ARIZONA DEPARTMENT OF CHILD SAFETY

SFY 2018 Annual Fatality/Near Fatality Review Report

Introduction

The Department of Child Safety's (DCS) Office of Ombudsman has a duty to review all fatalities and near fatalities that fall under the responsibility of the agency for the purpose of releasing information to the public as governed by A.R.S. § 8-807.01. This office oversees the Multidisciplinary Review Team (MDRT), which reviews reports of child fatalities and near fatalities due to abuse or neglect. This team was created to support the Department's vision of helping Arizona's children thrive in family environments free from abuse and neglect; support the Department's mission to successfully engage children and families to ensure safety, strengthen families, and achieve permanency; and guarantee compliance with A.R.S. § 8-807.01.

The agency seeks opportunities for improvement and learning to understand what led to an unforeseeable event and the systemic complexities that influence decision-making. Ultimately, the goal is to promote better outcomes for children and families while supporting the workforce who are tasked with making difficult decisions. The review process seeks to understand the contexts in which the decisions were made, and identify opportunities to change those contextual influences in future cases. The process will use a true systems approach to better understand those factors, which influence the quality and delivery of services provided to children and their families. It contributes to organizational learning while addressing issues discovered in individual events, and understanding the underlying systemic issues that influence adverse outcomes. To achieve this objective, the Department has developed Systemic Critical Incident Reviews (SCIR) with the technical assistance of Collaborative Safety, LLC in order to:

1. Discover patterns in the factors that influence decisions and actions in fatality and near fatality cases where the Department had prior involvement;
2. Recommend systemic adjustments to potentially decrease the likelihood of child fatalities and near-fatalities from child abuse or neglect; and
3. Promote an organizational safety culture within DCS by responding to fatality and near fatality cases in a manner that promotes learning, transparency, and employee health.

For this reporting period (July 1, 2017 through June 30, 2018), all fatality and confirmed near fatality reports were reviewed by the MDRT which is comprised of DCS representatives from Practice Improvement, Learning and Development, the Child Abuse Hotline, the Policy Unit, General Counsel, the Prevention Administration and the Office of Child Welfare Investigations (OCWI). The MDRT selected reports for a more comprehensive and robust review to be completed to understand the systemic trends that influence adverse outcomes. During this reporting period, 45 fatalities, near fatalities or critical incidents where chosen for this SCIR and the systemic themes found will be shared later in the report.

Definitions

Alleged Death Due to Abuse:
A report that contains an allegation that a child has died due to the infliction or allowing of physical injury, impairment of bodily function or disfigurement by a parent, guardian, or custodian.

Alleged Death Due to Neglect:
A report that contains an allegation that a child has died due to inability or unwillingness of a parent, guardian or custodian of a child to provide that child with supervision, food, clothing, shelter or medical care if that inability or unwillingness causes unreasonable risk of harm to the child's health or welfare.

Alleged Near Fatality:
A report that contains an allegation that a child is injured, it is believed that the injury is most consistent with a non-accidental injury, and the child is in serious or critical condition because of the injury, as defined by a medical professional.

Substantiated Finding:
A finding, after an investigation and review, that there is sufficient evidence to prove, by a probable cause standard of proof, that the alleged abuse or neglect occurred.

Unsubstantiated Findings:
A finding, after an investigation and review, that there is insufficient evidence to prove, by a probable cause standard of proof, that the alleged abuse or neglect occurred.

Pending Finding:
A report in which a final investigative finding has not yet been entered. This includes but is not limited to reports still actively being investigated, reports that are under administrative review by the Protective Services Review Team or reports in that are pending dependency adjudication proceedings in Juvenile Court.

No Jurisdiction for Investigation:
The information communicated to the Child Abuse Hotline meets the criteria to become a report of abuse or neglect, however DCS is not statutorily authorized to investigate the allegation, such as when the child resides on a Tribal land.

Drowning Tracking Characteristic
Assigned to a DCS report when there is indication that a caretaker did not practice adequate supervision causing the child to drown or nearly drown, and the child is in serious or critical condition; or if a caretaker purposely drown or attempted to drown a child.

Unsafe Sleep Tracking Characteristic:
Assigned to a DCS report where there is an indication that a caretaker did not place a child on his/her back, in a crib, or there is an indication that the caretaker slept with the child causing the child's death, near death, or other serious injury.

