Summary Report	Fatality	01/23/2024

Amendments to the information originally posted on 04/27/23 are displayed below in red.

1. Victim: Braylen Burgess – 4-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 October 15, 2021, the Department of Child Safety received a report regarding a 4-month-old male that was found unresponsive in his bassinet after being put to sleep between two pillows. The child was transported to the hospital where he was pronounced deceased. It was determined the child died of positional asphyxia due to the unsafe sleep environment. On April 3, 2023, the Department substantiated the allegation of neglect by Lashawn Groves. On January 12, 2024, the Department substantiated the allegation of neglect by Rackayla Brown.

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?**
>
> 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 mother, Ms. Brown, or Mr. Groves with DCS.

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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 allegations of neglect by Mr. Groves and Ms. Brown being substantiated. The other child in the home was assessed as safe and the case was closed.

A subsequent report involving the mother, Ms. Brown, was received on September 20, 2022, regarding allegations of neglect to one of her children. The allegation was unsubstantiated and the child was assessed as safe in the mother's care. The family was provided community resources and the case was closed.

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 allegations of neglect by Mr. Groves and Ms. Brown being substantiated. The other child in the home was assessed as safe and the case was closed.

A subsequent report involving the mother, Ms. Brown, was received on September 20, 2022, regarding allegations of neglect to one of her children. The allegation was unsubstantiated and the child was assessed as safe in the mother's care. The family was provided community resources and the case was closed.

The Department reminds all caregivers to practice safe sleep. For additional information please visit the DCS website at: https://dcs.az.gov/Services/Safe-Sleep.

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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 fatality and near fatality cases with prior DCS involvement, which are a key feature of the Strategic Plan and supports 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, 2023.

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