Arizona Child Fatality Review Team

AZ DEPARTMENT OF HEALTH SERVICES

33rd Annual Child Fatality Review Program Report

November 15, 2026

Mission: To reduce preventable child fatalities in Arizona through a systematic, multidisciplinary, multi-agency, and multi-modular review process. This report provides prevention strategies, interdisciplinary training, community-based education, and data-driven recommendations to inform legislation and public policy.



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Dedication:

We dedicate this report to the memory of the children and families represented within these pages. Their stories inspire us to continue working to improve the health of all children in Arizona.

Acknowledgments:

The Arizona Department of Health Services (ADHS) would like to acknowledge Dr. Mary Rimsza, MD, founding member and Chair of the Arizona Child Fatality Review Program (CFRP), and Susan Newberry, MEd, founding member and Arizona CFRP Contractor.

ADHS would also like to acknowledge the ten local CFRP teams and their coordinators in Arizona, whose persistent efforts ensured that 100.0 percent of child fatality reviews were conducted, thereby aiding the development of prevention recommendations. Additionally, ADHS would like to acknowledge the Sudden Unexpected Infant Death (SUID)/Undetermined and Neglect/Abuse deaths second-level review teams, who review cases that are classified as SUID/Undetermined or Neglect/Abuse deaths by the local CFRP teams to ensure proper classification. Second-level reviews of SUID/Undetermined and Neglect/Abuse deaths are done at the state level by subcommittees of the State Team. A complete list of second-level and local CFRP review members is in Appendix B. All child deaths in Arizona are reviewed to determine steps, if any, that could have prevented the child's death from occurring. It is the expertise and extensive experience of all our local and state team members within the program that make this report possible.

Lastly, the CFRP acknowledges the 22 Tribal Nations who have stewarded this land since time immemorial, recognizing their peoples, cultures, and histories.

ADHS aspires to present data humbly, recognizing that numbers never tell the whole story. We strive to work with individuals and communities to learn from and share their stories, thereby improving collective understanding. Recognizing that people across diverse life circumstances face inequitable opportunities to achieve optimal health, we commit to pairing numbers and stories to inform policy and systems change, ultimately improving health for all.

Photo Credit:

Harv Greenberg took the image on the front cover and section covers. You can view the photograph on the official Harv Greenberg Photography Website.

Submitted To:

The Honorable Katie Hobbs, Governor, State of Arizona
The Honorable Warren Petersen, President, Arizona State Senate
The Honorable Steve Montenegro, Speaker, Arizona State House of Representatives
This report is provided as required by A.R.S. §36-3501. C.3.

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Intended Audience:

This is a technical report on the analysis of the incidence and causes of infant and child deaths in Arizona. This report is primarily aimed at those actively improving child and infant health, including healthcare providers, policymakers, participating agencies, schools, community-based organizations, researchers, families, caregivers, and other relevant stakeholders. The key findings presented in this report should assist in the identification of future targets for intervention and guide effective and evidence-based efforts toward the reduction of preventable deaths for our Arizona children.

This publication can be made available in alternative formats. Contact the CFRP at (602) 543-1875. Individuals with hearing or speech challenges may dial 711 for relay services. For questions, contact aeval@azdhs.gov.

Disclaimers to the Annual Report

Public Health and Vital Statistics:

This report's data may differ from that published by the Business Intelligence Office (BIO). BIO only reports data on Arizona residents, whereas the CFRP investigates and reports on the deaths of all children who die in Arizona, regardless of state residency.

Department of Child Safety (DCS)/Child Protective Services (CPS):

This report's data may differ from that published by the Department of Child Safety (DCS) / Child Protective Services (CPS), as the CFRP and DCS/CPS have different definitions of child Neglect/Abuse. The CFRP works closely with DCS/CPS to further improve our surveillance of child Neglect/Abuse. A more detailed explanation, including the DCS definition of neglect and abuse, is available in Appendix A.

Race/Ethnicity Referencing:

The variables for race and ethnicity are based on specifications established by the Federal Office of Management and Budget (OMB), the Arizona State Demographer, and the ADHS Vital Statistics. Consistent with the OMB methodology, the web-based reporting system supports multiple race categories, as in U.S. Census enumerations [1]. For instance, individuals were asked to provide their ethnicity (such as Hispanic or Latino and/or Non-Hispanic or non-Latino) and race according to standard race categories (such as White, Black/African American, American Indian/Alaska Native, Asian/Pacific Islander). Additionally, if none of the OMB categories apply, selecting "Other" allows providers to enter specific race designations [1].

This year's report continues by combining, or bridging, race/ethnicity for individuals identified as Hispanic and another race, a practice introduced in the 2012 Arizona Health Status and Vital Statistics Report [2]. In this method, individuals identified as Hispanic plus another race are included in the race/ethnicity category with the lowest population in the state. This approach to bridging is defined as the smallest-group-deterministic whole method [2]. In this method, individuals identified as both White and Hispanic are classified as Hispanic. In contrast, individuals identified as Hispanic and any other race (Black or African American, American Indian or Alaska Native, and/or Asian or Pacific Islander) are categorized by their racial identification. This method allows us to match the categories of race/ethnicity used by the Arizona Department of Administration (ADOA) to create the population projections used as denominators in this report, as well as to create more meaningful racial/ethnic categories by placing individuals identified with both race and ethnicity into the group representing a smaller proportion of Arizona's population.

Due to spacing constraints, figures throughout the report will refer to the following racial/ethnic groups: American Indian, Asian, Black, Hispanic, and White. However, please note that American Indians include Alaska Natives, Asians include Pacific Islanders, Blacks include African Americans, and Hispanics include Latinos. All text accompanying the figures will be inclusive.

Data Suppression:

To protect the identities of individuals and their families, non-zero counts of fewer than six are suppressed. Percentages are not calculated for these suppressed values.

Prevention Recommendations:

The prevention recommendations developed by the CFRP State Team do not reflect the official views of ADHS or the State of Arizona. The recommendations presented in this report are based on input from the local review team, a literature review conducted by the CFRP, and analysis from the state CFRP team.

Additionally, state agencies identified in the recommendations were not formally consulted during their development to verify existing policies, programs, or practices. As such, some recommendations may address activities already being implemented or may benefit from additional technical clarification regarding agency responsibilities and implementation considerations. These recommendations are intended to identify opportunities for continued prevention and system improvement and should not be interpreted as findings of agency noncompliance or inadequate performance.

Urban and Rural Area Designation:

For this report, the following areas in Arizona were classified as urban: the Phoenix-Scottsdale-Mesa Metropolitan Statistical Area (comprising Maricopa and Pinal Counties), the Tucson Metropolitan Statistical Area (Pima County), and the Yuma Metropolitan Statistical Area (Yuma County). The remaining counties (Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Mohave, Navajo, Santa Cruz, and Yavapai) were considered rural [2].

Infant Mortality and SUID Mortality Rate Reporting:

In previous reports, the population denominator used to calculate infant and SUID mortality rates included the number of live births in Arizona among Arizona residents in the reported year. However, as determined by A.R.S. §36-3501, CFRP investigates and reports the deaths of all children who die in Arizona regardless of state residency. To ensure rates were calculated correctly, the population denominator was recalculated to include live births in Arizona, regardless of residency, dating back to 2014. As such, the rates reported here may differ from previously reported figures. Using the correct population denominator gives a more accurate representation of both infant and SUID mortality rates.

Prematurity Mortality Rate Reporting:

In previous reports, the population denominator used to calculate the prematurity mortality rate included the number of premature births among Arizona residents. However, as determined by A.R.S. §36-3501, CFRP investigates and reports the deaths of all children who die in Arizona regardless of state residency. To ensure accurate rate calculations, the population denominator was recalculated to include all premature births in Arizona, regardless of residency, dating back to 2015. As a result, the rates presented in this report will differ from those published in earlier reports. Using the correct population denominator gives a more accurate representation of the prematurity mortality rates in Arizona.

Congenital Syphilis Rate Reporting:

The congenital syphilis and sexually transmitted disease (STD) data in this report may differ from those published by the STD Control Team at ADHS. This team conducts surveillance and monitors sexually transmitted diseases in Arizona, using the ADHS STD Control Program (STDCP) surveillance system, PRISM (Patient Reporting Investigation Surveillance Manager). In contrast, CFRP investigates all child deaths identified through vital records and records submitted by the local teams. Due to these differing methodologies, the congenital syphilis and STD data are not directly comparable.

Acronyms

- AAP – American Academy of Pediatrics
- ACEs – Adverse Childhood Experiences
- ACOG – American College of Obstetricians and Gynecologists
- ADE – Arizona Department of Education
- ADHS – Arizona Department of Health Services
- ADOA – Arizona Department of Administration
- ADOT – Arizona Department of Transportation
- AHCCCS – Arizona Health Care Cost Containment System
- AIM – Alliance for Innovation on Maternal Health
- APAL – Arizona Perinatal Access Line
- A.R.S. – Arizona Revised Statutes
- ASH Line – Arizona Smokers Helpline
- ATV – All-Terrain Vehicle
- AZEIP – Arizona Early Intervention Program
- AZ – Arizona
- BCDHP – Bureau of Chronic Disease and Health Promotion
- BEMSTS – Bureau of Emergency Medical Services and Trauma System
- BIDS – Bureau of Infectious Disease and Services
- BIO – Business Intelligence Office
- BIZS – Bureau of Immunizations
- BWCH – Bureau of Women's and Children's Health
- CDC – Centers for Disease Control and Prevention
- CFR – Child Fatality Review
- CFRP – Child Fatality Review Program
- CPR – Cardiopulmonary Resuscitation
- CPS – Child Protective Services
- DCS – Arizona Department of Child Safety
- DDD – Arizona Division of Developmental Disabilities
- DPS – Arizona Department of Public Safety
- DUI – Driving Under the Influence
- EMCT – Emergency Medical Care Technicians
- EMT – Emergency Medical Technician
- EMS – Emergency Medical Services
- GOHS – Arizona Governor's Office of Highway Safety
- IHS – Indian Health Services
- IPAC – Injury Prevention Advisory Council
- ITCA – Inter-Tribal Council of Arizona
- MVC – Motor Vehicle Crash
- NHTSA – National Highway Traffic Safety Administration
- NRT – Nicotine Replacement Therapy
- OAR Line – Opioid Assistance Referral Line
- OEO – Arizona Office of Economic Opportunity
- OHV – Off-Highway Vehicle
- OMB – Federal Office of Management and Budget
- OTC – Over the Counter

- PRISM – Patient Reporting Investigation Surveillance Manager
- PROM – Premature Rupture of Membranes
- RFGA – Request for Grant Application
- RHTP – Rural Health Transformation Program
- SACLAz – Substance Abuse Coalition Leaders of Arizona
- SEN – Substance Exposed Newborn
- STD – Sexually Transmitted Disease
- STI – Sexually Transmitted Infection
- STDCP – Sexually Transmitted Disease Control Program
- SUID – Sudden Unexpected Infant Death
- SUV – Sports Utility Vehicle
- TANF – Temporary Assistance for Needy Families
- TAPI – The Arizona Partnership for Immunization
- USA – United States of America
- UTV – Utility Terrain Vehicle
- WIC – Women, Infants, and Children

Glossary

- Accidental Injury Death – A death resulting from an injury that occurs without intent to cause harm or death, also known as an unintentional injury.
- Adverse Childhood Experiences (ACEs) – Potentially traumatic events (such as abuse, neglect, household dysfunction) that occur before the age of 18. ACEs can include violence, abuse, and growing up in a family affected by mental health or substance use problems. The toxic stress caused by ACEs can disrupt brain development and affect how the body responds to stress.
- Blunt Force Trauma – Injury caused by force from a blunt object (such objects may include hands and feet). Includes abrasions, bruises, contusions, and lacerations.
- Cause of Death – The illness, disease, or injury responsible for the death. Examples of natural causes include heart defects, asthma, and cancer. Injury-related causes include blunt force impact, burns, and drowning.
- Child Fatality Review Program (CFRP) – Established within ADHS, the CFRP provides administrative and clerical support to the State Team, offers training and technical assistance to Local Teams, and develops and maintains the data system.
- CFRP Data Form – A standardized form approved by the State CFRP Team, required for collecting data on all child fatality reviews.
- Child Protective Services (CPS) History with Family – Review teams consider a family as having previous involvement with a CPS agency (including tribal DCS) if the agency investigated a report of neglect/abuse for any child in the family before the incident leading to the child's death.
- Child Relationship Issues – Child relationship issues are identified as a factor when records show concerns about isolation, arguments, or discord with family, friends, significant others, and social discord.
- Child's Chronic Condition – An illness that has a substantial long-term effect on the child's day-to-day function or health, including medical, orthopedic, cognitive, sensory, mental health, and substance use disorder.
- Choking – The inability to breathe due to blockage, constriction, or swelling of the trachea (airway).
- Confidentiality Statement – A form that all review process participants must sign, containing statutory information regarding the confidentiality of data reviewed by local child fatality teams.
- Congenital Syphilis – A disease occurring when a mother with syphilis, a sexually transmitted infection (STI), passes the infection to her baby during pregnancy or at childbirth.
- COVID-19 – A disease caused by the SARS-CoV-2 virus. A COVID-19 death is one where COVID-19 is identified as the immediate or underlying cause of death.
- Death of a Loved One – Identified as a factor when documentation reveals concern about the death of a close peer, friend, or family member of the child.
- Drowning Death – Death from an accidental or intentional submersion in a body of water.
- Firearm Injury Death – Death caused by an injury resulting from the penetrating force of a bullet or other projectile fired from a powder-charged gun.
- Fire/Flame Death – Death caused by injury from severe exposure to flames or fire heat, leading to tissue damage or smoke inhalation in the upper airway, lower airway, or lungs.

- History of Trauma/Violence – Refers to the child being a victim of physical or emotional abuse or experiencing family violence, domestic violence, social violence, or peer violence, including being a victim of rape.
- Homicide – Death resulting from injuries inflicted by another person with the intent to cause fear, harm, or death.
- Infant – A child under one year of age.
- Infectious Disease-Related Death – Death in which an infectious disease caused or contributed to the death. Infectious diseases are caused by organisms (such as bacteria, viruses, and fungi) that can be transmitted, directly or indirectly, from person to person, making them contagious (communicable).
- Intentional Injury – An injury resulting from the deliberate use of force or purposeful action against oneself or others. Intentional injuries include interpersonal acts of violence intended to cause harm, criminal negligence or neglect (such as homicide), and self-directed behavior with intent to kill oneself (such as suicide).
- Local CFRP Team – A multidisciplinary team authorized by the State CFRP Team to conduct reviews of child deaths within a specific geographic area (such as a county, reservation, or other geographic area).
- Manner of Death – The circumstances of the death as determined by CFRP teams through postmortem examinations, death scene investigations, police reports, medical reports, or other reports. Categories include natural, accident (such as unintentional injury), homicide (such as intentional injury), suicide (such as deliberate injury), and undetermined.
- Maternal Infection – Any infection in the mother during pregnancy, childbirth, or breastfeeding that can be vertically transmitted to her baby and cause death.
- Medical Error – An unintentional act, either an omission or commission, that deviates from the accepted standard of care or intended plan of action.
- Motor Vehicle Crash (MVC)-Related Death – Death caused by injuries from a motor vehicle incident, including injuries to motor vehicle occupant(s), pedestrian(s), pedal cyclist(s), or others.
- Natural Death – A death classified as a natural death when caused by a medical condition.
- Near Death Fatality – Defined by DCS as a case that was caused by abuse, abandonment, or neglect if:
    - The perpetrator is charged with an offense related to the incident,
    - A superior court finds a child dependent based on the allegations of abuse or neglect leading to near-death,
    - Or DCS, through its own internal review and administrative appeal process, substantiates findings linking the allegations of abuse or neglect to the near-death experience.
    - Further, if the posting is on a near-death, a medical professional must determine that the child was in a serious or critical condition.
- Neglect – Failure to provide appropriate and safe supervision, food, clothing, shelter, or medical care that causes or contributes to a child's death.
- Neglect/Abuse-Related Death – A death in which an act of neglect, physical abuse, sexual abuse, or emotional abuse contributed to a child's death as determined by the Second Level Neglect and Abuse Team.
- Neonatal Infants – A baby within the first 28 days of birth (four weeks of life).

- Off-Highway Vehicle (OHV) – Any motorized land vehicle designed or adapted predominantly for cross-country travel on unpaved surfaces, rough terrain, or trails not suitable for conventional two-wheel-drive vehicles. Examples include all-terrain vehicles (ATVs), utility terrain vehicles (UTVs), and dirt bikes.
- Parental Substance Use History – Identified as a risk factor when available documentation indicates current or past use of alcohol or other drugs by a parent.
- Perinatal Conditions – Health issues occurring during the perinatal period, defined by the World Health Organization as the time between 22 weeks of gestation and seven days after birth.
- Perpetrator – Individual identified as a possible perpetrator of physical, sexual, or emotional abuse or neglect. Caregivers may include individuals supervising the child, such as parents, parents' partners, friends, neighbors, childcare providers, or household members.
- Physical Abuse – The infliction of bodily harm, whether the inflictor planned to carry out the act or inflicted harm. This includes abuse occurring on or around the time of death or any prior abuse contributing to the child's death.
    - Note: Firearm injury deaths inflicted by a parent, guardian, or caregiver are included under this category of abuse and neglect.
- Poverty – Identified as a risk factor when documentation shows the child's family has limited financial resources and may live below the federal poverty level. This includes, but is not limited to, recipients of Temporary Assistance for Needy Families (TANF), Medicaid, Food Stamps, and Section 8 Housing.
- Post-neonatal Infants – A baby between 28 days and one year of age.
- Premature Rupture of Membranes (PROM): The rupture or breaking open of the membranes (amniotic sac) before labor begins, in a patient beyond 37 weeks' gestation.
- Prematurity Death – A death resulting from premature birth (less than 37 weeks of gestation) in an infant without underlying medical conditions that would otherwise cause death. Perinatal conditions are included if the birth was premature.
- Preventable Death – A child's death is considered preventable if actions by the community or an individual could have altered the circumstances leading to the death. This includes reasonable medical, educational, social, legal, or psychological interventions that could have prevented the death from occurring. The actions or inactions of the community, family, and individual's actions (or inactions) are considered when making this determination.
- Record Request Forms – The form required to request records for conducting a team review.
- Risk Factors – Refers to conditions, behaviors, or events that increase an individual’s likelihood of injury, disability, or death.
- Rural Counties in Arizona – As defined by the 2012 Arizona Health Status and Vital Statistics Report [2], Arizona's rural counties include Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Mohave, Navajo, Santa Cruz, and Yavapai.
- School Issues – Identified as a factor when documentation shows concerns related to school failure, pressure to succeed, issues with extracurricular activities, issues with being in a new school, or other school-related problems.
- Sexually Transmitted Disease (Infection) (STD or STI) – Disease transmitted by sexual contact, including chlamydia, trichomonas, gonorrhea, syphilis, hepatitis B, and HIV. The presence of an STD in a child is an indicator of possible sexual abuse. However, some STDs are passed on to the fetus during pregnancy or at birth.

- Sleep-Related Death – A unique category of infant injury deaths that includes select injury causes (accidental suffocation in bed, unspecified threat to breathing, and undetermined causes), where the infant was last known to be asleep when last seen alive.
- Substance Use – The act of consuming, inhaling, ingesting, or absorbing any selected illegal or legal substance (including alcohol, prescription medications, over-the-counter drugs, illicit drugs, marijuana, or inhalants).
- Substance Involved-Related Deaths – Defined by CFRP as deaths in which a substance was a direct or contributing factor in the child's death. To identify substance use as a factor, each case was reviewed to determine whether any individual involved in the child's death used substances such as legal or illegal drugs, prescription drugs, marijuana, or alcohol. The individual could have been the child's parent or caretaker, an acquaintance, a stranger, or the child themselves, and the substance use occurred proximate to the time of the incident leading to the death.
- Suffocation – Oxygen deprivation caused by mechanical obstruction of air passage into the lungs, usually at the level of the nose or mouth.
- State CFRP Team – Established under A.R.S. §36-3501. C.3, the State CFRP Team oversees Local CFRP teams, prepares an annual report of review findings, and develops recommendations to reduce preventable child deaths.
- Substance Exposed Newborn (SEN) – A newborn who was exposed to alcohol and/or a controlled substance (illicit or prescribed) while in the womb. The childbearing parent's history can determine this exposure, the newborn's clinical presentation, and laboratory testing or biological specimens (such as urine, blood, oral fluid, sweat, hair, and breast milk), neonatal matrices (such as urine, meconium, hair, umbilical cord, and tissue), and matrices from both the childbearing parent and neonate (such as placenta and amniotic fluid).
- Sudden Unexpected Infant Death (SUID) – Death of an infant for which no underlying medical condition was identified as a cause of death. This includes deaths formerly categorized as "crib deaths" if the death occurred during sleep. However, not all these deaths are sleep-related. Most SUIDs are associated with suffocation and unsafe sleep environments.
- Suicide – A death resulting from a self-directed, intentional behavior where the intent is to die because of that behavior.
- Tribal CPS – Child protective services (CPS) agencies and programs operated by Native American tribes that are responsible for protecting tribal members, particularly children, from abuse, neglect, or exploitation.
- Undetermined Manner Death – A classification used when the CFRP team cannot determine the manner of death, whether natural, accident, homicide, or suicide. Death may be listed as undetermined because there is insufficient information available for review.
- Urban Counties in Arizona – As defined by the 2012 Arizona Health Status and Vital Statistics Report [2], Arizona's urban areas include the Phoenix-Scottsdale-Mesa Metropolitan Statistical Area (comprising Maricopa and Pinal Counties), the Tucson Metropolitan Statistical Area (Pima County), and the Yuma Metropolitan Statistical Area (Yuma County).

Letter from the Chair of the CFRP Team

The Arizona Child Fatality Review Program (CFRP) systematically reviews every child death in our state annually and utilizes the findings to make recommendations on how Arizona can decrease child deaths. Our local teams reviewed all 773 child deaths in 2025. The leading causes of these deaths were prematurity, congenital anomalies, motor vehicle crashes, firearm injuries, and suffocation. The CFRP teams determined that 42.6% (329) of the deaths were preventable, a decrease from 48.0% of the deaths in 2024. Teams also determined that 100.0% of accidental injury deaths, suicides, and homicides were preventable.

The most common causes of preventable deaths were motor vehicle crashes, firearm injuries, suffocation, and drowning. Some of the risk factors for these deaths identified by CFRP teams included CPS history with family, poverty, substance use, parent substance use history, and child relationship issues. All manners of death decreased except for natural deaths (deaths due to medical conditions). The only two review categories that showed an increase were deaths associated with substance use and infectious diseases. Deaths in which substance use caused or contributed to the death increased by 8.6%.

Arizona's infant mortality rate continued to decrease in 2025 and was below the US rate; the infant mortality rate for Black and American Indian infants increased. The most common cause of neonatal deaths was prematurity. For infants > 28 days old, suffocation was the most common cause of death, but these deaths decreased 17% from 2024 to 2025. Sadly, 96% of these deaths occurred in an unsafe sleeping environment. Drowning is still the leading cause of death for 1–4 year olds, but the drowning death rate declined 38.1% from 2024 to 2025. For children over 4 years of age, the most common causes of death were motor vehicle crashes.

For each cause of death, we have made prevention recommendations, which are included in the report. The Child Fatality Review State Team has also listed "overarching" recommendations that could have prevented many deaths from various causes. Two of these recommendations are:

- Prioritize Arizona children by investing in families' financial well-being, including increasing access to healthcare, food, housing, employment, and childcare.
- Increase the availability and accessibility of affordable, quality mental health and substance use treatment services that are supportive for families with children to receive care, especially in rural and tribal areas.

I hope that if our communities addressed these two recommendations and the other Child Fatality Review State Team recommendations, we could further reduce Arizona child deaths.

I want to thank the Arizona Department of Health Services, Arizona Chapter, American Academy of Pediatrics, and all our local and state fatality team volunteers for their support of the CFRP and its mission to prevent child deaths in Arizona.

Sincerely



Mary Rimsza, MD, FAAP
Chair, Arizona Child Fatality Review Program

Executive Summary

The Arizona CFRP provides an annual comprehensive review of every child less than 18 years of age who died in Arizona, regardless of residence, including all deaths due to injuries and medical conditions. While most deaths due to medical conditions are not preventable, deaths due to intentional (such as suicides and homicides) and unintentional injuries (such as drowning, suffocation, and MVC-related) are preventable and vary by age. Historical data show that infants are most often injured by suffocation resulting from an unsafe sleep environment, toddlers are more likely to drown, and older children are more vulnerable to MVC or firearm injury. Analyzing risk factors enables injuries to be anticipated and, when appropriate, prevented through protective measures.

The CFRP was established to review all possible factors surrounding a child's death. The program aims to identify ways to reduce preventable fatalities. Legislation was passed in 1993 (A.R.S. §36-3501 C.3.) authorizing the creation of the CFRP. In 1994, the review process and data collection began. Today, ten local teams conduct initial reviews under the oversight of the State CFRP Team and its two subcommittees (Neglect/Abuse and SUID/Undetermined).

This report utilizes descriptive statistics and trend analyses to present summary information about child fatalities as well as the leading causes under each manner of death by factors such as age, sex, and race/ethnicity. This report's demographic and prevention information is used to help broadly inform public health initiatives and the community. Recommendations for prevention are decided by both state and local review teams based on the information collected and reviewed on each child's death.

The CFRP follows the National Center for Fatality Review and Prevention (National Center) steps to conduct practical review meetings [3]:

- Step 1: Share, question, and clarify all case information
- Step 2: Discuss the investigation
- Step 3: Discuss the delivery of services
- Step 4: Identify risk factors
- Step 5: Recommend systems improvements
- Step 6: Identify and take action to implement prevention recommendations

Review Process:

Arizona has ten local CFRP teams that complete reviews at the community level. Second-level reviews of SUID/Undetermined and Neglect/Abuse deaths are done at the state level by subcommittees of the State CFRP Team. The review process begins when the death of a child less than 18 years old in Arizona, regardless of residence, is identified through a vital records report. The CFRP sends information from the death certificate to a local CFRP team based in the county where the deceased child lived. If the child was not a resident of Arizona, the local team in the county where the death occurred will conduct the review. Information collected during the review is then entered into the National Child Death Review Database, which is managed by the National Center at the Michigan Public Health Institute. The resulting dataset is used to produce the statistics found in this annual report. Local CFRP team members and second-level review team members are listed in Appendix B.

Local CFRP Teams:

The following ten local teams represent the county partnerships and jurisdictions for the CFRP:

- Apache and Gila Counties
- Coconino County
- Graham and Greenlee Counties
- Maricopa County
- Mohave and La Paz Counties
- Navajo County
- Pima, Cochise, and Santa Cruz Counties
- Pinal County
- Yavapai County
- Yuma County

Local Team Membership:

The CFRP partners with local county health departments, academia, and non-profit organizations to establish review teams. These teams are located throughout the state, and membership includes (A.R.S. §36-3501 C.3.):

- County attorney's office
- County health department
- County medical examiner's office
- Department of Child Safety (DCS)
- Domestic violence specialist
- Mental health specialist
- Local law enforcement
- Parent
- Pediatrician or family physician

Report Statistics:

The descriptive statistics in this report summarize the information about child deaths by manner, cause, age, sex, race/ethnicity, and risk factors. Frequency percentages, rates, and cross-tabulation tables are shown throughout the report. A rate measures the frequency of an event within a defined population during a specified period. The numerator represents the number of events, while the denominator represents the population at risk. Rates express the likelihood (or risk) of the event occurring in the specified population during a particular time. They are generally described as population units in the denominators (per 1,000, 10,000, 100,000, and so forth). The rates were calculated using the following denominators: the number of live births (specific to infant mortality and SUID), the number of premature live births (specific to prematurity mortality), and the population of children (0 to 17 years) from the Arizona Office of Economic Opportunity (OEO) for all other groups. This report's demographic and prevention information is primarily used to inform public health initiatives and the community at large.

Manner of Death vs. Cause of Death:

In this report, the manner of death includes natural (such as cancer), accident (such as an unintentional car crash), homicide (such as assault), suicide (such as self-inflicted intentional firearm injury), and undetermined. The cause of death refers to the injury or medical condition that resulted in death (such as firearm injury, pneumonia, or cancer). The manner of death is not the same as the cause of death, but specifically refers to the intentionality of the reason. For example, if the cause of death was a firearm injury, then the manner of death may have been deliberate or accidental. If it was deliberate, then the manner of death was suicide or homicide. If the injury was unintentional, then the manner of death was an accident. In some cases, there was insufficient information to determine the manner of death, even though the cause was known. For example, it may not have been clear that a firearm injury was due to an accident, suicide, or homicide, and in these cases, the manner of death was listed as undetermined.

Limitations:

It is important to note that the report has certain limitations. While every child's death is important, the small numbers in some areas of preventable deaths reduce the ability to examine some trends in detail. The numbers are used to inform broader public health efforts. Still, the sample size limits the ability to make accurate statements about statistical significance for differences or causal relationships. It is also noteworthy that much of the data collected is obtained through qualitative methods, such as witness reports of child injury deaths. This means there is always the potential for bias when the information is collected. Other variables that may not be captured on the death certificate or other typical records may include family dynamics, mental health challenges, or other hazards.

Additionally, the data is based on vital records information and data from local jurisdictions. Arizona has a medical examiner system, with each county having its own authority. Law enforcement also varies around the state. Arizona has 22 American Indian tribes, each with sovereign laws and protocols. Jurisdiction and record-sharing among tribal governments vary. These intricate relationships and individual jurisdictions mean that sources and information may differ from case to case.

