



Summary Report	Fatality	12/10/15
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1. Victim: Diesel Henagar 2-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 fatality?

The child was residing in his home when the following incident occurred:

On June 21, 2015, the Department of Child Safety received a report regarding a near drowning. Diesel was with his father at a friend's home. All adults in the home, including father, lost track of Diesel. Diesel was eventually located in the pool and 911 was called. The pool was gated but still accessible due to the gate being damaged. Diesel was transported to the hospital and later died on June 26, 2015. The DCS investigation determined that the incident was the result of neglect due to insufficient supervision. The department substantiated the allegation of neglect.

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:

No services were being provided to the family by the Department of Child Safety at the time of the June 21, 2015 fatality 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:

On March 9, 2014, a report was received alleging physical abuse to Diesel by the mother's boyfriend at the time. The investigation assessed the child to be safe. The allegation was unsubstantiated and the case was closed.

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 fatality:

The DCS investigation determined that the incident was the result of neglect due to insufficient supervision. The department substantiated the allegation of neglect. No subsequent reports of abuse or neglect have been received.

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 DCS investigation determined that the incident was the result of neglect due to insufficient supervision by the child's father. The Department substantiated the allegation of neglect and the case was closed.

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, which 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 September 1, 2016.

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>

The Department reminds all caregivers to always watch children around water and follow the Arizona Department of Health Services (ADHS) Pool Safety Recommendations.

For more information, please visit the ADHS website at: http://www.azdhs.gov/phs/oeh/pool_rules.htm