



ARIZONA DEPARTMENT OF CHILD SAFETY

SFY 2022 Annual Fatality/Near Fatality Review Report

Introduction

The Department of Child Safety's (DCS) Office of Accountability (OAC) 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](#). The OAC 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, parents, families and community 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 engages in a Systemic Critical Incident Review (SCIR) process 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 a culture of psychological safety 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, 2021 through June 30, 2022), all fatality and near fatality reports were reviewed by the MDRT which is comprised of representatives from the following teams: DCS Safety Analysis Review Team, Hotline/Intake, Practice Improvement, DCS General Counsel, Attorney General's Office, Office of Child Welfare Investigations, DCS Policy Unit, DCS Comprehensive Health Plan, Protective Services Review Team, Learning and Development, Victim Services, and the Office of Prevention. 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, 35 fatalities, near fatalities or critical incidents were chosen for a SCIR and the systemic themes found will be shared later in this 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, 2021 through June 30, 2022). The summary data presented here describes a small number of Hotline reports (177), and even fewer with prior DCS involvement (72). 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. Therefore, the substantiated allegation may not be related to the allegation of fatality or near fatality. If seeking more specific information on child level data, please see the most recent Arizona Child Fatality Review Program Annual Report at www.azdhs.gov/documents/director/agency-reports/child-fatality-review-report.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 45,590 reports of child abuse or neglect. Of these, 177 (0.39 percent) reports contained an allegation of child fatality or near fatality due to abuse or neglect. Of these 177 reports, 160 involved a fatality allegation: 33 alleged deaths due to child abuse and 127 alleged deaths due to neglect. Eleven of these reports involved a fatality of a child in the custody of DCS. Of the 177 reports, 17 involved a near fatality allegation. There were no near fatality reports that 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 Alleged Fatality and Near Fatality Reports by Allegation and Finding¹

	Total Reports in SFY 2022	Substantiated Finding	Unsubstantiated Finding	Pending Finding	Unable to Locate ²
All Reports Received in SFY 2022					
Total Reports	45,590				
All Fatality/Near Fatality Reports Received in SFY 2022					
Total Reports	177	5	111	59	2
Alleged Death Due to Abuse					
Total Reports	33	1	19	13	0
% of All Reports Received	0.07%	0.002%	0.04%	0.03%	
Alleged Death Due to Neglect					
Total Reports	127	3	83	39	2
% of All Reports Received	0.28%	0.007%	0.18%	0.09%	.004%
Alleged Near Fatality					
Total Reports	17	1	9	7	0
% of All Reports Received	0.04%	0.002%	0.02%	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.

² This finding is entered by field personnel when they are unable to engage the family during the assessment.

More than half (63.8 percent) of the 177 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 15.8 percent involved a family living in Pima County. This breakdown is similar to non-fatality/near fatality report distribution for those two counties. Table 2 provides the total number of reports by county in which the report was received.

Table 2. Total Alleged Fatality and Near Fatality Reports by County

County	Number of Fatality Reports	Number of Near Fatality Reports	Total Reports	% of Total Reports
APACHE	1	0	1	0.56%
COCHISE	1	0	1	0.56%
COCONINO	3	0	3	1.69%
GILA	3	0	3	1.69%
GRAHAM	0	0	0	0.00%
GREENLEE	0	0	0	0.00%
LA PAZ	1	0	1	0.56%
MARICOPA	101	13	114	63.84%
MOHAVE	3	1	4	2.26%
NAVAJO	1	1	2	1.13%
PIMA	27	0	27	15.82%
PINAL	14	0	14	7.91%
SANTA CRUZ	0	0	0	0.00%
YAVAPAI	3	0	3	1.69%
YUMA	3	1	4	2.26%
UNKNOWN	0	0	0	0.00%
OUT OF COUNTRY	0	0	0	0.00%
OUT OF STATE	0	0	0	0.00%
STATEWIDE	160	17	177	100%