Data Sources

This annual summary report includes Child Abuse Hotline report level data from July 1, 2017 through June 30, 2018 extracted from the Children's Information Library and Data System (CHILDS). The summary data presented here describes a small number of Hotline reports (212), and even fewer with prior DCS involvement (111). It is important to note that the data contained in this annual summary is report level data and not child specific data. A report may contain more than one allegation involving multiple children. If seeking more specific information on child level data, please see the most recent Arizona Child Fatality Review Program Annual Report at http://azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/child-fatality-review-annual-reports/cfr-annual-report-2017.pdf. Additionally, caution must be taken when drawing conclusions from a small number of observations, particularly because of the wide variety of circumstances existing in the Hotline reports. The Department will continue to collect and analyze data over time to increase our ability to identify systemic trends that can be targeted for meaningful improvement.

Reports Received Alleging a Fatality or Near Fatality

In this review period, the Department's Child Abuse Hotline received 49,365 reports of child abuse or neglect. Of these, 0.43 percent (212) contained an allegation of child fatality or near fatality due to abuse or neglect. Of these 212 reports, 150 involved a fatality allegation: 40 alleged deaths due to child abuse and 110 alleged deaths due to neglect. Eight of these reports involved a fatality of a child in the custody of DCS. Of the 212 reports, 62 involved a near fatality allegation. One of the near fatality reports involved a child in the custody of DCS. Data regarding allegation findings (i.e. substantiation determinations) will change each reporting period as a result of subsequent decisions based on the parents' rights to due process as well as the completion of investigations and findings. Table 1 provides the total number of reports statewide, by fatality or near fatality allegation, and by current finding for each allegation type.

Table 1. Total Fatality and Near Fatality Reports by Allegation and Finding[1]

	Total Reports in SFY 2018	Substantiated Finding	Unsubstantiated Finding	Pending Finding	No Jurisdiction for Investigation
All Reports Received in SFY 2018					
Total Reports	49,365				
All Fatality/Near Fatality Reports Received in SFY 2018					
Total Reports	212	54	130	22	6
Alleged Death Due to Abuse					
Total Reports	40	10	23	5	2
% of All Reports Received	0.08%	0.02%	0.05%	0.01%	
Alleged Death Due to Neglect					
Total Reports	110	23	75	12	0
% of All Reports Received	0.22%	0.05%	0.15%	0.02%	
Alleged Near Fatality					
Total Reports	62	21	32	5	4
% of All Reports Received	0.13%	0.04%	0.06%	0.02%	

[1] Some of the cases posted this year, in accordance with A.R.S. § 8-807.01, are not reflected in the statistics as substantiated. Substantiation of an allegation of abuse or neglect occurs after an appeal process. In cases where there is a criminal proceeding regarding the allegations of abuse or neglect, the criminal proceeding will serve as the appeal process, and the allegation will not be substantiated until there is a judicial finding of abuse or neglect (either through a guilty plea or a conviction). However, the Department posts fatalities and near-fatalities on its website when an allegation of abuse or neglect has been substantiated against a perpetrator or when the perpetrator has been arrested for the abuse or neglect that led to the fatality or near fatality. Thus, some cases that have been posted in accordance with A.R.S. § 8-807.01 may not have substantiations at this time because the appeal process is still ongoing.

More than half (62 percent) of the 212 Child Abuse Hotline reports that contained an allegation of child fatality or near fatality due to abuse or neglect involved a family residing in Maricopa County, and 8.92 percent involved a family living in Pima County. This distribution is fairly consistent with statewide report volume. Table 2 provides the total number of reports by county in which the report was received.

Table 2. Total Fatality and Near Fatality Reports by County

County	Number of Fatality Reports	Number of Near Fatality Reports	Total Reports	% of Total Reports
APACHE	0	0	0	**0.00%**
COCHISE	1	1	2	**0.94%**
COCONINO	3	2	5	**2.35%**
GILA	1	0	1	**0.47%**
GRAHAM	1	1	2	**0.94%**
GREENLEE	0	0	0	**0.00%**
LA PAZ	0	0	0	**0.00%**
MARICOPA	91	42	133	**62.91%**
MOHAVE	3	1	4	**1.88%**
NAVAJO	3	5	8	**3.76%**
PIMA	17	2	19	**8.92%**
PINAL	7	1	8	**3.76%**
SANTA CRUZ	0	1	1	**0.47%**
YAVAPAI	4	1	5	**2.35%**
YUMA	2	2	4	**1.88%**
UNKNOWN	14	2	16	**7.51%**
OUT OF COUNTRY	1	0	1	**0.47%**
OUT OF STATE	2	1	3	**1.41%**
STATEWIDE	**150**	**62**	**212**	**100%**

Reports of Child Fatality

The DCS Child Abuse Hotline received 150 reports alleging a fatality due to abuse or neglect in this reporting period. Of these, 33 (22 percent) have been substantiated for abuse or neglect, 98 (65.3 percent) have been unsubstantiated, and 17 (11.3 percent) have findings pending. Of the 150 reports, 79 (53 percent) had at least one prior report involving the child or perpetrator, and 17 (22 percent) had at least one prior report and have been substantiated. Of the eight reports involving fatality of a child who was in the custody of DCS, one report was substantiated, two reports are pending a finding, and five reports were unsubstantiated. Reports alleging a fatality may contain multiple allegations of abuse or neglect and substantiation of these reports could be specific to findings not related to the fatality. Table 3 provides the total number of reports of child fatality by prior report and finding.

