ARIZONA DEPARTMENT OF CHILD SAFETY
2016 Annual Fatality/Near Fatality Review Report
For The Period of July 1, 2015 through June 30, 2016

Introduction

The Department of Child Safety's Office of Quality Improvement (OQI) is responsible for tracking all child fatality and near fatality reports made to DCS for the purpose of releasing information to the public as governed by A.R.S. § 8-807.01. This office oversees the newly created Multidisciplinary Review Team (MDRT), which reviews reports of child fatality and near fatality due to abuse or neglect. This team was created to support the Department's vision of seeing 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 MDRT reviews all fatality and near fatality reports to collect and record data on the family and incident, and determine if a detailed incident review will provide learning opportunities. The MDRT conducts comprehensive incident reviews of those identified DCS reports in order 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.

The Department is receiving technical assistance from Collaborative Safety, LLC to implement a more in-depth systemic critical incident review process. This innovative review process is based on the principle that decisions and actions are influenced by the circumstances that are present in the local environment at the time, and are typically reasonable when viewed with knowledge of those local circumstances and influences. 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 service 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. The MDRT will conduct systemic critical incident reviews with Department representatives from Practice Improvement, the Child Welfare Training Institute, the Child Abuse Hotline, Field Operation Regions, the Policy Unit, General Counsel, the Protective Services Review Team, the Prevention Administration, and the Office of Child Welfare Investigations.

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.

Data Sources

This initial annual summary report includes Child Abuse Hotline report level data extracted from the Children's Information Library and Data System (CHILDS). The summary data presented here describes a small number of Hotline reports (191), and even fewer with prior DCS involvement (78). 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.

This annual report includes data on reports received by the Child Abuse Hotline from July 1, 2015 through June 30, 2016. The data also includes information about MDRT reviews that were conducted on reports received from July 1, 2015 through June 30, 2016. This data has not been aggregated previously by the Department. The data reported here serves to establish a baseline of the number of fatality and near fatality reports received and their characteristics.

Reports Received Alleging a Fatality or Near Fatality

In the review period of July 1, 2015, through June 30, 2016, the Department's Child Abuse Hotline received 49,935 reports of child abuse or neglect. Of these, 0.38% (191) contained an allegation of child fatality or near fatality due to abuse or neglect. Of the 191 reports, 144 involved a fatality allegation: 36 alleged death due to child abuse and 108 alleged death due to neglect. Four of these reports involved a fatality of a child in the custody of DCS. Of the 191 reports, 47 involved a near fatality allegation. None of the near fatality reports involved a child in the custody of DCS. 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 in SFY2016	Substantiated Finding	Unsubstantiated Finding	Pending Finding	No Jurisdiction for Investigation
All Reports Received in SFY 2016					
Total Reports	49,935				
All Fatality/Near Fatality Reports Received in SFY 2016					
Total Reports	191	35	114	38	4
Alleged Death Due to Abuse					
Total Reports	36	7	18	10	1
% of All Reports Received (49,935)	0.07%	0.01%	0.04%	0.02%	
Alleged Death Due to Neglect					
Total Reports	108	18	69	19	2
% of All Reports Received (49,935)	0.22%	0.04%	0.14%	0.04%	
Alleged Near Fatality					
Total Reports	47	9	28	9	1
% of All Reports Received (49,935)	0.09%	0.02%	0.06%	0.02%	

[1] Some cases from this year that have been posted 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, those criminal proceedings 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 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 (57%) of the 191 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 21% involved a family living in Pima County. This distribution is 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	1	1	**0.52%**
COCHISE	2	0	2	**1.05%**
COCONINO	2	1	3	**1.57%**
GILA	0	1	1	**0.52%**
GRAHAM	0	1	1	**0.52%**
GREENLEE	0	0	0	**0.00%**
LA PAZ	1	1	2	**1.05%**
MARICOPA	87	22	109	**57.07%**
MOHAVE	6	3	9	**4.71%**
NAVAJO	4	1	5	**2.62%**
PIMA	29	11	40	**20.94%**
PINAL	10	3	13	**6.81%**
SANTA CRUZ	0	1	1	**0.52%**
YAVAPAI	1	0	1	**0.52%**
YUMA	2	1	3	**1.57%**
STATEWIDE	**144**	**47**	**191**	**100%**

