ARIZONA DEPARTMENT OF CHILD SAFETY
SFY 2017 Annual Fatality/Near Fatality Review Report

Introduction

The Department of Child Safety's (DCS) Office of Ombudsman reviews 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 utilizes a true systems approach to better understand those factors that 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 has developed Systemic Critical Incident Reviews (SCIR) with the technical assistance of Collaborative Safety, LLC 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.

For this reporting period (July 1, 2016 through June 30, 2017), 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, General Counsel, the Prevention Administration and the Office of Child Welfare Investigations. 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, 19 cases 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, 2016 through June 30, 2017 extracted from the Children's Information Library and Data Source (CHILDS). The summary data presented here describes a small number of Hotline reports (204), and even fewer with prior DCS involvement (93). 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 of abuse or neglect involving multiple children. 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 47,995 reports of child abuse or neglect. Of these, 0.43 percent (204) contained an allegation of child fatality or near fatality due to abuse or neglect. Of these 204 reports, 151 involved a fatality allegation: 36 alleged death due to child abuse and 115 alleged death due to neglect. Six of these reports involved a fatality of a child in the custody of DCS. Of the 204 reports, 53 involved a near fatality allegation. One 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 parent, guardian, or custodian's 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 in SFY 2017	Substantiated Finding	Unsubstantiated Finding	Pending Finding	No Jurisdiction for Investigation
All Reports Received in SFY 2017					
Total Reports	47,995				
All Fatality/Near Fatality Reports Received in SFY 2017					
Total Reports	204	50	116	33	5
Alleged Death Due to Abuse					
Total Reports	36	9	21	6	0
% of All Reports Received	0.08%	0.02%	0.04%	0.01%	
Alleged Death Due to Neglect					
Total Reports	115	30	63	20	2
% of All Reports Received	0.24%	0.06%	0.13%	0.04%	
Alleged Near Fatality					
Total Reports	53	11	31	8	3
% of All Reports Received	0.11%	0.02%	0.06%	0.02%	

[1] Some of the cases posted on the Department's website 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, 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 (65 percent) of the 204 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 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	0	0	**0.00%**
COCHISE	4	2	6	**2.94%**
COCONINO	0	2	2	**0.98%**
GILA	1	0	1	**0.49%**
GRAHAM	0	0	0	**0.00%**
GREENLEE	1	0	1	**0.49%**
LA PAZ	1	0	1	**0.49%**
MARICOPA	106	27	133	**65.20%**
MOHAVE	0	3	3	**1.47%**
NAVAJO	0	0	0	**0.00%**
PIMA	14	10	24	**11.76%**
PINAL	6	4	10	**4.90%**
SANTA CRUZ	1	0	1	**0.49%**
YAVAPAI	7	4	11	**5.39%**
YUMA	1	0	1	**0.49%**
UNKNOWN	7	0	7	**3.43%**
OUT OF COUNTRY	1	0	1	**0.49%**
OUT OF STATE	1	1	2	**0.98%**
STATEWIDE	**151**	**53**	**204**	**100%**

Examining the frequency of alleged fatalities and near-fatalities by zip code of the family's residence can be useful in identifying areas for a community-based prevention response. In the SYF 2016 annual report, the zip codes identified in the report were determined by DCS office location rather than the child's primary caregiver's residence. Therefore, this annual report shows a more equal distribution of reports among zip codes in the state based on the primary caregiver's residence. As a result, this table may not be provided in subsequent annual reporting depending on report distribution. 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 of Zip Code	Number of Fatality Reports	Number of Near Fatality Reports	Total Reports	% of Total Reports
Unknown	2	0	2	0.98%
0000	1	0	1	0.49%
85006	2	0	2	0.98%
85007	1	0	1	0.49%
85008	1	0	1	0.49%

85009	0	1	1	0.49%
85015	4	0	4	1.96%
85016	1	0	1	0.49%
85017	5	0	5	2.45%
85019	2	0	2	0.98%
85021	1	0	1	0.49%
85023	1	1	2	0.98%
85027	2	0	2	0.98%
85029	2	2	4	1.96%
85032	3	0	3	1.47%
85033	1	0	1	0.49%
85034	1	0	1	0.49%
85035	0	4	4	1.96%
85037	3	1	4	1.96%
85041	1	0	1	0.49%
85042	2	1	3	1.47%
85043	0	1	1	0.49%
85050	2	0	2	0.98%
85051	3	0	3	1.47%
85085	2	0	2	0.98%
85086	1	0	1	0.49%
85118	1	0	1	0.49%
85122	2	2	4	1.96%
85123	2	0	2	0.98%
85140	0	1	1	0.49%
85142	0	1	1	0.49%
85143	1	0	1	0.49%
85201	1	2	3	1.47%
85203	1	2	3	1.47%
85204	4	0	4	1.96%
85205	2	0	2	0.98%
85206	2	0	2	0.98%
85207	1	0	1	0.49%
85208	0	1	1	0.49%
85210	3	0	3	1.47%
85213	2	0	2	0.98%
85225	3	1	4	1.96%
85247	0	1	1	0.49%
85249	1	0	1	0.49%
85256	1	0	1	0.49%
85257	1	0	1	0.49%