Thirty-Third Annual Report Highlights

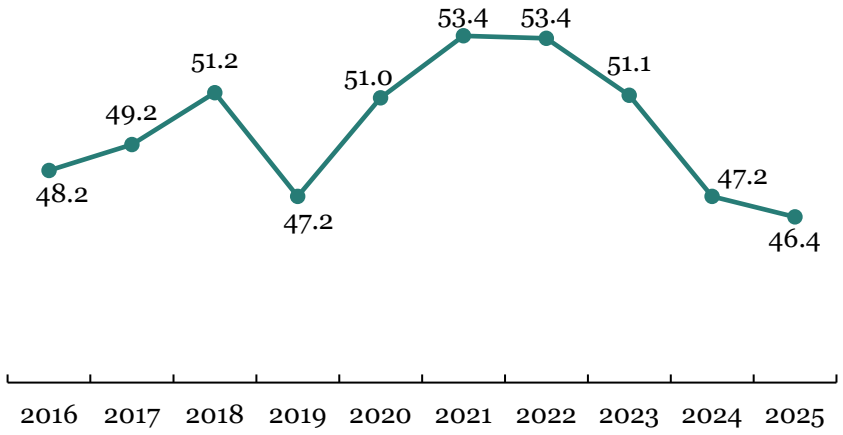
Total Deaths
773
(Out of State Residents: 22)

Preventable Deaths
329
(42.6% of all deaths)

Deaths Under 1 Year
421
(54.5% of all deaths)

Neglect/Abuse-Related Deaths
102
(13.2% of all deaths)

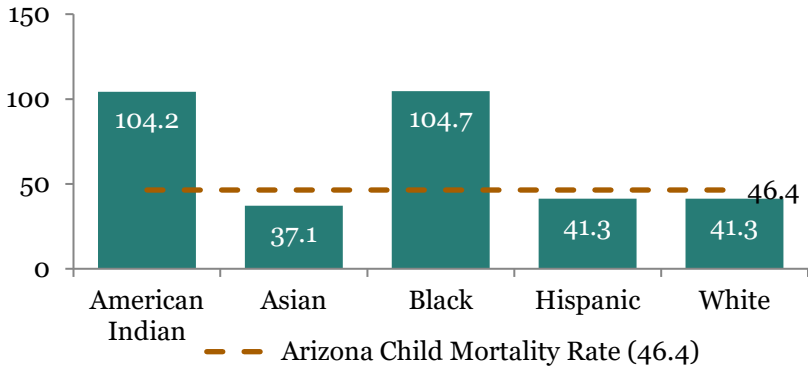
Overall Child Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



Manner of Child Death (Ages 0 to 17 Years):

Natural Deaths	Accidental Injuries	Homicides	Suicides	Undetermined Manner
64.6% (499 deaths)	22.1% (171 deaths)	6.3% (49 deaths)	4.9% (38 deaths)	2.1% (16 deaths)

Overall Child Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Arizona Child Mortality Rate, Arizona, 2025 [4]



Substance Use was involved in
16.4%
of child fatalities

Males were victims in
69.2%
of firearm injury deaths

64.7%
of children who died of Neglect/Abuse were less than five years of age

96.4%
of Sudden Unexpected Infant Deaths (SUIDs) occurred in an unsafe sleep environment

Leading Causes of Child Death (Ages 0 to 17 Years):

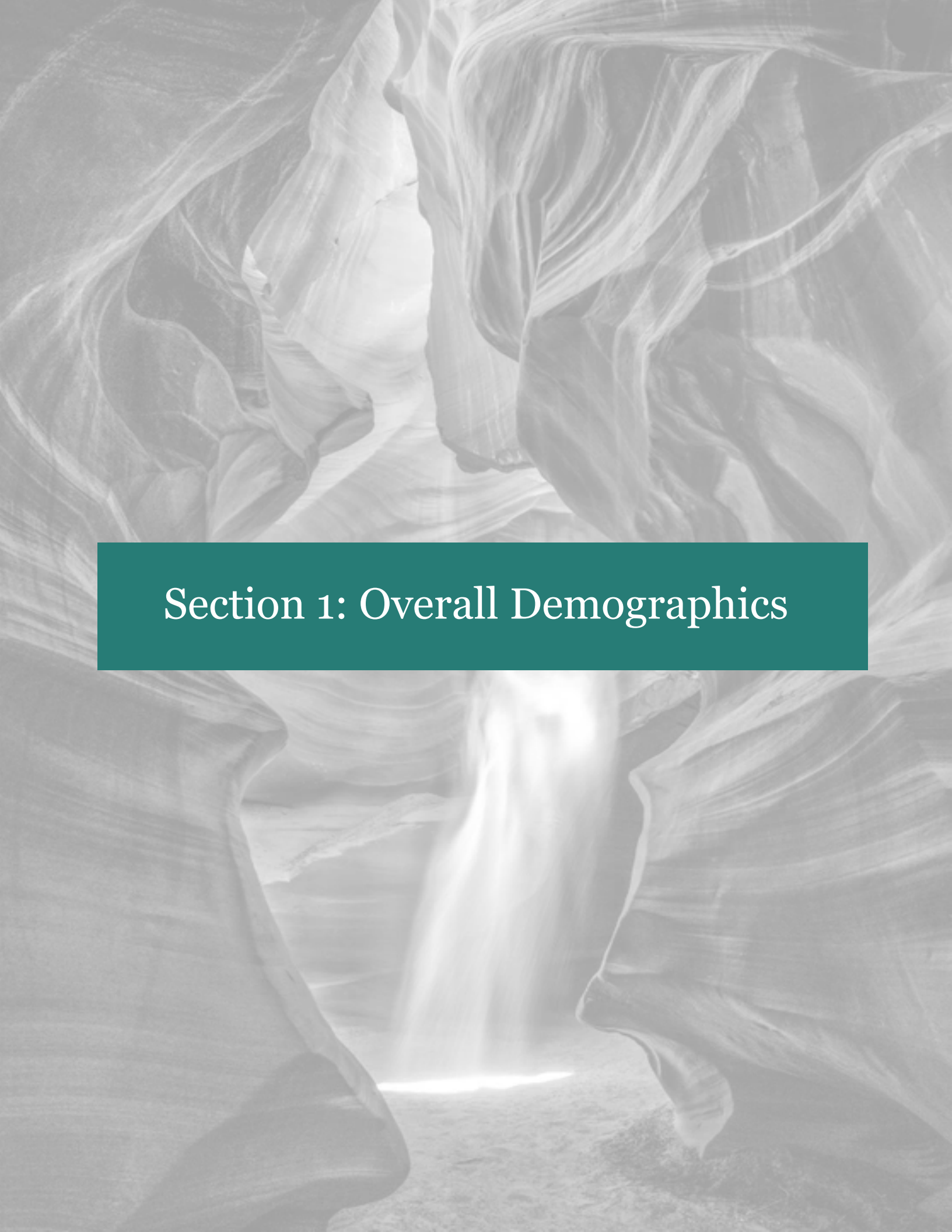
Prematurity	Congenital Anomaly	Motor Vehicle Crash	Firearm Injury	Suffocation
22.6% (175 deaths)	16.6% (128 deaths)	10.6% (82 deaths)	6.7% (52 deaths)	6.2% (48 deaths)

Prevention Recommendation:

Given the outcomes, the State CFRP Team and Local Review Teams identified recommendations to prevent these outcomes. These were initially derived from the recommendations made during the local review team's case reviews. CFRP staff completed qualitative analysis on all recommendations for 2025 deaths and presented the initial synthesized recommendations to the State CFRP Team. Following presentations of aggregate CFR data, the State CFRP Team added to and adjusted the list of recommendations based on overarching findings and observations from literature reviews. The final set of prevention recommendations in this report takes into account all these steps. These prevention recommendations are intended for wide dissemination so that partners and key stakeholders across the state will consider implementing them. In some cases, the recommendations may currently be in practice. This is particularly true for policy or practice recommendations aimed at payers, such as the Arizona Health Care Cost Containment System (AHCCCS), which has already implemented several of the models included in these recommendations.

Below are overarching recommendations found among the manners/causes of death reports in 2025:

- Increase the availability and accessibility of affordable, quality mental health and substance use treatment services that are supportive for families with children to receive care. Especially in rural and tribal areas. [76]
- Encourage Arizona policymakers to prioritize and invest in families' financial well-being, including increasing access to coordinated support for healthcare, food, housing, employment, and childcare. [86-87]
- Increase the availability of home visiting programs throughout the state. [82]
- Establish a coordinated community support framework that proactively identifies and provides wraparound services for high-risk families. This should include: [77-81]
    - Family support hubs that create or expand local centers where families can access case management, parenting programs, and immediate support for basic needs (food, housing, employment, mental health services) in one location.
    - Multi-agency collaboration to encourage cooperation between schools, healthcare providers, child protection, and community organizations to share relevant information and form joint care plans tailored to each family's circumstances.
    - Early identification and referrals by training frontline workers (teachers, nurses, community liaisons, social workers) to recognize early indicators of risk and refer families through a clear, supportive pathway – not a punitive one.
    - Peer and community membership to engage local volunteers, family members, and cultural leaders to provide social support and reduce isolation, particularly for marginalized communities.

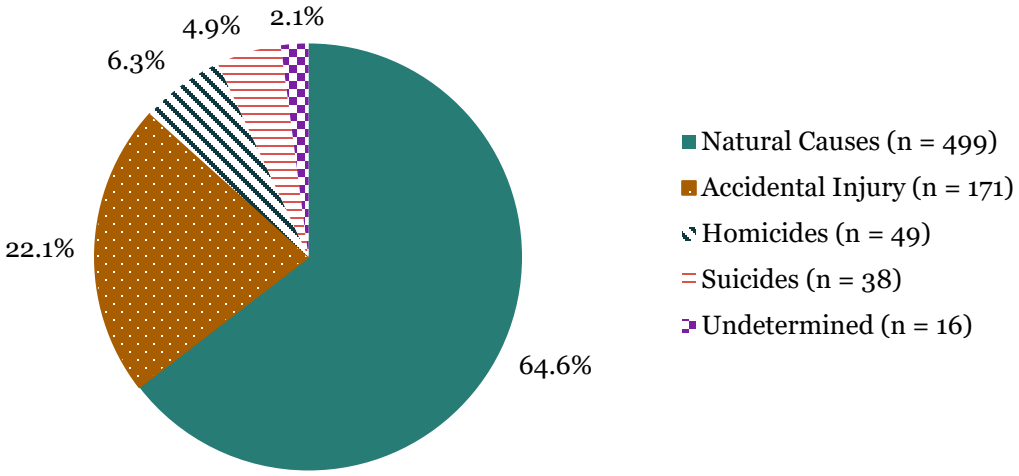


Section 1: Overall Demographics

Overall Child Mortality (0 to 17 Years)

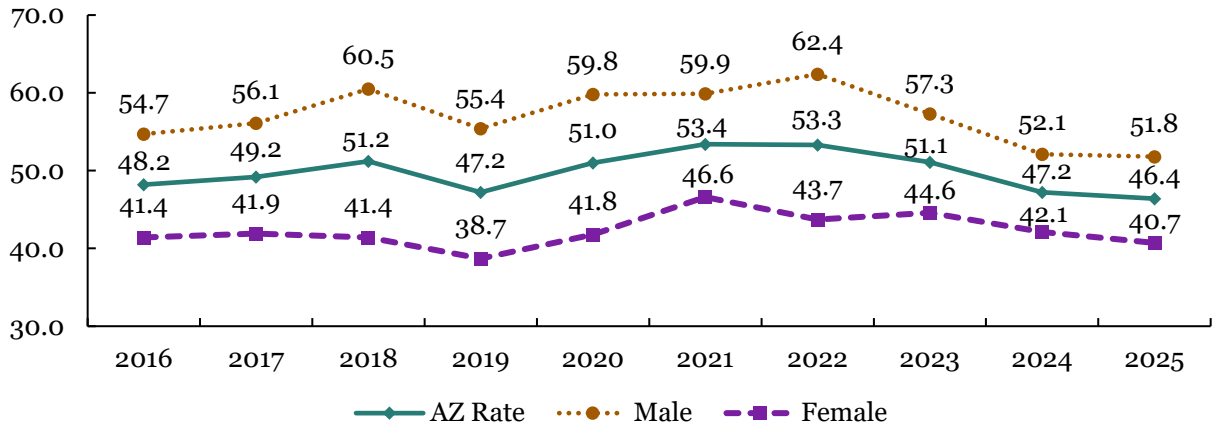
Overall, the majority of deaths were from natural causes (64.6 percent), followed by accidental injuries (22.1 percent) among children (0 to 17 years) (Figure 1).

Figure 1. Number and Percentage of Deaths by Manner of Death (Ages 0 to 17 Years), Arizona, 2025 (N = 773)



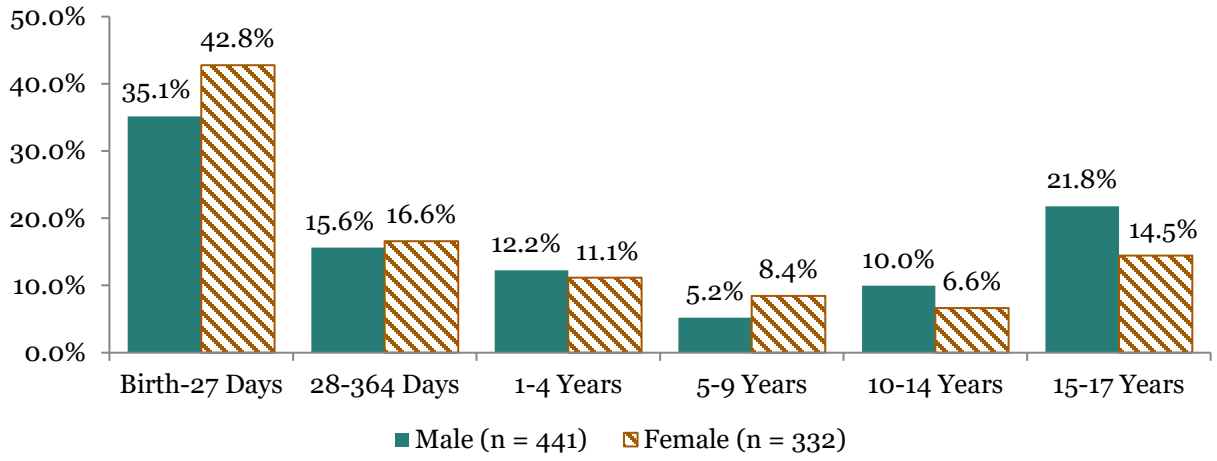
Arizona's overall child mortality rate (ages 0 to 17 years) decreased by 1.7 percent over the past year, falling from 47.2 deaths per 100,000 children in 2024 to 46.4 deaths per 100,000 children in 2025. Overall, the male child mortality rate has generally been higher than the female child mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male child mortality rate decreased by 0.6 percent (from 52.1 to 51.8 deaths per 100,000 children), while the female child mortality rate decreased by 3.3 percent (from 42.1 to 40.7 deaths per 100,000 children) (Figure 2).

Figure 2. Overall Child Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



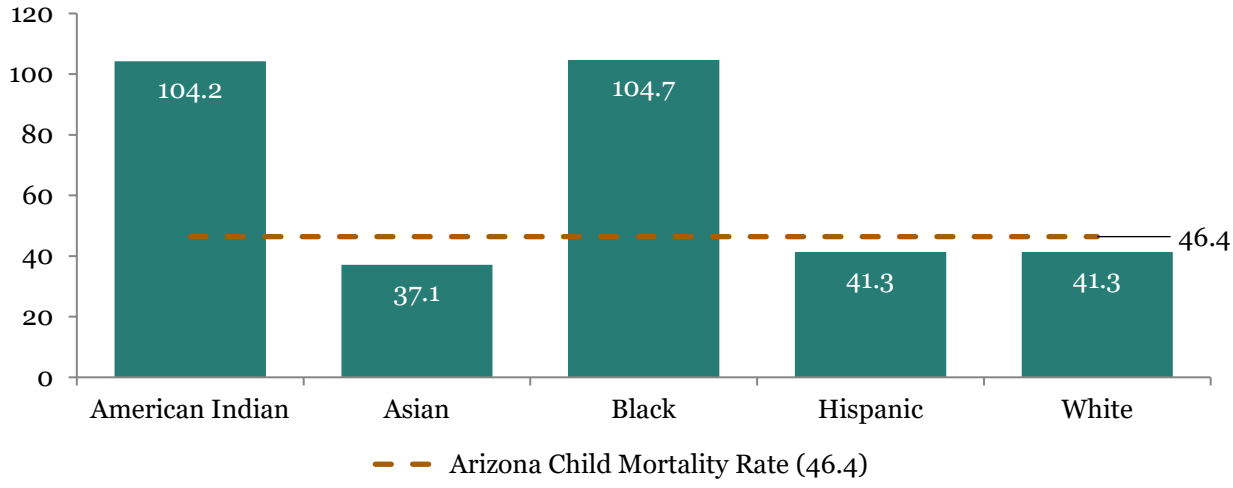
Among child deaths by sex, 57.1 percent were males and 42.9 percent were females. In both males and females, neonatal infants younger than 28 days old accounted for the highest percentage of deaths. Among males, neonatal infants younger than 28 days old accounted for 35.1 percent of deaths, followed by adolescents aged 15 to 17 years (21.8 percent). In females, neonatal infants accounted for 42.8 percent of deaths, followed by post-neonatal infants aged 28 days to less than 1 year (16.6 percent) (Figure 3).

Figure 3. Percentage of Deaths by Age Group and Sex (Ages 0 to 17 Years), Arizona, 2025 (N = 773)



When stratified by race/ethnicity, American Indian and Black children had higher mortality rates than the 2025 Arizona child mortality rate (46.4 deaths per 100,000 children), at 104.2 and 104.7 deaths per 100,000 children, respectively. Hispanic, White, and Asian children had lower mortality rates (Figure 4).

Figure 4. Overall Child Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Arizona Child Mortality Rate, Arizona, 2025 (N = 773) [4]



In 2025, the vast majority of child deaths (83.1 percent; 642 deaths) occurred in Arizona's urban counties, with a regional mortality rate of 44.2 deaths per 100,000 children. Rural counties accounted for 14.1 percent (109 deaths) of child fatalities but had a higher regional mortality rate of 51.0 deaths per 100,000 children. Additionally, 22 deaths (2.8 percent) were reported among children who resided out of the state but died inside the borders of Arizona (Table 1). For further details on urban/rural classification, see the glossary.

Table 1. Number, Percentage, and Rate of Deaths (per 100,000 children) by Residency (Ages 0 to 17 Years), Arizona and Out of State, 2025 (N = 773) [4]

Residency	Number	Percent	Rate (per 100,000 children)
Urban Counties	642	83.1%	44.2 deaths
Rural Counties	109	14.1%	51.0 deaths
Out-of-State	22	2.8%	N/A*

*Total number of children is not available for out-of-state residents.

Overall, prematurity was the leading cause of death, followed by congenital anomaly, MVC-related fatalities, firearm injury, and suffocation. The leading cause of death varied by age group. Prematurity was the leading cause of death among neonatal infants younger than 28 days old. In contrast, suffocation was the leading cause of death among post-neonatal infants aged 28 days to less than 1 year. For children aged 1 to 4 years, drowning was the leading cause of death. MVC-related fatalities were the leading cause of death for children aged 5 to 17 years (Table 2).

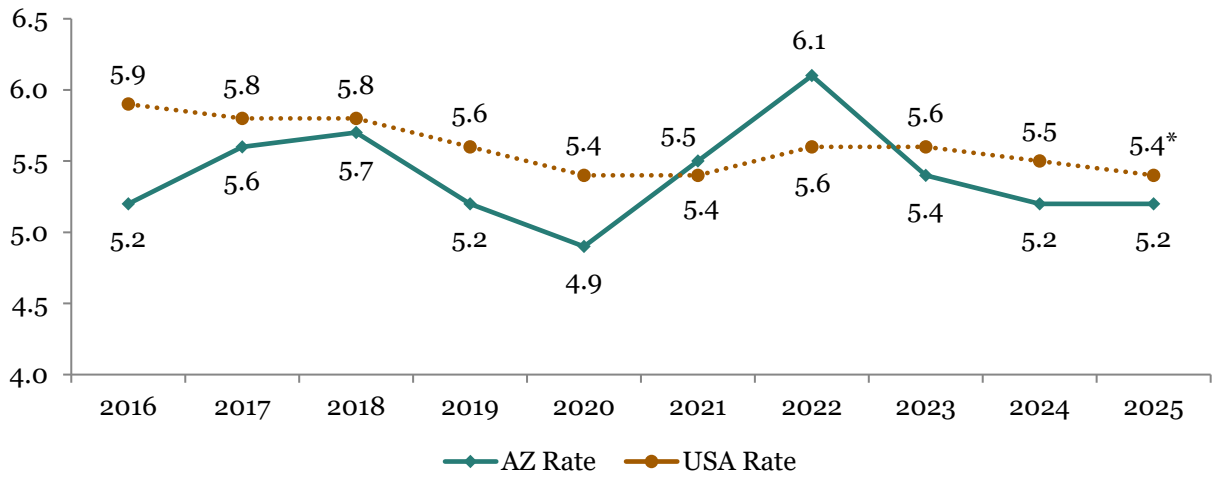
Table 2. Leading Causes of Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (N = 773)

Age Group	# 1	# 2	# 3	# 4	# 5
Birth – 27 Days (n = 297)	Prematurity (n = 160)	Congenital Anomaly (n = 82)	Other Infection (n = 11)	Perinatal Condition (n = 11)	Neurological/ Seizure Disorder (n = 9)
28 Days – <1 Year (n = 124)	Suffocation (n = 41)	Congenital Anomaly (n = 26)	Prematurity (n = 14)	Cardiovascular (n = 10)	Blunt Force Injury (n = 7)
1 – 4 Years (n = 91)	Drowning (n = 13)	Motor Vehicle Crash-Related (n = 12)	Cancer (n = 12)	Congenital Anomaly (n = 10)	Cardiovascular (n = 7)
5 – 9 Years (n = 51)	Motor Vehicle Crash-Related (n = 11)	Cancer (n = 11)	Congenital Anomaly (n < 6)	Firearm Injury (n < 6)	Neurological/ Seizure Disorder (n < 6)
10 – 14 Years (n = 66)	Motor Vehicle Crash-Related (n = 15)	Cancer (n = 9)	Firearm Injury (n = 9)	Strangulation (n < 6)	Cardiovascular (n < 6)
15 – 17 Years (n = 144)	Motor Vehicle Crash-Related (n = 38)	Firearm Injury (n = 35)	Poisoning (n = 11)	Cancer (n = 10)	Neurological/ Seizure Disorder (n = 10)
All Deaths (N = 773)	Prematurity (n = 175)	Congenital Anomaly (n = 128)	Motor Vehicle Crash- Related (n = 82)	Firearm Injury (n = 52)	Suffocation (n = 48)

Infant Mortality (Less than 1 Year)

Arizona's infant mortality rate (less than 1 year of age) remained steady over the last year at 5.2 deaths per 1,000 live births in both 2024 and 2025. While the state's infant mortality rate has fluctuated since 2016, it has consistently trended below the national average from 2016 to 2020 and again from 2023 to 2025 (Figure 5).

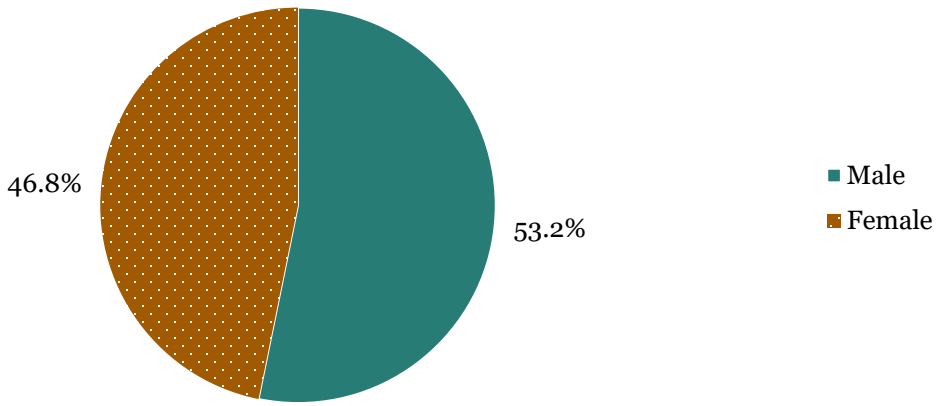
Figure 5. Infant Mortality Rate (per 1,000 Live Births, Less than 1 Year of Age), Arizona and USA, 2016-2025 [14-33]



*Preliminary infant mortality rate as reported by the National Center for Health Statistics, National Vital Statistics System.

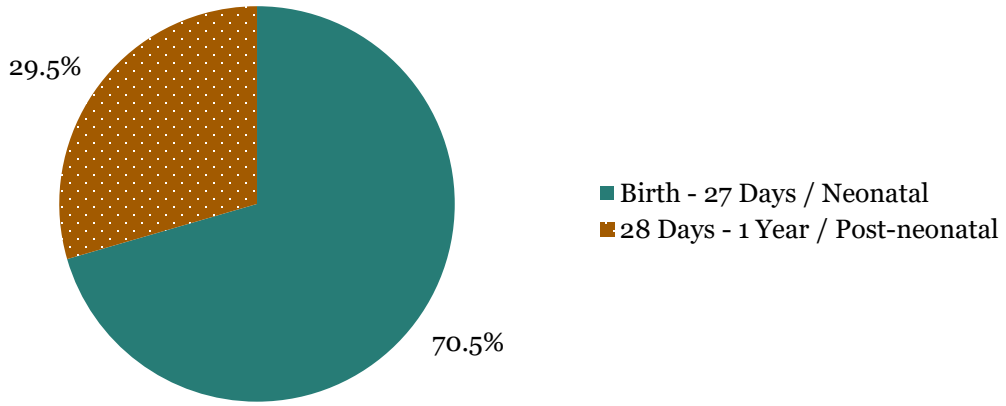
Among infant deaths by sex, 53.2 percent were male, while 46.8 percent were female (Figure 6).

Figure 6. Percentage of Infant Deaths by Sex (Less than 1 Year of Age), Arizona, 2025 (n = 421)



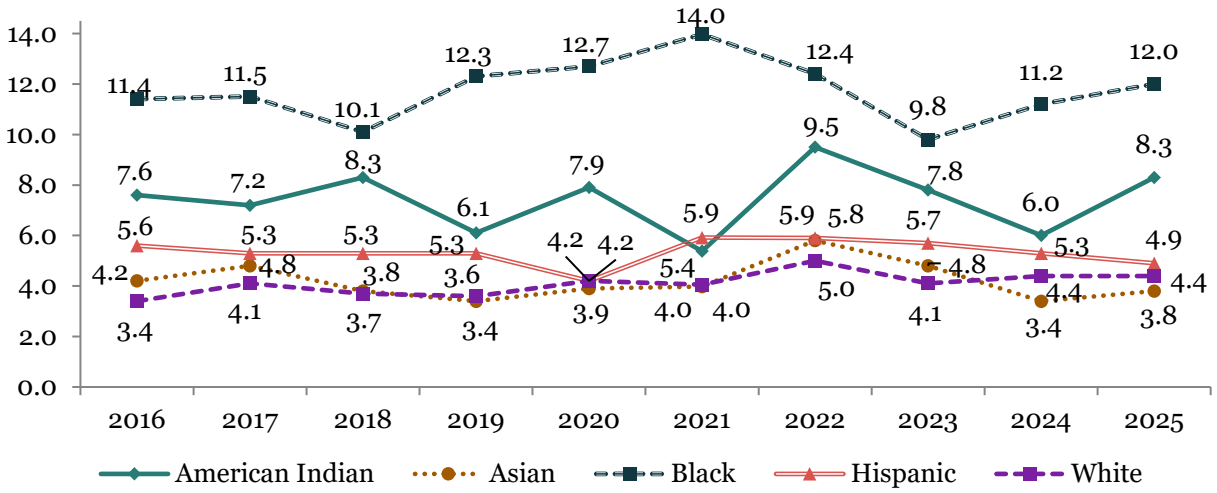
The majority of infant deaths occurred among neonatal infants aged less than 28 days old (70.5 percent), followed by post-neonatal infants aged 28 days to less than 1 year (29.5 percent) (Figure 7).

Figure 7. Percentage of Infant Deaths by Age Group (Less than 1 Year of Age), Arizona, 2025 (n = 421)



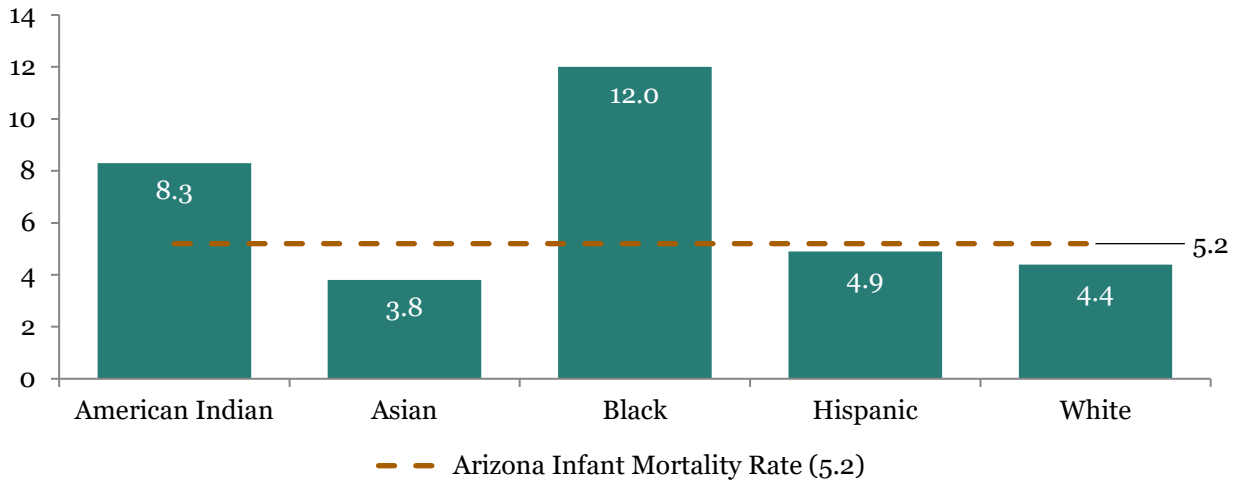
American Indian and Black infants have consistently had higher rates of infant mortality since 2016. In 2025, the infant mortality rates for Black and American Indians were 12.0 and 8.3 deaths per 1,000 live births, respectively. In comparison, the infant mortality rates for Hispanic and White infants were 4.9 and 4.4 deaths per 1,000 live births, respectively. From 2024 to 2025, the infant mortality rate increased by 38.3 percent among American Indian infants, 7.1 percent among Black infants, and 11.8 percent among Asian infants. Concurrently, the infant mortality rate decreased by 7.5 percent among Hispanic infants, while the rate for White infants remained unchanged (Figure 8).

Figure 8. Infant Mortality Rates (per 1,000 Live Births) by Race/Ethnicity (Less than 1 Year of Age), Arizona, 2016-2025 [24-33]



When stratified by race/ethnicity, American Indian and Black infants had higher mortality rates than the 2025 Arizona infant mortality rate (5.2 deaths per 1,000 live births), at 8.3 and 12.0 deaths per 1,000 live births, respectively. Hispanic, White, and Asian infants had lower mortality rates (Figure 9).

Figure 9. Infant Mortality Rate (per 1,000 Live Births) by Race/Ethnicity (Less than 1 Year of Age), Compared to the Arizona Infant Mortality Rate, Arizona, 2025 (n = 421) [24]



Overall, low birth weight was the leading risk factor in 63.9 percent of infant deaths (269 deaths). Among infants residing in urban counties and those residing out of state but died within Arizona, low birth weight was the leading risk factor, followed by poverty and a child's chronic condition. In rural counties, poverty was the leading risk factor, followed by low birth weight and a child's chronic condition (Table 3).

Table 3. Leading Risk Factors of Infant Death by Residency (Less than 1 Year of Age), Arizona, 2025 (n = 421)^

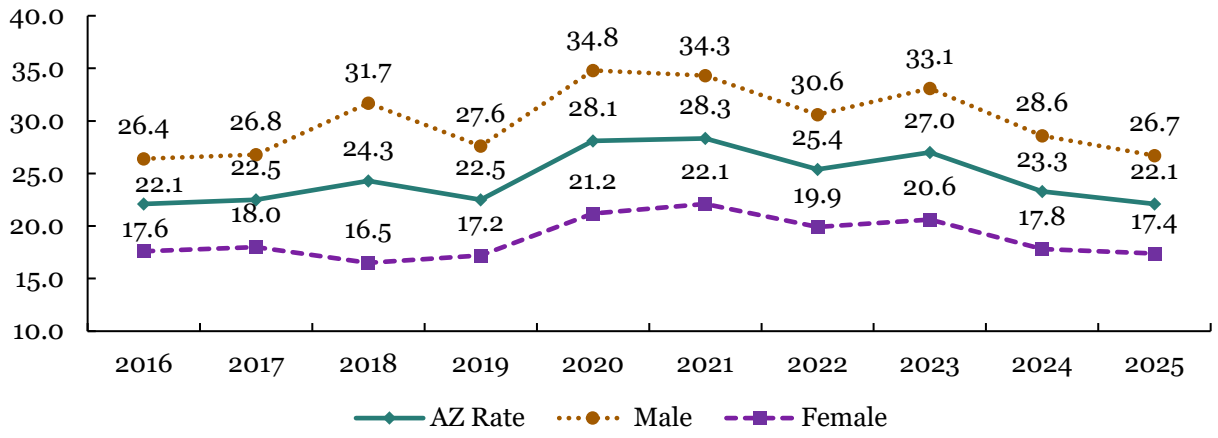
Residency	# 1	# 2	# 3	# 4	# 5
Urban (n = 364)	Low Birth Weight (n = 236)	Poverty (n = 193)	Child's Chronic Condition (n = 136)	Parent Substance Use History (n = 63)	CPS History with Family (n = 58)
Rural (n = 51)	Poverty (n = 29)	Low Birth Weight (n = 27)	Child's Chronic Condition (n = 24)	Parent Substance Use History (n = 13)	CPS History with Family (n = 8)
Out of State (n = 6)	Low Birth Weight (n = 6)	Poverty (n < 6*)	Child's Chronic Condition (n < 6*)	Maternal Infection (n < 6*)	No Prenatal Care (n < 6*)
Infant Deaths (n = 421)	Low Birth Weight (n = 269)	Poverty (n = 224)	Child's Chronic Condition (n = 162)	Parent Substance Use History (n = 76)	CPS History with Family (n = 66)

^More than one risk factor may have been identified for each death.
*The number/percentage was suppressed because the count was less than 6.

Child and Adolescent Mortality (1 to 17 Years)

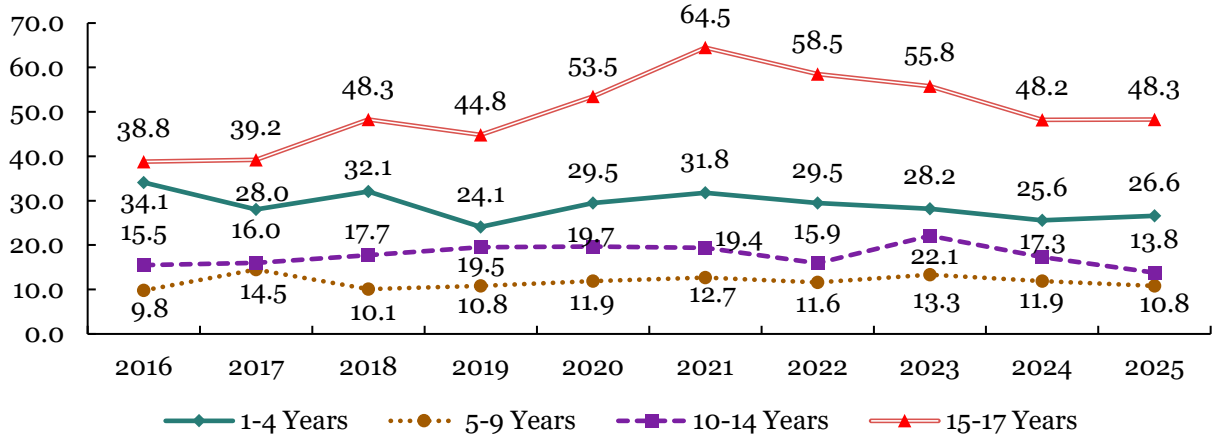
Arizona's child and adolescent mortality rate (ages 1 to 17 years) decreased by 5.2 percent over the past year, falling from 23.3 deaths per 100,000 children in 2024 to 22.1 deaths per 100,000 children in 2025. Overall, the male child and adolescent mortality rate has generally been higher than the female child and adolescent mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate decreased by 6.6 percent (from 28.6 to 26.7 deaths per 100,000 children), while the female mortality rate decreased by 2.2 percent (from 17.8 to 17.4 deaths per 100,000 children) (Figure 10).