Examining the frequency of alleged fatalities and near-fatalities by zip code of the family's residence can be useful to identifying areas for a community-based prevention response. Two zip codes in Maricopa County had a relatively high number and percentage of the alleged fatality and near fatality reports: 85719 in Tucson, and 85016 in Phoenix. Table 3 provides the total number of reports by zip code in which the child's primary caregiver resided.

Table 3. Total Fatality and Near Fatality Reports by Zip Code

Assignment Zip Code	Number of Fatality Reports	Number of Near Fatality Reports	Total Reports	% of Total Reports

85004	6	2	8	4.19%
85012	6	1	7	3.66%
85016	17	3	20	10.47%
85027	8	1	9	4.71%
85029	9	3	12	6.28%
85037	5	3	8	4.19%
85040	4	1	5	2.62%
85120	1	1	2	1.05%
85122	4	1	5	2.62%
85128	5	1	6	3.14%
85201	7	2	9	4.71%
85233	3	0	3	1.57%
85282	4	1	5	2.62%
85301	5	1	6	3.14%
85323	5	3	8	4.19%
85344	1	1	2	1.05%
85345	8	1	9	4.71%
85365	2	1	3	1.57%
85541	0	1	1	0.52%
85546	0	1	1	0.52%
85607	1	0	1	0.52%
85621	0	1	1	0.52%
85635	1	0	1	0.52%
85706	1	1	2	1.05%
85710	1	0	1	0.52%
85719	27	10	37	19.37%
85929	3	1	4	2.09%
85936	0	1	1	0.52%
86001	1	1	2	1.05%
86022	1	0	1	0.52%
86047	1	0	1	0.52%
86326	1	0	1	0.52%
86401	3	2	5	2.62%
86403	2	0	2	1.05%
86442	1	1	2	1.05%
STATEWIDE	144	47	191	100%

***4 reports received were "No Jurisdiction to Investigate": 86074, 85128 and 85344 each had 1 fatality report and 85323 had 1 near fatality report that was designated as "No Jurisdiction to Investigate."**

Reports of Child Fatality

The DCS Child Abuse Hotline received 144 reports alleging a fatality due to abuse or neglect in this reporting period. Of the 144, 25 (17%) have been substantiated for abuse or neglect, 87 (60%) have been

unsubstantiated, and 29 (20%) have findings pending. Of the 144 reports, 61 (42%) had at least one prior report involving the child or perpetrator, and 12 (8%) had at least one prior report and have been substantiated. Of the four reports involving fatality of a child who was in the custody of DCS, one report was substantiated, one report is pending a finding, and two reports were unsubstantiated. Table 4 provides the total number of reports of child fatality by prior report and finding.

Table 4. Reports of Child Fatality by Prior Report and Finding

	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of total
With at least one Prior Report	12	34	13	2	61	42%
No Prior Reports	13	53	16	1	83	58%
TOTALS	25	87	29	3	144	100%

Table 5 provides the cause of death identified in each report reviewed. Deaths from suffocation/asphyxia/strangulation and undetermined includes deaths as a result of sudden unexplained infant death, which is often related to an unsafe sleep environment.

Table 5. Cause of Death in Reports Substantiated for Abuse or Neglect

Cause of Death	Total # of Reports
Drowning	5
Blunt Force Trauma	7
Gunshot Wound	2
Suffocation/Asphyxia/Strangulation	4
Poisoning (salt/meth)	2
Vehicle Related (left in car)	1
Undetermined	2
Final OME Report Pending	2
Total	25

Table 6 provides the manner of death identified in each report that was substantiated for abuse or neglect.

