

Michael Wisehart, Interim Director Katie Hobbs, Governor

Summary Report	Near Fatality	03/31/2023

1. Victim: 11-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 his home when the following incident occurred:

On November 23, 2021, the Department of Child Safety received a report regarding an 11-monthold male involved in a near drowning incident. The child was transported to the hospital and determined to be in critical condition. On February 17, 2023, the Department substantiated the allegation of neglect of the child by his mother, Allyson Kozlik.

- 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, Allyson Kozlik was involved in the following prior reports:

On March 7, 2019, a report was received alleging neglect to another child in the home by their father and mother, Allyson Kozlik. The family declined in-home services from the Department. The allegations were unsubstantiated and the case was closed on March 22, 2019.

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On May 2, 2019, a report was received alleging neglect to another child by their father and mother, Allyson Kozlik. The family was provided with information for services available in the community. The allegations were unsubstantiated and the case was closed on July 24, 2019.

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 report regarding the near fatality incident was investigated and the child and a sibling were assessed as safe in the home. The case was transferred for in-home case management. The family declined services and chose to utilize services and resources available in the community. The case was closed on May 3, 2022.

A subsequent report alleging neglect to a sibling was received on September 16, 2022. The family was provided with information on resources available in the community. The children were assessed as safe in the home and the case was closed on September 28, 2022.

- 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 Scottsdale Police Department. The report regarding the near fatality incident was investigated and the child and a sibling were assessed as safe in the home. The family was transferred for in-home case management. The family declined these services and chose to utilize services and resources available in the community. The case was closed on May 3, 2022. A subsequent report alleging neglect to a sibling was received on September 16, 2022. The allegation has been proposed for substantiation and the family was provided with information on resources available in the community. The children were assessed as safe in the home and the case was closed on September 28, 2022.

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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, 2023.

The Department reminds all caregivers to always watch children around water and follow the Arizona Department of Health Services (ADHS) Pool Safety Recommendations.

For more information, please visit the ADHS website at: http://www.azdhs.gov/phs/oeh/pool rules.htm.