Figure 10. Child and Adolescent Mortality Rates (per 100,000 Children) by Sex (Ages 1 to 17 Years), Arizona, 2016-2025 [34-43]



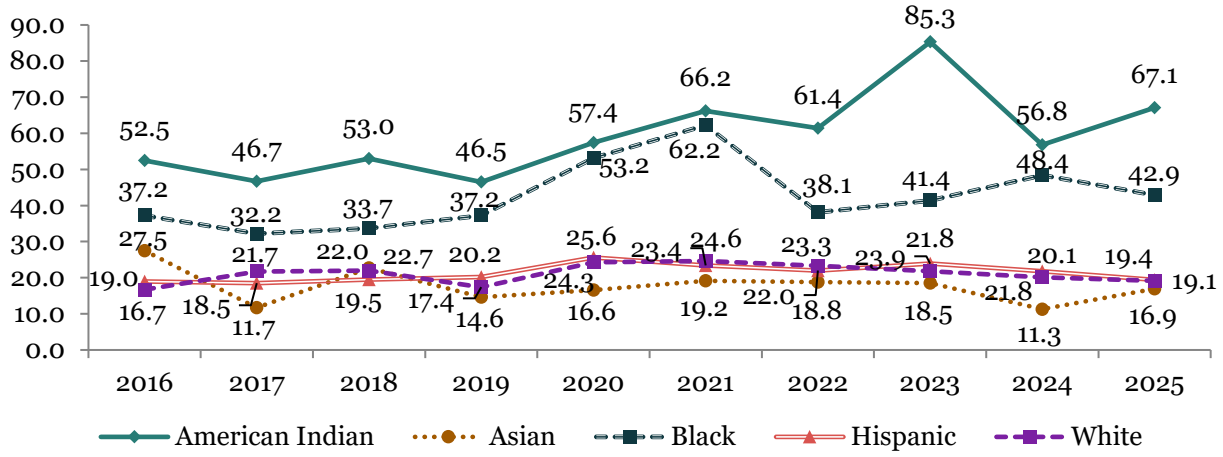
The mortality rate for children aged 10 to 14 years decreased by 20.2 percent from 2024 to 2025, while the rate for children aged 5 to 9 years decreased by 9.2 percent. In contrast, the mortality rate for adolescents aged 15 to 17 increased slightly by 0.2 percent over the same period. Concurrently, the mortality rate for children aged 1 to 4 years increased by 3.9 percent (Figure 11).

Figure 11. Child and Adolescent Mortality Rates (per 100,000 Children) by Age Group (Ages 1 to 17 Years), Arizona, 2016-2025 [34-43]



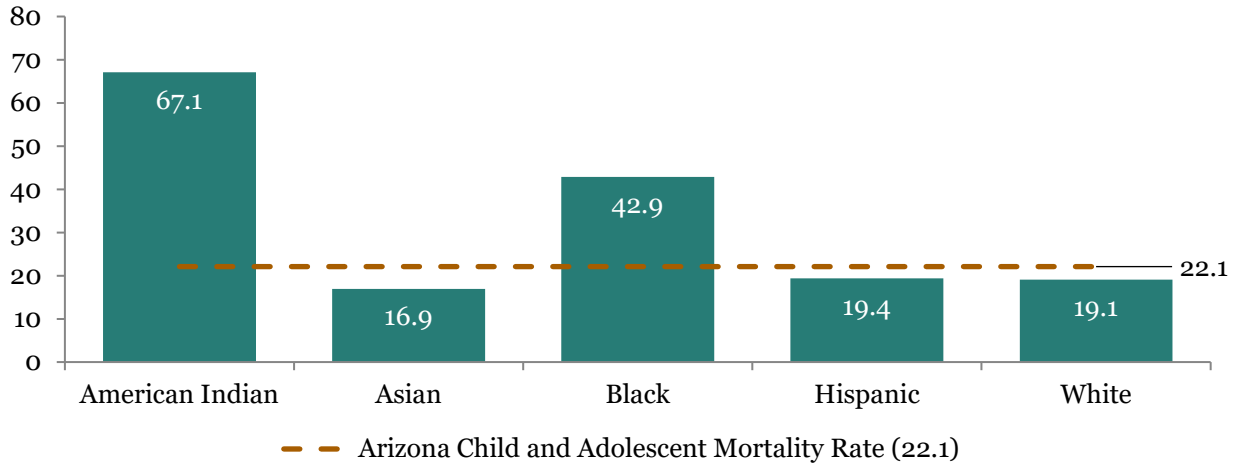
American Indian and Black children have consistently had higher rates of mortality since 2016. In 2025, the mortality rates for American Indians and Blacks were 67.1 and 42.9 deaths per 100,000 children, respectively. In comparison, the mortality rates for Hispanic, White, and Asian infants were 19.4, 19.1, and 16.9 deaths per 100,000 children, respectively. From 2024 to 2025, the mortality rate increased by 18.1 percent among American Indians and 49.6 percent among Asians. Concurrently, the mortality rate decreased by 11.4 percent among Blacks, 11.0 percent among Hispanics, and 5.0 percent among Whites (Figure 12).

Figure 12. Child and Adolescent Mortality Rates (per 100,000 Children) by Race/Ethnicity (Ages 1 to 17 Years), Arizona, 2016-2025 [34-43]



When stratified by race/ethnicity, American Indian and Black children had higher mortality rates than the 2025 Arizona child and adolescent mortality rate (22.1 deaths per 100,000 children), at 67.1 and 42.9 deaths per 100,000 children, respectively. Hispanic, White, and Asian children had lower mortality rates (Figure 13).

Figure 13. Child and Adolescent Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 1 to 17 Years), Compared to the Arizona Child and Adolescent Mortality Rate, Arizona, 2025 (n = 352) [34]

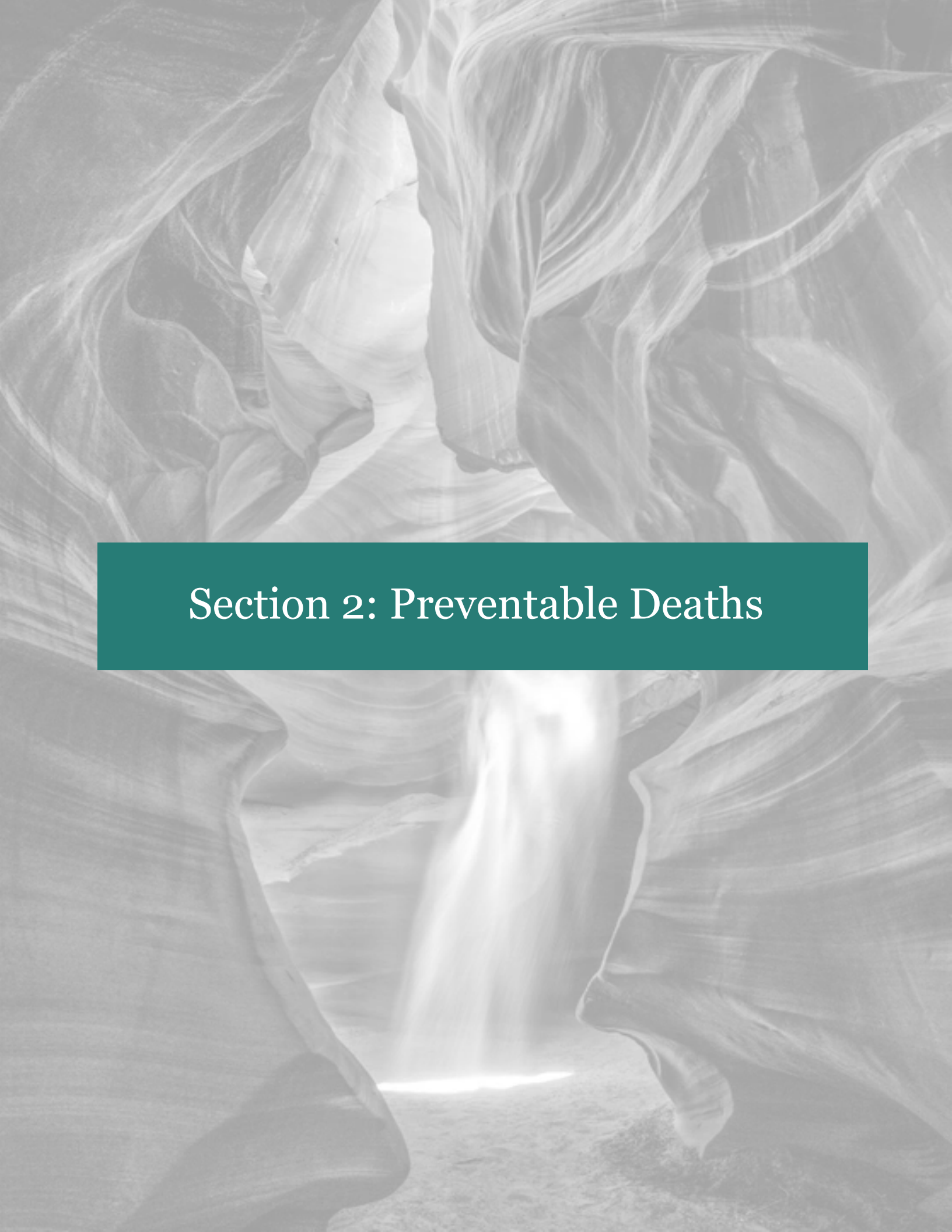


Overall, a child's chronic condition was the leading risk factor in 49.1 percent of child and adolescent deaths (173 deaths), irrespective of residency (Table 4).

Table 4. Leading Risk Factors of Child and Adolescent Death by Residency (Ages 1 to 17 Years), Arizona, 2025 (n = 352)^

Residency	# 1	# 2	# 3	# 4	# 5
Urban (n = 278)	Child's Chronic Condition (n = 139)	CPS History with Family (n = 107)	Poverty (n = 67)	Substance Use (n = 63)	Parent Substance Use History (n = 57)
Rural (n = 58)	Child's Chronic Condition (n = 29)	Poverty (n = 23)	Child Relationship Issues (n = 19)	CPS History with Family (n = 18)	Substance Use (n = 18)
Out of State (n = 16)	Child's Chronic Condition (n < 6*)	School Issues (n < 6*)	Substance Use (n < 6*)	Child Relationship Issues (n < 6*)	Lack of Supervision (n < 6*)
Child Deaths, Ages 1-17 Years (n = 352)	Child's Chronic Condition (n = 173)	CPS History with Family (n = 125)	Poverty (n = 90)	Substance Use (n = 85)	Parent Substance Use History (n = 76)

^More than one risk factor may have been identified for each death.



Section 2: Preventable Deaths

The primary purpose of the CFRP is to identify preventable factors in a child's death. Throughout the report, the term "preventable death" is used. Each multidisciplinary team is composed of professionals who review the circumstances of a child's death by examining records ranging from autopsies to law enforcement reports. The team then determines whether any preventable factors were present prior to the death. They use one of the following three labels to determine preventability: 1) Yes, probably, 2) No, probably not, and 3) Team could not determine. A determination is based on the program's operational definition of preventability in a child's death.

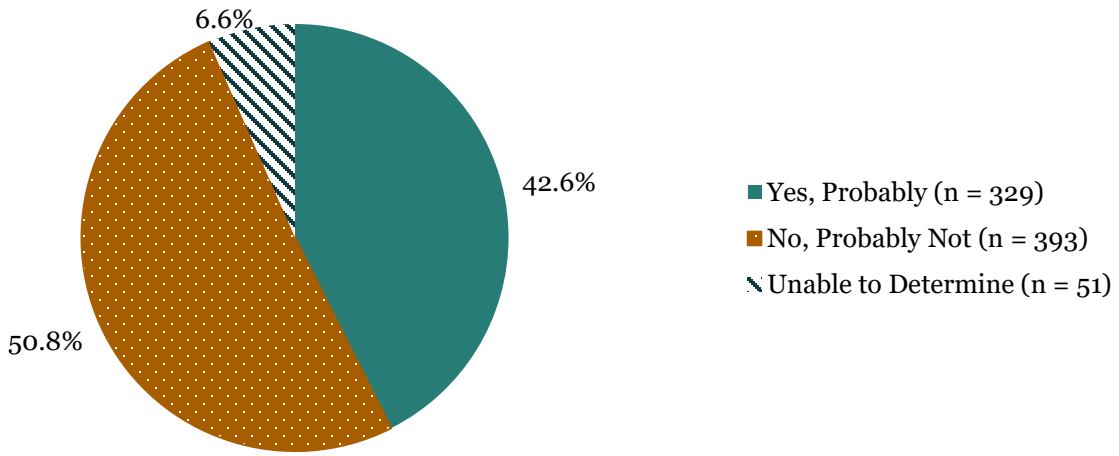
A child's death is considered preventable if the community (through education, legislation, etc.) or an individual could reasonably have done something that would have changed the circumstances leading to the child's death.

- "Yes, probably" indicates that certain circumstances or factors related to the death could have been prevented.
- "No, probably not" indicates that everything reasonable was likely done to prevent the death, but the child would still have died.
- A designation of "Team could not determine" means that there was insufficient information for the team to determine preventability.

The report discusses all 773 child deaths that occurred in 2025. Much of the data in this report is based on fatalities that the teams deemed preventable. This is important so that efforts are targeted to the areas where prevention initiatives will be the most effective.

In 2025, local review teams determined that 42.6 percent (329 deaths) of child deaths were preventable, while 50.8 percent (393 deaths) were probably not preventable. The teams were unable to determine preventability for 6.6 percent (51 deaths) of the recorded fatalities (Figure 14).

Figure 14. Number and Percentage of Deaths by Preventability (Ages 0 to 17 Years), Arizona, 2025 (N = 773)



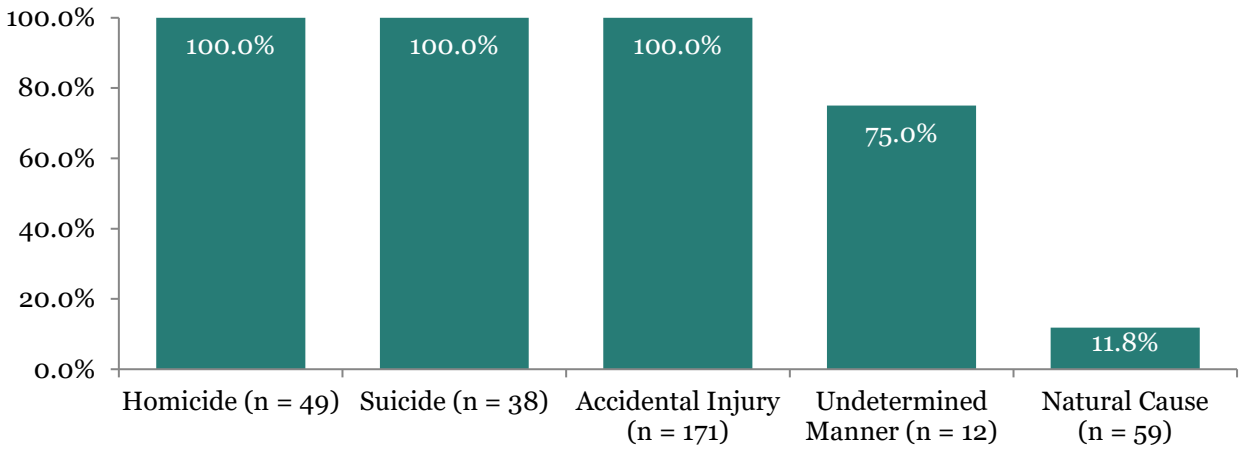
Among preventable deaths (ages 0 to 17 years), MVC-related fatalities were the leading cause, accounting for 25.2 percent (82 deaths) of preventable fatalities. This was followed by firearm injuries (16.0 percent; 52 deaths) and suffocation (14.7 percent; 48 deaths). Drowning and prematurity each accounted for 6.7 percent (22 deaths) of preventable child deaths (Table 5).

Table 5. Leading Causes of Preventable Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 329)

Leading Causes of Preventable Deaths	Number	Percent
MVC-Related	82	24.9%
Firearm Injury	52	15.8%
Suffocation	48	14.6%
Drowning	22	6.7%
Prematurity	22	6.7%

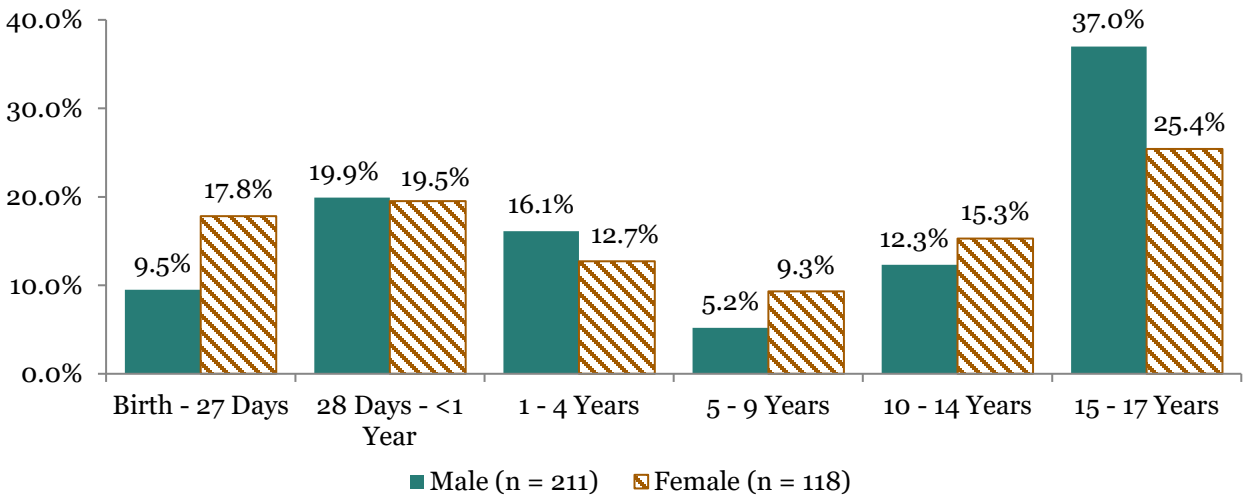
When classifying the manner of death as preventable, the local review teams determined that 11.8 percent of natural deaths (59 deaths) and 75.0 percent of undetermined manner deaths (12 deaths) were preventable. Additionally, 100.0 percent of accidental injury deaths (171 deaths), suicides (38 deaths), and homicides (49 deaths) were determined to be preventable (Figure 15).

Figure 15. Number and Percentage of Preventable Deaths by Manner of Death (Ages 0 to 17 Years), Arizona, 2025 (n = 329)



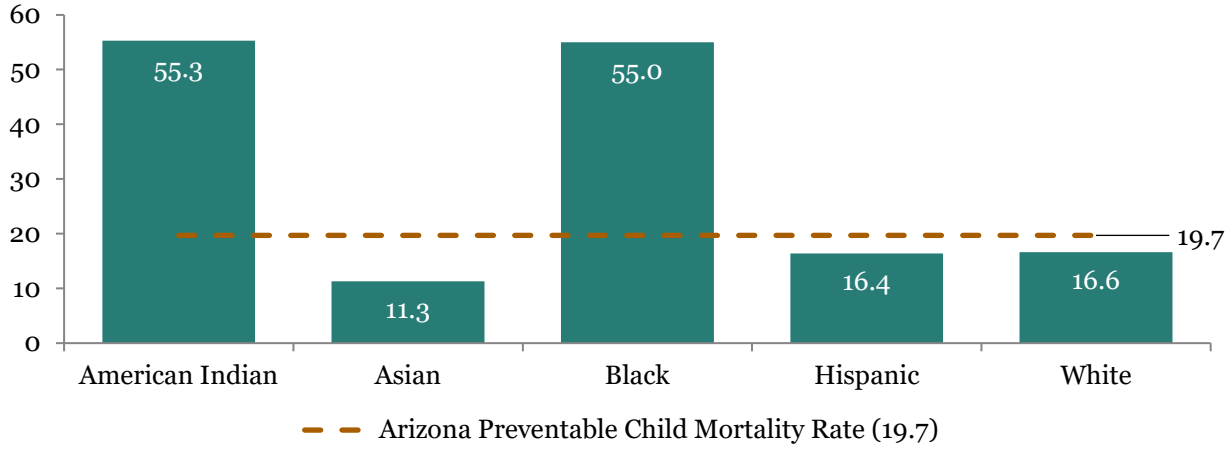
Of the preventable deaths, 64.1 percent were males and 35.9 percent were females. The largest sex difference was noted in adolescents aged 15 to 17 years. This group also accounted for the highest percentage of preventable deaths in both males and females (37.0 percent males, 25.4 percent females), followed by post-neonatal infants aged 28 days to less than 1 year (19.9 percent males, 19.5 percent females) (Figure 16).

Figure 16. Percentage of Preventable Deaths by Age Group and Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 329)



When stratified by race/ethnicity, American Indian and Black children had higher preventable death rates than the 2025 Arizona preventable child mortality rate (19.7 deaths per 100,000 children), at 55.3 and 55.0 deaths per 100,000 children, respectively. Hispanic, White, and Asian children had lower mortality rates (Figure 17).

Figure 17. Preventable Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Arizona Preventable Child Mortality Rate, Arizona, 2025 (n = 329) [4]



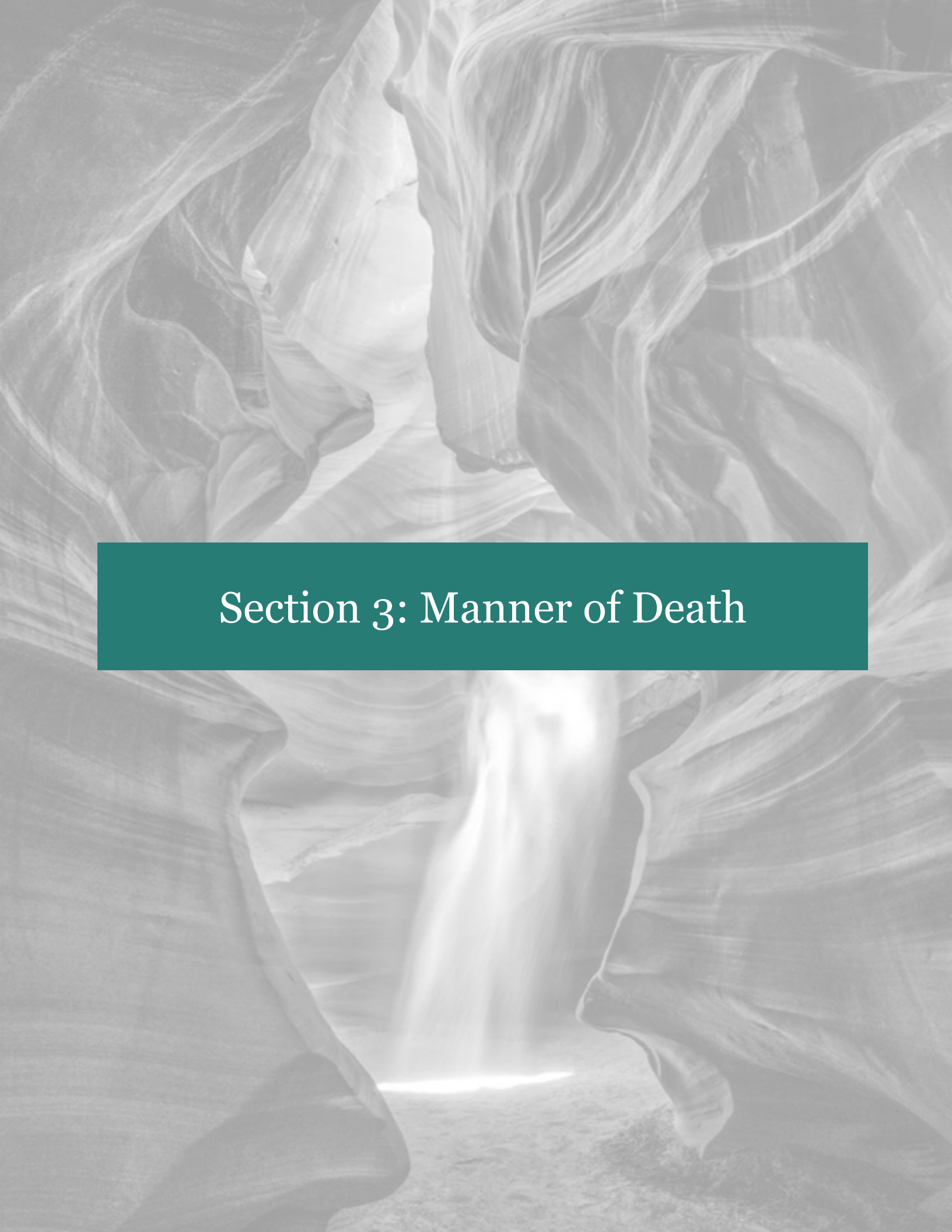
Overall, having a CPS history with family was the leading risk factor in 44.7 percent of preventable child deaths (147 deaths), followed by poverty (40.7 percent), substance use (38.6 percent), a parent's substance use history (38.6 percent), and child relationship issues (22.2 percent).

When analyzed by age groups, the leading risk factor of preventable mortality shifted. Poverty was the leading risk factor in preventable deaths among neonatal infants younger than 28 days old, post-neonatal infants aged 28 days to less than 1 year, and children aged 5 to 9 years. For children aged 1 to 4 years, a parent's substance use history was the leading risk factor for preventable death. Having a CPS history with family was the leading risk factor for preventable deaths among children aged 10 to 14 years. Substance use was the leading risk factor in preventable deaths among adolescents aged 15 to 17 years (Table 6).

Table 6. Leading Risk Factors of Preventable Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 329)^

Age Group	# 1	# 2	# 3	# 4	# 5
Birth – 27 Days (n = 41)	Poverty (n = 29)	Parent Substance Use History (n = 24)	Substance Use (n = 19)	No Prenatal Care (n = 18)	CPS History with Family (n = 17)
28 Days – <1 Year (n = 65)	Poverty (n = 54)	Unsafe Sleep Environment (n = 42)	Parent Substance Use History (n = 41)	CPS History with Family (n = 31)	Substance Use (n = 23)
1 – 4 Years (n = 49)	Parent Substance Use History (n = 24)	Lack of Supervision (n = 23)	CPS History with Family (n = 18)	Poverty (n = 16)	Substance Use (n = 15)
5 – 9 Years (n = 22)	Poverty (n = 9)	Lack of Seat Restraint Use (n = 7)	CPS History with Family (n = 6)	Lack of Supervision (n < 6)	Substance Use (n < 6)
10 – 14 Years (n = 44)	CPS History with Family (n = 21)	Child's Chronic Condition (n = 19)	Child Relationship Issues (n = 14)	Poverty (n = 13)	History of Trauma/ Violence (n = 12)
15 – 17 Years (n = 108)	Substance Use (n = 54)	CPS History with Family (n = 54)	Child's Chronic Condition (n = 38)	Child Relationship Issues (n = 34)	History of Trauma/ Violence (n = 32)
Preventable Deaths (n = 329)	CPS History with Family (n = 147)	Poverty (n = 134)	Substance Use (n = 127)	Parent Substance Use History (n = 127)	Child Relationship Issues (n = 73)

^More than one risk factor may have been identified for each death.



Section 3: Manner of Death

Accidental Injury Deaths

Death resulting from unintentional injuries. See the Glossary for further explanation.

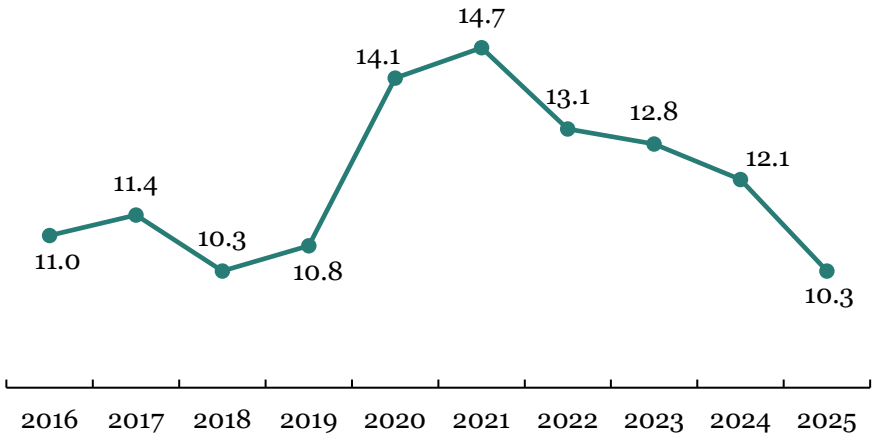
Total Accidental Injury Deaths

171
(22.1% of Child Deaths)

14.9% ↓
in the mortality rate from 2024

100.0%
of Accidental Injury Deaths were Preventable

Accidental Injury Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]

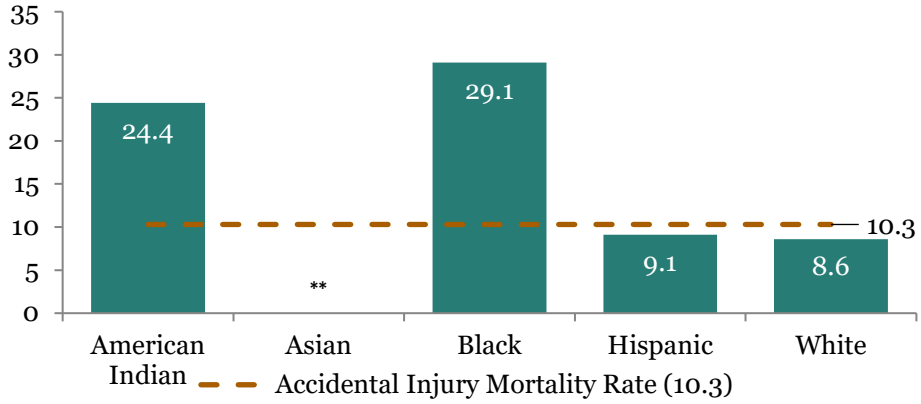


Leading Causes of Accidental Injury Deaths:

Motor Vehicle Crash	Suffocation	Drowning	Poisoning	Firearm Injury
45.6% (78 deaths)	27.5% (47 deaths)	12.3% (21 deaths)	7.0% (12 deaths)	* (<6 deaths)

*The number/percentage was suppressed because the count was less than 6.

Accidental Injury Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Accidental Injury Mortality Rate, Arizona, 2025 [4]



**Data for Asian children were suppressed because the count was less than 6.

32.2%
of Accidental Injury Deaths occurred in infants (less than one year of age)

64.3%
of Accidental Injury Deaths were among males

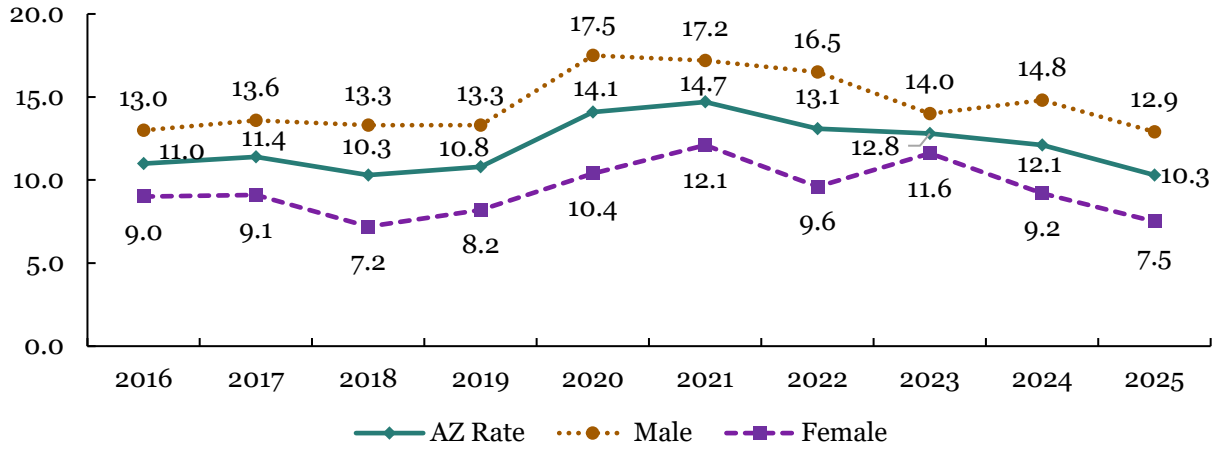
Leading Risk Factors of Accidental Injury Deaths^:

Poverty	Substance Use	CPS History with Family	Parent Substance Use History	Lack of Supervision
39.2%	38.6%	36.8%	35.1%	29.8%

^More than one risk factor may have been identified for each death.

