ARIZONA DEPARTMENT of CHILD SAFETY

Mike Faust, Director
Douglas A. Ducey, Governor

Summary Report	Fatality	11/20/20

1. Victim: Caden Sarver– 13-year-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 October 26, 2020, the Department of Child Safety received a report regarding 13-year-old Caden Sarver, who had been taken to the hospital in critical condition after being injured by his father during a domestic violence incident. The father, Paul Sarver, was shot and killed by police after they responded to the home. Upon investigation it was determined that Mr. Sarver inflicted the injuries to Caden and caused his death.

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:

There were no services 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?

Caden Sarver, a sibling, and the father, Paul Sarver, were subjects of the October 13, 2020 report.

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 prior report involving the child, Caden Sarver, and his father, Paul Sarver:

> On October 13, 2020, a report was received alleging physical abuse to Caden Sarver and his sibling by Mr. Sarver. The children were assessed as safe in the care of the mother and the report remained open at the time the fatality report was received. The allegations of abuse have since been unsubstantiated.

There has been no prior involvement of the child’s mother 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 fatality report resulted in the sibling being placed with a relative. The Department filed a dependency petition with the Maricopa County Superior Court and is providing services to the sibling. There were no subsequent reports of abuse or neglect received by the Department.

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 Phoenix Police Department. The investigation resulted in the sibling being placed with a relative. The Department filed a dependency petition with the Maricopa County Superior Court and is providing services to the sibling. There were no subsequent reports of abuse or neglect received by the Department.

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.