TITLE	POLICY NUMBER	
Safety Analysis Review Team	DCS 09-06	
RESPONSIBLE AREA	EFFECTIVE DATE	REVISION
Office of Accountability	12/29/2022	

I. POLICY STATEMENT

The purpose of this policy is to define the roles and responsibilities of the Safety Analyst. The responsibility of the Safety Analyst is and research and review child fatalities and near fatalities or critical incident, report the review results, and identify learning opportunities that will improve outcomes for children and families, increase fidelity of the safety model, and recommend changes to policy and practice.

II. APPLICABILITY

This policy applies to DCS employees who are part of the Safety Analysis Review Team (SART) and field staff who are involved in cases involving child fatalities, near fatalities or critical incidents.

III. AUTHORITY

A.R.S. § 8-451	Department; purpose
A.R.S. § 8-453	Powers and duties
A.R.S. § 8-807.01	Incidents involving fatality or near fatality; definition
A.R.S. § 36-3501	Child fatality review team; membership; duties
A.R.S. § 36-3502	Local teams; membership; duties

DCS Program Policy Ch. 7, Sec. 2 Safeguarding Records & Records Requests

IV. DEFINITIONS

Department or DCS: The Arizona Department of Child Safety.

Director: The Director of the Arizona Department of Child Safety.

Hotline: The Department shall operate a statewide Centralized Intake "Hotline" 24 hours a day, seven days a week, to protect children by receiving incoming communications/referrals concerning suspected child abuse or neglect. The Hotline encompasses a toll-free telephone number and an electronic reporting service, specifically for the purpose of accepting communications regarding suspected child abuse or neglect.

Multi-Disciplinary Team (MDT): a team of DCS employees who review child fatality and near fatality reports presented by SART.

Near fatality: an act that, as certified by a physician, including the child's treating physician, places a child in serious or critical condition.

Posting meeting: weekly meetings where the Safety Analysis Review Team (SART) presents fatality and near fatality cases for possible posting to the DCS website.

Safety Analyst: DCS employees whose duties are to track all fatalities and near fatalities across the state, conduct systemic incident reviews, issue press statements and public reports, and attend county child fatality review meetings.

Systemic Critical Incident Review (SCIR): comprehensive reviews of child fatalities, near fatalities or critical incidents conducted by the Safety Analyst Review Team (SART).

Team Decision Making (TDM) Meeting: a meeting held after the emergency removal of a child, or when child removal is being considered, to discuss the child's safety and determine where the child will live.

V. POLICY

A. The SART team becomes involved when a critical incident email is sent out by the Hotline regarding a fatality or near fatality. The SART team then assigns that case to a Safety Analyst to be tracked.

B. Systemic Critical Incident Reviews

Eligible cases for a SCIR include:

1. child was in DCS custody at the time of the critical incident and the allegation generated a report;

2. the critical incident occurred when the case was open;

3. DCS was involved with the child, the family or the perpetrator within the last 3 years; or

4. DCS Executive Team requests a review of the case.

C. Multi-Disciplinary Team (MDT)

The MDT conducts reviews of child fatality and near fatality cases on a monthly basis to:

1. identify learning opportunities that will improve outcomes for children and families;

2. increase fidelity of the safety model; and

3. recommend changes to policy and practice.

D. Posting Meeting

1. DCS shall promptly provide information to the public regarding the fatality or near fatality of a child as required in A.R.S. § 8-807.01.

2. The purpose of the meeting is to present cases to DCS General Counsel and/or an Assistant Attorney General (AAG) in an effort to ensure the legal nexus is met for the Preliminary and Summary Reports to be posted to the DCS website.

VI. PROCEDURES

A. Systemic Critical Incident Review (SCIR) Process

Multi-Disciplinary Team (MDT) selects a case for review.

1. The Safety Analysis Review Team (SART) will provide a case synopsis for all fatality and near fatality reports that are SCIR eligible and that occurred in the 45 days prior to the monthly MDT meeting.

2. The participants of the MDT must review all case synopses prior to the meeting.

3. The MDT participants must come prepared with areas needing greater understanding.

4. The SART will present the cases to the MDT and answer questions to the best of their ability.

5. Cases will be selected for a SCIR.

6. Extensive Review of the Case

   Each analyst does a thorough review of the case which includes, but is not limited to case notes, Child Safety Risk Assessments (CSRAs), provider notes, documentation in Guardian, and Hotline communications to understand decisions made throughout the case or assessment in the last three years.

