



ARIZONA DEPARTMENT of CHILD SAFETY

David Lujan, Cabinet Executive Officer/Executive Deputy Director
Katie Hobbs, Governor

Summary Report	Near Fatality	03/12/2024
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1. Victim: 6-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 June 13, 2022, the Department of Child Safety received a report regarding a 6-month-old male who was taken to hospital after being found unresponsive wedged between an adult bed and a wall. Upon evaluation by EMS, the child was determined to be in serious condition. On January 16, 2024, the Department substantiated the allegation of neglect to the child by his mother, Katherine Arellano.

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:

There has been no prior involvement of the child's parents with DCS.

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:

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The report regarding the near fatality was investigated and the case was closed. The near fatality victim and their sibling were assessed as safe in the home with their parents. The allegation of neglect to the near fatality victim by his mother was substantiated. The Department provided the family with information about services available in the community. 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:

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. The near fatality victim and their sibling were assessed as safe in the home with their parents and the case was closed. The allegation of neglect to the near fatality victim by his mother was substantiated. The Department provided the family with information about services available in the community. No subsequent reports of abuse or neglect were received regarding the family.

The Department reminds all caregivers to practice safe sleep. For additional information please visit the DCS website at: <https://dcs.az.gov/Services/Safe-Sleep>.

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, 2024.