present at the forums included healthcare professionals, educators, foster parents, and members of a support group for grandparents raising their grandchildren. Nearly all participants were parents. At least three of the participants were mandated reporters, and individuals may have had more than one role.

The following questions and comments surfaced at the public forums in Sierra Vista and Flagstaff:

- Why is the Child Protective Services Child Abuse Hotline centralized, rather than located regionally throughout the state?

- What are the qualifications and training requirements for the staff at the Child Protective Services Child Abuse Hotline?
- Child Protective Services caseworkers should increase efforts to return telephone calls in a timely manner. Telephone calls are not always returned or are returned untimely.
- What is the average time between when a report is received at the Child Protective Services Child Abuse Hotline and when the Child Protective Services investigation is initiated?
- Child Protective Services caseworkers should increase efforts to respond to allegations of child abuse and neglect in a more timely manner.
- Are reports made to the Child Protective Services Child Abuse Hotline by community members (such as grandparents) taken as seriously as reports made by law enforcement?
- Does the individual who makes the report to the Child Protective Services Child Abuse Hotline always get interviewed by Child Protective Services caseworkers during an investigation?
- Do all members of the child's family get interviewed by Child Protective Services caseworkers during an investigation?
- There does not appear to be consistency with regard to who is interviewed during a Child Protective Services investigation.
- Why are some families notified by Child Protective Services caseworkers prior to home visits?
- The focus of Child Protective Services on the biological parents can overshadow other caregivers or extended family members.
- How does Child Protective Services operate in other states?

Participants at the two forums were generally unaware of the existence of the Citizen Review Panel Program, showing that public education about the program will be critical in the future. The Arizona Department of Health Services has shared the comments from the two forums with Child Protective Services, who has agreed to respond to the questions and concerns. The Arizona Department of Health Services will send the responses from Child Protective Services to all forum participants who provided contact information.

APPENDIX A: AGENCY RESPONSE TO CITIZEN REVIEW PANEL'S 2007 RECOMMENDATIONS

State Panel Recommendations

Recommendation 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.

Response: The Department agrees with this recommendation. The Division implemented similar procedures in September 2007 to improve provider accountability and will integrate additional procedures to fully implement this recommendation immediately. The Division, through its Comprehensive Medical and Dental Program (CMDP), has a Quality of Care Review Policy and Procedure in place. Any quality of care concerns identified by the Citizen Review Panel will be referred to the Division's Policy Unit Manager. The Policy Unit Manager will coordinate the referral of the specific case and identified quality of care concern to the CMDP Quality Management Coordinator. The concern will be investigated in accordance with policies and procedures established by CMDP's Quality of Care Committee. This investigation includes:

- *sending an acknowledgement letter to the Citizen Review Panel of the quality of care concern within seven business days from receipt of the concern;*
- *requesting supporting documentation and/or medical records;*
- *reviewing and evaluating each quality of care concern;*
- *recommending a corrective action plan when the quality of care concern is substantiated;*
- *sending a letter of concern to the provider with a specific timeframe for a response;*
- *reviewing the response from the provider and providing continued monitoring to ensure that corrective actions are taken; and*
- *providing a closing letter to the Citizen Review Panel indicating that the quality of care concern has been addressed.*

When the concern involves the failure of a provider to report suspected child maltreatment, the recommended corrective action will include increasing the provider's knowledge of the mandatory reporting statute. Further, the Division will offer technical assistance to the provider.

Recommendation 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.

Response: The Department agrees with the intent of this recommendation. Staff who are responsible for investigating allegations of child abuse and neglect should have access to timely and relevant information including criminal history and parental custody to assist in assessing child safety and future risk of harm.

In collaboration with law enforcement, the Arizona Department of Public Safety and Arizona State Legislators, the Department actively supported House Bill 2602 (Criminal history records; DES) which authorizes the exchange of criminal history information with Child Protective Services (CPS) for the purposes of investigating or responding to reports of child abuse, neglect or exploitation. Designated CPS staff will have direct online terminal access to criminal history record information when all applicable state and federal rules, regulations and guidelines have been met including training, certification and background screening. Direct online terminal access includes information from the National Crime Information Center, the Interstate Identification Index, and the Arizona Criminal Justice Information System.

If House Bill 2602 is enacted, not later than December 1, 2008, the Department anticipates full implementation of the provisions of this bill.

