ARIZONA DEPARTMENT of CHILD SAFETY

Mike Faust, Director
Douglas A. Ducey, Governor

Summary Report	Fatality	6/16/2020

1. Victim: Samora Cousin – 4 month old female

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 an out-of-home placement when the following incident occurred:

On October 1, 2019, the Department of Child Safety received a report regarding Samora Cousin (4 month old female) who was found deceased in her caregiver's, Robert AKA Roger Young-Ham, vehicle, after being left unattended in the vehicle for several hours. An autopsy report, finalized on December 26, 2019, revealed the cause of death was environmental heat exposure and the manner was accident. The Department substantiated the allegations of neglect against her caregiver, Robert AKA Roger Young-Ham.

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:

Services were being provided to the biological family by the Department of Child Safety at the time of the incident due to the dependency action through Maricopa County Superior Court.

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?

Samora Cousin was the subject of a neglect report on May 23, 2019, involving the child's parents.

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 DCS involvement regarding Robert AKA Roger Young-Ham within the past five years.

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 after completion of in-home services. The allegation of neglect to Samora by her caregiver was substantiated. 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:

The caregiver, Robert AKA Roger Young-Ham, was not a licensed out-of-home placement at the time of the fatality.

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:

The license for the caregiver's home had expired in 2010.

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 Phoenix Police Department. The other children in the home were assessed as safe with their parents. The family was provided with in-home services. The Department substantiated the allegations as to Robert AKA Roger Young-Ham. No subsequent reports have been received.

The Department reminds all caregivers to always double check for children in cars.

For more information, please visit the DCS website at: https://dcs.az.gov/news/double-check.

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.

Cases are 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 uses 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 are compiled into an annual report to be shared on the DCS website. The target date for release of the next report is December 1, 2020.

For more information regarding the Department of Child Safety's Strategic Plan for State Fiscal Year 2016, please visit the DCS website.