ARIZONA DEPARTMENT OF CHILD SAFETY

SFY 2019 Annual Fatality/Near Fatality Review Report

Introduction

The Department of Child Safety's (DCS) Office of Accountability has a duty to review all fatalities and near fatalities that fall under the responsibility of the agency for the purpose of releasing information to the public as governed by A.R.S. § 8-807.01. This office oversees the Multidisciplinary Review Team (MDRT), which reviews reports of child fatalities and near fatalities due to abuse or neglect. This team was created to support the Department's vision of helping Arizona's children thrive in family environments free from abuse and neglect; support the Department's mission to successfully engage children and families to ensure safety, strengthen families, and achieve permanency; and guarantee compliance with A.R.S. § 8-807.01.

The agency seeks opportunities for improvement and learning to understand what led to an unforeseeable event and the systemic complexities that influence decision-making. Ultimately, the goal is to promote better outcomes for children and families while supporting the workforce who are tasked with making difficult decisions. The review process seeks to understand the contexts in which the decisions were made, and identify opportunities to change those contextual influences in future cases. The process will use a true systems approach to better understand those factors, which influence the quality and delivery of services provided to children and their families. It contributes to organizational learning while addressing issues discovered in individual events, and understanding the underlying systemic issues that influence adverse outcomes. To achieve this objective, the Department engages in a Systemic Critical Incident Review (SCIR) process to:

1. Discover patterns in the factors that influence decisions and actions in fatality and near fatality cases where the Department had prior involvement;
2. Recommend systemic adjustments to potentially decrease the likelihood of child fatalities and near-fatalities from child abuse or neglect; and
3. Promote an organizational safety culture within DCS by responding to fatality and near fatality cases in a manner that promotes learning, transparency, and employee health.

For this reporting period (July 1, 2018 through June 30, 2019), all fatality and confirmed near fatality reports were reviewed by the MDRT which is comprised of DCS representatives from Practice Improvement, Learning and Development, the Child Abuse Hotline, the Policy Unit, DCS General Counsel, the Attorney General's Office, the Office of Quality Improvement, the Prevention Administration and the Office of Child Welfare Investigations (OCWI). The MDRT selected reports for a more comprehensive and robust review to be completed to understand the systemic trends that influence adverse outcomes. During this reporting period, 45 fatalities, near fatalities or critical incidents where chosen for this SCIR and the systemic themes found will be shared later in the report.

Definitions

Alleged Death Due to Abuse:
A report that contains an allegation that a child has died due to the infliction or allowing of physical injury, impairment of bodily function or disfigurement by a parent, guardian, or custodian.

Alleged Death Due to Neglect:
A report that contains an allegation that a child has died due to inability or unwillingness of a parent, guardian or custodian of a child to provide that child with supervision, food, clothing, shelter or medical care if that inability or unwillingness causes unreasonable risk of harm to the child's health or welfare.

Alleged Near Fatality:
A report that contains an allegation that a child is injured, it is believed that the injury is most consistent with a non-accidental injury, and the child is in serious or critical condition because of the injury, as defined by a medical professional.

Substantiated Finding:
A finding, after an investigation and review, that there is sufficient evidence to prove, by a probable cause standard of proof, that the alleged abuse or neglect occurred.

Unsubstantiated Findings:
A finding, after an investigation and review, that there is insufficient evidence to prove, by a probable cause standard of proof, that the alleged abuse or neglect occurred.

Pending Finding:
A report in which a final investigative finding has not yet been entered. This includes but is not limited to reports still actively being investigated, reports that are under administrative review by the Protective Services Review Team or reports in that are pending dependency adjudication proceedings in Juvenile Court.

No Jurisdiction for Investigation:
The information communicated to the Child Abuse Hotline meets the criteria to become a report of abuse or neglect, however DCS is not statutorily authorized to investigate the allegation, such as when the child resides on a Tribal land.

Drowning Tracking Characteristic
Assigned to a DCS report when there is indication that a caretaker did not practice adequate supervision causing the child to drown or nearly drown, and the child is in serious or critical condition; or if a caretaker purposely drown or attempted to drown a child.

Unsafe Sleep Tracking Characteristic:
Assigned to a DCS report where there is an indication that a caretaker did not place a child on his/her back, in a crib, or there is an indication that the caretaker slept with the child causing the child's death, near death, or other serious injury.