It should be noted that in September 2007 the Department clarified its policy to direct CPS staff to collect and review criminal history record information (arrest, charge/indictment and/or conviction) of the parent, guardian or custodian, and other household members if there is indication of criminal activity involving a child or that places a child at risk of harm, domestic violence and/or past abuse or neglect of a child.

In addition, by July 1, 2008, the Division's Policy Unit will begin identifying which County Superior Courts throughout the State have electronic databases and the process by which CPS staff can access information contained in these databases. This information will be communicated to all CPS staff as it is received by the Division. Consistent with current policy, staff will be expected to search these databases when there is indication of criminal activity involving a child or that places a child at risk of harm, or indication that there is a court order restricting or denying a parent/caregiver's (or another person in the home) custody, visitation or contact with the child.

Recommendation 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.

Response: The Department agrees with this recommendation. The Division has already taken corrective measures to address this concern through full implementation of a quality assurance program that includes a thorough review and evaluation of the evidence collected to support or not support the finding, and whether concerted efforts were made to gather pertinent information to determine whether an allegation of child abuse or neglect should be substantiated. This quality assurance process identifies practice areas needing improvement including the need for

policy revisions. To further address this concern, by October 1, 2008, the Division will clarify its policy to ensure that staff understand the expectation that an unsubstantiated finding be amended when additional information is received to indicate that maltreatment did occur.

The quality assurance of practice occurs at all levels of the Division as follows:

- *In October 2007, the Division's Practice Improvement Unit implemented a process to conduct periodic reviews of a random selection of cases to identify strengths, areas needing improvement, and contributing factors. A random sample of investigation cases are reviewed from each district on a monthly basis. The majority of the cases reviewed have a finding of unsubstantiated entered into CHILDS. The review instrument includes an assessment of whether the agency made a concerted effort to gather sufficient information to determine whether maltreatment occurred, and whether the field unit accurately applied the substantiation guidelines to the information obtained to identify the report as substantiated or unsubstantiated.*

- *Each month, the outcome of each review is discussed with the District Program Manager or Assistant Program Manager and the assigned Supervisor and CPS Specialist. If the review found this to be an area needing improvement, the CPS Specialist and Supervisor are provided information about the specific practice standards relevant to the case, the substantiation guidelines, and/or resources for consultation about investigation findings, according to the Specialist's identified needs. Practice areas needing improvement are identified and a worker specific performance improvement plan may be developed and implemented.*

- *Each district's aggregated case review findings are provided in monthly reports to the District Program Managers and Central Office leadership. Program Managers distribute these within their districts, and discuss the results at monthly district leadership meetings.*

- *Statewide aggregated case review findings are provided in quarterly reports to the District Program Managers and Central Office leadership. Program Managers distribute these within their districts, and discuss the results at monthly district leadership meetings. Central Office leadership reviews the results to identify necessary additional program or practice improvement actions. These reports are also provided to the Child Welfare Training Institute so that identified needs can be addressed in initial, refresher, or advanced training.*

- *If the review identifies a case in which a finding is not supported by the evidence, the Practice Improvement Manager consults with the Protective Services Review Team and subsequently recommends to the Supervisor and CPS Specialist that the finding be amended accordingly.*

The Division's Critical Incident Review process has also been revised to include an assessment of the evidence collected to support or not support the finding, and whether concerted efforts were made to gather pertinent information to make a finding. This process includes a thorough

review of the facts regarding a critical incident. If the review indicates that the decision to substantiate or not to substantiate an incident of child abuse or neglect was not supported by the evidence, the District is directed to revise the finding accordingly. This revised process was implemented in February 2008.

The Protective Services Review Team continues to provide training to unit field staff regarding the evidence required to substantiate child abuse and neglect. Evidence required and documentation "tips" are accessible under public folders where all staff can refer to for clarity.

The Child Welfare Training Institute is completing its final revision of the Advanced Documentation Training for CPS staff. This training is designed to teach and assist field staff with case record documentation. The training will inform staff about the requirements for substantiating an incident of abuse or neglect. The Child Welfare Training Institute will begin delivering this training to field staff in June 2008.

Recommendation 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.

Response: The Department agrees with this recommendation and has already taken corrective measures to address this concern.