Table 3. Reports of Child Fatality by Prior Report and Finding

	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of total
With at least one Prior Report	17	49	12	1	79	53%
No Prior Reports	16	49	5	1	71	47%
TOTALS	33	98	17	2	150	100%

Table 4 provides the cause of death as identified by a county medical examiner in each report that was substantiated. Deaths from suffocation/asphyxia/strangulation and undetermined includes deaths resulting from sudden unexplained infant death, which is often related to an unsafe sleep environment.

Table 4. Cause of Death in Reports Substantiated for Abuse or Neglect[2]

Cause of Death	Total # of Reports
Drowning	3
Blunt Force Trauma	8
Gunshot Wound	5
Suffocation/Asphyxia/Strangulation	4
Poisoning	1
Vehicle Related	2
Undetermined	5
Final OME Report Pending	3
Total	31

[2] Two of the report's cause of death was natural but the report was substantiated for other reasons, therefore contributing to the unequal number of substantiated reports compared to cause of death.

Table 5 provides the manner of death as identified by a county medical examiner in each report that was substantiated for abuse or neglect.

Table 5. Manner of Death in Reports Substantiated for Abuse or Neglect[3]

Manner of Death	Total # of Reports
Accidental	12
Undetermined	7
Homicide	9
Suicide	0
Final OME Report Pending	3
Total	**31**

[3] Two of the report's cause of death was natural but the report was substantiated for other reasons, therefore contributing to the unequal number of substantiated report compared to manner of death.

Of the 150 reports alleging a fatality due to abuse or neglect in this reporting period, 32 (21 percent) reports had a tracking characteristic of unsafe sleep, and 11 (7 percent) had a tracking characteristic of a drowning.

Reports of Child Near Fatality

The DCS Hotline received 62 reports involving a near fatality in this reporting period. There was one report involving a near fatality of a child who was in DCS custody at the time of the near fatality incident, and this report was unsubstantiated. Of these 62 reports, 40 (65 percent) alleged a near fatality from neglect. Of the 62 near fatality reports, 21 reports were substantiated, 32 were unsubstantiated, and five are pending a finding. As previously indicated, reports alleging a near fatality may contain multiple allegations of abuse or neglect and substantiation of these reports could be specific to findings not related to the fatality.

Table 6 provides the number of near fatality reports by type of allegation.

Table 6. Type of Near Fatality Allegation

	Substantiated	Unsubstantiated	Pending Finding	No Jurisdiction	Total
Neglect	8	27	2	3	40
Physical Abuse	13	5	3	1	22
Total	**21**	**32**	**5**	**4**	**62**

Of the 62 reports alleging a near fatality, 30 (48 percent) had no prior reports to DCS involving the child or the perpetrator. Table 7 provides the number of near fatality reports by prior reports and investigation finding.

Table 7. Near Fatality Reports where Victims or Perpetrators had a Prior Report

Category	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of total
With at Least One Prior Report	14	12	3	3	32	52%
No Prior Reports	7	20	2	1	30	48%
TOTALS	**21**	**32**	**5**	**4**	**62**	**100%**

Improvement Opportunities

The Department's comprehensive incident review process was first initiated in July 2015, and improved in January 2017 with the development of the Systemic Critical Incident Review (SCIR) process with technical assistance provided by Collaborative Safety, LLC. During this reporting period, the MDRT recommended a comprehensive review of 45 fatality or near fatality reports or critical incidents. The MDRT identified five systemic trends that influenced the practices and decisions made by the Department and are areas for improvement. These areas will continue to be tracked and evaluated to better understand influences that can be addressed for system-wide improvement.

- *Collaboration with Law Enforcement on Fatality/Near Fatality Investigations*: There continues to be a noticeable trend of law enforcement not contacting the Department when investigating a suspicious death or injury to a child. This contributed to delays in the Department's investigation of the events surrounding an incident and the inability to assess the safety any siblings that may have been in the home at the time of the incident.

- *Support for staff to reduce turnover:* As part of the Department's strategic planning, a goal was to develop and retain a highly effective workforce. The Department quickly identified that more efforts were needed to reduce secondary trauma and burnout for DCS staff in order for them to feel successful in the work that they were doing. The Department had little supports internally to achieve this goal and external resources were limited.

