| Summary Report | Fatality | 3/3/17 |
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**1. Victim:** Charles Frymire – 3-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 31, 2016, the Department of Child Safety received a report regarding three-month-old Charles Frymire who died while co-sleeping on a couch with his mother. The allegations of neglect were substantiated as to the parents, Cheryl Morgan and Joseph Frymire, for failing to provide a safe living environment and allowing the baby to sleep with his mother on the couch. The cause of death was determined to be asphyxiation.

**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 mother, Cheryl Morgan, was involved in the following:

> On November 23, 2012, a report was received alleging neglect to a sibling by Cheryl Morgan. The allegations were unsubstantiated and the family was provided with information on services available in the community.

**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 assessed the other children in the home as safe in the care of the parents. The Department substantiated the allegations of neglect pertaining to the parents and provided the family with services. 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 Cochise County Sheriff's Office. The allegations pertaining to the parents were substantiated and the family was provided with services by the Department. The other children in the home were assessed as safe and 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/dcs-services/prevention/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, 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.