The Division has implemented a comprehensive automated child safety assessment, strengths and risk assessment and case planning process. This process guides the CPS Specialist through the assessment of child safety; family strengths, risks and service needs; case planning; and informs decision-making at each step of the process. This process requires the CPS Specialist to gather sufficient and relevant information about the parent's overall functioning including the use of substances and its direct impact upon parenting and child safety. Staff are required to develop a behaviorally-based case plan that describes how the parent's behavior must change in order to ensure child safety, and to reassess the parent's progress within three months intervals. This process requires demonstrated behavioral changes on the part of the parent prior to a recommendation that a child be returned to the parent's care. All safety concerns including the parent's substance abuse must be addressed and the child assessed as safe prior to case closure.

Strategies to improve client engagement in substance abuse treatment services and to enhance the CPS Specialist's expertise and resources related to substance abuse have been implemented. These include:

- *substance abuse treatment provider participation in family drug court, Team Decision Making meetings and dependency hearings;*
- *co-location of substance abuse staff in CPS offices;*
- *development and dissemination of informational publications to CPS staff to ensure staff are properly informed on the impact of methamphetamine*

abuse such as "How to Successfully Engage Clients";" "Safe, Family-Centered Responses to Methamphetamines"; "Risk Domains and Six Fundamental Safety Questions for Methamphetamine Abuse"; "Practice Guidelines for Utilizing Drug Testing"; and "Substance Abuse Screening";

- *development and dissemination of a screening tool, UNCOPE (Use Longer; Neglected; Cut-down; Objected; Preoccupied; Emotional Discomfort) to enhance the CPS Specialist's identification of substance abuse, and to assist in planning intervention for the family;*
- *hiring and deployment of the Assessment and Case Planning Specialist to provide "hands-on", onsite technical assistance (i.e. targeted instruction, case specific consultation, mentoring and group supervision) to front line staff in the application of the assessment and case planning process; and*
- *statewide intensive formal training on the assessment and case planning model.*

- 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.

Response: The Department agrees with this recommendation. By October 1, 2008, the Division's Reports and Statistics Unit will produce a monthly report detailing the number of reports requiring a joint investigation, the number of reports where a joint investigation was conducted, the number of reports where a joint investigation was not conducted and the reason the joint investigation did not occur. This information will be monitored by the Division's Executive Staff Assistant. Monitoring will include a review of a random sample of cases to determine:

- *the accuracy of the information entered in the case management information system (CHILDS);*
- *identification of the primary reasons for the failure to conduct joint investigation;*
- *review of the findings with the Division and District Management to identify any systemic factors affecting performance in this area; and*
- *coordination with District Management to implement strategies to address identified systemic factors affecting performance in this area.*

- 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.

Response: The Department agrees with this recommendation and has taken measures to address this recommendation. Current policy requires the CPS Specialist to interview the custodial and non-custodial parent when the identity and whereabouts of the non-custodial parent can

reasonably be determined, or when such contact would not likely endanger the life or safety of any person or compromise the integrity of a criminal or CPS investigation. The CPS Specialist must consult with the Supervisor when it is determined that the non-custodial parent will not be interviewed.

The Division's Management team (senior leadership, District Program Managers, Central Office Managers including Policy, Child Welfare Training Institute, and Practice Improvement) has engaged in extensive discussions regarding the role of CPS staff in ensuring child safety through a comprehensive, informed assessment of the caregiver and all adults in the caregiver's home when CPS is considering placement and visitation. This assessment includes criminal history, CPS history and any relevant orders regarding custody and contact. To further assist the CPS Specialist in accessing court orders and criminal history information, the Division's automated assessment and case planning process contains links to several designated web pages where this information is stored. Current policy also directs the CPS Specialist to contact the Clerk of Court in each county's Superior Court to request copies of court documents (such as orders, custody evaluation reports, conciliation conference reports, etc).

The Division revised its policy in 2007 to require the CPS Specialist to make efforts to obtain a copy of court orders when CPS has reason to believe that a court of competent jurisdiction has entered an order (active or expired) restricting or denying custody, visitation or contact by a parent/caregiver or other person in the home with the child. If it is not possible to obtain and/or view the order, the CPS Specialist must discuss the conditions and circumstances of the order with the custodial and non-custodial parent/caregiver. The CPS Specialist may also speak with other persons (such as relatives including grandparents) who have information or knowledge of the conditions and circumstances upon which the order was entered. If the CPS Specialist confirms that the parent/caregiver's custody, visitation or contact with the child was denied or restricted, the Specialist must abide by the terms of the order if the order is in effect. The CPS Specialist can not facilitate or concur with placement or contact of the child with the parent/caregiver in any manner which conflicts with the order. If the order has expired or the status of the order can not be confirmed, the CPS Specialist must consult with the Office of the Attorney General prior to facilitating or concurring with placement or contact of the child with the parent.