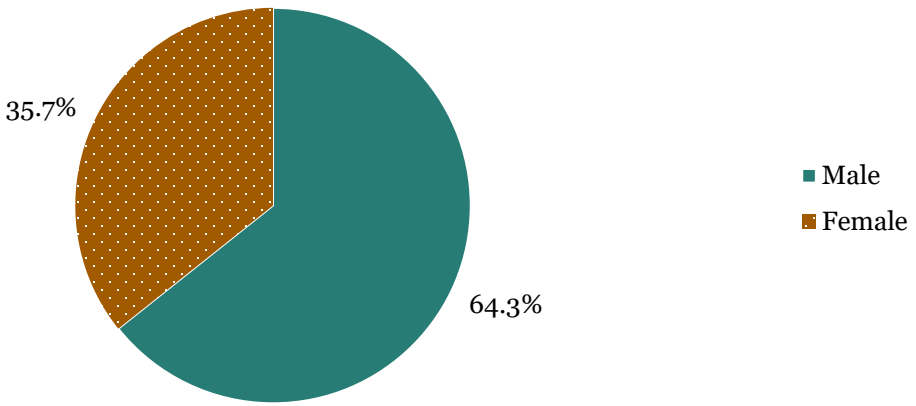
Arizona's accidental injury mortality rate (ages 0 to 17 years) decreased by 14.9 percent over the past year, falling from 12.1 deaths per 100,000 children in 2024 to 10.3 deaths per 100,000 children in 2025. Overall, the male accidental injury mortality rate has generally been higher than the female accidental injury mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate decreased by 12.8 percent (from 14.8 to 12.9 deaths per 100,000 children), while the female mortality rate decreased by 18.5 percent (from 9.2 to 7.5 deaths per 100,000 children) (Figure 18).

Figure 18. Accidental Injury Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



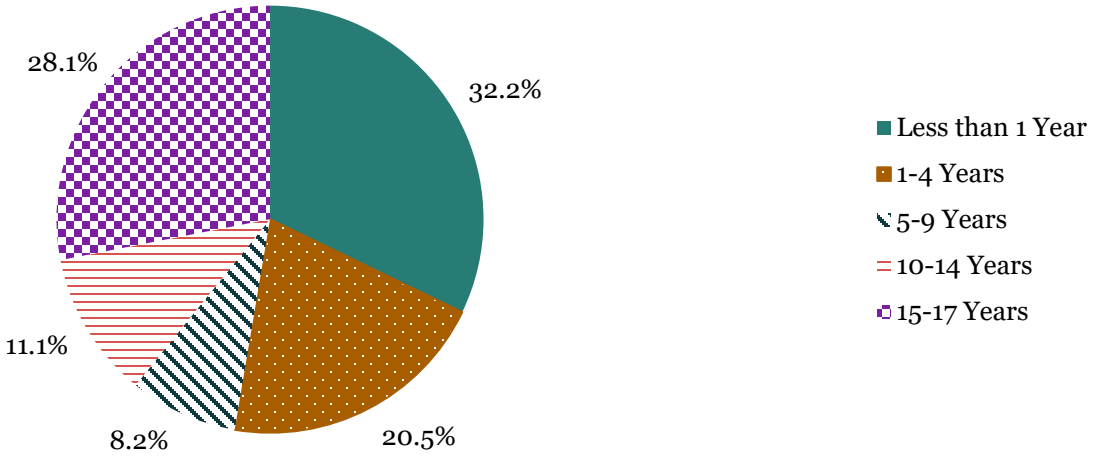
Among accidental injury deaths by sex, 64.3 percent were male, while 35.7 percent were female (Figure 19).

Figure 19. Percentage of Accidental Injury Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 171)



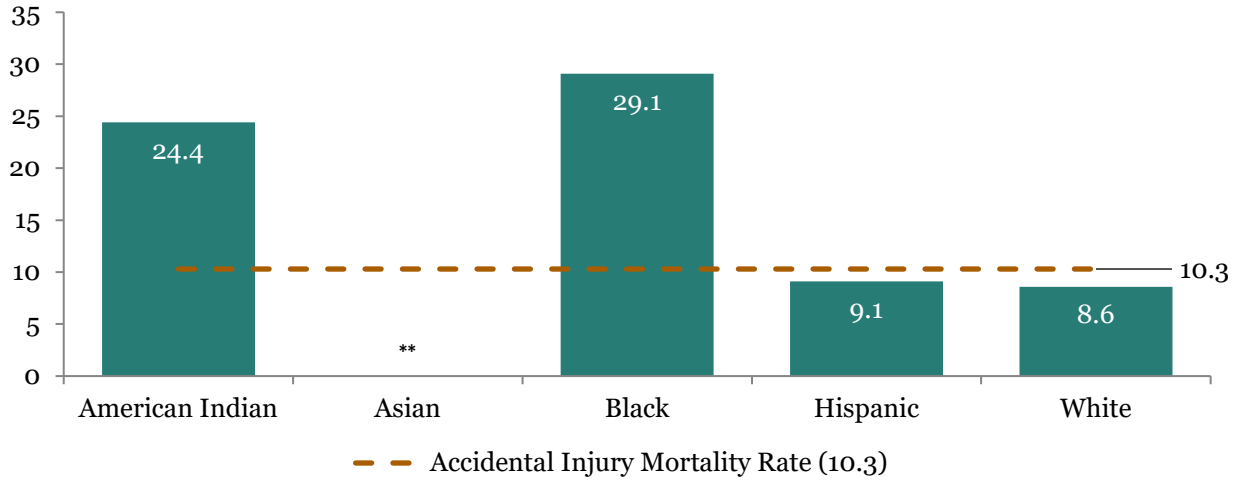
Accidental injury deaths occurred most frequently among infants less than one year (32.2 percent), followed by adolescents aged 15 to 17 years (28.1 percent) (Figure 20).

Figure 20. Percentage of Accidental Injury Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 171)



When stratified by race/ethnicity, American Indian and Black children had higher mortality rates than the 2025 Arizona accidental injury mortality rate (10.3 deaths per 100,000 children), at 24.2 and 29.1 deaths per 100,000 children, respectively. Hispanic and White children had lower mortality rates (Figure 21).

Figure 21. Accidental Injury Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Accidental Injury Mortality Rate, Arizona, 2025 (n = 171) [4]



**Data for Asian children were suppressed because the count was less than 6.

Among accidental injury deaths (ages 0 to 17 years), MVC-related fatalities were the leading cause, accounting for 45.6 percent (78 deaths) of accidental injury fatalities. This was followed by suffocation (27.5 percent; 47 deaths), drowning (12.3 percent; 21 deaths), and poisoning (7.0 percent; 12 deaths) (Table 7).

Table 7. Causes of Accidental Injury Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 171)

Causes of Death	Number	Percent
Motor Vehicle Crash-Related	78	45.6%
Suffocation	47	27.5%
Drowning	21	12.3%
Poisoning	12	7.0%
Firearm Injury	<6	*
Choking	<6	*
Environmental Heat Exposure	<6	*
Fall/Crush	<6	*
Strangulation	<6	*

*The number/percentage was suppressed because the count was less than 6.

While numerous risk factors contribute to accidental injury deaths, poverty was the most prominent, identified in 39.2 percent of the fatalities (67 deaths). This was closely followed by active substance use at 38.6 percent (66 deaths), a family history with CPS at 36.8 percent (63 deaths), and parental history of substance use at 35.1 percent (60 deaths) (Table 8).

Table 8. Risk Factors of Accidental Injury Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 171)

Risk Factors^	Number	Percent
Poverty	67	39.2%
Substance Use	66	38.6%
CPS History with Family	63	36.8%
Parent Substance Use History	60	35.1%
Lack of Supervision	51	29.8%
Lack of Seat Restraint Use	47	27.5%
Unsafe Sleep Environment	45	26.3%
Reckless Driving	40	23.4%
Child's Chronic Condition	25	14.6%
History of Trauma/Violence	23	13.5%
Housing Insecurity	21	12.3%
Child Relationship Issues	16	9.4%
Inability to Swim	15	8.8%
Family Discord	12	7.0%
Lack of Pool Barrier	10	5.8%
Access to Firearm (User < 18 Years)	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.

Homicides

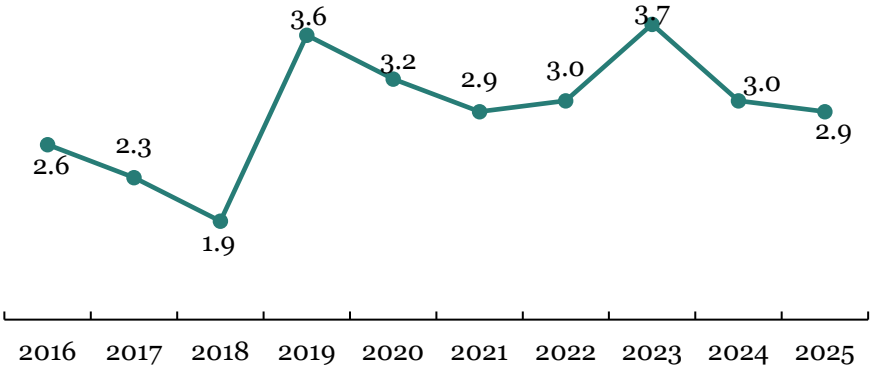
Death resulting from injuries inflicted by another person with the intent to cause fear, harm, or death. See the Glossary for further explanation.

Total Homicides
49
(6.3% of Child Deaths)

3.3% ↓
in the mortality rate from 2024

100.0%
of Homicides were Preventable

Homicides Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]

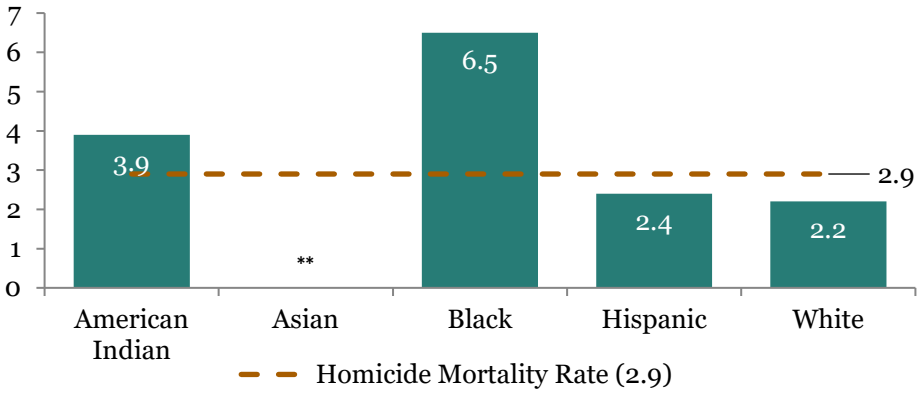


Leading Causes of Homicides:

Firearm Injury	Blunt Force Injury	Stabbing	Suffocation	Poisoning
57.1% (28 deaths)	30.6% (15 deaths)	* (<6 deaths)	* (<6 deaths)	* (<6 deaths)

*The number/percentage was suppressed because the count was less than 6.

Homicide Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Homicide Mortality Rate, Arizona, 2025 [4]



**Data for Asian children were suppressed because the count was less than 6.

22.4%
of Homicides occurred in infants (less than one year of age)

61.2%
of Homicides were among males

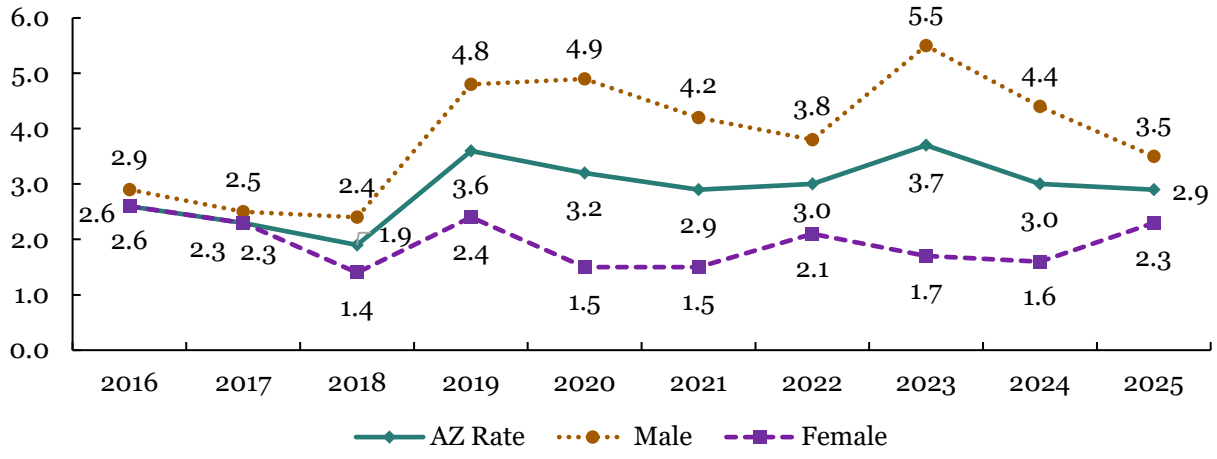
Leading Risk Factors of Homicide^:

CPS History with Family	History of Trauma/Violence	Substance Use	Criminal Activity	Parent Substance Use History
59.2%	49.0%	46.9%	44.9%	42.9%

^More than one risk factor may have been identified for each death.

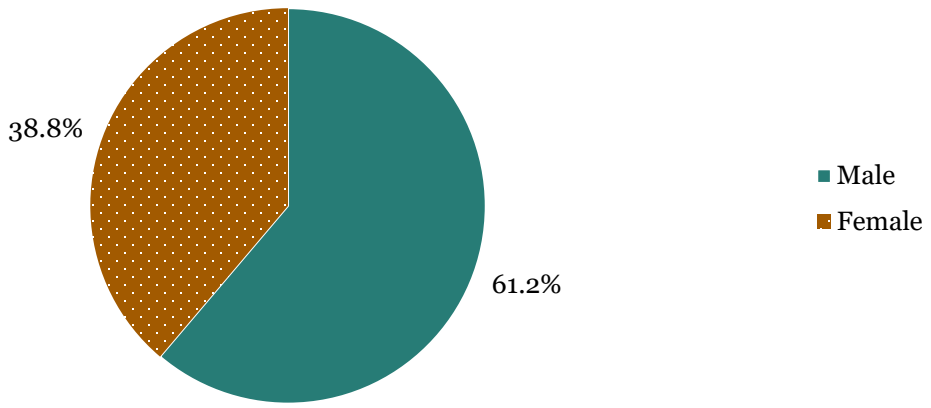
Arizona's homicide mortality rate (ages 0 to 17 years) decreased by 3.3 percent over the past year, falling from 3.0 deaths per 100,000 children in 2024 to 2.9 deaths per 100,000 children in 2025. Overall, the male homicide mortality rate has been generally higher than the female homicide mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate decreased by 20.5 percent (from 4.4 to 3.5 deaths per 100,000 children), while the female mortality rate increased by 43.8 percent (from 1.6 to 2.3 deaths per 100,000 children) (Figure 22).

Figure 22. Homicide Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



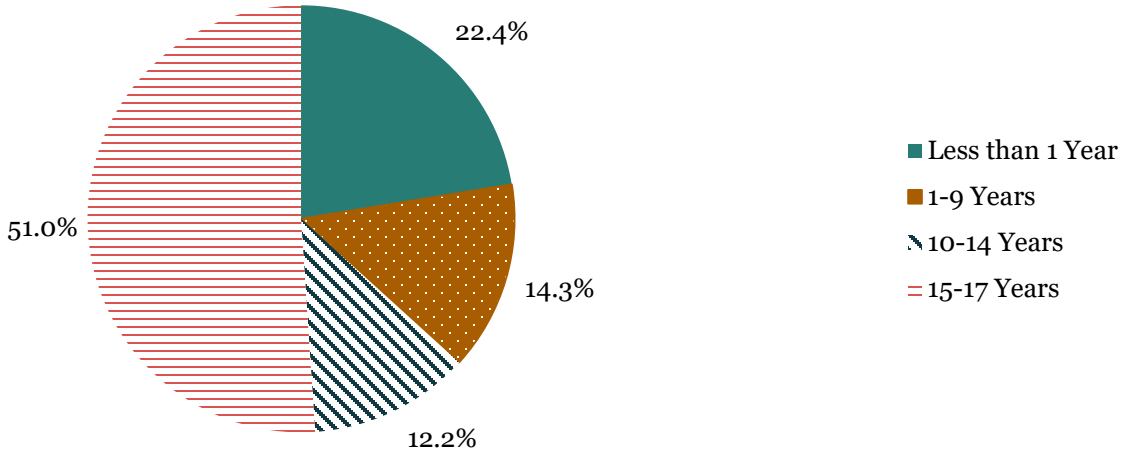
Among homicides by sex, 61.2 percent were male, while 38.8 percent were female (Figure 23).

Figure 23. Percentage of Homicides by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 49)



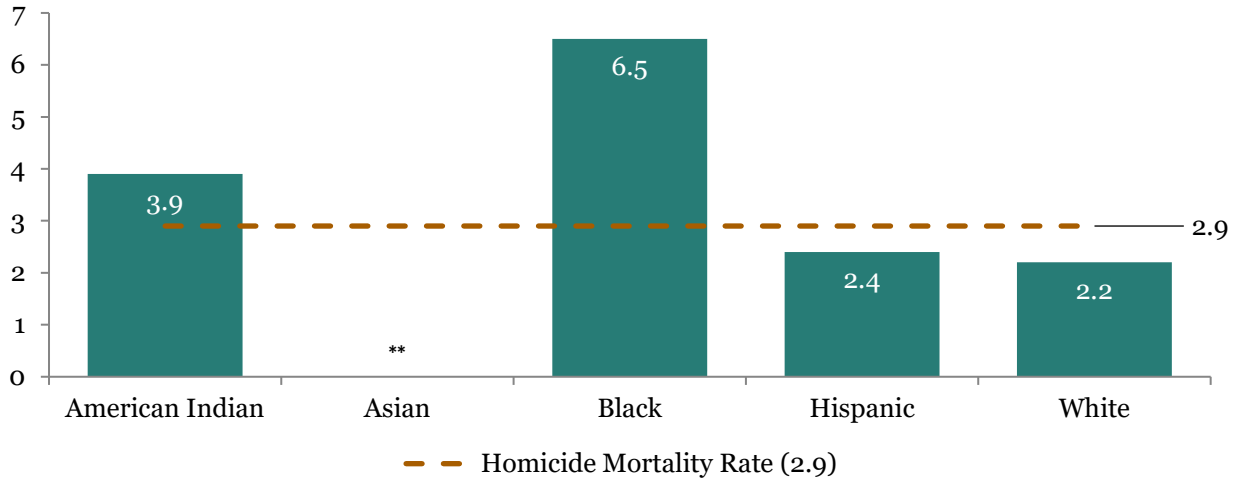
The majority of homicides occurred among adolescents aged 15 to 17 years (51.0 percent), followed by infants less than one year (22.4 percent) (Figure 24).

Figure 24. Percentage of Homicides by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 49)



When stratified by race/ethnicity, American Indian and Black children had higher mortality rates than the 2025 Arizona homicide mortality rate (2.9 deaths per 100,000 children), at 3.9 and 6.5 deaths per 100,000 children, respectively. Hispanic and White children had lower mortality rates (Figure 25).

Figure 25. Homicide Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Homicide Mortality Rate, Arizona, 2025 (n = 49) [4]



**Data for Asian children were suppressed because the count was less than 6.

Among homicides (ages 0 to 17 years), firearm injuries were the leading cause, accounting for 57.1 percent (28 deaths) of homicides. This was followed by blunt force injury, accounting for 30.6 percent (15 deaths) of homicides (Table 9).

Table 9. Causes of Homicides (Ages 0 to 17 Years), Arizona, 2025 (n = 49)

Causes of Death	Number	Percent
Firearm Injury	28	57.1%
Blunt Force Injury	15	30.6%
Stabbing	<6	*
Suffocation	<6	*
Poisoning	<6	*
Motor Vehicle Crash-Related	<6	*
Drowning	<6	*

*The number/percentage was suppressed because the count was less than 6.

An acquaintance was identified as the perpetrator in 32.7 percent (16 deaths) of the homicides, followed by the father at 26.5 percent (13 deaths) and the mother at 18.4 percent (9 deaths) (Table 10).

Table 10. Number and Percentage of Homicides by Perpetrator (Ages 0 to 17 Years), Arizona, 2025 (n = 49)

Perpetrator^	Number	Percent
Acquaintance	16	32.7%
Father	13	26.5%
Mother	9	18.4%
Stranger	7	14.3%
Other Relative	<6	*
Unknown	<6	*
Parent's Partner	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one perpetrator may have been identified in each death

While numerous risk factors contribute to homicides, a family history with CPS was the most prominent, identified in 59.2 percent of the fatalities (29 deaths). This was closely followed by a history of trauma/violence at 49.0 percent (24 deaths) and active substance use at 46.9 percent (23 deaths) (Table 11).

Table 11. Risk Factors of Homicides (Ages 0 to 17 Years), Arizona, 2025 (n = 49)

Risk Factors^	Number	Percent
CPS History with Family	29	59.2%
History of Trauma/Violence	24	49.0%
Substance Use	23	46.9%
Criminal Activity	22	44.9%
Parent Substance Use History	21	42.9%
Child's Relationship Issues	18	36.7%
Poverty	17	34.7%
Family Discord	11	22.4%
Access to Firearm (User < 18 Years)	9	18.4%
Child's Chronic Condition	8	16.3%
School Problems	7	14.3%

^More than one risk factor may have been identified in each death.

Natural Deaths

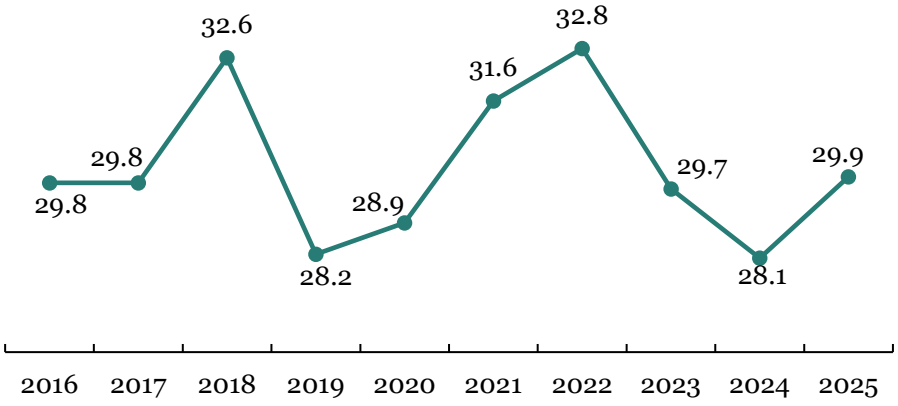
Death due to a medical condition. In Arizona and nationwide, these deaths account for the largest percentage of child deaths every year. See the Glossary for further explanation.

Total Natural Deaths
499
(64.6% of Child Deaths)

6.4% ↑
in the mortality rate from 2024

11.8%
of Natural Deaths were Preventable

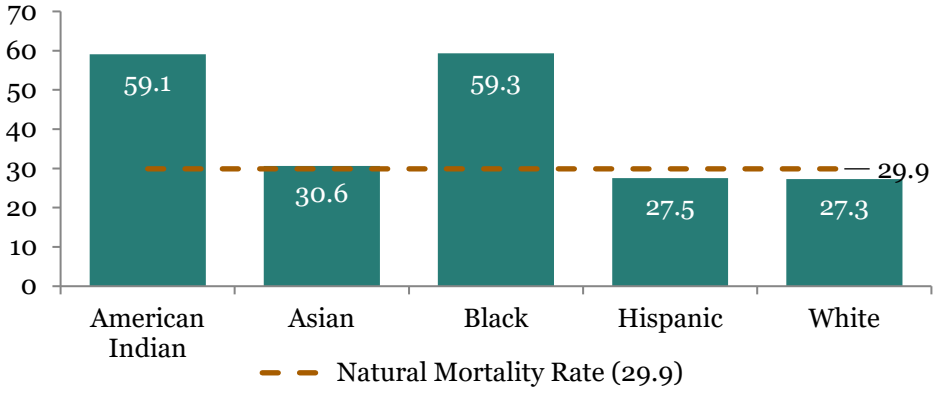
Natural Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



Leading Causes of Natural Deaths:

Prematurity	Congenital Anomaly	Cancer	Cardiovascular	Other Infection
35.1% (175 deaths)	25.7% (128 deaths)	8.4% (42 deaths)	7.0% (35 deaths)	6.2% (31 deaths)

Natural Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Natural Mortality Rate, Arizona, 2025 [4]



69.1%
of Natural Deaths occurred in infants (less than one year of age)

53.1%
of Natural Deaths were among males

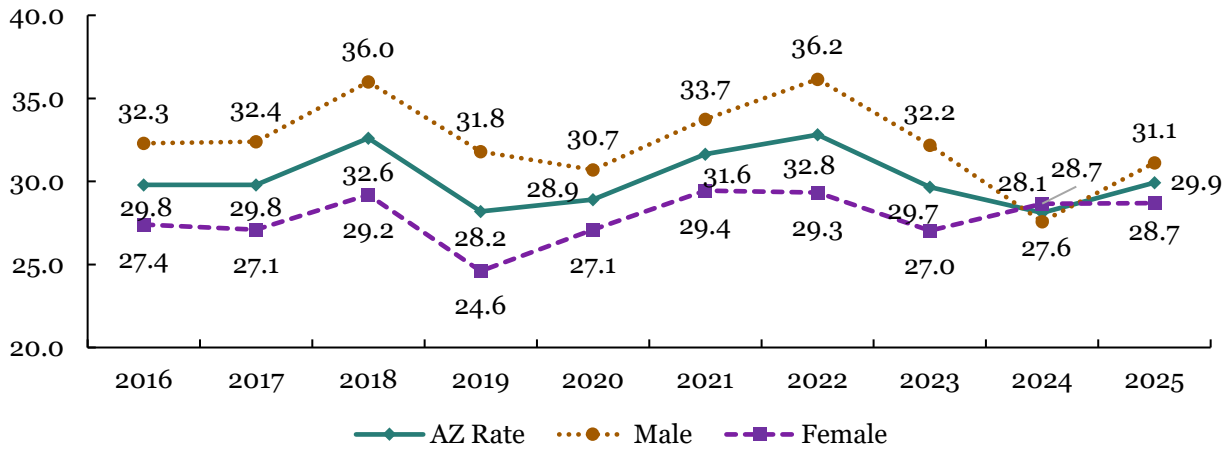
Leading Risk Factors of Natural Death^:

Child's Chronic Condition	Poverty	CPS History with Family	Lack of Prenatal Care	Maternal Infection
55.7%	43.5%	13.8%	9.2%	9.0%

^More than one risk factor may have been identified for each death.

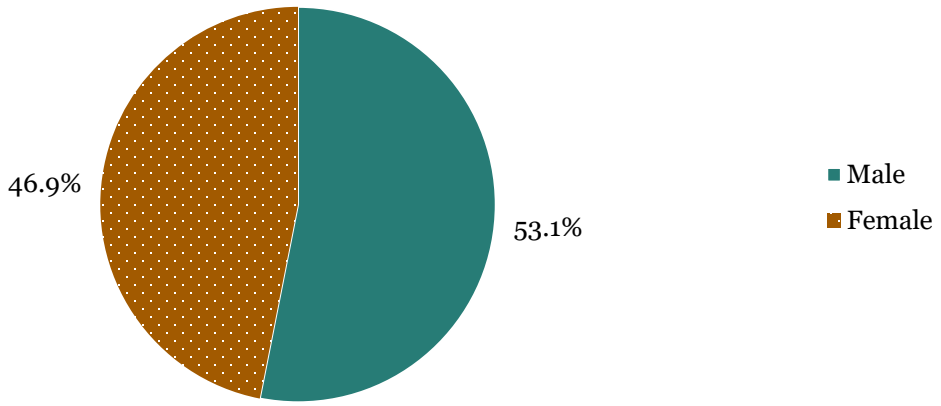
Arizona's natural mortality rate (ages 0 to 17 years) increased by 6.4 percent over the past year, increasing from 28.1 deaths per 100,000 children in 2024 to 29.9 deaths per 100,000 children in 2025. From 2024 to 2025, the male mortality rate increased by 12.7 percent (from 27.6 to 31.1 deaths per 100,000 children), while the female mortality rate remained constant at 28.7 deaths per 100,000 children (Figure 26).

Figure 26. Natural Mortality Rate (per 100,00 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



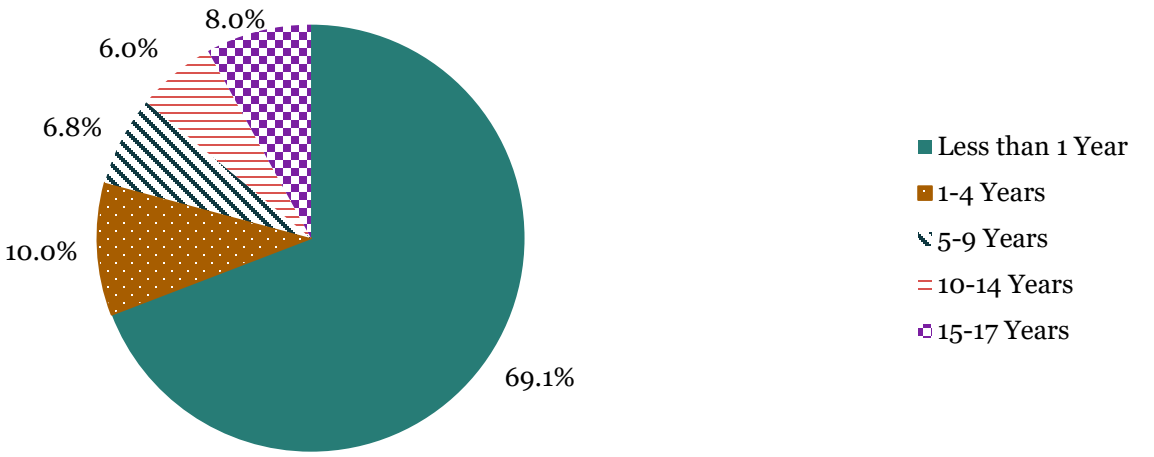
Among natural deaths by sex, 53.1 percent were male, while 46.9 percent were female (Figure 27).

Figure 27. Percentage of Natural Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 499)



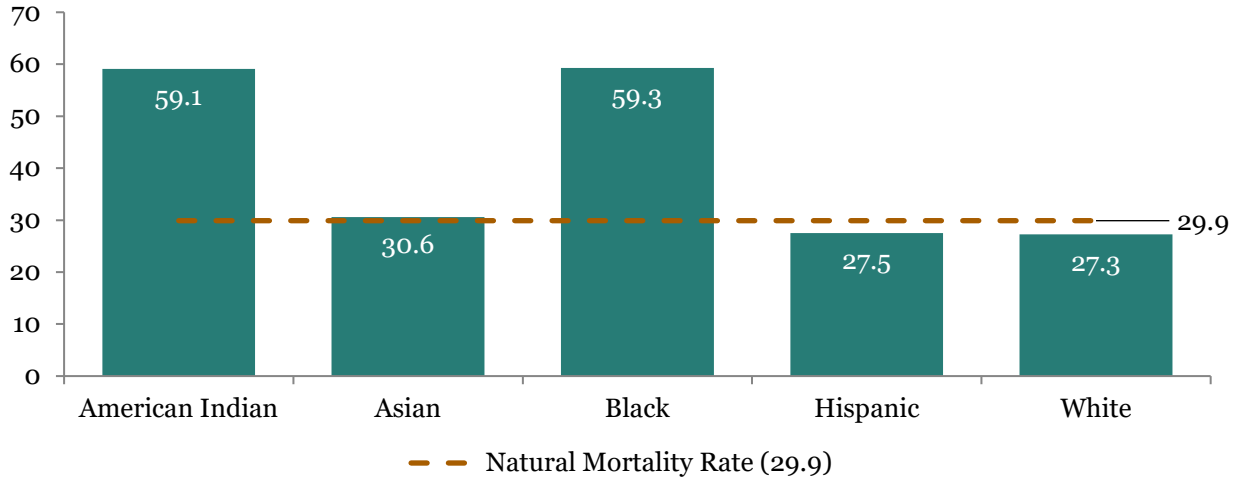
The majority of natural deaths occurred among infants less than one year (69.1 percent), followed by children aged 1 to 4 years (10.0 percent) (Figure 28).

