ARIZONA DEPARTMENT OF CHILD SAFETY
SFY 2023 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 partner with families, caregivers, and the community to strengthen families, ensure safety, and achieve permanency for all Arizona's children through prevention, services, and support; 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, 2022 through June 30, 2023), 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, 32 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, 2022 through June 30, 2023). The summary data presented here describes a small number of Hotline reports (124), and even fewer with prior DCS involvement (70). 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. 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 43,812 reports of child abuse or neglect. Of these, 124 (0.28 percent) reports contained an allegation of child fatality or near fatality due to abuse or neglect. Of these 124 reports, 114 involved a fatality allegation: 19 alleged deaths due to child abuse and 95 alleged deaths due to neglect. Four of these reports involved a fatality of a child in the custody of DCS. Of the 124 reports, 10 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 2022	Substantiated Finding	Unsubstantiated Finding	Pending Finding	Unable to Locate
All Reports Received in SFY 2023					
Total Reports	43,812				
All Fatality/Near Fatality Reports Received in SFY 2023					
Total Reports	124	1	88	35	0
Alleged Death Due to Abuse					
Total Reports	19	0	14	5	0
% of All Reports Received	0.04%	0.00%	0.03%	0.01%	0.00%
Alleged Death Due to Neglect					
Total Reports	95	0	70	25	0
% of All Reports Received	0.22%	0.00%	0.16%	0.06%	.00%
Alleged Near Fatality					
Total Reports	10	1	4	5	0
% of All Reports Received	0.02%	0.002%	0.009%	0.01%	0.00%

[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 (67.74 percent) of the 124 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 11.29 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	2	0	2	**1.61%**
COCONINO	1	1	2	**1.61%**
GILA	0	0	0	**0.00%**
GRAHAM	3	0	3	**2.42%**
GREENLEE	0	0	0	**0.00%**
LA PAZ	1	0	1	**0.81%**
MARICOPA	79	5	84	**67.74%**
MOHAVE	4	0	4	**3.23%**
NAVAJO	2	0	2	**1.61%**
PIMA	11	3	14	**11.29%**
PINAL	10	1	11	**8.87%**
SANTA CRUZ	0	0	0	**0.00%**
YAVAPAI	1	0	1	**0.81%**
YUMA	0	0	0	**0.00%**
UNKNOWN	0	0	0	**0.00%**
OUT OF COUNTRY	0	0	0	**0.00%**
OUT OF STATE	0	0	0	**0.00%**
STATEWIDE	**114**	**10**	**124**	**100%**

Reports Alleging Child Fatality

The DCS Child Abuse Hotline received 114 reports alleging a fatality due to abuse or neglect in this reporting period. Of these, zero (0.0 percent) have been substantiated for abuse or neglect, 84 (73.7 percent) have been unsubstantiated, and 30 (26.3 percent) have findings pending. Of the 114 reports, 65 (57.0 percent) had at least one prior report involving the child or perpetrator. The four reports involving the fatality of a child who was in the custody of DCS two were unsubstantiated and the remaining two reports are pending. 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	Unable to Locate	TOTALS	% of Total
At least one Prior Report	0	46	19	0	**65**	57%
No Prior Reports	0	38	11	0	**49**	43%
TOTALS	0	84	30	0	**114**	100%

Reports Alleging Child Near Fatality

The DCS Child Abuse Hotline received 10 reports involving a near fatality in this reporting period. Of these 10 reports, six (60 percent) alleged a near fatality from neglect and four (40 percent) alleged a near fatality from abuse. Of the 10 near fatality reports, 4 were unsubstantiated, and 5 are pending a finding. One (1) near fatality report was substantiated for neglect. 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 4 provides the number of near fatality reports by type of allegation.

Table 4. Reports Alleging Near Fatality by Finding

	Substantiated	Unsubstantiated	Pending Finding	No Jurisdiction	Total
Neglect	1	2	3	0	6
Physical Abuse	0	2	2	0	4
Total	**1**	**4**	**5**	**0**	**10**

Of the 10 reports alleging a near fatality, five (50 percent) had no prior reports to DCS involving the child or the perpetrator. Table 5 provides the number of near fatality reports by prior reports and investigation finding.

Table 5. Reports Alleging Near Fatality by Prior Report and Finding

Category	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of total
With at Least One Prior Report	1	2	2	0	5	50%
No Prior Reports	0	2	3	0	5	50%
TOTALS	**1**	**4**	**5**	**0**	**10**	**100%**

Improvement Opportunities

During this reporting period, the MDRT recommended a comprehensive review of 32 fatality or near fatality reports or critical incidents. The MDRT identified four 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 trend of law enforcement not contacting the Department timely when investigating a suspicious death or injury to a child. The delays range from several hours to several days; including one instance of a report delay for over a year. 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 providing staff with opportunities for career development and professional advancement.

- *Supportive Services for Teen Substance Use*: The Department has seen an increase in teen substance use, especially involving fentanyl. To increase the participation of youth in the Arizona Families FIRST substance abuse program, the Department created incentives for youth who met the programmatic milestones of sobriety, employment/education and housing.

- *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 contributes to untimely completion of DCS investigations. More importantly, lack of timely and accessible 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's outreach efforts have included attending and presenting joint investigative trainings to multidisciplinary teams across the state. These multidisciplinary teams include the local law enforcement agencies. OCWI has also met with various partners involved in the joint investigative process to include medical providers, educators, child advocate teams and victim services, as well as collaboration with each county to update their joint investigative protocols.

- 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 58 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 1000 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.

- The Office of Prevention continues to facilitate a Car Seat Program to ensure that every Arizona family has access to a car seat. The Car Seat Program facilitates training for DCS staff and community agencies on the importance and correct use of car seats, booster seats, and restraints. The Office of Prevention provides car seats and trainings to community agencies, who ensure the information is shared with those that receive the gift of a car seat. This year we increased our community agency partnership from 22 to 39. This will expand the current reach of accessibility to families in need of car seats. Our goal is to partner with Family Resource Centers and child care facilities to be a hub in their communities to provide families with car seats as needed. Intentional efforts continue to be made to ensure that underserved communities have access to these resources as often as needed, which has resulted in the Department developing partnerships with local churches and teen parenting agencies to support the car seat program.

- During the last state fiscal year, the Office of Prevention launched a Safe Sleep Campaign during the Child Abuse Prevention Month in April. The Safe Sleep Campaign is to promote safe sleep practices and reduce the number of sleep-related deaths. The Campaign highlighted the ABCs of Safe Sleep: Alone, Back, Crib. The Office of Prevention utilized Out of Home digital billboards on several commonly used highways that reached 18.7 million people, and placed Safe Sleep awareness posters in OB/GYN and pediatrician offices. Additionally, the Department website hosted a Safe Sleep quiz to increase public knowledge. Participants were entered into a raffle for a chance to receive safe sleep essentials.

- In an effort to align efforts amongst state agencies, DCS has transitioned from Baby Boxes to Pack N Plays for Safe Sleep alongside the Arizona Department of Health Services. The Office of Prevention also continues to participate in the Statewide Safe Sleep Taskforce.