ARIZONA DEPARTMENT OF CHILD SAFETY

SFY 2024 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 partner with families, caregivers, and the community to strengthen families, ensure safety, and achieve permanency for all Arizona's children through prevention, services, and support; 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, 2023 through June 30, 2024), 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, 15 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.

Data Sources

This annual summary report includes Child Abuse Hotline report level data from July 1, 2023 through June 30, 2024). The summary data presented here describes a small number of Hotline reports (153), and even fewer with prior DCS involvement (76). 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. 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 42,566 reports of child abuse or neglect. Of these, 153 (0.36 percent) reports contained an allegation of child fatality or near fatality due to abuse or neglect. Of these 153 reports, 143 involved a fatality allegation: 46 alleged deaths due to child abuse and 97 alleged deaths due to neglect. Of the 153 reports, 10 involved a near fatality allegation. 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 Finding[1]

	Total Reports in SFY 2023	Substantiated Finding	Unsubstantiated Finding	Pending Finding	Unable to Locate
All Reports Received in SFY 2023					
Total Reports	42,566				
All Fatality/Near Fatality Reports Received in SFY 2023					
Total Reports	153	4	112	37	1
Alleged Death Due to Abuse					
Total Reports	46	0	30	15	1
% of All Reports Received	0.11%	0.00%	0.07%	0.04%	0.002%
Alleged Death Due to Neglect					
Total Reports	97	4	73	20	0
% of All Reports Received	0.23%	0.01%	0.17%	0.05%	.00%
Alleged Near Fatality					
Total Reports	10	0	8	2	0
% of All Reports Received	0.02%	0.00%	0.02%	0.004%	0.00%

[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 (61.44 percent) of the 153 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 16.99 percent involved a family living in Pima County. 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	2	0	2	**1.31%**
COCHISE	2	1	3	**1.96%**
COCONINO	2	1	3	**1.96%**
GILA	0	0	0	**0.00%**
GRAHAM	0	0	0	**0.00%**
GREENLEE	0	0	0	**0.00%**
LA PAZ	1	1	2	**1.31%**
MARICOPA	90	4	94	**61.44%**
MOHAVE	3	0	3	**1.96%**
NAVAJO	4	0	0	**2.61%**
PIMA	25	1	26	**16.99%**
PINAL	8	2	10	**6.54%**
SANTA CRUZ	0	0	0	**0.00%**
YAVAPAI	2	0	2	**1.31%**
YUMA	4	0	4	**2.61%**
UNKNOWN	0	0	0	**0.00%**
OUT OF COUNTRY	0	0	0	**0.00%**
OUT OF STATE	0	0	0	**0.00%**
STATEWIDE	**143**	**10**	**153**	**100%**

Reports Alleging Child Fatality

The DCS Child Abuse Hotline received 143 reports alleging a fatality due to abuse or neglect in this reporting period. Of these, 4 (2.8 percent) have been substantiated for abuse or neglect, 103 (72 percent) have been unsubstantiated, 35 (24.5 percent) have findings pending, and 1 (.7 percent) was unable to locate. Of the 143 reports, 76 (53 percent) had at least one prior report involving the child or perpetrator. 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	3	48	24	1	**76**	53%
No Prior Reports	1	55	11	0	**67**	47%
TOTALS	4	103	35	1	**143**	100%

Reports Alleging Child Near Fatality

The DCS Child Abuse Hotline received 10 reports involving a near fatality in this reporting period. Of these 10 reports, 8 (80 percent) alleged a near fatality from neglect and 2 (20 percent) alleged a near fatality from abuse. Of the 10 near fatality reports, 8 were unsubstantiated, and 2 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 4 provides the number of near fatality reports by type of allegation.

Table 4. Reports Alleging Near Fatality by Finding

	Substantiated	Unsubstantiated	Pending Finding	No Jurisdiction	Total
Neglect	0	7	1	0	8
Physical Abuse	0	1	1	0	2
Total	**0**	**8**	**2**	**0**	**10**

Of the 10 reports alleging a near fatality, 6 (60 percent) had no prior reports to DCS involving the child or the perpetrator. Table 5 provides the number of near fatality reports by prior reports and investigation finding.

