Summary Report	Fatality	05/23/18

1. Victim: Ariel Horn – age 19 months - 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 her home when the following incident occurred:

On May 4, 2017, the Department of Child Safety received a report regarding 19 month old Ariel Horn who was found unresponsive in her bed by her mother. The investigation determined that Ariel had taken a morphine pill she found on the floor that had not been picked up by the maternal grandmother and grandfather, Wanda and John Watson. The Office of the Medical Examiner determined the cause of Ariel's death was due to morphine toxicity. The Department substantiated the allegations of neglect to Ariel by Wanda and John Watson.

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:

DCS received the following reports involving the child's parents in the past five years:

On April 10, 2013, a report was received alleging physical abuse of the child's sibling by the mother. The allegation was unsubstantiated. The family was provided with information on services available in the community and the case was closed.

On July 9, 2013, a report was received alleging neglect of the child's siblings by the mother and father. The allegations were unsubstantiated as to both parents. The family was provided with information on services available in the community and the case was closed.

On December 9, 2013, a report was received alleging physical abuse of the child's sibling by the mother and father. The allegations were unsubstantiated as to both parents. The family declined services provided by the Department and had obtained services available in the community and the case was closed.

On March 3, 2015, a report was received alleging neglect of the child's siblings by the mother and father. The allegations were unsubstantiated as to both parents. The family was provided with information on services available in the community and the case was closed.

DCS received the following report involving Ariel Horn in the past five years:

On September 9, 2016, a report was received alleging neglect of the child and her siblings by the mother and father and allegations of physical abuse of a sibling by the father. The allegations were unsubstantiated as to both parents. The family was provided with information on services available in the community 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:

No.

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 Cochise County Sheriff's Office. The other children in the home were assessed as safe with their parent. No subsequent reports have been received. The Department substantiated the allegations of neglect to the victim by the maternal grandparents, Wanda and John Watson.

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, 2018.

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