Summary Report	Near Fatality	11/22/2023

1. Victim: 2-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 near fatality?

The child was residing in a licensed foster home when the following incident occurred:

> On July 24, 2022, the Department of Child Safety received a report regarding a 2-month-old male who was taken to the hospital after becoming unresponsive. Upon examination, the child was determined to be in critical condition with severe head trauma. The child sustained the injuries while in the care of the child's foster parent, Martin Teeter. On October 27, 2023, the Department substantiated the allegation of abuse by Mr. Teeter.

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:

The Department was providing services to the child and his family, as there was an open case resulting from the child being removed from his home on May 23, 2022. The Department's last contact with the child was an in-person visit at his foster home on July 12, 2022.

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 were no prior DCS reports involving Mr. Teeter.

DCS received the following prior report involving the near fatality victim and his mother:

> On May 20, 2022, a report was received alleging neglect to the near fatality victim by his mother. Upon investigation, the child was removed and placed in licensed foster care. The Department filed a dependency petition with the Coconino County Superior Court and is providing services to the family.

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Telephone (602) 255-2500

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 near fatality:

The investigation of the near fatality report resulted in the children being removed from the foster home. The Department substantiated the allegation of abuse by Mr. Teeter. The Department is providing services to the near fatality victim and his mother. No subsequent reports of abuse or neglect were received regarding the 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:

A Circle Together, LLC.

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:

The family foster home license was active from 3/26/21 to 2/22/23.

c. Summary of all violations by the licensee:

None.

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.

None.

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. Upon investigation, the children were removed from the foster home. The Department substantiated the allegation of abuse by Mr. Teeter. The Department is providing services to the near fatality victim and his mother. No subsequent reports of abuse or neglect were received regarding the family.

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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