Recommendation 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.

Response: The Department agrees with the intent of this recommendation, but is of the opinion that trained child abuse experts conducting forensic examinations should, based on the case specific circumstances, determine the content of the examination. By December 31, 2008, the Division's Policy Unit will revise current policy to further clarify when a forensic evaluation should be completed.

It should be noted that current policy does specify case specific circumstances that require a medical evaluation and when medical opinions should be reviewed with a physician who has

substantial experience and expertise in child abuse and neglect diagnosis. Department policy provides the following guidance for CPS staff:

- *Medical examinations and/or consultation by a physician, preferably with expertise in child abuse and neglect, are required for the following:*
  - *Injuries requiring emergency medical treatment;*
  - *Untreated medical condition that is life threatening, or permanently disabling;*
  - *Serious physical injury requiring emergency medical treatment due to neglect; and*
  - *Injuries that may require medical treatment.*
- *Medical examinations may be obtained in other circumstances based on consultation with the Supervisor.*
- *When the CPS Specialist suspects that abuse or neglect has occurred, but a physician or other medical personnel is unable to confirm the abuse or neglect, or the CPS Specialist has received differing or conflicting medical opinions from the same or different physicians regarding the diagnosis or specific medical finding(s), the case including all medical opinions should be reviewed within 48 hours with:*
  - *a physician who has substantial experience and expertise in child abuse and neglect diagnosis, or*
  - *a multidisciplinary team (including a physician who has substantial experience and expertise in child abuse or neglect diagnosis), or*
  - *base intervention on the most serious diagnosis if a multidisciplinary team or expert medical consultation is unavailable.*
- *If a multidisciplinary team or expert medical consultation is unavailable in your area, consult with your Supervisor and have your Supervisor or Assistant Program Manager contact the CMDP Medical Director at 602-351-2245. Otherwise, follow your District Operating Procedures to request assistance in arranging for expert medical consultation.*

Recommendation 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.

Response: The Department agrees with this recommendation. By September 30, 2008 and on a quarterly basis thereafter, the Division's Policy Unit Manager will provide an update on the implementation of the Panel's recommendations including any policy revisions.

Pima County Panel Recommendations

Recommendation 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.

See Department response to the State Panel Recommendation 4 above.

Recommendation 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 Services be identified to resolve coordination or communication problems with either agency.

Response: The Department agrees with this recommendation. The Division will address this recommendation through implementation of House Bill 2455 (CPS; criminal investigations). House Bill 2455 requires each County Attorney, in cooperation with the Department and law enforcement entities in each county, to develop and implement protocols to guide the conduct of investigations involving criminal conduct allegations. These protocols include but are not limited to the notification of receipt and investigation of such allegations, procedures for the timely sharing of information, and cooperation in the implementation of the protocols. The Division will seek to include in these protocols a process for the timely identification and resolution of any coordination or communication problems between CPS and law enforcement.

If House Bill 2455 is enacted, not later than December 1, 2008, the Department anticipates full implementation of this provision of the bill.

Yavapai County Panel Recommendations

Recommendation 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.

Response: The Department agrees with recommendation and will refer this recommendation to the Arizona Department of Education for action. The Department of Education is the appropriate department to examine policies regarding educational assessments for those children whose educational progress is not being assessed.

It should be noted that the Department's assessment and case planning process includes an assessment of the child's special needs and/or behavioral problems. If the child's educational needs are relevant to the reason for the family's involvement with CPS, the CPS Specialist is expected to address this need during the case planning process. The CPS Specialist is expected to gather relevant information from the child's educational providers, and make appropriate referrals to meet the child's educational needs. These referrals may be part of the case plan or found in the family's "aftercare" plan.

Recommendation 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.

See Department response to the State Panel Recommendation 3 above.

