



Summary Report	Fatality	1/28/16
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1. Victim: Paula Harvey – 18 month old – female

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 her home when the following incident occurred:

On June 30, 2015, the Department of Child Safety received a report that paramedics responded to a call regarding an 18 month old female who was having trouble breathing and was unresponsive. The child was taken to the hospital. It was learned that the child sustained an occipital hematoma to her head, retinal hemorrhages and a retinal detachment. Paula died from her injuries on 07-02-15. The fatality victim had been in the care of her step-father, William Defour. The Department substantiated the allegation as to William Defour.

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 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 January 19, 2014, a report was received alleging physical abuse and neglect by the mother to Paula's sibling. Although Paula was not listed as victim in this report she was seen and assessed as safe by the Department. The case was open pending all necessary documentation when the fatality report was received. The allegations were ultimately unsubstantiated.

There has been no prior DCS involvement with William Defour.

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 into the fatality report resulted in the Department substantiating the allegations as to Richard Defour. Following an assessment of child safety, a sibling was removed from the home and placed in a licensed DCS placement. The DCS filed a dependency petition with



the Pima County Juvenile Court. The Department is providing services to the family. 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 of the fatality report resulted in the Department substantiating the allegations as to Richard Defour. Following an assessment of child safety, a sibling was removed from the home and placed in a licensed DCS placement. The DCS filed a dependency petition with the Pima County Juvenile Court. The Department is providing services to the 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 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>.