Data Sources

This annual summary report includes Child Abuse Hotline report level data from July 1, 2018 through June 30, 2019 extracted from the Children's Information Library and Data System (CHILDS). The summary data presented here describes a small number of Hotline reports (226), and even fewer with prior DCS involvement (106). It is important to note that the data contained in this annual summary is report level data and not child specific data. A report may contain more than one allegation involving multiple children. Therefore, the substantiated allegation could not be related to the allegation of fatality or near fatality. If seeking more specific information on child level data, please see the most recent Arizona Child Fatality Review Program Annual Report at http://azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/child-fatality-review-annual-reports/cfr-annual-report-2017.pdf. Additionally, caution must be taken when drawing conclusions from a small number of observations, particularly because of the wide variety of circumstances existing in the Hotline reports. The Department will continue to collect and analyze data over time to increase our ability to identify systemic trends that can be targeted for meaningful improvement.

Reports Received Alleging a Fatality or Near Fatality

In this review period, the Department's Child Abuse Hotline received 48,420 reports of child abuse or neglect. Of these, 226 (.46 percent) reports contained an allegation of child fatality or near fatality due to abuse or neglect. Of these 226 reports, 163 involved a fatality allegation: 40 alleged deaths due to child abuse and 123 alleged deaths due to neglect. Five of these reports involved a fatality of a child in the custody of DCS. Of the 226 reports, 63 involved a near fatality allegation. Four of the near fatality reports involved a child in the custody of DCS. Data regarding allegation findings (i.e. substantiation determinations) will change each reporting period as a result of subsequent decisions based on the parents' rights to due process as well as the completion of investigations and findings. Table 1 provides the total number of reports statewide, by fatality or near fatality allegation, and by current finding for each allegation type.

Table 1. Total Fatality and Near Fatality Reports by Allegation and Finding[1]

	Total Reports SFY 2019	Substantiated Finding	Unsubstantiated Finding	Unable to Locate	Pending Finding	No Jurisdiction for Investigation
All Report Received in SFY 2019						
Total Reports	48,420					
All Fatality/Near Fatality Reports Received in SFY 2019						
Total Reports	226	69	131	3	19	4
Alleged Death Due to Abuse						
Total Reports	40	8	27	0	4	1
% of All Reports Received	0.08%	0.02%	0.06%	0.00%	0.01%	
Alleged Death Due to Neglect						
Total Reports	123	30	79	3	10	1
% of All Reports Received	0.25%	0.06%	0.16%	0.01%	0.02%	
Alleged Near Fatality						
Total Reports	63	31	25	0	5	2
% of All Reports Received	0.13%	0.06%	0.05%	0.00%	0.01%	

[1] Some of the cases posted this year, in accordance with A.R.S. § 8-807.01, are not reflected in the statistics as substantiated. Substantiation of an allegation of abuse or neglect occurs after an appeal process. In cases where there is a criminal proceeding regarding the allegations of abuse or neglect, the criminal proceeding will serve as the appeal process, and the allegation will not be substantiated until there is a judicial finding of abuse or neglect (either through a guilty plea or a conviction). However, the Department posts fatalities and near-fatalities on its website when an allegation of abuse or neglect has been substantiated against a perpetrator or when the perpetrator has been arrested for the abuse or neglect that led to the fatality or near fatality. Thus, some cases that have been posted in accordance with A.R.S. § 8-807.01 may not have substantiations at this time because the appeal process is still ongoing.

More than half (58.4 percent) of the 226 Child Abuse Hotline reports that contained an allegation of child fatality or near fatality due to abuse or neglect involved a family residing in Maricopa County, and 16.4 percent involved a family living in Pima County. This distribution is fairly consistent with statewide report volume. Table 2 provides the total number of reports by county in which the report was received.

Table 2. Total Fatality and Near Fatality Reports by County

County	Number of Fatality Reports	Number of Near Fatality Reports	Total Reports	% of Total Reports
APACHE	0	2	2	**0.87%**
COCHISE	2	0	2	**0.87%**
COCONINO	5	0	5	**2.18%**
GILA	2	0	2	**0.87%**
GRAHAM	0	3	3	**1.31%**
GREENLEE	0	1	1	**0.44%**
LA PAZ	0	0	0	**0.00%**
MARICOPA	93	39	132	**58.4%**
MOHAVE	2	1	3	**1.31%**
NAVAJO	2	1	3	**1.31%**
PIMA	32	5	37	**16.37%**
PINAL	7	1	8	**3.49%**
SANTA CRUZ	1	0	1	**0.44%**
YAVAPAI	4	2	6	**2.62%**
YUMA	4	2	6	**2.62%**
UNKNOWN	7	5	12	**5.24%**
OUT OF COUNTRY	0	1	1	**0.44%**
OUT OF STATE	2	0	2	**0.87%**
STATEWIDE	**163**	**63**	**226**	**100%**