The Department is confident that the Critical Incident Review process will result in a review of the accuracy of findings involving child fatalities. This process involves a thorough review of all cases involving child fatalities, near fatalities, severe and serious injury to a child and other events of a critical nature. This review includes an assessment of the evidence collected to support or not support the finding, and whether concerted efforts were made to gather pertinent information to make a finding. If the review indicates that the decision to substantiate or not to substantiate an incident of child abuse or neglect was not supported by the evidence, the District is directed to amend the finding accordingly. This revised process was implemented in February 2008.

APPENDIX B: PANEL MEMBERS

STATE CITIZEN REVIEW PANEL

Chair:
Mary Ellen Rimsza, M.D. FAAP (resigned January 2008)
American Academy of Pediatrics
University of Arizona College of Medicine

Members:

Susan Anderson
University of Arizona
Department of Pediatrics

Megan Baker
ADES/Administration for Children, Youth & Families

Lisa Barrientos
Mesa Police Department

Cindy Copp
ADES/Administration for Children, Youth & Families

Frank DiModica
Phoenix Police Department

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

Barbara Jorgensen
Yavapai County Community Health Services

Simon Kottoor
Sunshine Group Home

Becky Lowry
University of Arizona College of Medicine
Department of Pediatrics

Nancy Logan
Attorney General's Office

Princess Lucas-Wilson
ADES/Division of Developmental Disabilities

Natalie Miles Thompson
Crisis Nursery

Evelyn Roanhorse
Bureau of Indian Affairs

Beth Rosenberg
Children's Action Alliance

Ivy Sandifer, M.D.
Physician

Roy Teramoto, M.D.
Indian Health Services

Kara Van Hise
Ombudsman's Office

Consultants:

Linda Johnson
ADES/Administration for Children, Youth & Families

Jacob Schmidt
ADES/Administration for Children, Youth & Families

PIMA COUNTY CITIZEN REVIEW PANEL

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

Coordinator:
Becky Lowry

Members:

Susan Anderson
University of Arizona
Department of Pediatrics

Sandy Guizzetti
Arizona Supreme Court
Foster Care Review Board

Susie Huhn
Casa de los Ninos

Penelope Jacks
Children's Acton Alliance of Southern Arizona

Lynn Kallis
Pilot Parents of Southern Arizona

Christie Kroger
ADES/Administration for Children, Youth & Families

Stacy C. Meade
Epidemiologist

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

Tina Tarin
Tucson Fire Department

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:
Barbara Jorgensen, R.N., M.S.N.
Yavapai County Community Health Services

Members:

Esther Brohner
CASA Coordinator, Superior Court

Sue Carlson
Licensed Professional Counselor

Bill Hobbs
Yavapai County Attorney's Office

Dawn Kimsey
ADES/Administration for Children, Youth & Families

Rodney Lewis
ADES/Administration for Children, Youth & Families

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:_____

_____

_____

_____

_____

APPENDIX D: PUBLIC FORUM AGENDA

6:00 – 6:10 p.m. **Introductions and Overview**
Purpose of forum and outline of proceedings.

Facilitator: Dr. Paul Holley, Chief of Assessment and Evaluation
Bureau of Women's and Children's Health
Arizona Department of Health Services

6:10 – 6:40 p.m. **Agency/Organization Questions and Participant Dialogue**

Q1. What policies does your agency/organization have in place for reporting child abuse?

Q2. Does your agency/organization provide any training to its personnel on how to identify and report child abuse and/or neglect?

6:40 – 7:00 p.m. **The Citizen Review Panel in Arizona**
Description of presentation: background, purpose, composition, findings and recommendations of the Citizen Review Panel in Arizona

Facilitator: Jamie Smith, Child Fatality Review Program Manager
Bureau of Women's and Children's Health
Arizona Department of Health Services

7:00 – 7:20 p.m. **Agency Organization/Individual Questions and Participant Dialogue**

Q3. How would you describe your experience in reporting suspected child abuse and/or neglect to the Child Abuse Hotline?

7:20 – 8:00 p.m. **Closing Remarks and Session Evaluation**
Facilitator: Paul Holley

Q4. How can the Child Protective Services system improve in its efforts to ensure the safety of children in the State of Arizona?

To obtain further information, contact:

Child Fatality Review Program
Bureau of Women's and Children's Health
130 N. 18th Avenue, Suite 320
Phoenix, AZ 85017-3242
Phone: (602) 364-1400
Fax: (602) 542-1843

Information about the Arizona Citizen Review Panel Program can 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 Program at (602) 364-1400 (voice) or call 1-800-367-8939 (TDD).

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