85281	2	0	2	0.98%
85283	1	0	1	0.49%
85284	0	1	1	0.49%
85297	1	1	2	0.98%
85298	2	0	2	0.98%
85301	4	0	4	1.96%
85302	3	0	3	1.47%
85303	3	0	3	1.47%
85306	1	0	1	0.49%
85308	1	0	1	0.49%
85320	1	0	1	0.49%
85323	1	2	3	1.47%
85326	4	1	5	2.45%
85335	0	1	1	0.49%
85338	2	0	2	0.98%
85339	2	1	3	1.47%
85345	4	0	4	1.96%
85346	1	0	1	0.49%
85353	5	0	5	2.45%
85361	0	1	1	0.49%
85362	1	1	2	0.98%
85363	1	0	1	0.49%
85365	1	0	1	0.49%
85374	1	1	2	0.98%
85378	1	0	1	0.49%
85379	1	0	1	0.49%
85381	1	0	1	0.49%
85382	1	0	1	0.49%
85387	2	0	2	0.98%
85395	1	0	1	0.49%
85501	1	0	1	0.49%
85540	1	0	1	0.49%
85607	0	1	1	0.49%
85615	1	0	1	0.49%
85635	1	0	1	0.49%
85640	1	0	1	0.49%
85641	1	0	1	0.49%
85643	1	1	2	0.98%
85650	1	0	1	0.49%
85653	1	0	1	0.49%
85702	1	0	1	0.49%

85705	0	1	1	0.49%
85706	1	0	1	0.49%
85710	1	0	1	0.49%
85711	2	1	3	1.47%
85712	0	1	1	0.49%
85713	1	2	3	1.47%
85714	0	1	1	0.49%
85715	1	0	1	0.49%
85716	2	0	2	0.98%
85741	2	1	3	1.47%
85742	1	2	3	1.47%
85749	1	0	1	0.49%
85750	1	0	1	0.49%
85756	0	1	1	0.49%
86001	0	1	1	0.49%
86040	0	1	1	0.49%
86321	0	1	1	0.49%
86322	1	1	2	0.98%
86323	1	1	2	0.98%
86324	1	0	1	0.49%
86325	2	0	2	0.98%
86326	1	0	1	0.49%
86403	0	1	1	0.49%
86409	0	1	1	0.49%
86442	0	1	1	0.49%
90062	1	0	1	0.49%
94541	0	1	1	0.49%
STATEWIDE	**151**	**53**	**204**	**100%**

Reports of Child Fatality

The DCS Child Abuse Hotline received 151 reports alleging a fatality due to abuse or neglect in this reporting period. Of these, 39 (26 percent) have been substantiated for abuse or neglect, 84 (56 percent) have been unsubstantiated, and 26 (17 percent) have findings pending. Of the 151 reports, 71 (47 percent) had at least one prior report involving the child or perpetrator, and 22 (15 percent) had at least one prior report and have been substantiated. Of the six reports involving fatality of a child who was in the custody of DCS, one report was substantiated, two reports are pending a finding, and three reports were unsubstantiated. Reports alleging a fatality may contain multiple allegations of abuse or neglect on more than one child and substantiation of these reports could be specific to findings not related to the fatality. 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	22	38	11	0	71	47%
No Prior Reports	17	46	15	2	80	53%
TOTALS	39	84	26	2	151	100%

Table 5 provides the cause of death identified in each report reviewed. 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 5. Cause of Death in Reports Substantiated for Abuse or Neglect[1]

Cause of Death	Total # of Reports
Drowning	6
Blunt Force Trauma	9
Gunshot Wound	4
Suffocation/Asphyxia/Strangulation	1
Poisoning (salt/meth)	0
Vehicle Related (left in car)	1
Undetermined	14
Final OME Report Pending	3
Total	38

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

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[2]

Manner of Death	Total # of Reports
Accidental	11
Undetermined	14
Homicide	10
Suicide	0
Final OME Report Pending	3
Total	**38**

[1] One 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 151 reports alleging a fatality due to abuse or neglect in this reporting period, 30 (20 percent) had a tracking characteristic of unsafe sleep, and 14 (9 percent) had a tracking characteristic of a drowning.