Reports of Child Fatality

The DCS Child Abuse Hotline received 163 reports alleging a fatality due to abuse or neglect in this reporting period. Of these, 38 (23.3 percent) have been substantiated for abuse or neglect, 106 (65 percent) have been unsubstantiated, 2 (1.2 percent) have a finding of unable to locate and 14 (8.6 percent) have findings pending. Of the 163 reports, 82 (50.3 percent) had at least one prior report involving the child or perpetrator. Of the five reports involving fatality of a child who was in the custody of DCS, one report was substantiated and four reports were unsubstantiated. Reports alleging a fatality may contain multiple allegations of abuse or neglect and substantiation of these reports could be specific to findings not related to the fatality. For example, the surviving siblings could be found dependent for parental substance abuse or conditions of the home that would be unrelated to the fatality allegations. Table 3 provides the total number of reports of child fatality by prior report and finding.

Table 3. Reports of Child Fatality by Prior Report and Finding

	Substantiated	Unsubstantiated	Unable to Locate	Pending	No Jurisdiction	TOTALS	% of total
With at least one Prior Report	24	49	0	7	1	81	49.7%
No Prior Reports	14	57	3	7	1	82	50.3%
TOTALS	38	106	3	14	2	163	100%

Table 4 provides the cause of death as identified by a county medical examiner in each report that was substantiated. Deaths from suffocation/asphyxia/strangulation and undetermined includes deaths resulting from sudden unexplained infant death, which is often related to an unsafe sleep environment.

Table 4. Cause of Death in Reports Substantiated for Abuse or Neglect[2]

Cause of Death	Total # of Reports
Drowning	5
Blunt Force Trauma	7
Gunshot Wound	2
Suffocation/Asphyxia/Strangulation	3
Environmental Heat Exposure/Hyperthermia	2
Vehicle Related	2
Undetermined	3
Final OME Report Pending	5
Total	29

[2] One of the report's cause of death was listed as viral pneumonia but the report was substantiated for other reasons, therefore contributing to the unequal number of substantiated reports compared to cause of death.

Table 5 provides the manner of death as identified by a county medical examiner in each report that was substantiated for abuse or neglect.

Table 5. Manner of Death in Reports Substantiated for Abuse or Neglect[3]

Manner of Death	Total # of Reports
Accidental	11
Undetermined	4
Homicide	9
Suicide	0
Final OME Report Pending	5
Total	**29**

[3] One of the report's cause of death was natural but the report was substantiated for other reasons, therefore contributing to the unequal number of substantiated report compared to manner of death.

Of the 163 reports alleging a fatality due to abuse or neglect in this reporting period, 61 (37.4 percent) reports had a tracking characteristic of unsafe sleep, and 12 (7.4 percent) had a tracking characteristic of a drowning.

Reports of Child Near Fatality

The DCS Hotline received 63 reports involving a near fatality in this reporting period. There were four reports involving a near fatality of a child who was in DCS custody at the time of the near fatality incident, three reports was substantiated and one is pending. Of these 63 reports, 34 (54 percent) alleged a near fatality from neglect and 29 (46 percent) alleged a near fatality from abuse. Of the 63 near fatality reports, 31 reports were substantiated, 25 were unsubstantiated, and 5 are pending a finding. As

previously indicated, reports alleging a near fatality may contain multiple allegations of abuse or neglect and substantiation of these reports could be specific to findings not related to the near fatality.

Table 6 provides the number of near fatality reports by type of allegation.

Table 6. Type of Near Fatality Allegation

	Substantiated	Unsubstantiated	Pending Finding	No Jurisdiction	Total
Neglect	13	17	2	2	34
Physical Abuse	18	8	3	0	29
Total	**31**	**25**	**5**	**2**	**63**

Of the 63 reports alleging a near fatality, 38 (60.3 percent) had no prior reports to DCS involving the child or the perpetrator. Table 7 provides the number of near fatality reports by prior reports and investigation finding.

Table 7. Near Fatality Reports where Victims or Perpetrators had a Prior Report

Category	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of total
With at Least One Prior Report	17	5	2	0	24	38.1%
No Prior Reports	13	20	4	2	39	61.9%
TOTALS	**27**	**25**	**9**	**2**	**63**	**100%**

Improvement Opportunities

The Department's comprehensive incident review process was first initiated in July 2015, and improved in January 2017 with the development of the Systemic Critical Incident Review (SCIR) process with technical assistance provided by Collaborative Safety, LLC. During this reporting period, the MDRT recommended a comprehensive review of 45 fatality or near fatality reports or critical incidents. The MDRT identified five systemic trends that influenced the practices and decisions made by the Department and are areas for improvement. These areas will continue to be tracked and evaluated to better understand influences that can be addressed for system-wide improvement.

