ARIZONA DEPARTMENT of CHILD SAFETY

Michael Wisehart, Interim Director
Katie Hobbs, Governor

Summary Report	Near Fatality	03/30/2023

1. Victim: one-year-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 May 8, 2022, the Department of Child Safety received a report regarding a three-year-old female and a one-year-old female who were taken to the hospital after a motor vehicle accident. Upon evaluation, they were determined to be in critical condition. The children were unrestrained in the vehicle and the one-year-old was on the mother's lap at the time of the accident. On February 17, 2023, the Department substantiated the allegations of neglect by the children's mother, Cameron Olvera.

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:

Upon release from the hospital, the near fatality victims were assessed as safe in the care of the other parent. On February 17, 2023, the Department substantiated the allegations of neglect by the children's mother, Cameron Olvera. The father was provided with information on services available in the community.

A subsequent report alleging neglect by the mother, Cameron Olvera, to a newborn sibling was received on May 9, 2022. The allegation was substantiated and the mother completed in-home services with the Department. The newborn sibling was assessed as safe in the mother's care and the case was closed on November 29, 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 Phoenix Police Department. Upon release from the hospital, the near fatality victims were assessed as safe with their other parent. The Department also investigated a subsequent report of neglect to a newborn sibling. On February 17, 2023, the Department substantiated the allegations of neglect by the children's mother, Cameron Olvera, for both reports. The mother completed in-home services for the newborn sibling and the case was closed on November 29, 2022.

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

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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.

The Department reminds all caregivers to always properly restrain children in vehicles.

For additional information please visit the Arizona Department of Health Services (ADHS) Office of Injury Prevention: A Safe Ride home at: http://www.azdhs.gov/phs/owch/ipcfr/a-safe-ride-home/index.php.

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