Summary Report	Near Fatality	6/15/17

1. Victim: 4-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 near fatality?

The child was residing in an out-of-home placement when the following incident occurred:

On March 9, 2016, the Department of Child Safety received a report regarding a 4-month-old baby who was brought to the hospital after appearing lethargic in the foster home where she was being cared for. It was later determined that she had injuries that placed her in critical condition including retinal hemorrhaging and bilateral sub-dural hematomas. The child was in the care of her licensed foster parents, Marina and William McKale, when the injuries occurred. The Department substantiated the allegations of physical abuse pertaining to each of them.

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:

N/A

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?

N/A

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:

N/A

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:

N/A

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:

Casa De Los Ninos

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 out-of-home placement was initially licensed on February 19, 2009 for two children, male or female, ages 0-18 years. The license was restricted during the investigation of the near fatality report to not allow any new placements. The license was closed on November 7, 2016.

c. Summary of all violations by the licensee:

On September 23, 2013, a licensing issue was reported regarding a child in the home having a minor injury received after falling off the top of a bunk bed in the home. The licensing agency put a safety plan in place noting that the child is no longer allowed in the room with the bunk beds.

On December 5, 2015, a report was received alleging neglect to a child in the home by Marina McKale. The allegation was unsubstantiated and the Department required the family to review policy and procedures with their licensing agency.

On March 9, 2016, a report was received regarding the injuries to the near fatality victim. The child was removed from the home and foster family's license was restricted to not allow any new placements. The family later withdrew their license during the investigation.

In June 2016, the following violations were reported as deficiencies on a safety inspection: (1) covers were needed for electrical outlets in the kitchen, (2) items needed to be moved three feet from water heater with temperature set at 120 degrees or below. A follow-up visit in July 2016 determined that the violations had been corrected.

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 Tucson Police Department. The near fatality victim was removed and hospitalized. Upon release from the hospital, she was moved to a new placement. Another child placed in the home was also moved to a new placement. The other children in the home were assessed as safe in the care of the parents.

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.