Figure 28. Percentage of Natural Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 499)



When stratified by race/ethnicity, American Indian, Asian, and Black children had higher mortality rates than the 2025 Arizona natural mortality rate (29.9 deaths per 100,000 children), at 59.1, 30.6, and 59.3 deaths per 100,000 children, respectively. Hispanic and White children had lower mortality rates (Figure 29).

Figure 29. Natural Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Natural Mortality Rate, Arizona, 2025 (n = 499) [4]



Among natural deaths (ages 0 to 17 years), prematurity was the leading cause, accounting for 35.1 percent (175 deaths) of natural fatalities. This was followed by congenital anomalies at 25.7 percent (128 deaths) (Table 12).

Table 12. Cause of Natural Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 499)

Causes of Death	Number	Percent
Prematurity	175	35.1%
Congenital Anomaly	128	25.7%
Cancer	42	8.4%
Cardiovascular	35	7.0%
Other Infection	31	6.2%
Neurological/ Seizure Disorder	29	5.8%
Other Medical Condition	14	2.8%
Pneumonia	13	2.6%
Other Perinatal Condition	13	2.6%
Influenza	8	1.6%
Diabetes	<6	*
COVID-19	<6	*
Asthma/Respiratory	<6	*
Undetermined Medical Cause	<6	*

*The number/percentage was suppressed because the count was less than 6.

While numerous risk factors contribute to natural deaths, the child's chronic condition was the most prominent, identified in 55.7 percent of the fatalities (278 deaths). This was closely followed by poverty at 43.5 percent (217 deaths), and a family history with CPS at 13.8 percent (69 deaths) (Table 13).

Table 13. Risk Factors of Natural Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 499)

Risk Factors^	Number	Percent
Child's Chronic Condition	278	55.7%
Poverty	217	43.5%
CPS History with Family	69	13.8%
Lack of Prenatal Care	46	9.2%
Maternal Infection	45	9.0%
Uninsured Status	29	5.8%
Inadequate Medical Treatment	23	4.6%
Substance Use	19	3.8%
Medical Error	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.

Suicides

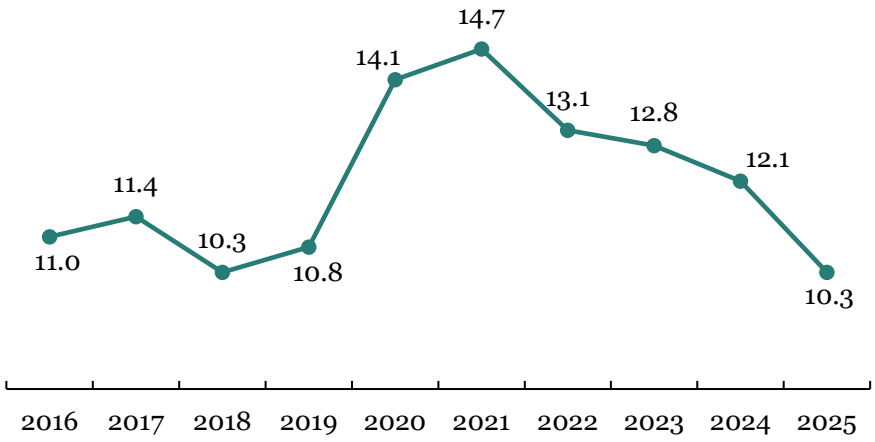
Death resulting from a self-directed, intentional behavior where the intent is to die because of that behavior. See the Glossary for further explanation.

Total Suicides
38
(4.9% of Child Deaths)

9.3% ↓
in the mortality rate from 2024

100.0%
of Suicides were Preventable

Suicide Mortality Rate (per 100,000 Children, Ages 10 to 17 Years+), Arizona, 2016-2025 [4-13]

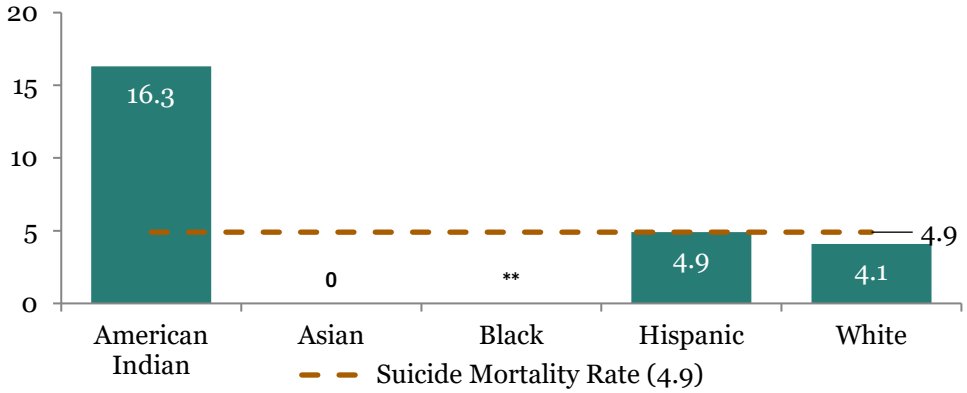


Leading Causes of Suicide:

Firearm Injury	Strangulation	Poisoning	Motor Vehicle Crash
50.0% (19 deaths)	31.6% (12 deaths)	* (<6 deaths)	* (<6 deaths)

*The number/percentage was suppressed because the count was less than 6.

Suicide Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 10 to 17 Years+), Compared to the Suicide Mortality Rate, Arizona, 2025 [4]



**Data for Black children were suppressed because the count was less than 6.

73.7%
of Suicides occurred in children aged 15-17 years+

68.4%
of Suicides were among males+

Leading Risk Factors of Suicide^:

Child Relationship Issues	Recent Suicide Warnings	Communicated Suicide Thoughts	Child's Chronic Condition	School Issues
81.6%	73.7%	57.9%	55.3%	50.0%

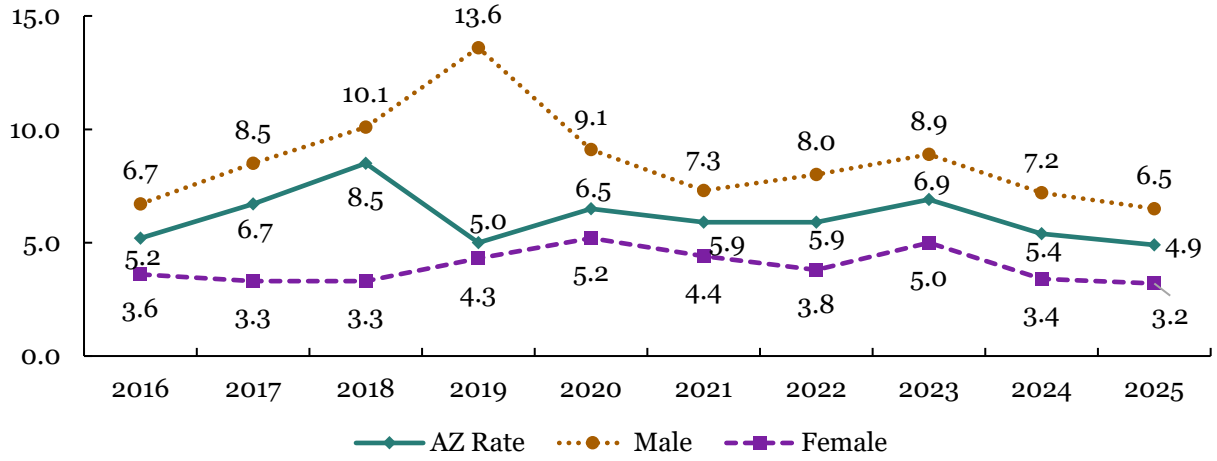
^More than one risk factor may have been identified for each death.
+ Data for children under the age of 10 were suppressed because the count was less than 6.

Suicide Prevention Recommendations:

- State and local public health, healthcare, schools, and youth-serving organizations should integrate suicide prevention education into existing outreach and programming for parents, caregivers, peers, and the public. Education should include recognizing suicide risk and warning signs, how to respond to concerns, and when and how to connect someone to 988 or other appropriate crisis and behavioral health services. [44]
- Public and private schools should maintain comprehensive suicide prevention, intervention, and postvention protocols appropriate to their setting and available resources. Schools should train staff to recognize and respond to suicide risk; establish clear processes for students and staff to report concerns; maintain referral pathways to appropriate behavioral health services; provide evidence-informed suicide and bullying prevention programming; and have procedures for responding to a student suicide or suicide attempt that reduce the risk of contagion. [45-53]
- State, local, Tribal, healthcare, and behavioral health partners should strengthen coordination and referral pathways for counseling, therapy, grief, crisis, and other behavioral health services, with particular attention to identified gaps in availability and accessibility. Efforts involving Tribal communities should be developed in partnership with Tribal Nations and Tribal health systems to reflect community-identified needs and resources. [46]
- State and local partners should provide parents, caregivers, schools, youth-serving professionals, and young people with practical education for recognizing and responding to concerning online activity that may indicate suicidal ideation, self-harm, or emotional crisis. Education should address age-appropriate online safety and supervision, warning signs, platform reporting resources, and when and how to involve a trusted adult, 988, behavioral health services, or emergency services. [55]
- Pediatricians and all pediatric healthcare providers should conduct universal screening for mental health issues and provide anticipatory guidance on safety planning during healthcare visits, as well as have education on prescribing and managing medications to treat mental health concerns and make appropriate referrals. Home safety planning should include standardized anticipatory guidance on adolescent safety and suicide prevention, including: [55-56]
    - Promote firearm safety and secure storage practices that reduce unauthorized access to firearms in the home. Education for parents, families, and caregivers should include information about the relationship between firearm access and suicide risk, strategies for securely storing firearms, and the importance of further limiting access when a young person is experiencing suicidal thoughts or other periods of elevated risk. [49, 54]
    - Pediatric healthcare providers should implement age-appropriate, evidence-informed screening for behavioral health and suicide risk consistent with applicable clinical guidance and establish clear pathways for responding to identified risk. Responses should include further assessment when indicated, safety planning, counseling on reducing access to lethal means—including secure firearm and medication storage—and appropriate referral and follow-up. [58]
- Schools, youth-serving organizations, community organizations, and other partners should strengthen protective factors for children and adolescents by expanding evidence-informed opportunities for positive relationships, trusted adult connections, peer support, family engagement, resilience-building, and school and community connectedness. [57]

Arizona's suicide mortality rate (ages 10 to 17 years) decreased by 9.3 percent over the past year, falling from 5.4 deaths per 100,000 children in 2024 to 4.9 deaths per 100,000 children in 2025. Overall, the male suicide mortality rate has been higher than the female suicide mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate decreased by 9.7 percent (from 7.2 to 6.5 deaths per 100,000 children aged 10 to 17 years), while the female mortality rate decreased by 5.9 percent (from 3.4 to 3.2 deaths per 100,000 children aged 10 to 17 years) (Figure 30).

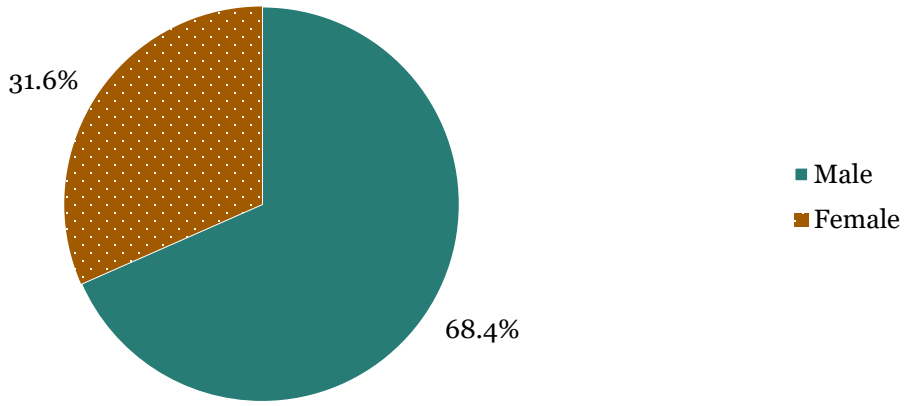
Figure 30. Suicide Mortality Rate (per 100,000 Children) by Sex (Ages 10 to 17 Years), Arizona, 2016-2025+ [4-13]



+Data for children under the age of 10 were suppressed because the count was less than 6.

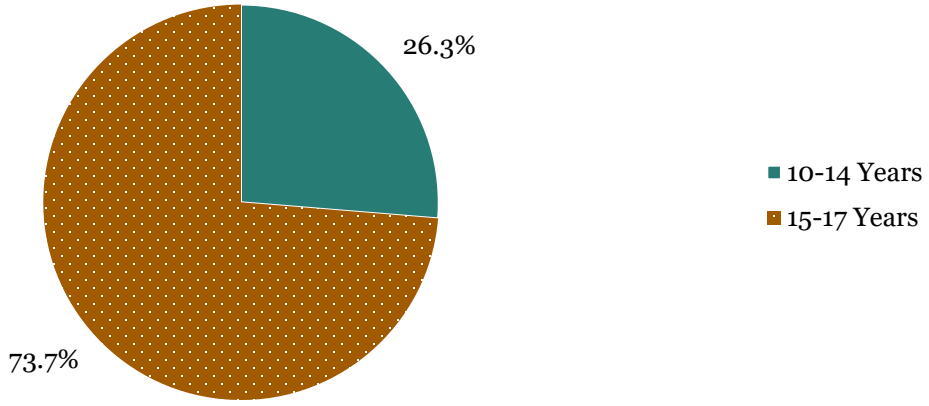
Among suicides by sex, 68.4 percent were male, while 31.6 percent were female (Figure 31).

Figure 31. Percentage of Suicides by Sex (Ages 10 to 17 Years), Arizona, 2025 (n = 38)



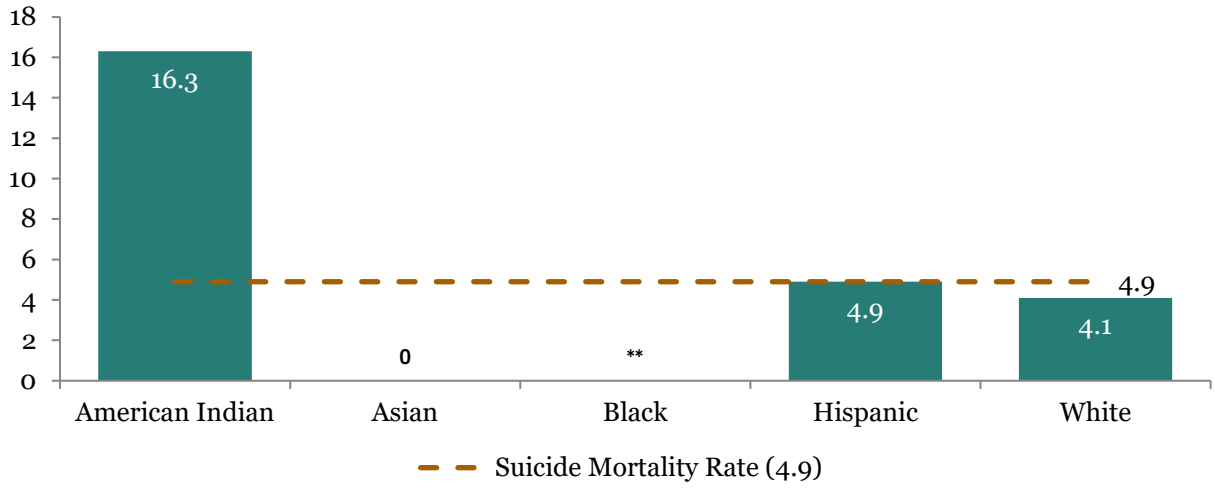
The majority of suicides occurred among adolescents aged 15 to 17 years (73.7 percent), followed by children aged 10 to 14 years (26.3 percent) (Figure 32).

Figure 32. Percentage of Suicides by Age Group (Ages 10 to 17 Years), Arizona, 2025 (n = 38)



When stratified by race/ethnicity, American Indian children had a higher mortality rate than the 2025 Arizona suicide mortality rate (4.9 deaths per 100,000 children aged 10 to 17 years), at 16.3 deaths per 100,000 children aged 10 to 17 years. Hispanic and White children had lower mortality rates. Asian children experienced no suicides in Arizona in 2025 (Figure 33).

Figure 33. Suicide Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 10 to 17 Years), Compared to the Suicide Mortality Rate, Arizona, 2025 (n = 38) [4]



**Data for Black children was suppressed because the count was less than 6.

Among suicides (ages 10 to 17 years), firearm injuries were the leading cause, accounting for 50.0 percent (19 deaths) of suicides. This was followed by strangulation at 31.6 percent (12 deaths) (Table 14).

Table 14. Causes of Suicides (Ages 10 to 17 Years), Arizona, 2025 (n = 38)

Causes of Death	Number	Percent
Firearm Injury	19	50.0%
Strangulation	12	31.6%
Poisoning	<6	*
Motor Vehicle Crash-Related	<6	*

*The number/percentage was suppressed because the count was less than 6.

While numerous risk factors contribute to suicides, a child's relationship issues were the most prominent, identified in 81.6 percent of the fatalities (31 deaths). This was followed by the child having a recent suicide warning at 73.7 percent (28 deaths), and the child communicated suicidal thoughts at 57.9 percent (22 deaths) (Table 15).

Table 15. Risk Factors of Suicides (Ages 10 to 17 Years), Arizona, 2025 (n = 38)

Risk Factors^	Number	Percent
Child Relationship Issues	31	81.6%
Recent Suicide Warnings	28	73.7%
Communicated Suicidal Thoughts	22	57.9%
Child's Chronic Condition	21	55.3%
School Issues	19	50.0%
Mental Health/ Substance Use Disorder	19	50.0%
CPS History with Family	17	44.7%
Prior Suicide Attempt	14	36.8%
Substance Use	14	36.8%
Recent Crisis	12	31.6%
History of Trauma/ Violence	12	31.6%
Parent Substance Use History	8	21.1%
Death of a Loved One (such as a peer, friend, or family member)	8	21.1%
Isolation	<6	*
Poverty	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.

Undetermined Manner Deaths

Death for which the CFRP Team, after review of all available documents, is unable to decide whether the manner of death was natural, accidental, homicide, or suicide. See the Glossary for further explanation.

Total Undetermined Manner Deaths

16

(2.1% of Child Deaths)

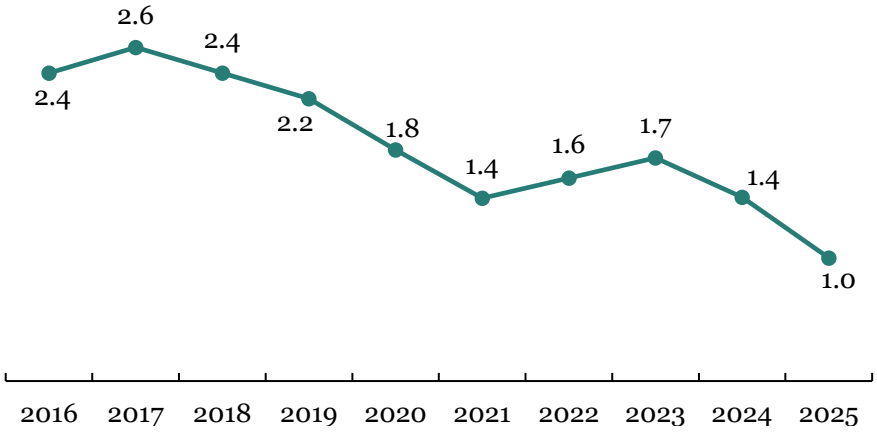
28.6% ↓

in the mortality rate from 2024

75.0%

of Undetermined Manner Deaths were Preventable

Undetermined Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]

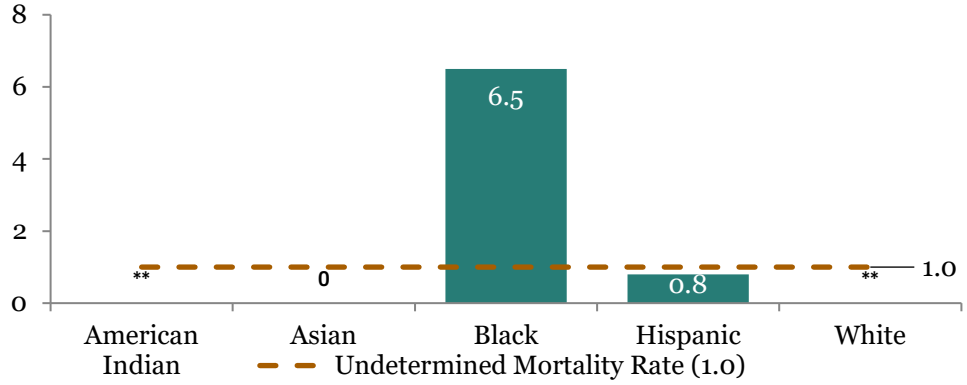


Leading Causes of Undetermined Manner Deaths:

Undetermined	Strangulation	Poisoning	Other Injury	Firearm Injury
75.0%	*	*	*	*

*The number/percentage was suppressed because the count was less than 6.

Undetermined Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Undetermined Mortality Rate, Arizona, 2025 [4]



**Data for American Indian and White children were suppressed because the counts were less than 6.

62.5%

of Undetermined Manner Deaths occurred in infants (less than one year of age)

62.5%

of Undetermined Manner Deaths were among males

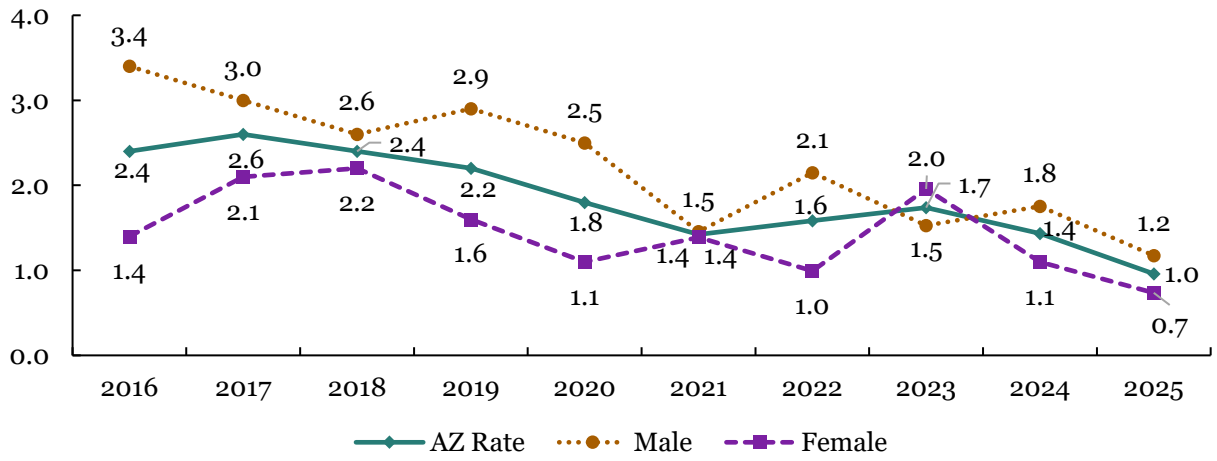
Leading Risk Factors of Undetermined Manner Deaths^:

Parent Substance Use History	CPS History with Family	Poverty	Unsafe Sleep Environment	Substance Use
75.0%	68.8^	62.5%	50.0%	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified for each death.

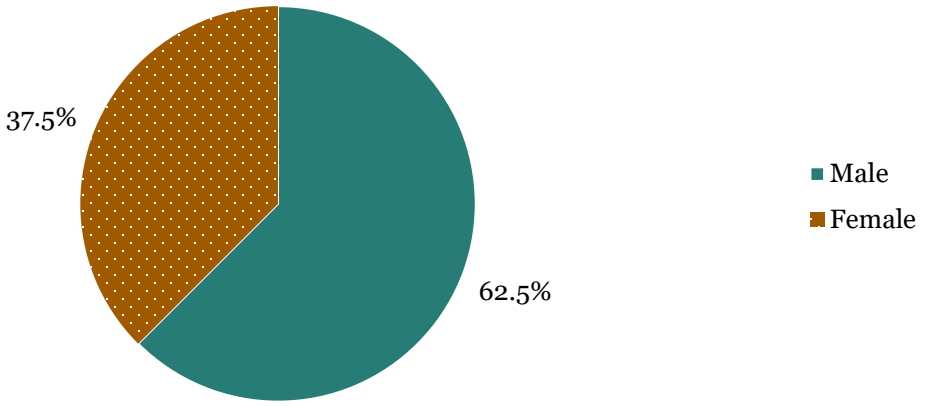
Arizona's undetermined mortality rate (ages 0 to 17 years) decreased by 28.6 percent over the past year, falling from 1.4 deaths per 100,000 children in 2024 to 1.0 deaths per 100,000 children in 2025. From 2024 to 2025, the male mortality rate decreased by 33.3 percent (from 1.8 to 1.2 deaths per 100,000 children), while the female mortality rate decreased by 36.4 percent (from 1.1 to 0.7 deaths per 100,000 children) (Figure 34).

Figure 34. Undetermined Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



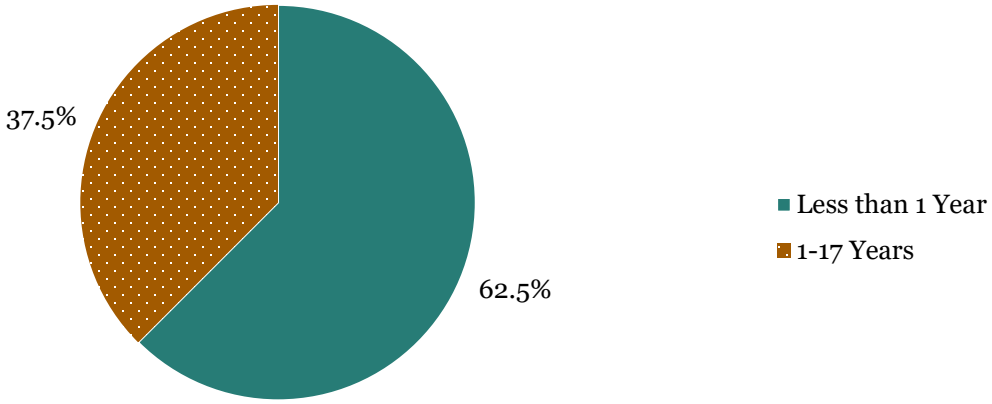
Among undetermined deaths by sex, 62.5 percent were male, while 37.5 percent were female (Figure 35).

Figure 35. Percentage of Undetermined Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 16)



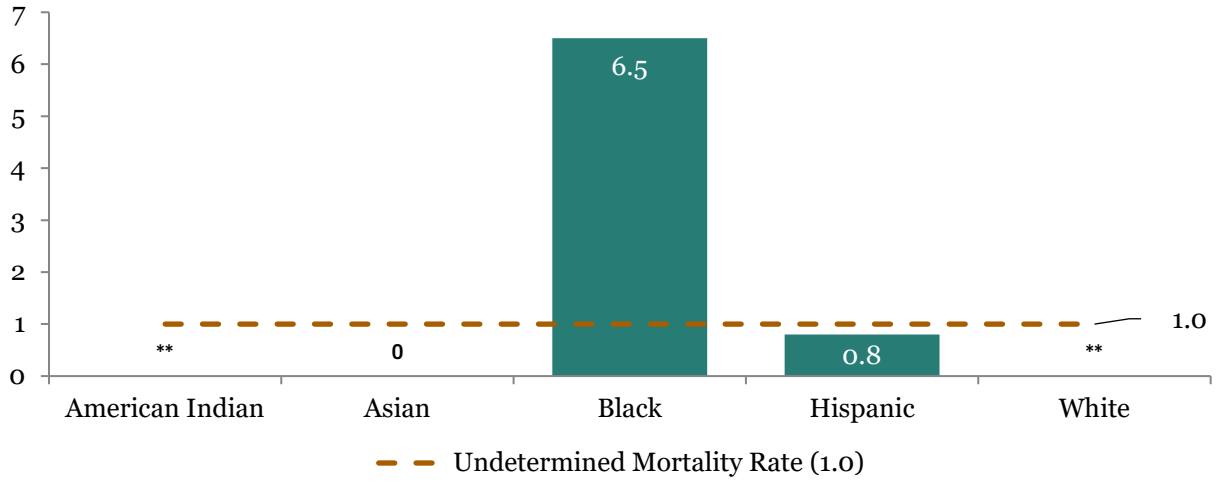
The majority of undetermined deaths occurred among infants less than one year (62.5 percent), followed by children aged 1 to 17 years (37.5 percent) (Figure 36).

Figure 36. Percentage of Undetermined Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 16)



When stratified by race/ethnicity, Black children had a higher undetermined mortality rate than the 2025 Arizona undetermined mortality rate (1.0 deaths per 100,000 children), at 6.5 deaths per 100,000 children. Hispanic children had a lower mortality rate. Asian children experienced no undetermined deaths in Arizona in 2025 (Figure 37).

Figure 37. Undetermined Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Undetermined Mortality Rate, Arizona, 2025 (n = 16) [4]



**Data for American Indian and White children were suppressed because the counts were less than 6.

Among undetermined deaths (ages 0 to 17 years), undetermined fatalities were the leading cause, accounting for 75.0 percent (12 deaths) of undetermined deaths (Table 16).

Table 16. Causes of Undetermined Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 16)

Causes of Death	Number	Percent
Undetermined	12	75.0%
Strangulation	<6	*
Poisoning	<6	*
Other Injury	<6	*
Firearm Injury	<6	*

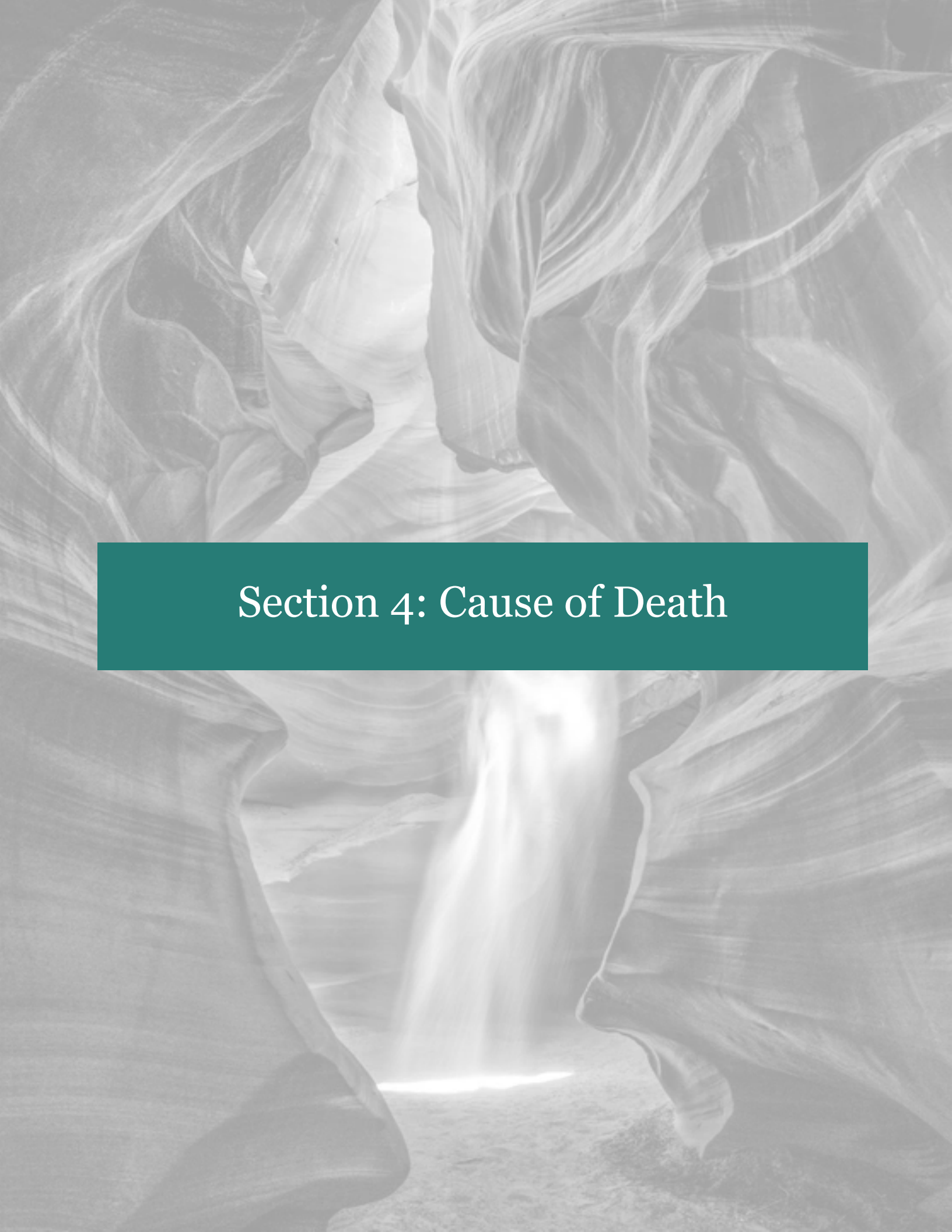
*The number/percentage was suppressed because the count was less than 6.

