



Summary Report	Near Fatality	03/18/2022
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1. Victim: 1-year-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 14, 2021, the Department of Child Safety received a report regarding a 1-year-old male who was taken to the hospital after being found unresponsive at home. Upon examination, the child was determined to be in critical condition due to fentanyl ingestion. On July 14, 2021, a dependency petition was filed with the Maricopa County Superior Court. On October 27, 2021, the court found the mother, Antoinette Malone, failed to protect the near fatality victim.

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:

DCS received the following prior report involving the child's mother, Antoinette Malone, and the near fatality victim:

On January 9, 2020, a report was received alleging neglect to the near fatality victim by his mother, Antoinette Malone. The investigation assessed the child as safe with his mother and the allegation was unsubstantiated. The mother declined child care services offered by the Department and the case was closed on March 13, 2020.

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 a safety plan being implemented with relatives requiring the contact between the parents and child be monitored. An in-home



dependency petition was filed with the Maricopa County Superior Court on July 14, 2021. On October 27, 2021, the court found the mother, Antoinette Malone, failed to protect the near fatality victim. There have been no subsequent reports of abuse or neglect involving this 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. Following an assessment of child safety, a safety plan was implemented with relatives requiring the contact between the parents and child be monitored. An in-home dependency petition was filed with the Maricopa County Superior Court on July 14, 2021. The family is being provided with services. On October 27, 2021, the court found the mother, Antoinette Malone, failed to protect the near fatality victim. There have been no subsequent reports of abuse or neglect involving this family.

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, 2021.

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>.