- *Collaboration with Law Enforcement on Fatality/Near Fatality Investigations*: There continues to be a noticeable trend of law enforcement not contacting the Department when investigating a suspicious death or injury to a child. This contributed to delays in the Department's investigation of the events surrounding an incident and the inability to assess the safety any siblings that may have been in the home at the time of the incident.

- *Support for staff to reduce turnover:* As part of the Department's strategic planning, a goal was to develop and retain a highly effective workforce. The Department quickly identified that more efforts were needed to reduce secondary trauma and burnout for DCS staff in order for them to feel successful in the work that they were doing. The Department had little supports internally to achieve this goal and external resources were limited.

- *Education Regarding Sleep Suffocation*: There was an increase in fatality and/or near fatality reports that involved unsafe sleeping environments, to include bed sharing. The Department must collaborate with stakeholders to increase the messaging to the community.

- *Education and Assistance in Detecting Fentanyl Use:* There has been a noticeable trend in fentanyl exposure to children resulting in fatality or near fatality reports. Detecting the presence of fentanyl can be difficult and results in delayed identification and treatment. The Department has identified a need to increase the knowledge of its workforce.

- *Delays with Maricopa County Medical Examiners Reports on Fatality Investigations*: The Department continues to experience significant delays in receiving medical examiners reports on child fatalities. The impacts of these delays contribute to untimely completion of DCS investigations. More importantly, lack of timely Office of Medical Examiner (OME) reports limits the Department's ability to conduct a comprehensive safety assessment for surviving children.

Current Improvement Actions and Recommendations

- The OCWI continues to engage various law enforcement agencies and the greater Department around the state to provide education and support regarding joint investigation protocols within their jurisdictions. The OCWI added two Joint Investigative Liaisons that engage with DCS staff on criminal conduct reports outside of Maricopa and Pima counties. These Liaisons also work to build and strengthen relationships with law enforcement to improve outcomes for children and families.

- To support staff in the reduction of secondary trauma and burnout, the Department continues to utilize the Workforce Resilience program. This team is comprised of 44 DCS professionals from all levels of the organization and regions in the state. The team of peers received specialized training in trauma exposure, stress management and peer support. The team provided 624 confidential and timely resources to aid DCS employees over this reporting period. This support allows staff to process any trauma or stress they are feeling. Additional supports outside of DCS are provided as needed.

- DCS is committed to reducing turnover for line level staff. This year DCS developed the Supervision Coach program. This program is designed to support supervisors and improve supervision through continual coaching and education.

- DCS is committed to working with the Governor's Office of Strategic Planning and Budgeting and the Legislature to address compensation strategies. DCS Human Resource exit surveys completed by Child Safety Specialists when they leave employment with DCS continue to reveal that low pay is a reason for their decision to leave. Currently, Child Safety Specialist starting pay is $34,978 annually.

- DCS is committed to working with various stakeholders to reduce the number of fatality and near fatality reports due to sleep suffocation. The Governor declared October 2019 National Safe Sleep

Month. The DCS Office of Prevention is partnering with the Arizona Academy of Pediatricians (AAP), First Things First, Arizona Department of Health Services, Prevent Child Abuse and AHCCCS to disseminate materials for the new safe sleep initiative, "Don't Wake Up to a Tragedy" Infant Sleep Suffocation Prevention Campaign. The AAP was granted permission from LA County to utilize their curriculum; LA County has seen a 50% reduction in unsafe sleep related deaths three years in a row. The AAP members, DCS staff and providers and community partners will be provided with the new campaign materials which include posters for offices, safe sleep flier and Pledge to use infant safe sleeping practices to be signed by parents and caregivers. The DCS Office of Prevention continues the Baby Box Program as well as safe sleep workshops during Young Parent University. The DCS Office of Licensing and Regulation (OLR) implemented curriculum around safe sleep practices for licensed out of home care providers for children under the age of three. OLR has also created a Safe Sleep Commitment form that must be signed by a licensing agency representative as well as the out of home care provider at the initial, renewal and amendment application point as well as during placement visits completed by the licensing agency.

- Due to the identified trend of delayed medical examiners reports, the OCWI has worked diligently with a variety of county Medical Examiner Offices to receive expedited toxicology results to guide the Department's investigation surrounding a suspicious child fatality while waiting for the final OME report. The Maricopa County Medical Examiner has recently outsourced the toxicology process which has resulted in improved turnaround time in the toxicology report as well as the final OME report.