Reports of Child Near Fatality

The DCS Hotline received 53 reports involving a near fatality in this reporting period. There was one report involving a near fatality of a child who was in DCS custody at the time of the near fatality incident, and this report was unsubstantiated. Of these 53 reports, 42 (79 percent) alleged a near fatality from neglect. Of the 53 near fatality reports, 11 reports were substantiated, 31 were unsubstantiated, and eight are pending a finding. As previously indicated, 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. 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	7	28	4	3	42
Physical Abuse	4	3	4	0	11
Total	**11**	**31**	**8**	**3**	**53**

Of the 53 reports alleging a near fatality, 31 (58 percent) had no prior reports to DCS involving the child or the 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	11	4	0	22	42%
No Prior Reports	4	20	4	3	31	58%
TOTALS	**11**	**31**	**8**	**3**	**53**	**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 19 fatality or near fatality reports. 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 tracked and evaluated to better understand influences that can be addressed for system-wide improvement.

- *Caseload*: As reported in the last annual report, caseload volume continued to influence practice in this current reporting period when reviewing historical reports involving a family. These reviewed historical reports may have had relevant reviewed information dating back three years (2014, 2015 and 2016). While this trend is expected to decrease with the reduction of the investigation backlog and children in care, it still remains important to note given that the backlog was officially cleared March 2017. 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.

- *Collaboration with Law Enforcement on Fatality/Near Fatality Investigations*: We continue to see opportunities for improvement as it pertains to law enforcement's duty to report child fatality/near fatality investigations to the department. Often times, law enforcement personnel are investigating and attempting to determine the cause of death of a child whom had siblings living within the same location. In those cases, the Department of Child Safety must ensure the safety of potentially vulnerable, surviving children. Moreover, the Department can aid law enforcement in their work by informing of prior DCS history regarding the involved victim and family. Obviously, the Department's ability to ensure child safety is significantly impacted if no report, or a delayed report, is received.

- *Assessment of a safe sleeping environment for infants*: Previously, the Department had limited information available to field staff regarding how to assess a safe sleeping environment for infants when working with a family. This led field staff to not feeling supported and prepared when interacting with a family that may be engaging in unsafe sleep practices. Additionally, there were limited resources that the Department could offer a family, therefore field staff had limited options when advocating for an infant to sleep in a safer environment.

- *Delays with Medical Examiners Reports on Fatality Investigations*: There have been significant delays in the Department 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 Actions and Recommendations

- The Department successfully reduced the investigation backlog below targeted benchmarks by March 2017, and open reports reduced from an average of 145 per caseworker to 22 per caseworker. As a result, the decreased backlog has helped to improve response times on abuse allegations, lowered caseloads for workers, and allowed more time for DCS workers to complete a comprehensive assessment on investigations. Additionally, all of these changes have contributed to fewer children in out-of-home care. The Department will continue to monitor caseloads and provide additional resources to ensure that staff have a manageable workload.

- The Office of Child Welfare Investigations has been engaging various law enforcement agencies around the state to provide education and support regarding joint investigation protocols within their jurisdictions. These outreach efforts will continue throughout the next year, and law enforcement agencies are encouraged to contact the Department when they suspect abuse or neglect of a child.

- In response to identifying this trend, DCS started the safe sleep campaign and Baby Box Program in November 2016. The Safe Sleep Campaign focuses on training DCS Specialists and contracted providers to help them address safe sleep practices while engaging with families. The Department

has also developed a policy addressing Infant Care Plans, which require staff to evaluate the infants sleeping environment. To support this effort, the Department has also deployed 1300 tablets that provide staff with the ability to show a safe sleep instructional video. In addition to training and policy modifications, DCS purchased baby boxes that can be used as an alternative to cribs. These baby boxes are offered to any parents involved with DCS who need a safe place for their infant to sleep. Parents who agree to the program are trained in safe sleep practices and sign a "Commitment Form" stating they have been trained in safe sleep practices and are committed to practicing them. The training curriculum used is in line with the 2016 Recommendations for a Safe Infant Sleeping Environment from the American Academy of Pediatrics. In the past year, 396 boxes were distributed to DCS offices across the state. Seven DCS contracted agencies, who provide In-Home Services were also provided baby boxes. DCS plans to expand this program by participating in a free baby box program that provides an online educational tool called Baby Box University: https://www.babyboxuniversity.com. Additional safe sleep materials have been created and shared on the DCS Safe Sleep page: https://dcs.az.gov/Services/Safe-Sleep by the DCS Office of Prevention.

- Due to the identified trend of delayed medical examiners reports, the Office of Child Welfare Investigations 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 Office of Child Welfare will continue to collaborate with all Medical Examiner offices around the state to find a solution to address this need.