Table 5. 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	3	1	0	4	40%
No Prior Reports	0	5	1	0	6	60%
TOTALS	**0**	**8**	**2**	**0**	**10**	**100%**

Improvement Opportunities

During this reporting period, the MDRT recommended a comprehensive review of 15 fatality or near fatality reports or critical incidents. The MDRT identified four 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.

- *Increased awareness of the System of Care coordinators (SOCC).* The Department experiences barriers with different behavioral health providers including hospitals, in-patient providers and outpatient providers, when navigating services for children in DCS custody. To support field staff in meeting youth's behavioral health needs, there have been improvements in locating and utilizing the internal system of care coordinators (SOCC). SOCCs provide consultation and technical assistance to Department staff and facilitate collaboration between the Department and behavioral health system.

- *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 months; including one instance of a report delay for over eight months. 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. This is accomplished through the promotion of a culture of safety. A culture of safety includes open communication, a team approach to problem solving and a commitment to continuous quality improvement. Additionally, the Department is committed to providing staff with opportunities for career development and professional advancement to continue to grow a skilled an competent workforce.

- *Supportive Services for Teens in care*: The Department continues to see an increase in teen substance use, especially involving fentanyl. To increase the participation of youth in the Arizona Families FIRST substance abuse program, the Department created incentives for youth who met the programmatic milestones of sobriety, employment, education, and housing. The Department continues to navigate behavioral health services for children in care with support from SOCC's. Additionally, the Department has increased supports available for youth who have experienced trafficking by increasing utilization of the DCS CReST Coordinators and Strength Specialists, internal DCS employees who receive additional training and resources to work with children who are suspected or confirmed to be survivors of human trafficking. The Department also continues to provide education and support to caregivers to help ensure youth have opportunities for normalcy activities, especially after school or school related sports and clubs, as participation in normalcy activities has been shown to decrease substance use in youth.

- *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 and accessible 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 continues to utilize the Workforce Resilience program to support staff in the reduction of secondary trauma and burnout. This team is comprised of 64 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 continues to provide 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.

- The Office of Prevention continues to facilitate a Car Seat Program to ensure that every Arizona family has access to a car seat. The Car Seat Program facilitates training for DCS staff and community agencies on 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. This year we increased our community agency partnership from 39 to 54. This expansion included 2 Family Resource Centers, 4 Elementary Schools, and 1 Early Learning Center.

- The DCS Office of Prevention continues to raise awareness about Safe Sleep practices. During this fiscal year, transitioned to Playard distribution to align with Arizona Department of Health Services (ADHS). The Safe Sleep Program promotes safe sleep practices to reduce the number of sleep-related deaths. The awareness campaign highlights the ABCs of Safe Sleep: Alone, Back, Crib. The Office of Prevention utilizes Out of Home digital billboards on several commonly used highways that reaches millions of people statewide. As in past year, we contract with a marketing agency to place Safe Sleep awareness posters in OB/GYN and pediatrician offices. This year we authored print media articles, sponsored social media ads and short local television interview segments. DCS Office of Prevention partnered with ADHS to create a standard training on safe sleep that is available for providers, community partners and child care facilities to utilize when training caregivers on safe sleep. The training is housed on the ADHS and DCS webpages.

- The Department's Safety Analysis Review Team (SART) has continued to work with the National Partnership for Child Safety (NPCS), whose mission is improving safety and prevent child maltreatment related fatalities by strengthening families and promoting innovations in child protection. NPCS assisted the Department in completing the first iteration of the TeamFirst Assessment of Safety Culture. This created a baseline data set for the Department to better understand employees' perceptions of safety culture and allows for the Department to understand how these perceptions change over time and direct efforts to promote a learning culture.

- The Department, with support from Casey Family Programs, has partnered with Collaborative Safety, who has provided technical assistance to SART to further support systemic critical incident reviews. Collaborative Safety and DCS also conducted a mapping as a method of root cause analysis, which assisted in development of strategies for the CFSR PIP. Additionally, Collaborative Safety has provided Executive Leadership with training to assist in deepening in the integration of safety science and a culture of learning as outlined in the DCS Strategic Plan. This partnership and additional training will continue into SFY 25.