ARIZONA DEPARTMENT of CHILD SAFETY

Mike Faust, Director
Douglas A. Ducey, Governor

Summary Report	Fatality	01/03/2022

1. Victim: Emani Bridges – One-year-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 September 11, 2020, the Department of Child Safety received a report regarding the fatality of one-year-old, Emani Bridges. The Department substantiated the allegations of neglect by an unknown perpetrator when Emani was able to access fentanyl causing her to overdose.

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 September 17, 2018, a report was received alleging neglect to Emani Bridges by her mother. The allegation was unsubstantiated. The family was provided with a day care referral and information on services available in the community. The case was closed without further involvement from the Department.

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 Department substantiated the allegation of neglect against an unknown perpetrator. It was determined that the sibling was safe in the home with the mother. Services are being provided.

A subsequent report involving a sibling was received on September 29, 2021 regarding an allegation of neglect. The allegation was unsubstantiated. The family was given services and the case was closed.

An additional subsequent report alleging physical abuse and neglect to a sibling was received on November 8, 2021. The allegations were unsubstantiated and the case was closed.

An additional subsequent report alleging neglect with the sibling was received on December 13, 2021. The investigation is ongoing.

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 Maricopa County Sheriff's Office. The Department substantiated the allegation of neglect as to an unknown perpetrator. Services were provided to the family. The Department also investigated the report regarding another child who lived in the home part time. That child was assessed as safe with the other parent. There were no subsequent reports received.

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, 2022.

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