7. Voluntary Debriefing with the Field

   Safety Analysts meet with DCS staff, who have been involved with the case within the last three years, in person in their field offices, via Microsoft Teams, telephonically, or wherever the worker feels comfortable. DCS staff who were involved in the case include, but is not limited to:

   a. DCS Specialists;

b. Office of Child Welfare Investigations (OCWI);

c. DCS Supervisors;

d. Program Managers; and

e. TDM (Team Decision Making) meeting facilitators

8. Regional Mapping Review Team

a. Mapping Team consists of DCS Specialists, Supervisors, Program Managers, Program Administrators, Supervisor Coaches, Team Decision Making (TDM) Facilitators, Young Adult Program (YAP) and Indian Child Welfare Act (ICWA) Specialists.

b. A meeting is conducted to discuss the influences and systematic barriers within the field, region, central office, community entities, and government.

9. Aggregate MDT Meeting (Quarterly)

Information from the review of the cases, debriefings, and mappings are presented at the Aggregate Multidisciplinary Team (MDT) meeting. The meetings are held quarterly, and practice improvement case reviews are also conducted at that meeting.

Participants meet to discuss:

a. the narratives created from the debriefings and mappings;

b. considerations to make to the Executive Leadership; and

c. areas identified by Executive Leadership are added to the Problem Filter Process for decisions regarding timing and implementation

B. SCIR Process in Response to a Lawsuit

1. When Arizona Department of Administration (ADOA) requests an action plan due to a DCS lawsuit settlement, the Audit Manager will email the Assistant Director (AD) for the Office of Accountability requesting a

SCIR on the associated assessment and/or case.

2. The SCIR request email will contain the following information:

   a. Assessment and/or Case name;

   b. Allegations contained in the lawsuit; and

   c. Requested due date for the SCIR.

3. The AD will assign the lawsuit to a Safety Analyst (SA) within the Safety Analysis Review Team (SART) within two business days.

4. The assigned SA will schedule a meeting with the Audit Manager to discuss the actions within the assessment and/or case that are associated with the allegations in the lawsuit. This meeting will be scheduled within one business day of assignment.

5. The assigned SA will complete the case review and complete debriefings with staff associated to the involved assessment and/or case.

6. If appropriate, the assigned SA will conduct a Mapping with the Regional team where the assessment and/or case was assigned.

7. The assigned SA will provide the learning gained from the SCIR and any possible changes to practice that have occurred since the involved case was open with DCS to the Audit Manager.

C. Posting Meeting

1. The Safety Analyst will email the Assistant Attorney General (AAG), DCS General Counsel and AD of the Office of Accountability the case summary, the preliminary and/or summary reports, as well as all supporting documentation for review at least one business day before the Posting meeting.

2. If a juvenile court proceeding determined that the abuse, abandonment or neglect by a parent, guardian, or custodian resulted in a fatality or near fatality of a child, the AAG and/or DCS General Counsel may provide the nexus determination for posting via email.

3. If a determination that the abuse, abandonment or neglect by a parent, guardian, or custodian resulted in a fatality or near fatality of a child is made by an arrest or substantiation, then the AAG and/or DCS General Counsel will provide the nexus determination for posting during a meeting.

4. If additional, or clarifying, information is required in order to make a nexus determination, then the Safety Analyst will communicate this request to the appropriate DCS/OCWI staff (person on investigation or their supervisor) within one business day.

    a. If there is no response provided from the DCS/OCWI staff within 72 hours, the Safety Analyst will elevate the request to the next step in the chain of command. This will repeat until the request has been responded to and completed.

    b. If a communication elevation is being made to a Program Administrator, the Safety Analyst will ensure that the Assistant Director of Office of Accountability is included on that communication.

5. When the additional or clarifying information is received, the fatality or near fatality case will be presented again at the next scheduled Posting meeting.

6. Once the nexus determination for posting has been satisfied, the Safety Analyst will finalize the Preliminary and Summary reports and press statement, if applicable, with the Assistant Director within two business days.

7. When the Preliminary and Summary reports have been finalized, the Safety Analyst will send the reports to the DCS Webmaster for posting to the DCS website. If the case has an accompanying press statement, the Safety Analyst will send the finalized reports to the Assistant Director of the Office of Accountability and Assistant Director of Communications for review.

D. Child Fatality Review Board

DCS Safety analysts attend monthly meetings that are run by the Department of Health and reviews child fatalities from motor vehicle accidents, other accidents, homicides, and natural and undetermined causes. Meetings to review fatalities due to child maltreatment are held quarterly. A case list will be sent to DCS prior to the meeting, and DCS Safety Analysts will present case information at the meeting. As stated in A.R.S. § 36-3502, local teams are located throughout the state and membership includes, but is not limited to:

1. County attorney's office;
2. County health department;
3. County medical examiner's office;
4. Department of Child Safety;
5. Domestic violence specialist;
6. Local law enforcement;
7. Parents;
8. Pediatrician or family physician; and
9. Psychiatrist or psychologist.