Summary Report	Fatality	2/8/18

1. Victim: Adam Grace – 6-day-old male

2. Was the child residing in the child's home or in an out-of-home placement at the time of the fatality?

The child was residing in his home when the following incident occurred:

On September 27, 2017, the Department of Child Safety received a report regarding the 3/23/16 death of 6-day-old Adam Grace. Adam was reportedly sleeping in a bed with his mother when he was found unresponsive. He was transferred to the hospital and pronounced deceased. An autopsy was performed and Adam tested positive for oxycodone. The Office of the Medical Examiner reported the cause of Adam's death as acute oxycodone intoxication and co-sleeping with parent. The allegation of neglect pertaining to the mother, Kacie Grant, was substantiated by the Department.

3. If the victim in the Preliminary Report involved a child residing in the child's home, the following information will be provided:

a. Services being provided to the child, a member of the child's family or the person suspected of the abuse or neglect at the time of the incident and the date of the last contact before the incident between the entity providing services and the person receiving services:

No services were being provided to the family by the Department of Child Safety at the time of the incident.

b. Was the child, a member of the child's family or the person suspected of the abuse or neglect the subject of a report for investigation at the time of the incident?

No.

c. All involvement of the child's parents and of the person suspected of the abuse or neglect in a situation for which a report for investigation was made or in services provided pursuant to this chapter in the five years preceding the incident:

The child's father and mother, Kacie Grant, were involved in the following prior reports:

On May 1, 2015, a report was received alleging neglect to Adam's siblings by his father and mother. There was also an allegation of physical abuse to one of the siblings by Adam's father. An investigation was initiated and the case remained open when a subsequent report was received. The allegations were later unsubstantiated.

On October 1, 2015, a report was received alleging neglect to Adam's siblings by the mother, Kacie Grant. There were also allegations of physical abuse to one sibling and neglect to another sibling by Adam's father. The allegations were unsubstantiated and the case was closed.

d. Any investigation pursuant to a report for investigation concerning the child, a member of the child's family or the person suspected of the abuse or neglect or services provided to the child or the child's family since the date of the incident involving the fatality:

The report regarding the fatality was investigated and the case was closed. The allegation of neglect to Adam by his mother was substantiated. The other children in the home were assessed as safe. No subsequent reports of abuse or neglect have been received.

4. If the victim in the Preliminary Report involved a child residing in an out-of-home placement, the following information will be provided:

a. Licensing Agency:

N/A

b. Licensing history of the out-of-home placement, including the type of license held by the operator of the placement and the period for which the placement has been licensed:

N/A

c. Summary of all violations by the licensee:

N/A

d. Any other actions by the licensee or an employee of the licensee that constitute a substantial failure to protect and promote the health, safety and welfare of a child.

N/A

5. Actions taken by the Department in response to the case including any changes to policy or practice and/or recommendations for further changes in policies, practices, rules or statutes:

The Department conducted a joint investigation with the Flagstaff Police Department. The allegation of neglect to Adam by his mother was substantiated. The other children were assessed as safe in the home. No subsequent reports of abuse or neglect have been received.

The Department reminds all caregivers to practice safe sleep. For additional information please visit the DCS website at: https://dcs.az.gov/Services/Safe-Sleep.

Additionally, in accordance with the DCS Strategic Plan for State Fiscal Year 2016 (FY16), multidisciplinary team (MDT) reviews of fatality and near fatality cases were implemented during the first quarter of FY16. The MDT reviews of fatality and near fatality cases, especially those with prior DCS involvement, are a key feature of the Strategic Plan and support the objective of increasing the accuracy of safety and risk assessments in investigations.

This case was reviewed by the MDT in order to identify any systemic factors, both internal and external to the Department that may have had an impact. The Department is using the aggregate data gathered through all of the MDT reviews to assess and guide future changes and/or recommendations to policies, practices, rules or statutes. Findings from these reviews will be compiled into an annual report to be shared on the DCS website. The target date for release of this report is December 1, 2018.

For more information regarding the Department of Child Safety's Strategic Plan for State Fiscal Year 2016, please visit the DCS website at: https://dcs.az.gov/news/dcs-strategic-plan.