



Summary Report	Fatality	6/16/16
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1. Victim: Savanna Nance – 2-day-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 24, 2015, the Department of Child Safety received a report regarding 2-day-old Savanna Nance who was found unresponsive at home after co-sleeping with her father, Dennis Nance. The investigation determined that the father was under the influence of prescription pain medications when he fell asleep holding the baby on his chest in a reclining chair. The baby was later found wedged between the father and the chair and the Office of the Medical Examiner ruled the cause of death as probable asphyxia due to wedging. The Department substantiated the allegation that Dennis Nance neglected the baby by failing to provide a safe environment and adequate supervision when he fell asleep with her in the chair while under the influence of prescription medications.

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:

There has been no prior involvement of the child's parents with DCS in the five years preceding the incident.

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 investigation of the fatality report initially assessed the other children in the home as safe with the parents with a safety plan in place. A subsequent report was received on December 15, 2015 alleging neglect to the siblings by the parents. The investigation of this report resulted in the children being removed and placed in foster care. The Department filed a dependency petition with the Maricopa County Juvenile Court and is providing services to the family.



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 Department conducted a joint investigation with the Maricopa County Sheriff's Office. The other children in the home were initially assessed as safe with the parents with a safety plan in place. A subsequent report was received on December 15, 2015 alleging neglect to the siblings by the parents. The investigation of this report resulted in the children being removed and placed in foster care. The Department filed a dependency petition with the Maricopa County Juvenile Court and 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>.