Reports Alleging Child Fatality

The DCS Child Abuse Hotline received 160 reports alleging a fatality due to abuse or neglect in this reporting period. Of these, 5 (3.1 percent) have been substantiated for abuse or neglect, 101 (63.1 percent) have been unsubstantiated, and 51 (31.9 percent) have findings pending. Of the 160 reports, 65 (40.6 percent) had at least one prior report involving the child or perpetrator. The eleven reports involving the fatality of a child who was in the custody of DCS six were unsubstantiated and the remaining five reports are pending. 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. For example, the surviving siblings could be found dependent for parental substance abuse or conditions of the home that would be unrelated to the fatality allegations. Table 3 provides the total number of reports of child fatality by prior report and finding.

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

	Substantiated	Unsubstantiated	Pending	Unable to Locate	TOTALS	% of Total
At least one Prior Report	2	43	18	2	65	40.6%
No Prior Reports	3	60	33	0	95	59.4%
TOTALS	5	103	51	2	160	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

Cause of Death	Total # of Reports
Gunshot Wound	1
Environmental Heat Exposure	1
Fentanyl Toxicity	1
Anemia due to Chronic Pediculosis	1
Blunt Force Injuries	1
Drowning	1
Total	6

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

Manner of Death	Total # of Reports
Accidental	2
Undetermined	3
Homicide	1
Suicide	0
Natural	0
Total	6

Of the 160 reports alleging a fatality due to abuse or neglect in this reporting period, 53 (33.1 percent) reports had a tracking characteristic of unsafe sleep, and 29 (18.1 percent) had a tracking characteristic of a drowning.

Reports Alleging Child Near Fatality

The DCS Child Abuse Hotline received 17 reports involving a near fatality in this reporting period. Of these 16 reports, 14 (87.5 percent) alleged a near fatality from neglect and 2 (12.5 percent) alleged a near fatality from abuse. Of the 16 near fatality reports, 10 were unsubstantiated, and 6 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 near fatality. Table 6 provides the number of near fatality reports by type of allegation.

Table 6. Reports Alleging Near Fatality by Finding

	Substantiated	Unsubstantiated	Pending Finding	No Jurisdiction	Total
Neglect	0	8	6	0	14
Physical Abuse	0	2	0	0	2
Total	0	10	6	0	16

Of the 16 reports alleging a near fatality, 9 (56.3 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. Reports Alleging Near Fatality by Prior Report and Finding

Category	Substantiated	Unsubstantiated	Pending	No Jurisdiction	TOTALS	% of total
With at Least One Prior Report	0	5	1	0	7	43.8%
No Prior Reports	0	5	2	0	9	56.3%
TOTALS	0	10	3	0	16	100%

Improvement Opportunities

During this reporting period, the MDRT recommended a comprehensive review of 35 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 monitored 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 trend of law enforcement not contacting the Department timely when investigating a suspicious death or injury to a child. The delays range from several hours to several days. This contributed to delays in the Department’s investigation of the events surrounding the incident and the inability to assess the safety any siblings that may have been in the home at the time of the incident.
- *Increase support for staff:* As part of the Department’s strategic planning, a goal is to create a DCS culture that fosters and inspires mission-driven professionals who believe in and practice the Department’s shared values. The Department is committed to creating a learning and coaching mindset and behavioral integrity across the agency.
- *Supportive Services for Teen Substance Use:* The Department has seen an increase in teen substance use, especially involving fentanyl. The Department is dedicated to creating a process to expedite supportive services to youth known to be using substances.
- *Delays with Medical Examiners Reports on Fatality Investigations:* The Department continues to experience significant delays in receiving medical examiners’ reports on child fatalities. The impact 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