While numerous risk factors contribute to undetermined deaths, a parental history of substance use was the most prominent, identified in 75.0 percent of the fatalities (12 deaths). A family history with CPS closely followed this at 68.8 percent (11 deaths), poverty at 62.5 percent (10 deaths), and the child having an unsafe sleep environment at 50.0 percent (8 deaths) (Table 17).

Table 17. Risk Factors of Undetermined Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 16)

Risk Factors^	Number	Percent
Parent Substance Use History	12	75.0%
CPS History with Family	11	68.8%
Poverty	10	62.5%
Unsafe Sleep Environment	8	50.0%
Substance Use	<6	*
History of Trauma/Violence	<6	*
Child Relationship Issues	<6	*
Lack of Supervision	<6	*
Family Discord	<6	*
Housing Insecurity	<6	*
Child's Chronic Condition	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.



Section 4: Cause of Death

Drowning Deaths

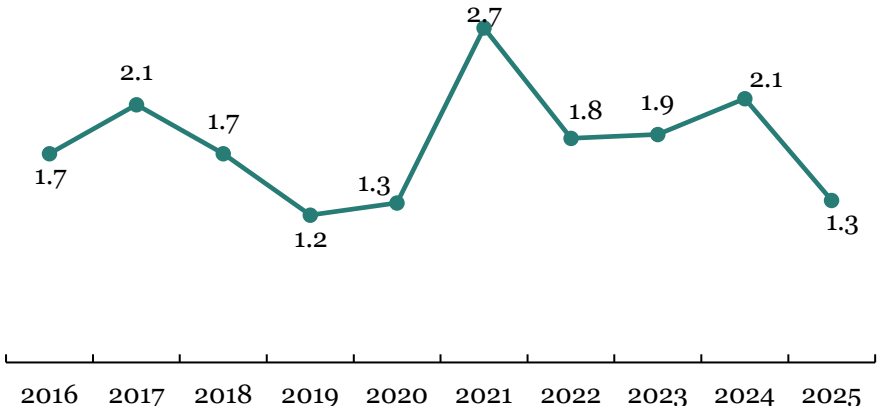
Death from an accidental or intentional submersion in a body of water. See the Glossary for further explanation.

Total Drowning Deaths
22
(2.8% of Child Deaths)

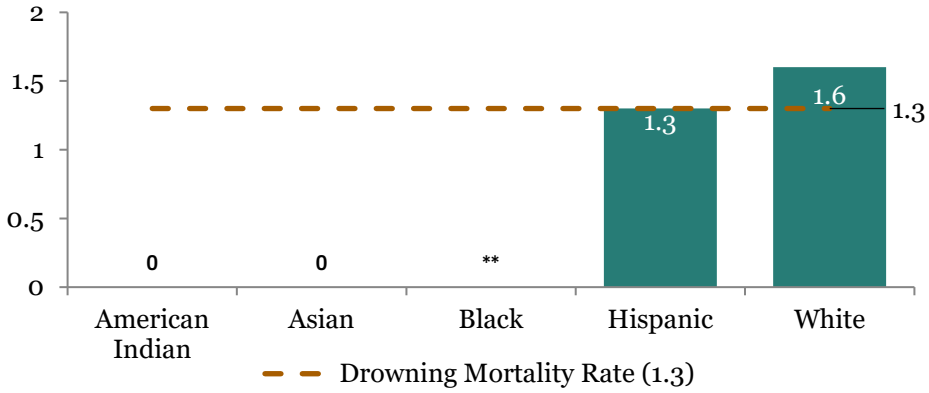
38.1% ↓
in the mortality rate from 2024

100.0%
of Drowning Deaths were Preventable

Drowning Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



Drowning Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Drowning Mortality Rate, Arizona, 2025 [4]



**Data for Black children were suppressed because the count was less than 6.

68.2%
of Drowning Deaths occurred in children less than five years of age

77.3%
of Drowning Deaths were among males

Leading Risk Factors of Drowning Death^:

Lack of Supervision	Inability to Swim	Lack of Pool Barrier	CPS History with Family	Child's Chronic Condition
77.3%	72.7%	45.5%	40.9%	36.4%

^More than one risk factor may have been identified for each death.

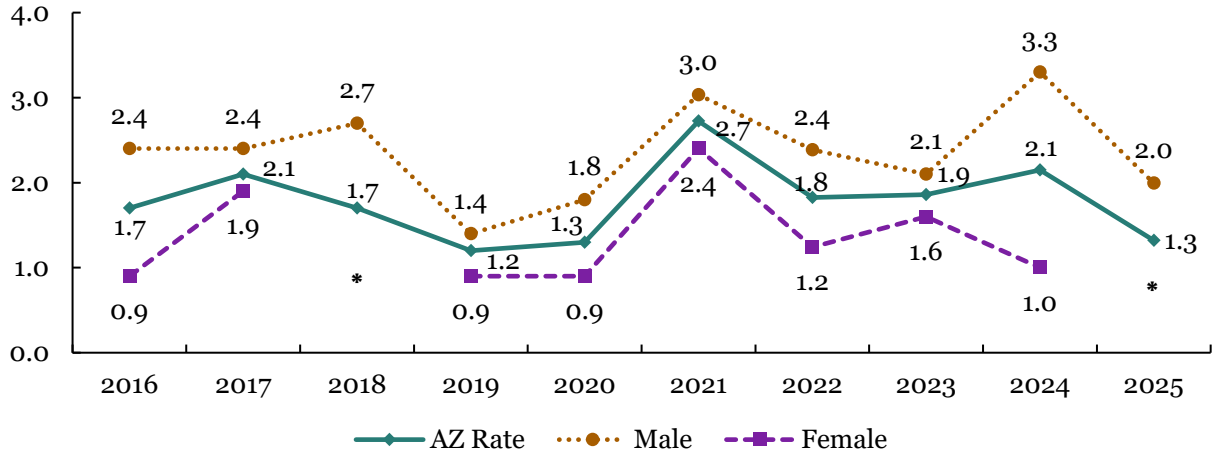
Drowning Death Prevention Recommendations:

- Home inspectors and those renting houses (especially to families with young children) should be aware of and abide by A.R.S. § 36-1681 to ensure that public pools, businesses (including rental properties) with pools, and privately owned pools (including those in existing homes) have proper enclosures and are up to code. This also includes strengthening pool-barrier codes and enforcement, increasing the number of water-safety warning signs at public pools, and alerting new homeowners to pool-barrier codes and requirements. [60-63, 68-69]
- Drowning prevention partners should promote water safety and provide materials to support anyone who works with families and children to educate parents and caregivers about the need for constant sober adult supervision around water for children under 4 years of age, including during bath time. Encourage the use of lifeguards for large numbers of attendees. [59-64, 68-69]
- Drowning prevention partners should promote water safety and provide materials to support anyone who works with families and children, increasing drowning education and family outreach in multiple languages, especially for children with medical, behavioral, and developmental concerns. This includes: [59-65, 68-69]
    - Adult Supervision
        - Do not leave children unattended near pools or pool areas.
        - Provide constant supervision for children under 4 years of age during bath time.
        - There should be a focused adult supervisor responsible for supervising children in or around open water, pools, and spas, especially for high-risk groups such as young children and children with special needs.
        - Designate at least one responsible adult to monitor the pool area when children are present.
        - Use “touch supervision,” where the adult can always reach out and touch the child.
    - Barriers
        - Those with pools need to ensure they are enclosed on all four sides by a wall, fence, or other barrier to restrict access to young children. Pool enclosures need to be at least 5 feet tall, be at least 20 inches from the water’s edge, and have a gate at least 54 inches above the floor that swings away from the pool. The gate should have a self-closing/latching mechanism.
        - Those with pools should ensure there are no openings in pool enclosures that are wide enough for a child to get through or under. There should also be no protrusions, such as handholds, that could be used to climb the enclosure.
        - Ensure barriers comply with your city's barrier codes.
        - Talk with rental companies to ensure safety features for renters with children. Including pool fencing, alarms, and other safety features/devices.
    - Classes
        - If possible, teach children to swim as early as possible, ideally after age 1.
        - Parents and caregivers should learn first aid and CPR in case of an emergency.
    - Devices
        - Ensure that children wear properly fitted Coast Guard-approved life jackets (inflatable swimming aids and personal flotation devices are not substitutes for life jackets).

    - Always have children wear life jackets in and around natural bodies of water, such as lakes or the ocean, even if they know how to swim.
    - Life jackets can be used in and around pools for young swimmers, too.
    - Do not rely solely on flotation devices to protect children from drowning.
- Ensure the availability and accessibility of affordable, developmentally appropriate swim lessons for all children, especially those older than 1 year. [60, 62, 68-69]
- Arizona Game and Fish should ensure parents/caregivers are aware of the dangers of open water and the importance of strong swim skills when navigating such waters. [66-69]

Arizona's drowning mortality rate (ages 0 to 17 years) decreased by 38.1 percent over the past year, falling from 2.1 deaths per 100,000 children in 2024 to 1.3 deaths per 100,000 children in 2025. Overall, the male drowning mortality rate has generally been higher than the female drowning mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate decreased 39.4 percent (from 3.3 to 2.0 deaths per 100,000 children) (Figure 38).

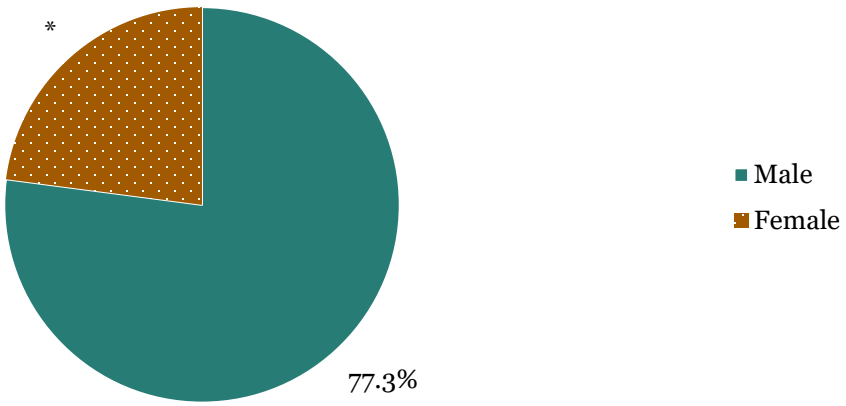
Figure 38. Drowning Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



*2018 and 2025 data on female children were not included due to a small sample size

Among drowning deaths by sex, 77.3 percent were male (Figure 39).

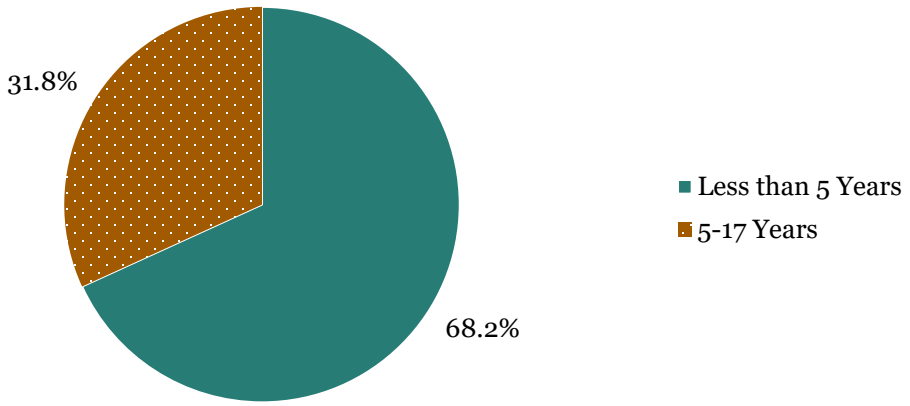
Figure 39. Percentage of Drowning Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 22)



*The percentage was suppressed because the count was less than 6.

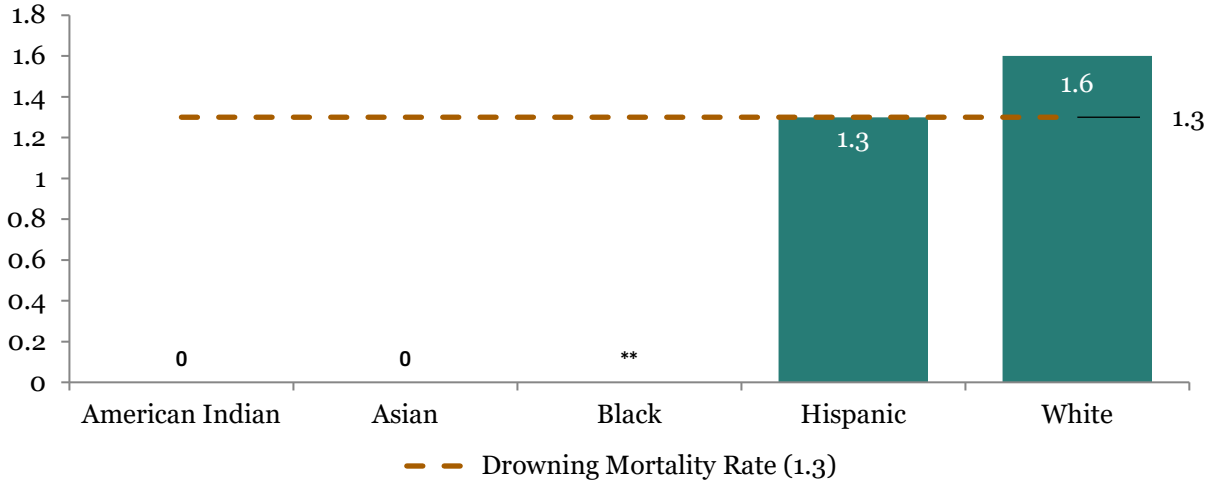
The majority of drowning deaths occurred among children less than 5 years (68.2 percent), followed by children aged 5 to 17 years (31.8 percent) (Figure 40).

Figure 40. Percentage of Drowning Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 22)



When stratified by race/ethnicity, White children had a higher mortality rate than the 2025 Arizona drowning mortality rate (1.3 deaths per 100,000 children), at 1.6 deaths per 100,000 children. Hispanic children had lower mortality rates. American Indian and Asian children experienced no drowning deaths in Arizona in 2025 (Figure 41).

Figure 41. Drowning Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Drowning Mortality Rate, Arizona, 2025 (n = 22) [4]



**Data for Black children were suppressed because the count was fewer than 6.

The majority of drowning deaths occurred in pools, hot tubs, or spas at 68.2 percent (15 deaths) (Table 18).

Table 18. Number and Percentage of Drowning Deaths by Location (Ages 0 to 17 Years), Arizona, 2025 (n = 22)

Location	Number	Percent
Pool, Hot Tub, Spa	15	68.2%
Open Water/Pond	<6	*
Bathtub	<6	*
Unknown	<6	*
Other	<6	*

*The number/percentage was suppressed because the count was less than 6.

Among drowning fatalities where a pool barrier was in place, the most frequently breached barrier was the fence at 40.9 percent (9 deaths), followed by the door at 31.8 percent (7 deaths) (Table 19). For fence breaches, 88.9 percent of the fatalities involved the complete absence of a fence (not shown).

Table 19. Number and Percentage of Drowning Deaths by Breach Location (Ages 0 to 17 Years), Arizona, 2025 (n = 22)

Breach Location^	Number	Percent
Fence (such as no fence, climbed, broken, gap)	9	40.9%
Door (such as left open, lock broken, door broken)	7	31.8%
Gate (such as left open, unlocked, broken)	<6	*
Pet Door	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one breach location may have been identified in each death.

While numerous risk factors contribute to drowning deaths, the lack of supervision was the most prominent, identified in 77.3 percent of the fatalities (17 deaths). This was closely followed by the inability to swim at 72.7 percent (16 deaths), a lack of a pool barrier at 45.5 percent (10 deaths), and a family history with CPS at 40.9 percent (9 deaths) (Table 20).

Table 20. Risk Factors of Drowning Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 22)

Risk Factors^	Number	Percent
Lack of Supervision	17	77.3%
Inability to Swim	16	72.7%
Lack of Pool Barrier	10	45.5%
CPS History with Family	9	40.9%
Child's Chronic Condition	8	36.4%
Parent Substance Use History	6	27.3%
Poverty	<6	*
Substance Use	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.

Of the 22 drowning incidents, the parent was responsible for supervising the child in 81.8 percent of fatalities (18 deaths) (Table 21).

Table 21. Number and Percentage of Drowning Deaths by Responsible Supervisor (Ages 0-17 Years) – Arizona, 2025 (n = 22)

Responsible Supervisor	Number	Percent
Parent	18	81.8%
Other (such as Other Relative, Foster Parent, Educational Staff)	<6	*

*The number/percentage was suppressed because the count was less than 6.

Firearm Injury Deaths

Death caused by an injury resulting from the penetrating force of a bullet or other projectile fired from a powder-charged gun. See the Glossary for further explanation.

Total Firearm Injury Deaths

52

(6.7% of Child Deaths)

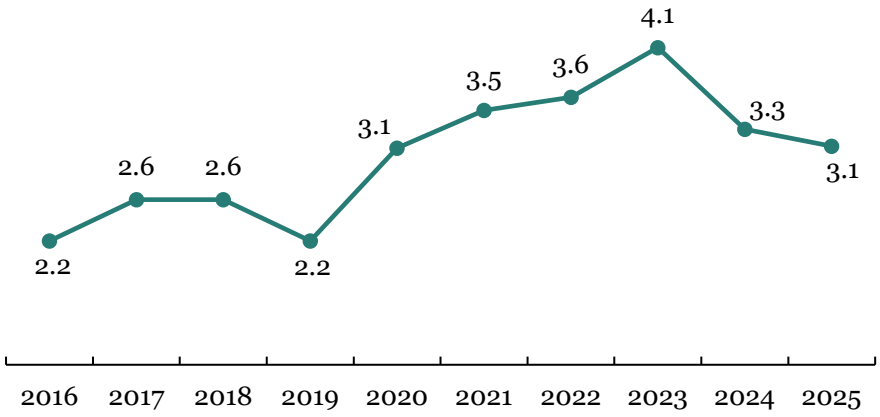
6.1% ↓

in the mortality rate from 2024

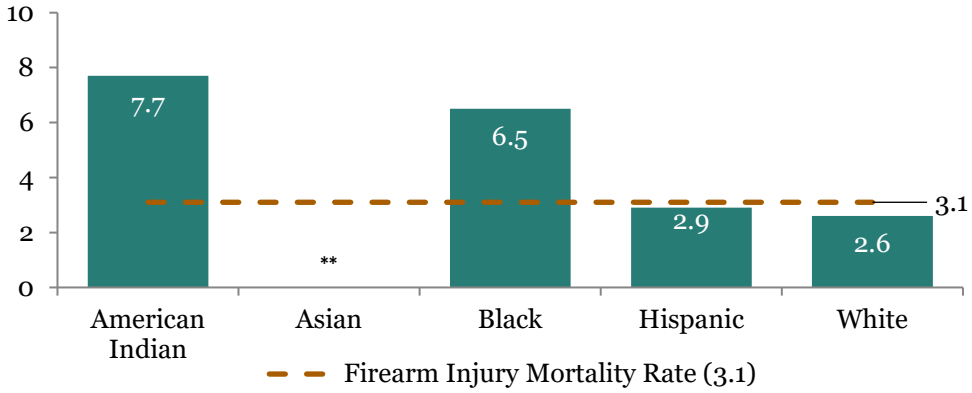
100.0%

of Firearm Injury Deaths were Preventable

Firearm Injury Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



Firearm Injury Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Firearm Injury Mortality Rate, Arizona, 2025 [4]



**Data for Asian children were suppressed because the count was less than 6.

67.3%

of Firearm Injury Deaths occurred among adolescents aged 15-17 years

69.2%

of Firearm Injury Deaths were among males

Leading Risk Factors of Firearm Injury Death^:

Access to Firearm (User < 18 Years)	Unsecured Firearm	Child Relationship Issues	CPS History with Family	Substance Use
55.8%	51.9%	50.0%	48.1%	36.5%

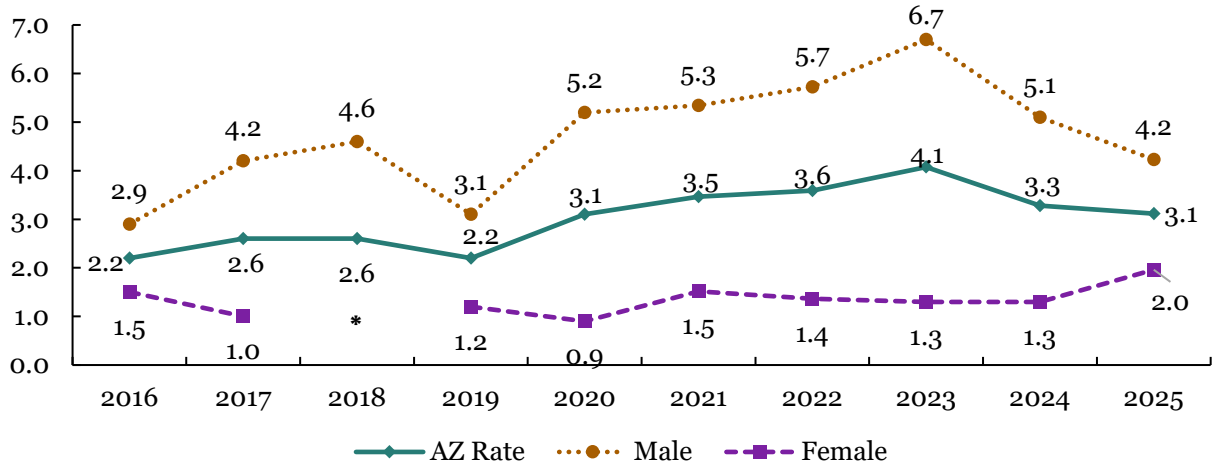
^More than one risk factor may have been identified for each death.

Firearm Injury Death Prevention Recommendations:

- Implement education, campaigns, and initiatives for gun owners to reduce firearm deaths. Strategies include: [70-74]
    - Healthcare providers and community agencies that serve families and children should promote safe storage of firearms, which requires keeping the gun unloaded and locked in a safe separate from the ammunition.
    - Businesses that sell firearms should distribute lock boxes to promote safe storage and provide information on safety classes with all firearm purchases.
    - Strengthen firearm ownership and purchase restrictions on those with serious mental illness diagnoses and domestic violence perpetrator history, and continue to promote and support prohibited possessor laws.
    - Community agencies serving children, adolescents, and families should increase awareness of firearm safety guidance and what to do if you find a firearm.
- Local partners, including schools, families, law enforcement, and community-based organizations, should support comprehensive, evidence-based programs that address risk and protective factors associated with youth violence, gang involvement, and substance use. This could include mentoring, conflict resolution, coping skills, substance use prevention, and opportunities for engagement in school and community/extracurricular activities. Especially for at-risk teens, including those in foster care, diversion programs, the juvenile justice system, etc. [75]
- Increase the availability and accessibility of affordable, quality mental health and substance use treatment services that are supportive for families with children to receive care. Especially in rural and tribal areas. [76]
- Establish a coordinated community support framework that proactively identifies and provides wraparound services for high-risk families. This should include: [77-81]
    - Family Support Hubs that create or expand local centers where families can access case management, parenting programs, and immediate support for basic needs (food, housing, employment, mental health services) in one location.
    - Multi-Agency Collaboration to encourage cooperation between schools, healthcare providers, child protection, and community organizations to share relevant information and form joint care plans tailored to each family's circumstances.
    - Early identification and referrals by training frontline workers (teachers, nurses, community liaisons, social workers) to recognize early risk indicators and to refer families through a clear, supportive pathway—not a punitive one.
    - Peer and community mentorship to engage local volunteers, family mentors, and cultural leaders to provide social support and reduce isolation, particularly for marginalized communities.

Arizona's firearm injury mortality rate (ages 0 to 17 years) decreased by 6.1 percent over the past year, falling from 3.3 deaths per 100,000 children in 2024 to 3.1 deaths per 100,000 children in 2025. Overall, the male firearm injury mortality rate has generally been higher than the female firearm injury mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate decreased by 17.6 percent (from 5.1 to 4.2 deaths per 100,000 children), while the female mortality rate increased by 53.8 percent (from 1.3 to 2.0 deaths per 100,000 children) (Figure 42).

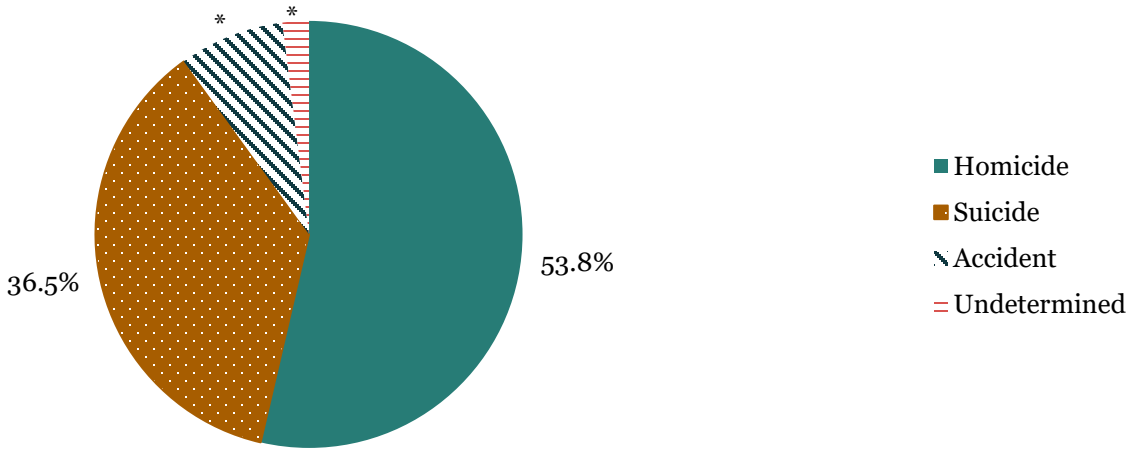
Figure 42. Firearm Injury Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



*2018 data on female children were not included due to the small sample size

Within firearm injury deaths, the majority of deaths were classified as homicides at 53.8 percent, followed by suicides at 36.5 percent (Figure 43).

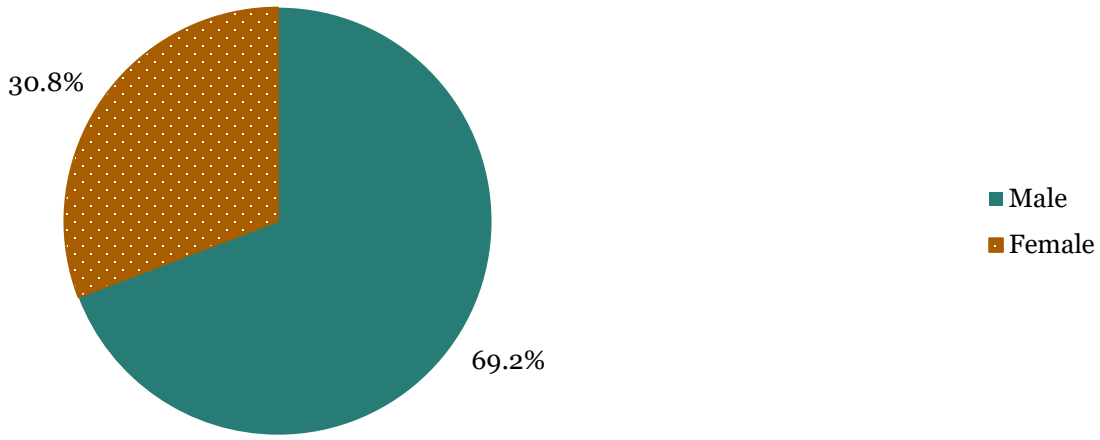
Figure 43. Percentage of Firearm Injury Deaths by Manner of Death (Ages 0 to 17 Years), Arizona, 2025 (n = 52)



*The percentage was suppressed because the count was less than 6.

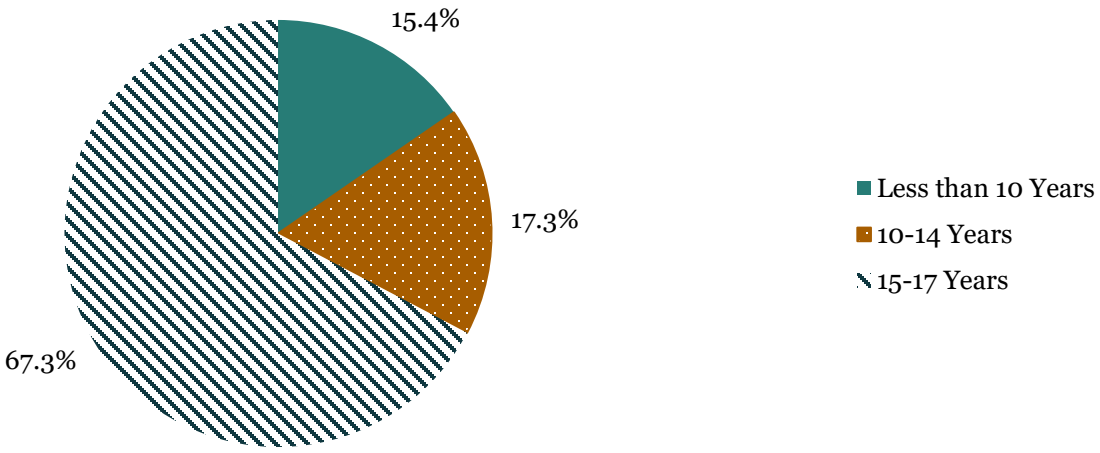
Among firearm injury deaths by sex, 69.2 percent were male, while 30.8 percent were female (Figure 44).

Figure 44. Percentage of Firearm Injury Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 52)



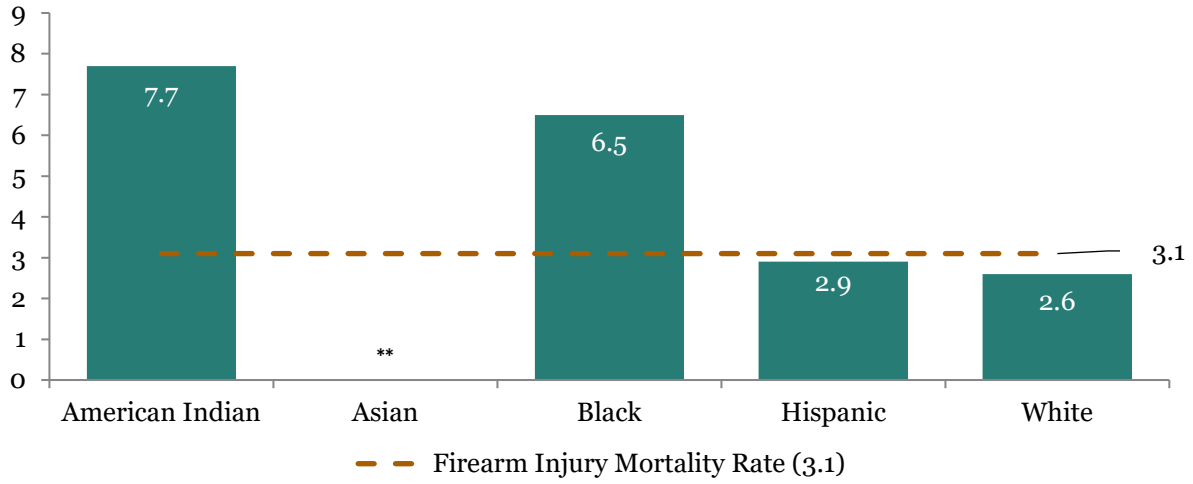
The vast majority of firearm injury deaths occurred among children aged 15 to 17 years (67.3 percent), followed by children aged 10 to 14 years (17.3 percent) (Figure 45).

Figure 45. Percentage of Firearm Injury Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n= 52)



When stratified by race/ethnicity, American Indian and Black children had higher mortality rates than the 2025 Arizona firearm injury mortality rate (3.1 deaths per 100,000 children), at 7.7 and 6.5 deaths per 100,000 children, respectively. Hispanic and White children had lower mortality rates (Figure 46).

