ARIZONA DEPARTMENT OF CHILD SAFETY
SFY 2021 Annual Fatality/Near Fatality Review Report

Introduction

The Department of Child Safety's (DCS) Office of Accountability (OAC) 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. The OAC 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 a culture of psychological safety 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, 2020 through June 30, 2021), all fatality and near fatality reports were reviewed by the MDRT which is comprised of representatives from the following teams: DCS Safety Analysis Review Team, Hotline/Intake, Practice Improvement, DCS General Counsel, Attorney General's Office, Office of Child Welfare Investigations, DCS Policy Unit, DCS Comprehensive Health Plan, Protective Services Review Team, Learning and Development, Victim Services, and the Office of Prevention. 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, 25 fatalities, near fatalities or critical incidents were chosen for a SCIR and the systemic themes found will be shared later in this 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, 2020 through June 30, 2021 extracted from the Children's Information Library and Data System (CHILDS) (July 2020 through January 2021) and Guardian (February 2021 through June 2021) . The summary data presented here describes a small number of Hotline reports (170), and even fewer with prior DCS involvement (77). 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 may 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 https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/child-fatality-review-annual-reports/cfr-annual-report-2018.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 44,504 reports of child abuse or neglect. Of these, 170 (0.38 percent) reports contained an allegation of child fatality or near fatality due to abuse or neglect. Of these 170 reports, 133 involved a fatality allegation: 36 alleged deaths due to child abuse and 97 alleged deaths due to neglect. Three of these reports involved a fatality of a child in the custody of DCS. Of the 170 reports, 37 involved a near fatality allegation. There were no near fatality reports that 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 Alleged Fatality and Near Fatality Reports by Allegation and Finding[1]

	Total Reports in SFY 2021	Substantiated Finding	Unsubstantiated Finding	Pending Finding	No Jurisdiction for Investigation
All Reports Received in SFY 2021					
Total Reports	44,504				
All Fatality/Near Fatality Reports Received in SFY 2021					
Total Reports	170	5	107	53	5
Alleged Death Due to Abuse					
Total Reports	36	1	25	5	1
% of All Reports Received	0.07%	0.002%	0.06%	0.01%	
Alleged Death Due to Neglect					
Total Reports	97	3	62	33	3
% of All Reports Received	0.22%	0.007%	0.14%	0.07%	
Alleged Near Fatality					
Total Reports	37	1	20	15	1
% of All Reports Received	0.08%	0.002%	0.04%	0.03%	

[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 (58.8 percent) of the 170 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 14.1 percent involved a family living in Pima County. This breakdown is similar to non-fatality/near fatality report distribution for those two counties. Table 2 provides the total number of reports by county in which the report was received.

Table 2. Total Alleged Fatality and Near Fatality Reports by County

County	Number of Fatality Reports	Number of Near Fatality Reports	Total Reports	% of Total Reports
APACHE	0	0	0	**0.00%**
COCHISE	4	0	4	**2.35%**
COCONINO	2	0	2	**1.18%**
GILA	2	0	2	**1.18%**
GRAHAM	0	1	1	**0.59%**
GREENLEE	0	0	0	**0.00%**
LA PAZ	0	0	0	**0.00%**
MARICOPA	79	21	100	**58.82%**
MOHAVE	6	2	8	**4.71%**
NAVAJO	1	0	1	**0.59%**
PIMA	19	5	24	**14.12%**
PINAL	4	2	6	**3.53%**
SANTA CRUZ	2	0	2	**1.18%**
YAVAPAI	5	4	9	**5.29%**
YUMA	3	0	3	**1.76%**
UNKNOWN	6	2	8	**4.71%**
OUT OF COUNTRY	0	0	0	**0.00%**
OUT OF STATE	0	0	0	**0.00%**
STATEWIDE	**133**	**37**	**170**	**100%**

Reports Alleging Child Fatality

The DCS Child Abuse Hotline received 133 reports alleging a fatality due to abuse or neglect in this reporting period. Of these, 4 (3 percent) have been substantiated for abuse or neglect, 87 (65 percent) have been unsubstantiated, and 20 (15 percent) have findings pending. Of the 133 reports, 33 (24.8 percent) had at least one prior report involving the child or perpetrator. The three reports involving the fatality of a child who was in the custody of DCS 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 Alleging Child Fatality by Prior Report and Finding

	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of Total
At least one Prior Report	3	17	11	2	**33**	24.8%
No Prior Reports	1	70	27	2	**100**	75.2%
TOTALS	4	87	38	4	**133**	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

Cause of Death	Total # of Reports
Poisoning/Overdose	2
Inadequate Care/Neglect	1
Upper Gastrointestinal Hemorrhage	1
Total	**4**

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

Manner of Death	Total # of Reports
Accidental	2
Undetermined	0
Homicide	1
Suicide	0
Natural	1
Total	**4**

Of the 133 reports alleging a fatality due to abuse or neglect in this reporting period, 11 (8.3 percent) reports had a tracking characteristic of unsafe sleep, and 5 (3.8 percent) had a tracking characteristic of a drowning.