- OCWI's outreach efforts have included attending and presenting joint investigative trainings to multidisciplinary teams across the state. These multidisciplinary teams include the local law enforcement agencies. OCWI has also met with various partners involved in the joint investigative process to include medical providers, educators, child advocate teams and victim services, as well as collaboration with each county to update their joint investigative protocols.
- The Department collaborated with the Arizona Prosecuting Attorney's Advisory Counsel to update and standardize Mandated Reporter training.
- The Department continues to utilize the Workforce Resilience program to support staff in the reduction of secondary trauma and burnout. This team is comprised of 68 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 provided over 1000 confidential and timely resources to aid DCS employees over this reporting period. The program implemented automatic outreach to any staff responding to a fatality or near fatality report. This outreach allows staff to process any trauma or stress they are feeling. The program also created "mindful moments" for any staff that need to step away from the work and refresh/reset. This support is available to all areas of the Department and to all levels of staff. Additional supports outside of DCS are provided as needed.
- It is a part of the DCS Office of Prevention's strategic plan to ensure that every Arizona family has access to a car seat or booster for infants and/or children. The Office of Prevention facilitates a Car Seat Program, which collaborates with community agencies about the importance and correct use of car seats, booster seats, and restraints. The Office of Prevention provides car seats and trainings to community agencies, who ensure the information is shared with those that receive the gift of a car seat. There are currently 22 community agencies that collaborate with the DCS car seat education and distribution program. Due to the number of child fatalities in recent years from children being unrestrained, The DCS Office of Prevention will utilize State and Federal funds to expand the Car Seat Program. The Office of Prevention will collaborate with Phoenix Fire, International Rescue Committee, RICE AZ and Arizona Helping Hands to ensure that all families in need of a car seat can be provided one within their community. Intentional efforts are being made to ensure that underserved communities have access to these resources as often as needed therefore discussions are being had to incorporate local churches and teen parenting agencies into this car seat program.

In response to the continued unsafe sleep fatalities in Arizona, the Office of Prevention continued the Safe Sleep campaign to promote safe sleep practices and reduce the number of sleep-related deaths. The Safe Sleep Campaign focuses on training DCS Specialists and contracted providers to address safe sleep practices with families who have children under one year of age. The Safe Sleep Campaign includes the provision of baby boxes for families involved with DCS in need of a safe place for their infant to sleep but will be transitioning to Pack N Plays alongside the Arizona Department of Health Services. Due to large disproportionalities in co-sleeping deaths, intentional

efforts are being made to engage African American, Hispanic and Refugee communities in safe sleep awareness. Since April 2022, DCS Office of Prevention began participating in cultural orientation workshops with International Rescue Committee, a refugee resettlement agency, to discuss safe sleep practices and distribute Baby Boxes as needed. Along with the baby box, the parent is able to watch awareness videos found on the DCS website about Safe Sleep, which is consistent with the recommendations for a safe infant sleeping environment from the American Academy of Pediatrics. The main message that is taught during the online training is the ABC's of safe sleep; baby sleeps safest alone, on their back, and in a crib. The Office of Prevention participates in the Statewide Safe Sleep Taskforce, who is currently discussing the creation and implementation of a statewide safe sleep training for all community and service providers.

The DCS Office of Prevention continues its baby box partnership with one of the Regional Child Abuse Prevention Council Agencies, Three Precious Miracles, which represents communities on Native Tribal Lands. The collaboration allows DCS to provide safe sleep resources and education to communities as Native American babies are over represented in the unsafe sleep death data. This year Newfound Hope was added to this partnership as they also serve the Native American community. Furthermore, DCS Office of Prevention continues its collaboration with local health care facilities to provide baby boxes to new parents without a safe sleep environment. DCS Office of Prevention is looking to partner with Arizona Department of Health Services to collectively spread the message of safe sleep practices in a unified format. In addition to the boxes, community partners are encouraged to provide safe sleep education and review the "Don't wake Up to a Tragedy" safe sleep checklist when providing a baby box to a family. DCS Office of Prevention plans to continue expanding the baby box program by partnering with additional community agencies and health clinics. During Safe Sleep month, DCS runs safe sleep add campaign.