TITLE	POLICY NUMBER	
Safety Analysis Review Team	DCS 09-06	
RESPONSIBLE AREA	EFFECTIVE DATE	REVISION
Office of Accountability	12/29/2022	2

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 to research and review child fatalities and near fatalities or critical incidents, report the 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. § 8-469	Child safety fatality and near fatality review team; membership; duties; definition
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, appointed by the DCS Director, of DCS employees and public members identified in A.R.S. § 8-469 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 and review 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): The process by which the Safety Analysis Review Team (SART) evaluates fatalities, near fatalities, and critical incidents to identify patterns in the factors that influence decisions and actions and to improve the quality outcomes for children and families receiving services from the Department.

V. POLICY

A. The Safety Analysis Review Team (SART) becomes involved when a case is identified regarding a fatality or near fatality incident that occurred and a report was generated. The SART then assigns that case to a Safety Analyst to be tracked. The SART shall:

1. hold regular multidisciplinary team meetings to review reports of child fatalities or near fatalities where the Department had prior involvement with the child, the child's family, or the perpetrator;

2. identify systemic trends that that influence decisions and actions made by the Department;

3. recommend changes to Department policy and practice to improve outcomes for children and families;

4. promote a culture of psychological safety within the Department by responding to fatality and near fatality cases in a manner that promotes learning, transparency, and employee health;

5. produce an annual child fatality and near fatality report as described in section V.E below;

6. select cases that present opportunities for systemic learning or that demonstrate opportunities for systemic change and respond to requests for further information by a standing committee of the Arizona Legislature, a joint legislative oversight committee, or another committee appointed by the president of the Arizona Senate or the speaker of the Arizona House of Representatives;

7. respond to requests for additional information regarding a child fatality or near fatality from the Joint Legislative Oversight Committee on DCS within ninety days after receiving the request.

B. Systemic Critical Incident Reviews (SCIR)

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)

1. The MDT shall consist of Department employees designated by the Director who shall also appoint, at a minimum, the following public members trained in safe system improvement:

   a. a licensed pediatrician who has professional experience relating to child abuse and neglect;

   b. a peace office who has experience investigating child abuse and neglect fatalities and near fatalities;

   c. a practicing social worker;

   d. a behavioral health practitioner;

   e. an attorney who has professional experience representing children in child abuse and neglect cases.

   Public members of the team may receive confidential Department information but may not further disclose the information unless authorized by law.

2. The MDT conducts reviews of child fatality and near fatality cases where the Department had prior involvement with the child, the child's family, or the perpetrator on a regular basis to select cases for a more thorough review by the SART.

3. The purpose of multidisciplinary meetings is to:

a. review reports of child fatalities or near fatalities made to the child abuse hotline where the Department was involved with the child, the child's family, or the perpetrator within the prior three years;

b. identify systemic trends that influence decisions and actions made by the Department;

c. select cases for systematic learning in order for SART to perform a SCIR of those cases;

d. evaluate findings from system critical incident reviews at least quarterly and recommend changes to Department policy and practice.

In conducting child fatality and near fatality reviews, the MDT may consult with the Department of Health Services, the Department of Economic Security, the Arizona Health Care Cost Containment System or any other governmental entity that may have information pertinent to a child fatality or near fatality.

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.

E. Annual Report

The Department shall produce an annual report of information gathered during its review of child fatalities and near fatalities. This report shall include all of the following:

1. the total number of fatality and near fatality child abuse/neglect reports in a fiscal year, by county;

2. the number of allegations that are substantiated and unsubstantiated;

3. the number of reports due to abuse and whether the reports were substantiated or unsubstantiated;

4. the number of reports due to neglect and whether the reports were substantiated or unsubstantiated;

5. the number of reports where the family had previous Department involvement;

6. systemic trends that influence the practice and decisions made by the Department and areas for improvement;

7. details of cases that present opportunities for systemic learning or that demonstrate opportunities for systemic change.

The Department shall present this report at a public meeting of a standing committee of the Arizona Legislature, a joint legislative oversight committee, or a committee appointed by the president of the Arizona Senate or the speaker of the Arizona House of Representatives. The purpose of the report is to inform policy makers on systemic changes required to improve the child welfare system. At its discretion, the applicable committee may choose to hold an executive session to protect the privacy or safety of individuals involved in the fatality or near fatality.

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 that occurred or were identified in the 60 days prior to the monthly MDT meeting.

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

3. The MDT participants engage in the meeting to help identify areas needing greater understanding.

4. Cases will be selected for a SCIR.

5. Extensive Review of the Case

   Each analyst does a thorough review of the case which includes, but is not limited to case notes, Family Functioning Assessments, provider notes, documentation in Guardian, and Hotline communications to understand decisions made throughout the case or assessment.

6. Voluntary Debriefing with the Field

   Safety Analysts meet with DCS staff, who voluntarily agree to participate and have been involved with the family 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 are 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

7. Mapping Review Team

   a. Mapping Team consists of:

      i. DCS Specialists;

      ii. Supervisors;

      iii. Program Managers;

iv. Program Administrators;

v. Supervisor Coaches;

vi. Team Decision Making (TDM) Facilitators;

vii. Other staff who may have relevant information.

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

8. 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.

Participants meet to discuss:

a. information learned from the debriefings and mappings;

b. considerations to make to the Executive Leadership; and

c. areas that are 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.

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 Assistant Director of the Office of Accountability the case summary 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 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 of the Office of Accountability, the Assistant Attorney General (AAG), DCS General Counsel.

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.