Summary Report	Fatality	08/02/2024

1. Victim: Krislynn Mcneill - 2-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 her home when the following incident occurred:

> On April 21, 2024, the Department of Child Safety received a report regarding 2-month-old Krislynn Mcneill who had been found not breathing and was later pronounced deceased. The Maricopa County Medical Examiner concluded that the cause of death was related to unsafe sleep and exposure to high levels of methamphetamines. The manner of death was undetermined. The alleged perpetrator is unknown.

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:

The child's mother was involved in the following prior report:

> On December 3, 2019, a report was received alleging neglect to a child by their mother. The children in the home were assessed as safe and the allegation was unsubstantiated. The family was offered community resources and the case was closed on January 29, 2020.

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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 report regarding the fatality was investigated and the case was closed. The family was offered information on services available within the community. The other children in the home were assessed as safe. There were no subsequent reports of abuse or neglect regarding this family.

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 Peoria Police Department. The other children in the home were assessed as safe. The family was offered information on services available within the community and the case was closed. There were no subsequent reports of abuse or neglect regarding this family.

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.

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

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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, 2024.

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