Summary Report	Fatality	3/3/17

1. Victim: Dante Houck – 10-month-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 March 22, 2013, the Department of Child Safety received a report regarding 10-month-old Dante Houck. The report stated Dante had died on October 29, 2012. An investigation was initiated and found that the parents, Heather Bissland and Devin Houck, had left Dante unattended in an empty bathtub for over 17 hours without checking on him. The Medical Examiner ruled the manner and cause of death as "Undetermined," but stated severe undernourishment and probable dehydration were significant contributory factors. The Arizona Child Fatality Review Team, which includes at least one medical doctor, determined that Dante's death was due to neglect. In addition, the DCS investigation determined that Dante's death was a result of the parents' neglect based on their failure to provide him with adequate nutrition, fluids and supervision.

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:

There has been no prior involvement of the child's parents with DCS.

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 investigation of the report resulted in the Department substantiating the allegations of neglect pertaining to each parent. There were no other children in the home and the case was closed with no services provided. 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 Mesa Police Department. The allegations of neglect pertaining to each parent were substantiated. There were no other children in the home and the case was closed with no services provided. No subsequent reports of abuse or neglect have been received.

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, 2017.

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.