Table 6. Manner of Death in Reports Substantiated for Abuse or Neglect

Manner of Death	Total # of Reports
Accidental	13
Undetermined	3
Homicide	7
Suicide	0
Final OME Report Pending	2
Total	**25**

Reports of Child Near Fatality

The DCS Hotline received 47 reports involving a near fatality in this reporting period. There were no reports involving a near fatality of a child who was in DCS custody at the time of the near fatality incident. Of the 47 reports alleging a near fatality, 72% (34) alleged a near fatality from neglect. Of the 47 near

fatality reports, nine reports have been substantiated, 28 reports have been unsubstantiated, and nine are pending a finding. Table 7 provides the number of near fatality reports by type of allegation.

Table 7. Type of Near Fatality Allegation

	Substantiated	Unsubstantiated	Pending Finding	No Jurisdiction	Total
Neglect	4	22	7	1	34
Physical Abuse	5	6	2	0	13
Total	**9**	**28**	**9**	**1**	**47**

Of the 47 reports alleging a near fatality, 64% (30) had no prior reports to DCS involving the child or perpetrator. Table 8 provides the number of near fatality reports by prior reports and investigation finding.

Table 8. 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	7	7	3	0	17	36%
No Prior Reports	2	21	6	1	30	64%
TOTALS	9	28	9	1	47	100%

Fatality and Near Fatality Reports Reviewed by the MDRT

The MDRT has reviewed 176 of the fatality and near fatality reports that were received during this reporting period, including 141 reports of a fatality and 35 reports of a near fatality. The remaining 15 reports received during the reporting period will be reviewed by the MDRT during the next reporting period. Table 9 provides the number of reports reviewed by the MDRT by abuse category.

Table 9. Fatality and Near Fatality Reports Reviewed by MDRT

Report Category	Pending Review by MDRT	Reviewed by MDRT	Totals
Alleged Death Due to Abuse	0	36	36
Alleged Death Due to Neglect	3	105	108
Alleged Near Fatality	12	35	47
Totals	15	176	191

Improvement Opportunities

The MDRT's comprehensive incident review process was initiated in July 2015, with the first review held on July 23, 2015. During this reporting year, the MDRT conducted a comprehensive incident review of 42 fatality or near fatality reports. The MDRT identified two primary improvement opportunities. These

areas will continue to be tracked and evaluated to better understand influences that can be addressed for system-wide improvement.

- Caseload volume – Workforce capacity may not have been sufficient to manage caseload volume during the review period. When caseload exceeds workforce capacity, employees are forced to choose between the many priorities and requirements with which they are faced each day. This factor has influenced practices such as the thoroughness of documentation in the Child Safety and Risk Assessment and case notes, completion of DPS background checks that might have been pertinent to the assessment, and communication between multiple Child Safety Specialists involved with a family.

- Supervisor turnover/retention – Many supervisors have been in their positions a short time, which may have influenced their development of proficiency in supervision to guide the consistent application of the Department's safety and risk assessment model.

Recommendations

- The Department will continue to address caseload volume by completing the investigation backlog reduction project, and by implementing targeted retention strategies. The strategic initiatives include refining the onboarding process and defining and implemented a leadership development program.

- The Department will improve the application of Arizona's child safety assessment framework, known as the Arizona SAFE Model, by updating procedures and decision-making guidance, and by developing safety assessment experts within the Department to provide coaching and consultation for Child Safety Specialists and Supervisors. Technical assistance to support this initiative is being provided by Action for Child Protection.

- The Department will conduct further analysis on reports from zip codes 85719 and 85016 to identify community level influences and possible prevention strategies.

- The CHILDS system previously had no method to identify cases with alleged concerns about unsafe sleep environments. Tracking characteristics were recently added, which will enable greater analysis of these cases. The Department will use this data to guide the safe sleep initiatives.