Figure 46. Firearm Injury Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Firearm Injury Mortality Rate, Arizona, 2025 (n = 52) [4]



**Data for Asian children were suppressed because the count was less than 6.

Access to firearms was the most frequently identified risk factor among children under 18 years of age, identified in 55.8 percent of the fatalities (29 deaths). This was followed by the firearm being unsecured at 51.9 percent (27 deaths), and a child's relationship issues at 50.0 percent (26 deaths) (Table 22).

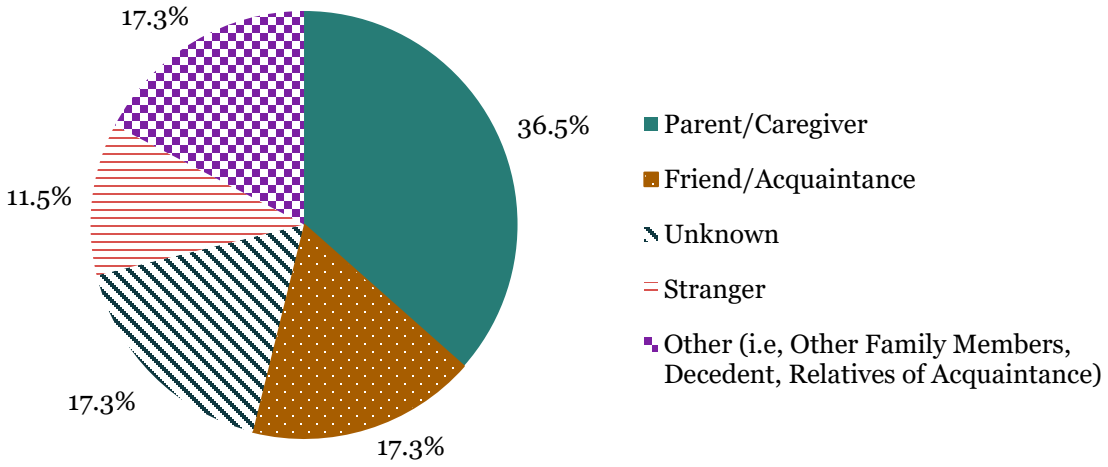
Table 22. Risk Factors of Firearm Injury Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 52)

Risk Factors^	Number	Percent
Access to Firearm (User < 18 Years)	29	55.8%
Unsecured Firearm	27	51.9%
Child Relationship Issues	26	50.0%
CPS History with Family	25	48.1%
Substance Use	19	36.5%
History of Trauma/Violence	18	34.6%
Criminal Activity	16	30.8%
Parent Substance Use History	10	19.2%
Lack of Supervision	7	13.5%
Poverty	6	11.5%
Child's Chronic Condition	6	11.5%

^More than one risk factor may have been identified in each death.

The parent or caregiver was the owner of the firearm used in 36.5 percent of the firearm injury deaths, while the owner of the weapon was unknown in 11.5 percent of these fatalities (Figure 47).

Figure 47. Percentage of Firearm Injury Deaths by Firearm Owner (Ages 0 to 17 Years), Arizona, 2025 (n = 52)



The child themself was the firearm user in 38.5 percent of firearm injury deaths (Table 23).

Table 23. Number and Percentage of Firearm Injury Deaths by Firearm User (Ages 0 to 17 Years), Arizona, 2025 (n = 52)

Person Using Firearm^	Number	Percent
Self	20	38.5%
Friend/Acquaintance	14	26.9%
Relative (such as Parent, Sibling, Other Relatives)	11	21.2%
Stranger	8	15.4%

^More than one person may be using a firearm.

Handguns were involved in 82.7 percent of firearm injury deaths (Table 24).

Table 24. Number and Percentage of Firearm Injury Deaths by Type of Firearm (Ages 0 to 17 Years), Arizona, 2025 (n = 52)

Type of Firearm	Number	Percent
Handgun	43	82.7%
Rifle	8	15.4%
Unknown	<6	*

*The number/percentage was suppressed because the count was less than 6.

The majority of firearm injury deaths occurred within a known home, whether it be the child's home, accounting for 46.2 percent of the fatalities, or a friend/relative's home, accounting for 15.4 percent of the fatalities (Table 25).

Table 25. Number and Percentage of Firearm Injury Deaths by Location (Ages 0 to 17 Years), Arizona, 2025 (n = 52)

Location^	Number	Percent
Child's Home	24	46.2%
Friend/Relative's Home	8	15.4%
Recreational Area	6	11.5%
Sidewalk	<6	*
Parking Lot	<6	*
Other (such as Desert Area, Wash)	<6	*
Road	<6	*
Indian Reservation	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one location may have been identified for each death.

84.6 percent of firearm injury deaths occurred in Arizona's urban counties (Table 26).

Table 26. Number and Percentage of Firearm Injury Deaths by Residency (Ages 0 to 17 Years), Arizona, 2025 (n = 52)

Residency	Number	Percent
Urban Counties	44	84.6%
Rural Counties	8	15.4%

Firearms were used for self-harm in 42.3 percent (22 deaths) of firearm injury fatalities (Table 27).

Table 27. Number and Percentage of Firearm Injury Deaths by Use of Firearm (Ages 0 to 17 Years), Arizona, 2025 (n = 52)

Use of Firearm^	Number	Percent
Self-Harm	22	42.3%
Drug Deal/Criminal Activity	11	21.2%
Argument	8	15.4%
Playing with a Firearm	6	11.5%
Intimate Partner Violence	<6	*
Child Abuse	<6	*
Child was a Bystander	<6	*
Self Defense	<6	*
Gang Violence	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one use may have been identified in each death.

Infectious Disease-Related Deaths

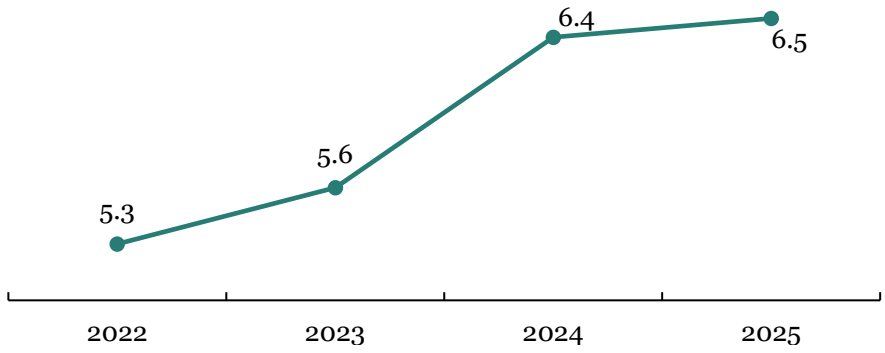
Death in which an infectious disease caused or contributed to the death. See the Glossary for further explanation.

Total Infectious Disease-Related Deaths
109
(24.1% of Child Deaths)

1.6% ↑
in the mortality rate from 2024

21.1%
of Infectious Disease-Related Deaths were Preventable

Infectious Disease-Related Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2022-2025 [4-7]

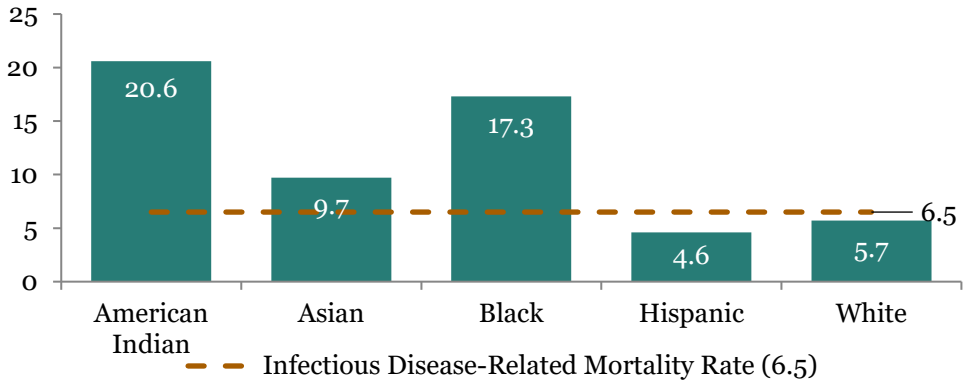


Leading Causes of Infectious Disease-Related Deaths:

Prematurity	Other Infection	Pneumonia	Influenza	Congenital Anomaly
35.8% (39 deaths)	27.5% (30 deaths)	9.2% (10 deaths)	7.3% (8 deaths)	* (<6 deaths)

*The number/percentage was suppressed because the count was less than 6.

Infectious Disease-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Infectious Disease-Related Mortality Rate, Arizona, 2025 [4]



61.5%
of Infectious Disease-Related Deaths occurred in infants (less than one year of age)

56.9%
of Infectious Disease-Related Deaths were among males

Leading Risk Factors of Infectious Disease-Related Death^:

Poverty	Maternal Infection	Child's Chronic Condition	CPS History with Family	Parent Substance Use History
42.2%	37.6%	33.9%	22.9%	18.3%

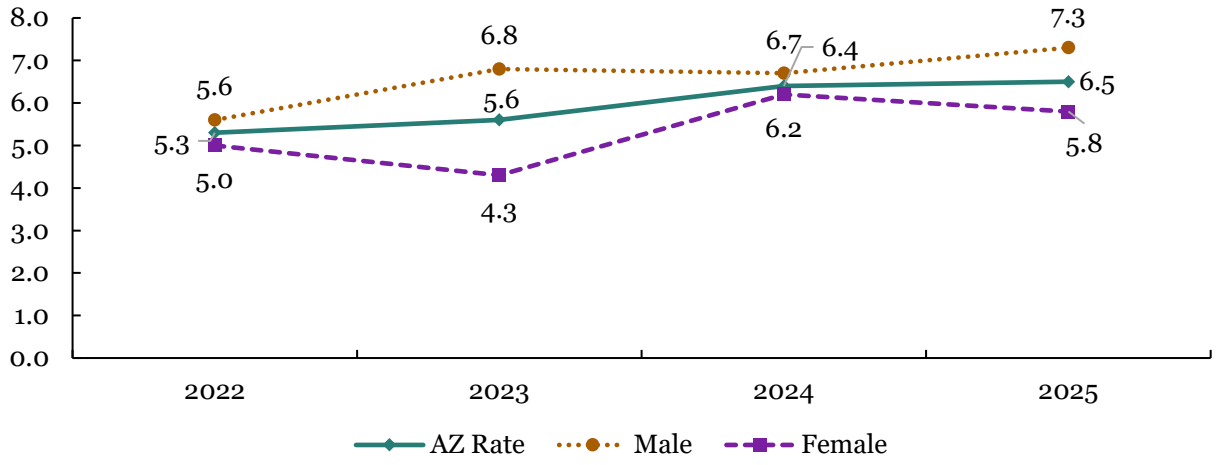
^More than one risk factor may have been identified for each death.

Infectious Disease-Related Death Prevention Recommendations:

- State and local health departments and health care providers should promote vaccination and vaccine confidence through ongoing, proactive messaging (including anticipatory guidance, awareness campaigns, etc.) and strategies to increase vaccination rates, such as sending vaccine reminders, setting up vaccine clinics, and providing vaccine education and administration at all health care visits, including urgent care and emergency room visits. [82-84]
- Educate and encourage parents/caregivers on when to seek medical care for sick children, including when to consult medical providers before administering over-the-counter or prescription medications, and when to call 911. [85]
- Encourage Arizona policymakers to prioritize and invest in families' financial well-being, including increasing access to coordinated support for healthcare, food, housing, employment, and childcare. [86-87]
- Enhance specialized care management, preventative health access, and emergent care literacy for families of children with complex medical needs (Arizona's Division of Developmental Disabilities (DDD), Arizona's Early Intervention Program (AZEIP), etc.). [88]
- Families and caregivers of children and adolescents should familiarize themselves with and make appointments with their child's pediatrician or healthcare provider in alignment with the American Academy of Pediatrics (AAP) Schedule of Well-Child Care Visits. [89-90]
- Funding should be allocated to increase the availability of and access to emergency medical services (EMS), urgent care, and emergency department services in rural areas to strengthen their ability to respond to pediatric medical emergencies and connect those in need of care in a timely manner. [91-92]

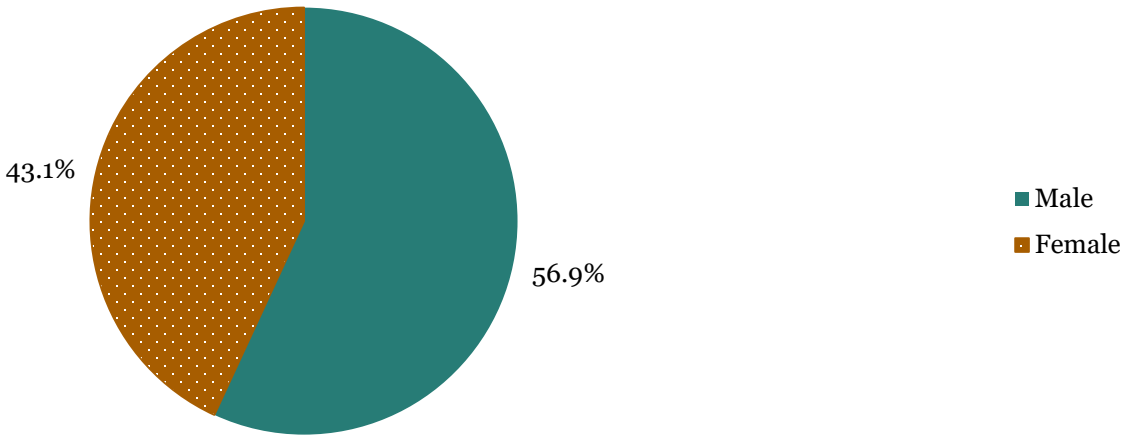
Arizona's infectious disease-related mortality rate (ages 0 to 17 years) increased by 1.6 percent over the past year, increasing from 6.4 deaths per 100,000 children in 2024 to 6.5 deaths per 100,000 children in 2025. Overall, the male infectious disease-related mortality rate has generally been higher than the female infectious disease-related mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate increased by 9.0 percent (from 6.7 to 7.3 deaths per 100,000 children), while the female mortality rate decreased by 6.5 percent (from 6.2 to 5.8 deaths per 100,000 children) (Figure 48).

Figure 48. Infectious Disease-Related Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2022-2025 [4-7]



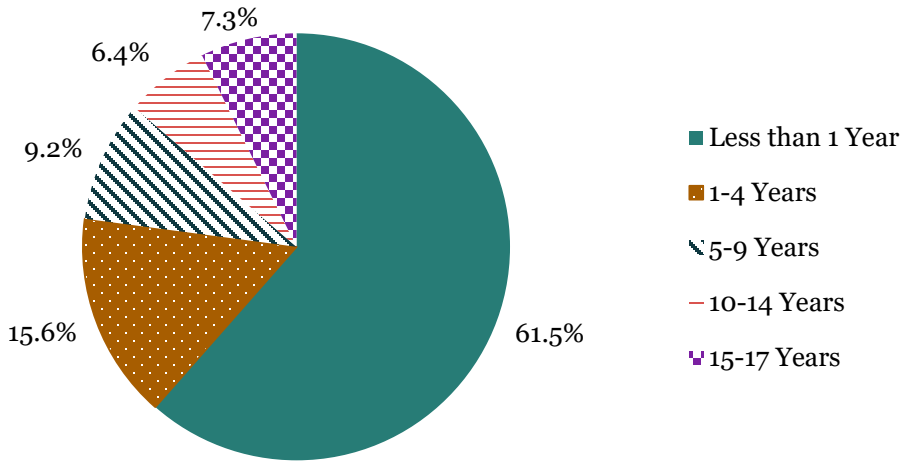
Among infectious disease-related deaths by sex, 56.9 percent were male, while 43.1 percent were female (Figure 49).

Figure 49. Percentage of Infectious Disease-Related Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 109)



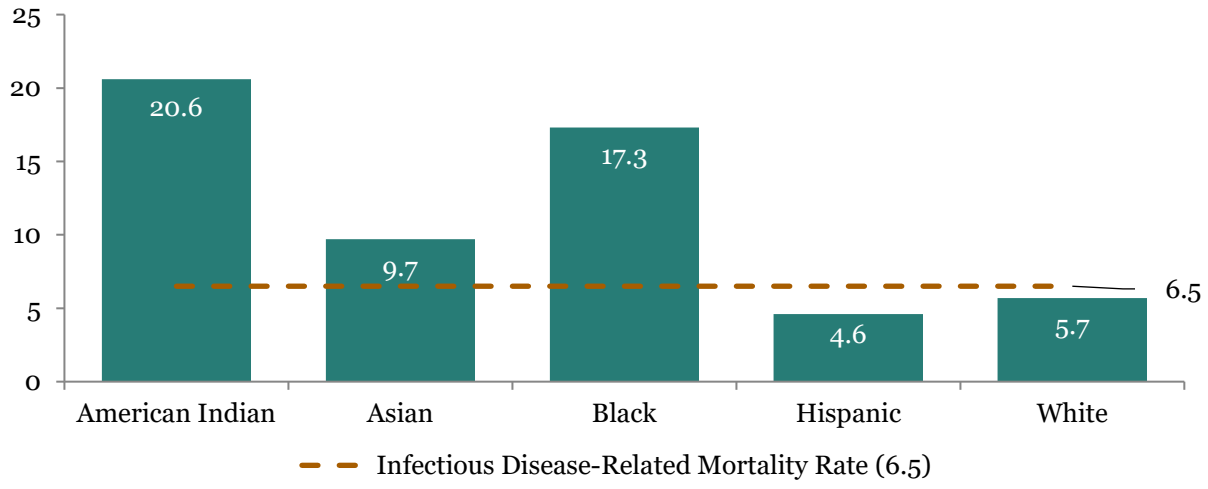
The vast majority of infectious disease-related deaths occurred among infants less than one year (61.5 percent), followed by children aged 1 to 4 years (15.6 percent) (Figure 50).

Figure 50. Percentage of Infectious Disease-Related Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 109)



When stratified by race/ethnicity, American Indian, Asian, and Black children had higher mortality rates than the 2025 Arizona infectious disease-related mortality rate (6.5 deaths per 100,000 children), at 20.6, 9.7, and 17.3 deaths per 100,000 children, respectively. Hispanic and White children had lower mortality rates (Figure 51).

Figure 51. Infectious Disease-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Infectious Disease-Related Mortality Rate, Arizona, 2025 (n = 109) [4]



Among infectious disease-related deaths (ages 0 to 17 years), prematurity was the leading cause, accounting for 35.8 percent (39 deaths) of infectious disease-related fatalities. This was followed by other infections (not including pneumonia, influenza, or COVID-19) at 27.5 percent (30 deaths) (Table 28).

Table 28. Causes of Infectious Disease-Related Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 109)

Causes of Death	Number	Percent
Prematurity^	39	35.8%
Other Infection (not including pneumonia, influenza, or COVID-19)	30	27.5%
Pneumonia	10	9.2%
Influenza	8	7.3%
Congenital Anomaly	<6	*
Cancer	<6	*
Other Perinatal Condition	<6	*
COVID-19	<6	*
Undetermined	<6	*
Other Medical Condition	<6	*
Cardiovascular	<6	*
Suffocation	<6	*
Asthma/Respiratory	<6	*

*The number/percentage was suppressed because the count was less than 6.
^ Prematurity as a cause of death refers to the infection that contributed to the prematurity.

While numerous risk factors contribute to infectious disease-related deaths, poverty was the most prominent, identified in 42.2 percent of the fatalities (46 deaths). This was followed by maternal infection (such as chorioamnionitis) at 37.6 percent (41 deaths), a child's chronic condition at 33.9 percent (37 deaths), and a family history with CPS at 22.9 percent (25 deaths) (Table 29).

Table 29. Risk Factors of Infectious Disease-Related Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 109)

Risk Factors^	Number	Percent
Poverty	46	42.2%
Maternal Infection (such as Chorioamnionitis)	41	37.6%
Child's Chronic Condition	37	33.9%
CPS History with Family	25	22.9%
Parent Substance Use History	20	18.3%
Inadequate Treatment	12	11.0%
Substance Use	7	6.4%
Housing Insecurity	<6	*
Uninsured Status	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.

Motor Vehicle Crash (MVC)-Related Deaths

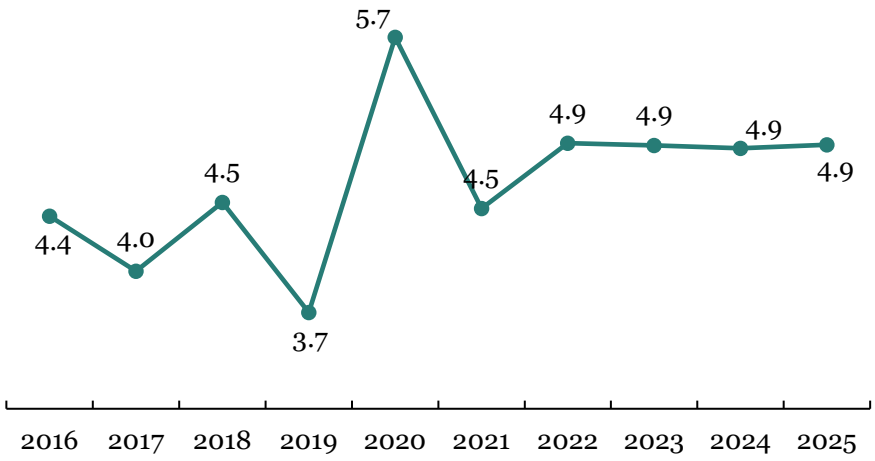
Death caused by injuries from a motor vehicle incident, including injuries to motor vehicle occupant(s), pedestrian(s), pedal cyclist(s), or others. See the Glossary for further explanation.

Total MVC-Related Deaths
171
(10.6% of Child Deaths)

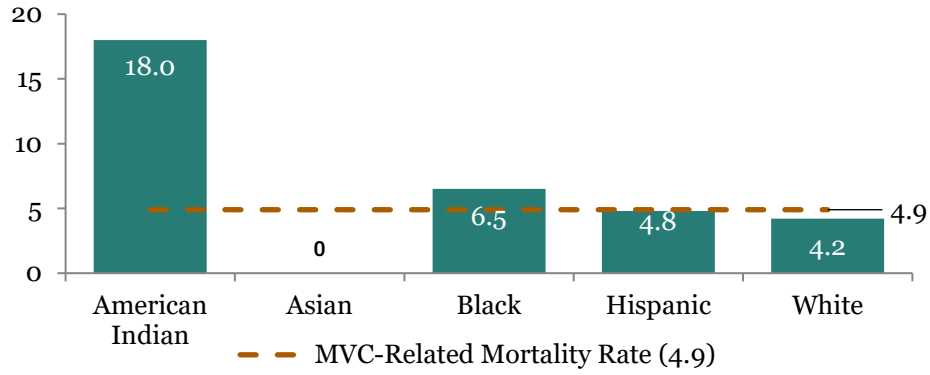
No Change
in the mortality rate from 2024

100.0%
of MVC-Related Deaths were Preventable

MVC-Related Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



MVC-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the MVC-Related Mortality Rate, Arizona, 2025 [4]



46.3%
of MVC-related Deaths occurred in adolescents aged 15-17 years

63.4%
of MVC-related Deaths were among males

Leading Risk Factors of MVC-Related Death^:

Lack of Seat Restraint Use	Reckless Driving	Careless Driving	Substance Use	Excess Speed
59.8%	51.2%	46.3%	43.9%	35.4%

^More than one risk factor may have been identified for each death.

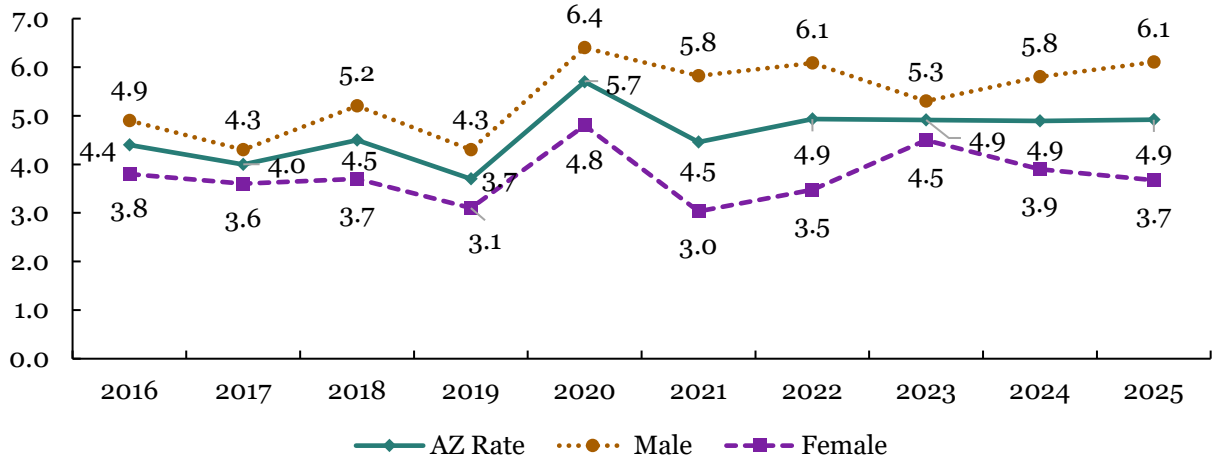
MVC-Related Death Prevention Recommendations:

- The Governor's Office of Highway Safety (GOHS) and the Arizona Department of Education (ADE) should implement education campaigns and initiatives to promote safe, sober, distraction-free defensive driving for young drivers and their parents/caregivers, with a focus on education on proper supervision of teen drivers and the risks of driving while intoxicated/under the influence (youth and adults). Including increasing the availability of driver's education in all high schools to provide standardized instruction on safe driving. [93-94]
- Encourage families to follow the four evidence-based recommendations provided by the AAP, healthychildren.org, and the National Highway Traffic Safety Administration (NHTSA) for best practices in choosing a child restraint system to optimize safety in passenger vehicles for children, and to access affordable, appropriate restraint systems. [95]
    - Birth-12 Months: Your child under age one should always ride in a rear-facing car seat. There are different types of rear-facing car seats:
        - Infant-only seats can only be used in a rear-facing position.
        - Convertible and all-in-one car seats typically have higher height and weight limits for the rear-facing position, allowing you to keep your child rear-facing for longer.
    - 1-3 Years: Your child should remain in a rear-facing seat until they reach the height or weight limit specified by their car seat's manufacturer. Once your child outgrows the rear-facing car seat, they are ready to travel in a forward-facing car seat with a harness and tether.
    - 4-7 Years: Keep your child in a forward-facing car seat with a harness and tether until they reach the height or weight limit specified by the car seat's manufacturer. Once your child outgrows the forward-facing seat with a harness, it is time to travel in a booster seat, but still in the back seat.
    - 8-12 Years: Keep your child in a booster seat until they are big enough to fit in a seat belt properly. For a seat belt to fit properly, the lap belt must lie snugly across the upper thighs, not the stomach. The shoulder belt should lie snugly across the shoulder and chest and not cross the neck or face. Remember: your child should still ride in the back seat because it is safer there.
    - 12+ Years: Lap-and-shoulder seat belts are recommended for children who have outgrown booster seats. All children (especially those younger than 13 should ride in the rear seats of vehicles.
- Arizona Game and Fish should encourage the safe, responsible, and ethical operation of off-highway vehicles. All riders under 18 years of age should wear a properly fitted, fastened, and U.S. DOT-approved protective helmet, unless properly secured in an approved child safety seat. The Arizona Game and Fish Department should encourage parents and guardians to actively supervise young riders, match machine size and engine capacity to the operator's age and physical capability, and prohibit riding under the influence. The Department should also encourage users to complete the Off-Highway Vehicle Safety Education Program. [96]
- The Arizona Department of Public Safety (DPS), Arizona Department of Transportation (ADOT), and agencies that oversee roadway and public safety improvements should continue evaluating the safety features of roadways with high injury/fatality incidence, including: [97-98]
    - Road closure signage/barriers
    - Fencing around non-pedestrian areas (such as train tracks, etc.)
    - Traffic volume assessment
    - Lighting

    - Speed limits
    - Wrong-way alert system
    - Incident Management Alerts
- Organizations and agencies that improve and support roadway and pedestrian safety should increase education on, and encourage stronger regulations around, e-bikes, e-scooters, motorcycles, and other motorized/electric-powered consumer products, including safe operation, helmet requirements, appropriate speed limits, age restrictions, and appropriate roadways for use. [100-102]
- Justice system partners should strengthen programs and interventions that prevent repeat impaired and reckless driving offenses, particularly among individuals with prior driving under the influence (DUI) convictions.
- Organizations and agencies that improve and support roadway/pedestrian safety should educate children, parents, and caregivers on safe pedestrian practices, avoiding distracted walking, and awareness of proper use of crosswalks, especially at night with low visibility. [95, 99]
- DPS should continue to evaluate outcomes of and strengthen graduated license laws and implement follow-up for minors with motor vehicle crash history (safety courses, revoke license, etc.) [103]
- Organizations and agencies that improve and support motor vehicle safety should promote community funding and support programs that help families access vehicles equipped with advanced safety features, and provide education for parents and caregivers on the availability, use, and benefits of vehicle safety technologies, such as child locks, automatic emergency braking, collision warning systems, and backup cameras. [104-105]

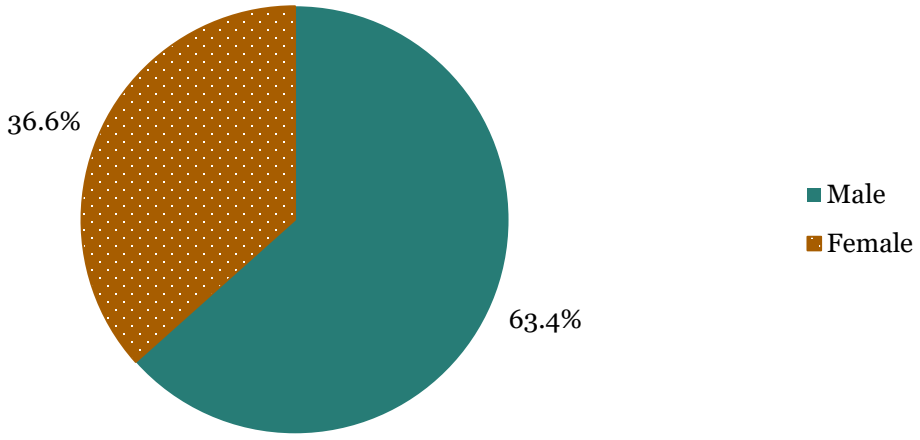
Arizona's MVC-related mortality rate (ages 0 to 17 years) remained constant at 4.9 deaths per 100,000 children over the past year. Overall, the male MVC-related mortality rate has generally been higher than the female MVC-related mortality rate since 2016, and it remained higher in 2025. From 2024 to 2025, the male mortality rate increased by 5.2 percent (from 5.8 to 6.1 deaths per 100,000 children), while the female mortality rate decreased by 5.1 percent (from 3.9 to 3.7 deaths per 100,000 children) (Figure 52).

Figure 52. MVC-Related Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



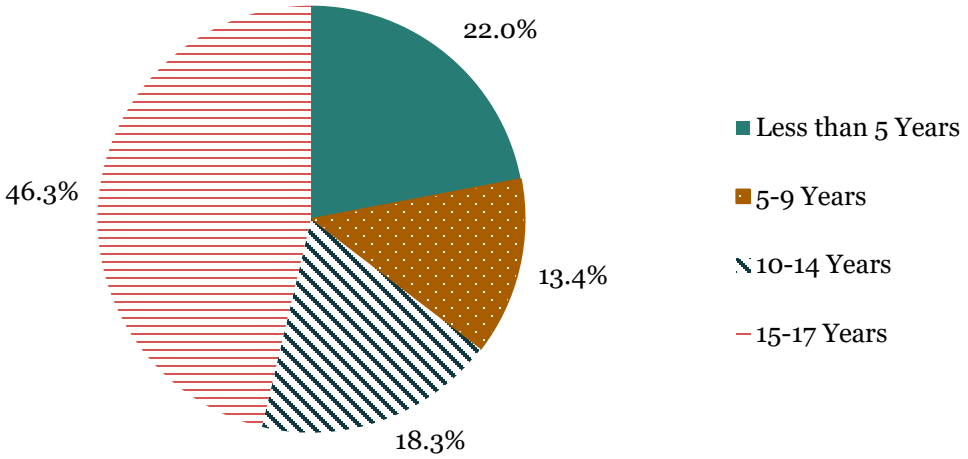
Among MVC-related deaths by sex, 63.4 percent of fatalities were male, while 36.6 percent were female (Figure 53).

