Arizona Department of Child Safety

Douglas A. Ducey
Governor

Gregory McKay
Director

Summary Report	Near Fatality	6/19/19

1. Victim: 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 near fatality?

The child was residing in her home when the following incident occurred:

On March 17th, 2018, the Department of Child Safety received a report regarding the near fatality of a 2-month-old female. The infant was taken to the hospital after becoming unresponsive. At the hospital, the child presented in critical condition with multiple subdural hemorrhages and hematomas consistent with non-accidental, repetitive injury. On May 21st, 2019, the Maricopa County Superior Court found that the parents, Felicity Mayfield and Abraham Herro, physically abused the child and/or failed to protect the child from physical abuse.

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:

No services were 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:

DCS has received the following prior report involving the near-fatality victim and the mother, Felicity Mayfield:

On January 12, 2018, a report was received alleging neglect to the child by her mother, Felicity Mayfield. The investigation assessed the child as safe with her mother and the allegation was unsubstantiated. The family was offered daycare but refused and the case was closed.

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 child being placed with a relative after release from the hospital. The Department filed a dependency petition with the Maricopa County Superior Court and provided services to the family. No subsequent reports of abuse or neglect have been received.

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. Upon release from the hospital, the near fatality victim was placed with a relative. The Department filed a dependency petition with the Maricopa County Superior Court and provided services to the family. No subsequent reports of abuse or neglect have been 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, 2019.

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