Reports Alleging Child Near Fatality

The DCS Child Abuse Hotline received 37 reports involving a near fatality in this reporting period. Of these 37 reports, 24 (64.9 percent) alleged a near fatality from neglect and 12 (32.4 percent) alleged a near fatality from abuse. Of the 37 near fatality reports, 1 report was substantiated, 20 were unsubstantiated, and 15 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. Reports Alleging Near Fatality by Finding

	Substantiated	Unsubstantiated	Pending Finding	No Jurisdiction	Total
Neglect	1	12	11	1	24
Physical Abuse	0	8	4	0	12
Total	**1**	**20**	**15**	**1**	**37**

Of the 37 reports alleging a near fatality, 8 (21.6 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. Reports Alleging Near Fatality by Prior Report and Finding

Category	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of total
With at Least One Prior Report	0	4	4	0	8	21.6%
No Prior Reports	1	16	11	1	29	78.4%
TOTALS	**1**	**20**	**15**	**1**	**37**	**100%**

Improvement Opportunities

During this reporting period, the MDRT recommended a comprehensive review of 25 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 monitored 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 timely when investigating a suspicious death or injury to a child. For this reporting time, there were 38 instances of delayed reporting to the Hotline. The delays range from several hours to several days. This contributed to delays in the Department's investigation of the events surrounding the incident and the inability to assess the safety any siblings that may have been in the home at the time of the incident.

- *Increase support for staff:* As part of the Department's strategic planning, a goal is to create a DCS culture that fosters and inspires mission-driven professionals who believe in and practice the Department's shared values. The Department is committed to creating a learning and coaching mindset and behavioral integrity across the agency.

- *Education and Assistance in Detecting Fentanyl Use:* There continues to be a noticeable trend in fentanyl exposure to children and fentanyl overdoses resulting in fatality or near fatality reports. Detecting the use of fentanyl can be difficult and result in tragic outcomes very quickly. The Department will be meeting with caregivers to hear from them the difficulties with detecting and/or reacting to a child's fentanyl use. The Department will be creating educational materials that will be made available to all caregivers.

- *Delays with Medical Examiners Reports on Fatality Investigations*: The Department continues to experience significant delays in receiving medical examiners' reports on child fatalities. The impact 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

- OCWI continues to engage in outreach efforts with law enforcement agencies across the state in an effort to improve the joint investigative process. OCWI has provided 20 joint investigation trainings, reaching over 30 different law enforcement agencies across the State. OCWI's Joint Investigation Liaisons have attended over 50 Multidisciplinary Team meetings throughout the State. These activities are completed with the goal of increasing information sharing and ultimately better investigative outcomes for children and families.

- The Department continues to utilize the Workforce Resilience program to support staff in the reduction of secondary trauma and burnout. This team is comprised of 57 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 over 950 confidential and timely resources to aid DCS employees over this reporting period. The program implemented automatic outreach to any staff responding to a fatality or near fatality report. This outreach allows staff to process any trauma or stress they are feeling. The program also created "mindful moments" for any staff that need to step away from the work and refresh/reset. This support is available to all areas of the Department and to all levels of staff. Additional supports outside of DCS are provided as needed.

- DCS is committed to reducing turnover for line level staff by improving the quality of supervision. Two years ago, DCS implemented the Supervision Coach program. This program is designed to support supervisors and improve supervision through continual coaching and education. There are currently 16 Supervision Coaches in place across the State. Due to the success and need for this support, DCS added 3 additional positions for Supervision Coaches that are in the process of being filled.

- The DCS Office of Prevention continues to engage in activities to support families in an effort to reduce maltreatment, as well as fatality prevention. One area of focus remains young parents who have a history of involvement in the child welfare system. These youth are at an increased level of risk to experience income inequality, intimate partner violence, lack stable housing, and are almost twice as likely to become involved with the child welfare system as parents. Young parents in child welfare are more susceptible to allegations of child maltreatment as to their own children, given their often-unstable family system and inherent limitations due to their developmental stage. For the third year in a row, DCS Office of Prevention collaborated with specific key community partners and offered the 'Young Parent University.

  The Office of Prevention has managed the Young Parent University for the past 4 years because of internal reviews that identify a disproportionate rate of child fatality and near-fatalities related to young parents and children. The current configuration of the Young Parent University involves both young people who are in foster or extended foster care and youth within the community who have never interacted with the child welfare system. Development and management of the program has been the responsibility of the Office of Prevention in cooperation with planning team members comprised of State of Arizona agency representatives, community partners and service providers, non-profits, and more. Input from these planning team members, and past participants is an integral part of the topic and presentation development.

This two-day event was able to offer a way to encourage frequent engagement with young parents throughout the year. It was previously determined that the most effective method of communication with the age group of 13 – 21 is through electronic means – emails, texts, and social media. Due to the continued need of offering the University in a virtual environment, it was determined early in the planning stages that some young parents may not have the technology to accommodate their attendance at the event. The Office of Prevention was once again able to purchase Dell Inspiron laptops to provide to the participants who reported not having access to a stable and reliable device to participate in the Young Parent University with. Those eligible to receive this level of support, were able to attend the University, and will be able to receive other communication throughout the year from DCS.

- During SFY 2021, DCS joined the National Partnership for Child Safety (NPCS). The NPCS is made up of 26 state, county and tribal child welfare agencies. The goal of the partnership is to reduce and prevent child maltreatment and fatalities by sharing data as well as the use of safety science. Safety science allows DCS to review child fatality and near fatality reports with an understanding of the complexity of child welfare work and determine the factors that influence decision making. This approach creates a safe, supportive structure for DCS staff and leadership to learn from fatality and near fatality reports in an effort to prevent future critical incidents. DCS has practice safety science for critical incidents for the past 5 years. DCS was the second jurisdiction in the nation to implement this process and has practiced Systemic Critical Incident Reviews of child fatality and near fatality cases using Safety Science principals since 2016. Joining NPCS will help further the learning for better outcomes for children and families.