- *Assessment of a safe sleeping environment for infants*: Previously, the Department had limited information available to field staff regarding how to assess a safe sleeping environment for infants when working with a family. This led to field staff not feeling supported and/or prepared when

interacting with a family that may be engaging in unsafe sleep practices. Additionally, there were limited resources that the Department could offer a family, therefore field staff had limited options when advocating for an infant to sleep in a safer environment.

- *Education and guidance for teen parents involved with the child welfare system:* The Department identified a need to increase successful transitions for all children older than 14 years old, which includes teen parents and their children. To further support this initiative, the Department found teen parents in care are at high risk for future child abuse or neglect of their children.

- *Delays with Maricopa County Medical Examiners Reports on Fatality Investigations*: The Department continues to experience significant delays in receiving medical examiners reports on child fatalities. The impacts of these delays contribute to untimely completion of DCS investigations. More importantly, lack of timely Office of Medical Examiner (OME) reports limits the Department's ability to conduct a comprehensive safety assessment for surviving children.

Current Improvement Actions and Recommendations

- The OCWI continues to engage various law enforcement agencies around the state to provide education and support regarding joint investigation protocols within their jurisdictions. The OCWI added a Senior Law Enforcement Advisor to build relationships between DCS and law enforcement jurisdictions. This position can also provide trainings to law enforcement agencies and guidance specific to cases. These outreach efforts will continue throughout the next year, and law enforcement agencies are encouraged to contact the Department when they suspect abuse or neglect of a child.

- To support staff in the reduction of secondary trauma and burnout, the Department created the Workforce Resilience Program in May 2018. This team is comprised of DCS professionals from all levels of the organization and regions in the state. The team of peers received specialized training in trauma exposure, stress management and peer support. The team provides a confidential and timely resource to aid DCS employees with the unique challenges of their roles and the impact it can have on personal and professional lives.

- DCS is committed to working with the Governor's Office of Strategic Planning and Budgeting and the Legislature to address compensation strategies. DCS Human Resource exit surveys completed by Child Safety Specialists when they leave employment with DCS continue to reveal that low pay is a key reason for their decision to leave. Currently, Child Safety Specialist starting pay is $33,000 annually.

- To further address this identified trend of assessing infants in unsafe sleep environments, DCS started the safe sleep campaign and Baby Box Program in November 2016. . DCS purchased baby boxes that can be used as an alternative to cribs. These baby boxes are offered to any parents involved with DCS who need a safe place for their infant to sleep. Parents who agree to the program are trained in safe sleep practices and sign a "Commitment Form" stating they have been trained in safe sleep practices and are committed to practicing them. The training curriculum used is in line

with the 2016 Recommendations for a Safe Infant Sleeping Environment from the American Academy of Pediatrics. The Department developed a safe sleep poster for child care centers and area where families gather and as a result has provided these posters free to child care centers, social service agencies, local DCS offices and the Regional Child Abuse Prevention Councils. The Department has also developed an Infant Care Plan in policy which includes information about safe sleep when engaging with parents. In addition, the Department has deployed 1400 tablets which provide staff with the ability to show a safe sleep instructional video with family testimony. In the past year, hundreds of boxes were distributed to DCS offices across the state. DCS expanded this program in 2018 by participating in a free baby box program that requires the use of an online educational tool called Baby Box University: https://www.babyboxuniversity.com. Parents can log in and complete tutorials on safe sleep and injury prevention and are able to get a free baby box, health kit and hygiene items. Other safe sleep materials have been created and shared on the DCS Safe Sleep page: https://dcs.az.gov/Services/Safe-Sleep.

- As a response to this identified trend, the Department hosted a Teen Parent University in which 49 teen parents and their partners attended to gain information and education on well baby, safe sleep, co-parenting, baby brain workshops and support on legal issues. There was also a resource fair that included the following resource tables: Arizona Family Health Partnership, Empowered Young Parents Program, Department of Health Services (DHS), Comprehensive Medical & Dental Program (CMDP), Department of Economic Security, Department of Education (Graduation Program), Eagles Pathway, Family Involvement Center, First Things First, Parent Partners Plus, Phoenix Children's Hospital-Car Seat Safety, Phoenix Children's Hospital-Triple P Parenting, Phoenix Children's Hospital-Water Safety, Rio Salado Community College, Southwest Human Development (Nurse Family Partnership and Parent Partners Plus), Teen Lifeline, and Arizona's Children Association. Additionally, the Department was able to purchase baby books with developmental information and community resources to be given to all teen parents in the Departments custody.

- Due to the identified trend of delayed medical examiners reports, the OCWI has worked diligently with a variety of county Medical Examiner Offices to receive expedited toxicology results to guide the Department’s investigation surrounding a suspicious child fatality while waiting for the final OME report. The OCWI will continue to collaborate with all Medical Examiner offices around the state to find a solution to address this need.