Figure 53. Percentage of MVC-Related Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 82)



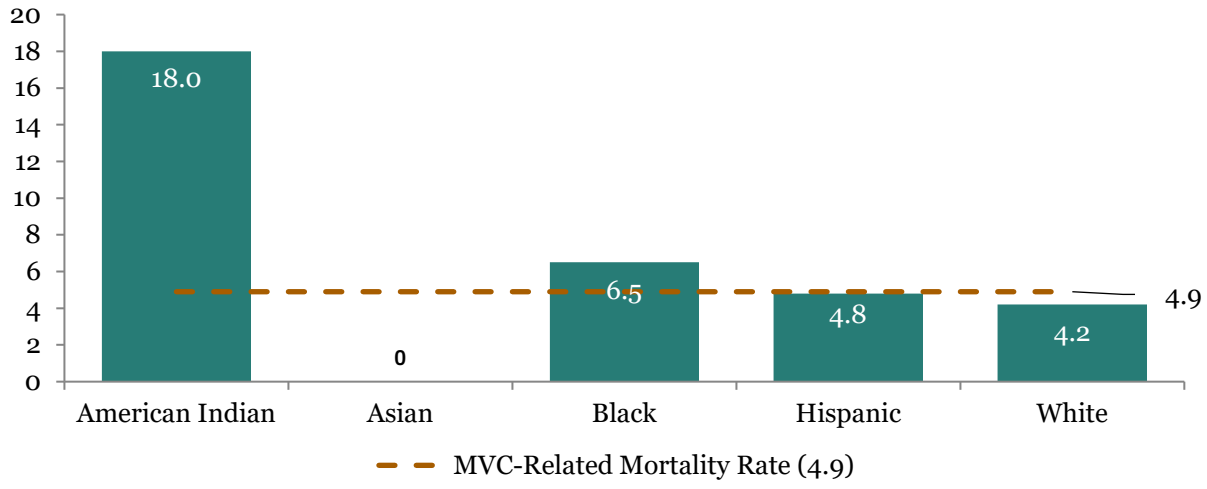
The majority of MVC-related deaths occurred among adolescents aged 15 to 17 years (46.3 percent), followed by children less than 5 years (22.0 percent) (Figure 54).

Figure 54. Percentage of MVC-Related Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 82)



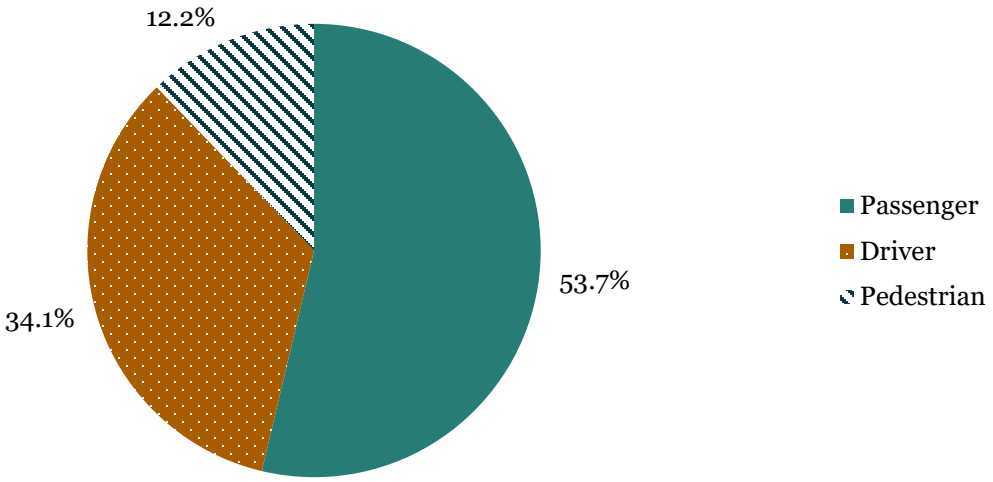
When stratified by race/ethnicity, American Indian and Black children had higher mortality rates than the 2025 Arizona MVC-related mortality rate (4.9 deaths per 100,000 children), at 18.0 and 6.5 deaths per 100,000 children, respectively. Hispanic and White children had lower mortality rates. Asian children experienced no MVC-related deaths in Arizona in 2025 (Figure 55).

Figure 55. MVC-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the MVC-Related Mortality Rate, Arizona, 2025 (n = 82) [4]



The child was a passenger in 53.7 percent of the MVC-related deaths (Figure 56).

Figure 56. Percentage of MVC-Related Deaths by Location of Child in Accident (Ages 0 to 17 Years), Arizona, 2025 (n = 82)



MVC-related deaths most frequently occurred while the child was in a car (29.3 percent), followed by a sport utility vehicle (SUV; 20.7 percent). 11.0 percent of the deaths occurred while the child was a pedestrian (9 deaths) (Table 30).

Table 30. Number and Percentage of MVC-Related Deaths by Type of Vehicle (Ages 0 to 17 Years), Arizona, 2025 (n = 82)

Type of Vehicle	Number	Percent
Car	24	29.3%
Sport Utility Vehicle (SUV)	17	20.7%
Pedestrian	9	11.0%
Truck	9	11.0%
Motorcycle	9	11.0%
Off-Highway Vehicle (OHV)	8	9.8%
Scooter	<6	*
Van	<6	*
Tractor/Farm Equipment	<6	*

Among drivers involved in an MVC-related death, 65.8 percent were aged 19 and older, 20.7 percent were aged 16 to 18, and 13.4 percent were aged 13 to 15 years (Table 31). 18.0 percent of the MVC-related deaths had both a teenage driver and a teenage passenger (not shown).

Table 31. Number and Percentage of MVC-Related Deaths by Age of Driver (Ages 0 to 17 Years), Arizona, 2025 (n = 82)

Age of Responsible Driver	Number	Percent
19 years or more	54	65.8%
16 to 18 years	17	20.7%
13 to 15 years	11	13.4%

Highways were the most frequent location for MVC-related deaths at 31.7 percent (26 deaths), followed by rural roads at 28.0 percent (23 deaths) and city streets at 25.6 percent (21 deaths) (Table 32).

Table 32. Number and Percentage of MVC-Related Deaths by Location (Ages 0 to 17 Years), Arizona, 2025 (n = 82)

Location^	Number	Percent
Highway	26	31.7%
Rural Road	23	28.0%
City Street	21	25.6%
Off-Road	8	9.8%
Other (such as Railroad Tracks, Creek, Farmland, Jogging Path)	6	7.3%
Residential Street	<6	*
Parking Lot	<6	*
Intersection	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one location may have been identified in each death.

While numerous risk factors contribute to MVC-related deaths, the lack of seat restraint use by the child was the most prominent, identified in 59.8 percent of the fatalities (49 deaths). This was followed by reckless driving at 51.2 percent (42 deaths), and careless driving at 46.3 percent (38 deaths) (Table 33).

Table 33. Risk Factors of MVC-Related Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 82)

Risk Factors^	Number	Percent
Lack of Seat Restraint Use	49	59.8%
Reckless Driving	42	51.2%
Careless Driving	38	46.3%
Substance Use	36	43.9%
Excess Speed	29	35.4%
CPS History with Family	25	30.5%
Inexperienced Driver	22	26.8%
Rollover	22	26.8%
Unsafe Speed	20	24.4%
Poverty	18	22.0%
Lack of Supervision	16	19.5%
Criminal Activity	16	19.5%
No Helmet	14	17.1%
History of Trauma/Violence	14	17.1%
Other Driver Error	11	13.4%
Backover/ Frontover	8	9.8%
Poor Visibility	7	8.5%
Changing Lane	7	8.5%
Distracted Driver	6	7.3%
Poor Sightline	<6	*
Weather Conditions	<6	*
Running a Red Light	<6	*
Road Hazard	<6	*
Racing	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.

Neglect/Abuse-Related Deaths

Death in which an act of neglect, physical abuse, sexual abuse, or emotional abuse contributed to a child's death. See the Glossary for further explanation.

Total Neglect/Abuse-Related Deaths

102

(13.2% of Child Deaths)

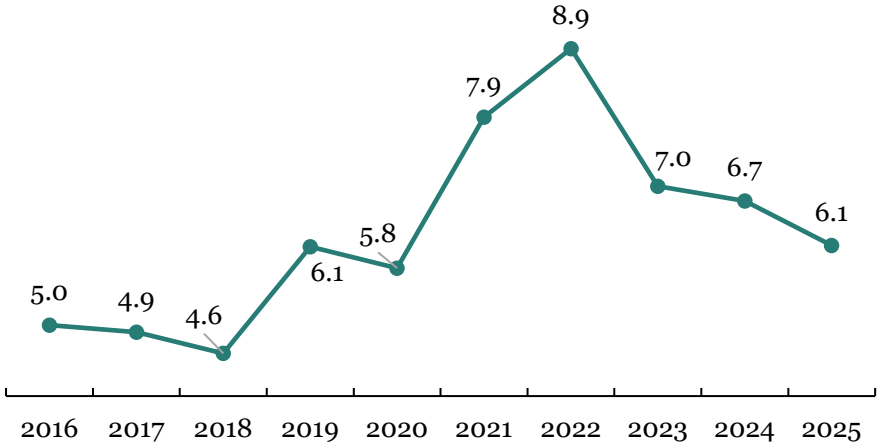
9.0% ↓

in the mortality rate from 2024

100.0%

of Neglect/Abuse-Related Deaths were Preventable

Neglect/Abuse-Related Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]

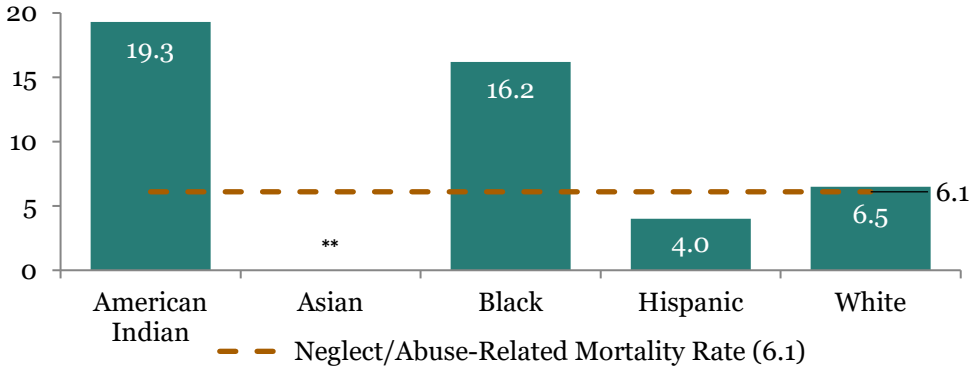


Leading Causes of Neglect/Abuse-Related Deaths:

Suffocation	Motor Vehicle Crash	Firearm Injury	Blunt Force Injury	Drowning
18.6% (19 deaths)	15.7% (16 deaths)	15.7% (16 deaths)	12.7% (13 deaths)	6.9% (7 deaths)

*The number/percentage was suppressed because the count was less than 6.

Neglect/Abuse-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Neglect/Abuse-Related Mortality Rate, Arizona, 2025 [4]



**Data for Asian children were suppressed because the count was less than 6.

44.1%

of Neglect/Abuse-Related Deaths occurred in infants (less than one year of age)

56.9%

of Neglect/Abuse-Related Deaths were among males

Leading Risk Factors of Neglect/Abuse-Related Deaths^:

Parent Substance Use History	CPS History with Family	Substance Use	Poverty	Lack of Supervision
67.6%	56.9%	56.9%	52.9%	24.5%

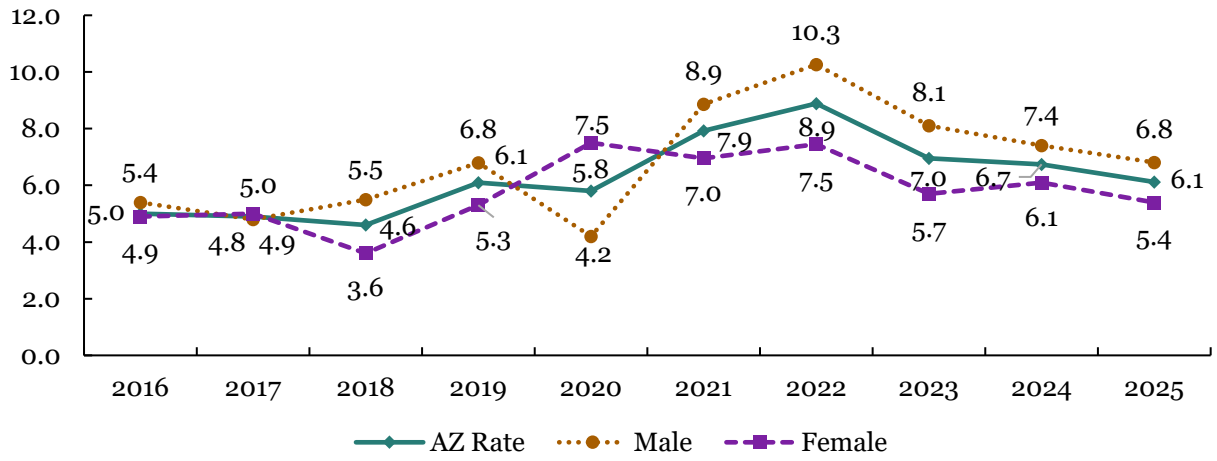
^More than one risk factor may have been identified for each death.

Neglect/Abuse-Related Death Prevention Recommendations:

- Increase the availability and accessibility of affordable, quality mental health and substance use treatment services that are supportive for families with children to receive care. Especially in rural and tribal areas. [76]
- Increase the availability of domestic violence screening and resources by all healthcare providers for victims of domestic and interpersonal violence, including raising awareness of available resources and support, and how and where to find help. [106]
- Encourage Arizona policymakers to prioritize and invest in families' financial well-being, including increasing access to coordinated support for healthcare, food, housing, employment, and childcare. [86-87]
- Establish a coordinated community support framework that proactively identifies and provides wraparound services for high-risk families. This should include: [77-81]
    - Family Support Hubs that create or expand local centers where families can access case management, parenting programs, and immediate support for basic needs (food, housing, employment, mental health services) in one location.
    - Multi-Agency Collaboration to encourage cooperation between schools, healthcare providers, child protection, and community organizations to share relevant information and form joint care plans tailored to each family's circumstances.
    - Early identification and referrals by training frontline workers (teachers, nurses, community liaisons, social workers) to recognize early risk indicators and refer families through a clear, supportive pathway—not a punitive one.
    - Peer and community mentorship to engage local volunteers, family mentors, and cultural leaders to provide social support and reduce isolation, particularly for marginalized communities.
- Increase the availability of home visiting programs throughout the state. [82]
- Increase community awareness of how and when to report suspected child neglect or abuse so that any individual who suspects a child who is being neglected or abused can act by calling 911 in an emergency or, in non-emergency cases, call the Arizona Child Abuse hotline (1-888-SOS-CHILD). This includes increasing awareness among professionals about mandated reporting laws (A.R.S. § 13-3620), who is a mandated reporter, and training requirements for identifying and reporting suspected neglect/abuse. [107]
- Encourage Arizona hospitals and healthcare providers to support and implement child abuse prevention activities throughout the state [108-109]

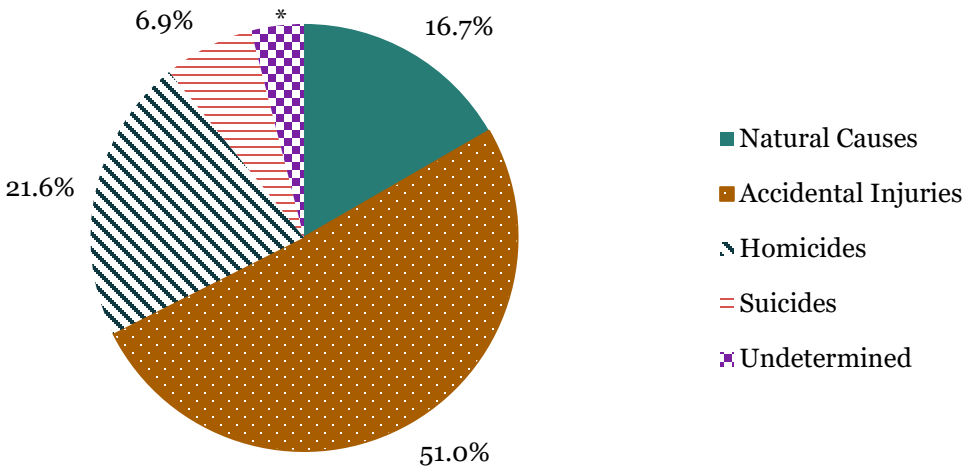
Arizona's neglect/abuse-related mortality rate (ages 0 to 17 years) decreased by 9.0 percent over the past year, falling from 6.7 deaths per 100,000 children in 2024 to 6.1 deaths per 100,000 children in 2025. From 2024 to 2025, the male mortality rate decreased by 8.1 percent (from 7.4 to 6.8 deaths per 100,000 children), while the female mortality rate decreased by 11.5 percent (from 6.1 to 5.4 deaths per 100,000 children) (Figure 57).

Figure 57. Neglect/Abuse-Related Mortality Rate (per 100,000 Children) by Sex (Ages 0 to 17 Years), Arizona, 2016-2025 [4-13]



Within neglect/abuse-related deaths, the majority of deaths were classified as accidental injuries at 51.0 percent, followed by homicides at 21.6 percent (Figure 58).

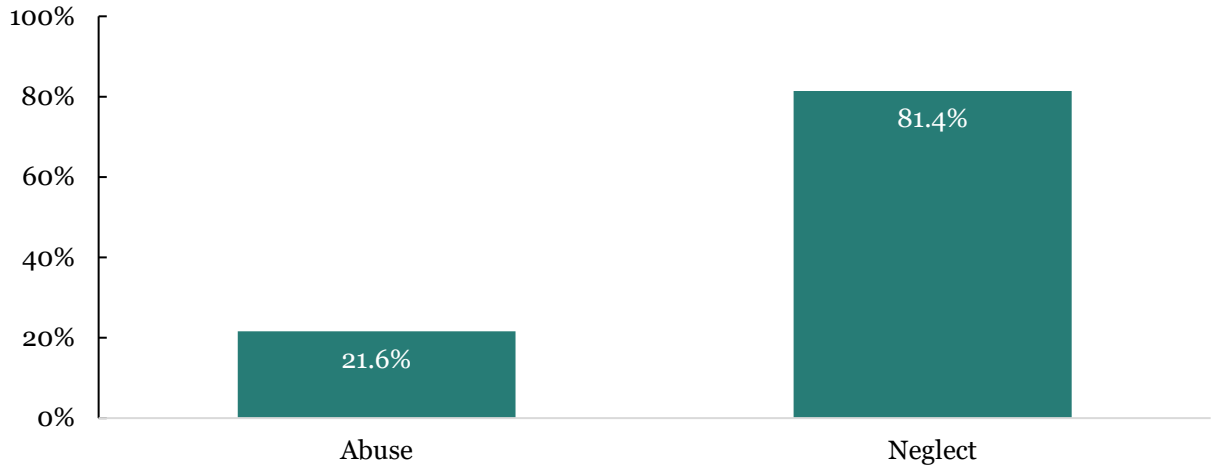
Figure 58. Percentage of Neglect/Abuse-Related Deaths by Manner of Death (Ages 0 to 17 Years), Arizona, 2025 (n = 102)



*The percentage was suppressed because the count was less than 6.

81.4 percent of neglect/abuse-related deaths involved neglect, and 21.6 percent involved abuse. In some deaths, the child was a victim of both neglect and abuse (Figure 59).

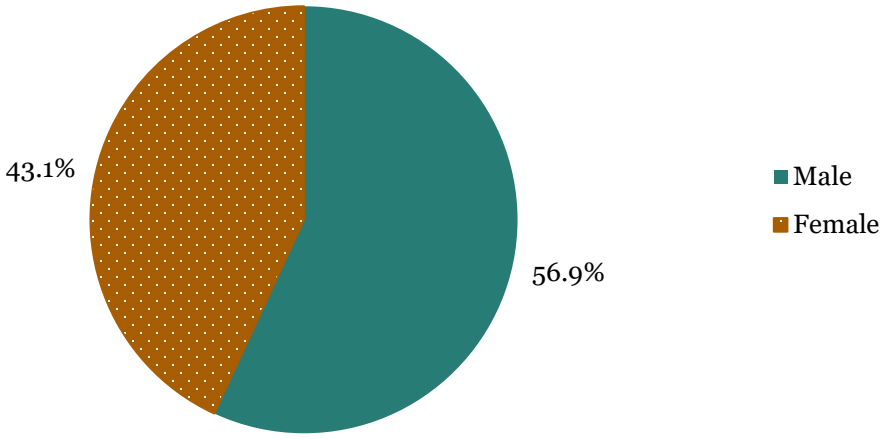
Figure 59. Percentage of Neglect/Abuse-Related Deaths by Abuse and Neglect (Ages 0 to 17 Years), Arizona, 2025 (n = 102)^



^ Totals do not equal 100.0 percent as abuse and neglect may have both been involved.

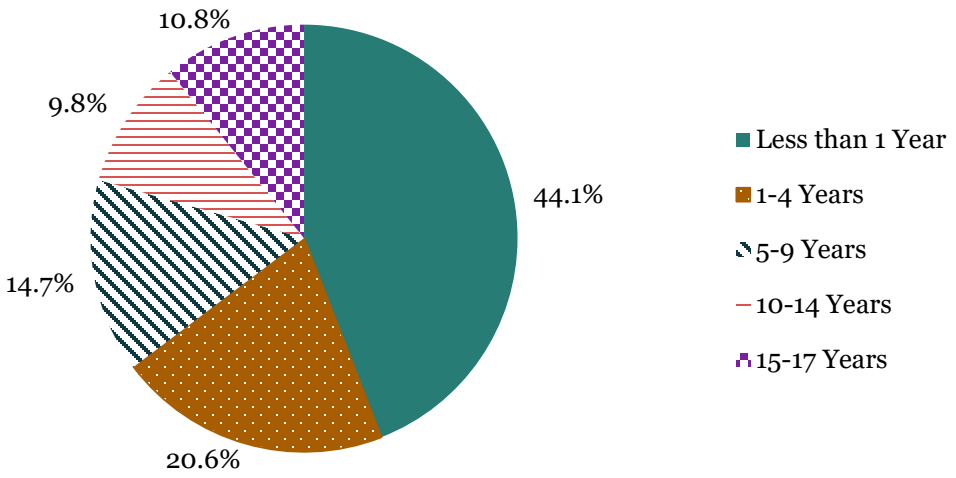
Among neglect/abuse-related deaths by sex, 56.9 percent were male, while 43.1 percent were female (Figure 60).

Figure 60. Percentage of Neglect/Abuse-Related Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 102)



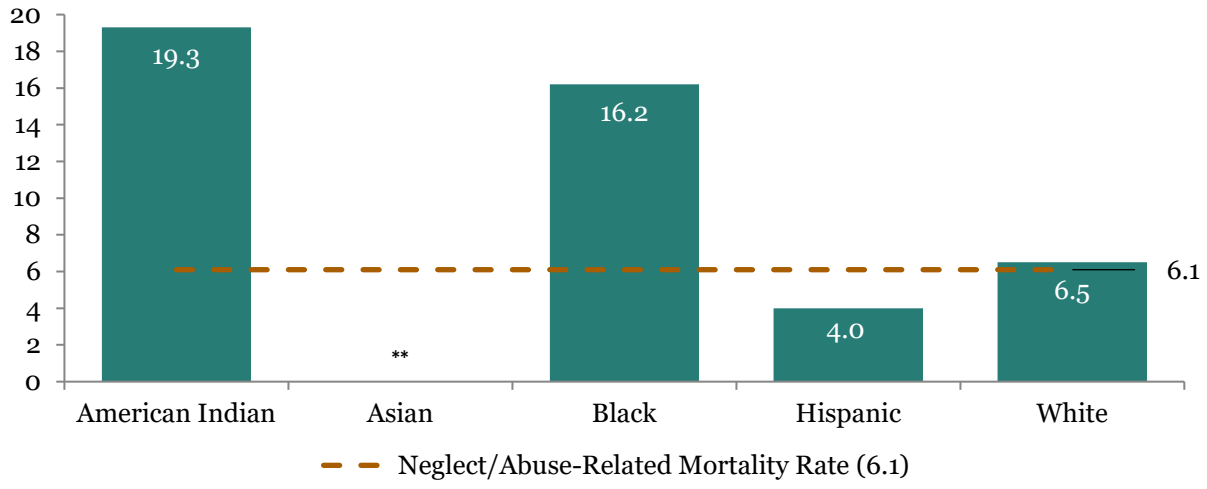
Neglect/abuse-related deaths most frequently occurred among infants less than one year (44.1 percent), followed by children aged 1 to 4 years (20.6 percent) (Figure 61).

Figure 61. Percentage of Neglect/Abuse-Related Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 102)



When stratified by race/ethnicity, American Indian, Black, and White children had higher mortality rates than the 2025 Arizona neglect/abuse-related mortality rate (6.1 deaths per 100,000 children), at 19.3, 16.2, and 6.5 deaths per 100,000 children, respectively. Hispanic children had a lower mortality rate (Figure 62).

Figure 62. Neglect/Abuse-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Neglect/Abuse-Related Mortality Rate, Arizona, 2025 (n = 102) [4]



**Data for Asian children were suppressed because the count was less than 6.

Among neglect/abuse-related deaths (ages 0 to 17 years), suffocation was the leading cause, accounting for 18.6 percent (19 deaths) of neglect/abuse-related fatalities. This was followed by MVC-related fatalities and firearm injury fatalities, both at 15.7 percent (16 deaths) (Table 34).

Table 34. Causes of Neglect/Abuse-Related Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 102)

Causes of Death	Number	Percent
Suffocation	19	18.6%
MVC-Related	16	15.7%
Firearm Injury	16	15.7%
Blunt Force Injury	13	12.7%
Drowning	7	6.9%
Prematurity^	7	6.9%
Poisoning	6	5.9%
Undetermined	<6	*
Other Infection	<6	*
Environmental Heat Exposure	<6	*
Influenza	<6	*
Strangulation	<6	*
Other Medical Condition	<6	*
COVID-19	<6	*
Fall/Crush	<6	*
Diabetes	<6	*

*The number/percentage was suppressed because the count was less than 6.
^ Prematurity as a cause of death refers to the infection that contributed to the prematurity.

While numerous risk factors contribute to neglect/abuse-related deaths, a parental history of substance use was the most prominent, identified in 67.6 percent of the fatalities (69 deaths). This was followed by a family history with CPS and active substance use, both at 56.9 percent (58 deaths) (Table 35).

Table 35. Risk Factors of Neglect/Abuse-Related Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 102)

Risk Factors^	Number	Percent
Parent Substance Use History	69	67.6%
CPS History with Family	58	56.9%
Substance Use	58	56.9%
Poverty	54	52.9%
Lack of Supervision	25	24.5%
Substance-Exposed Newborn (SEN)	24	23.5%
History of Trauma/Violence	23	22.5%
Family Discord	23	22.5%
Housing Insecurity	21	20.6%
Child's Chronic Condition	19	18.6%
Unsafe Sleep Environment	18	17.6%
Open CPS Case (only applies to the decedent)	16	15.7%
Isolation	7	6.9%
Access to Firearm (User < 18 Years)	7	6.9%

^More than one risk factor may have been identified in each death.

The mother was identified as the person responsible for the child's care in 69.6 percent (71 deaths) of neglect/abuse-related deaths, followed by the father at 50.0 percent (51 deaths) (Table 36).

Table 36. Number and Percentage of Neglect/Abuse-Related Deaths by Person Responsible for Child's Care (Ages 0 to 17 Years), Arizona, 2025 (n = 102)

Person Responsible for Child's Care^	Number	Percent
Mother	71	69.6%
Father	51	50.0%
Other Relative (such as Grandparents, Siblings)	9	8.8%
Other (such as Parents' Partners, Foster Parents, Other Caregivers)	9	8.8%

^More than one perpetrator may have been identified in each death.

Substances were involved in 56.9 percent (58 deaths) of neglect/abuse-related deaths, with marijuana being the most common substance at 26.5 percent (27 deaths) of neglect/abuse-related deaths, followed by alcohol at 24.5 percent (25 deaths) (Table 37).

Table 37. Number and Percentage of Substance Type Identified in Neglect/Abuse-Related Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 102)

Substance Type^	Number	Percent of N/A Cases
Marijuana	27	26.5%
Alcohol	25	24.5%
Methamphetamine	13	12.7%
Opiate	12	11.8%
Cocaine	<6	*
Prescription Drug	<6	*
Other	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one substance may have contributed to each death.

Among the 58 deaths involving substances, the mother was the substance user in 35 of them, accounting for 60.3 percent of neglect/abuse-related deaths involving substances (Table 38).

Table 38. Number and Percentage of Substance Users Identified in Neglect/Abuse-Related Deaths Involving Substance Use (Ages 0 to 17 Years), Arizona, 2025 (n = 58)

Substance User^	Number	Percent
Mother	35	60.3%
Father	25	43.1%
Self	9	15.5%
Grandparent	<6	*
Partner	<6	*
Other Relative	<6	*
Sibling	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one person may have been using a substance.

Prematurity Deaths

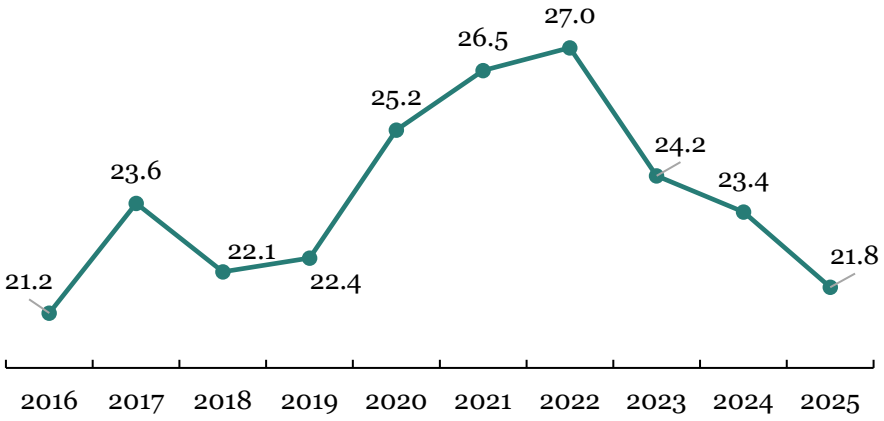
Death resulting from a premature birth (less than 37 weeks of gestation) in an infant without underlying medical conditions that would otherwise cause death. See the Glossary for further explanation.

Total Prematurity Deaths
175
(22.6% of Child Deaths)

6.8% ↓
in the mortality rate from 2024

12.6%
of Prematurity Deaths were Preventable

Prematurity Mortality Rate (per 1,000 Premature Births, Less than 1 Year), Arizona, 2016-2025 [24-33]

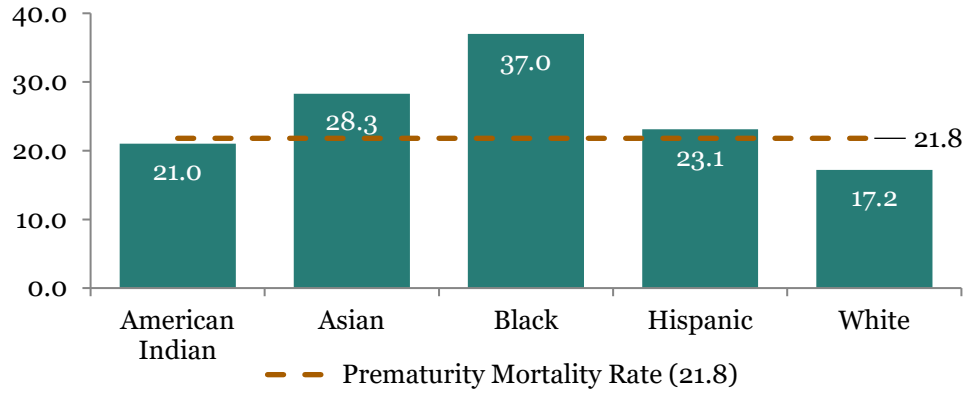


Leading Causes of Prematurity Deaths:

Prematurity**	Perinatal Condition
84.6% (148 deaths)	15.4% (27 deaths)

**Prematurity as a cause of death refers to the infection that contributed to the prematurity.

Prematurity Mortality Rate (per 1,000 Premature Births) by Race/Ethnicity (Less than 1 Year), Compared to the Prematurity Mortality Rate, Arizona, 2025 [24]



50.9%
of Prematurity Deaths were among males

Leading Risk Factors of Prematurity Death^:

Preterm Labor	Premature Rupture of Membranes (PROM)	Poverty	No Prenatal Care	Multiple Births
53.7%	51.4%	43.4%	20.0%	19.4%

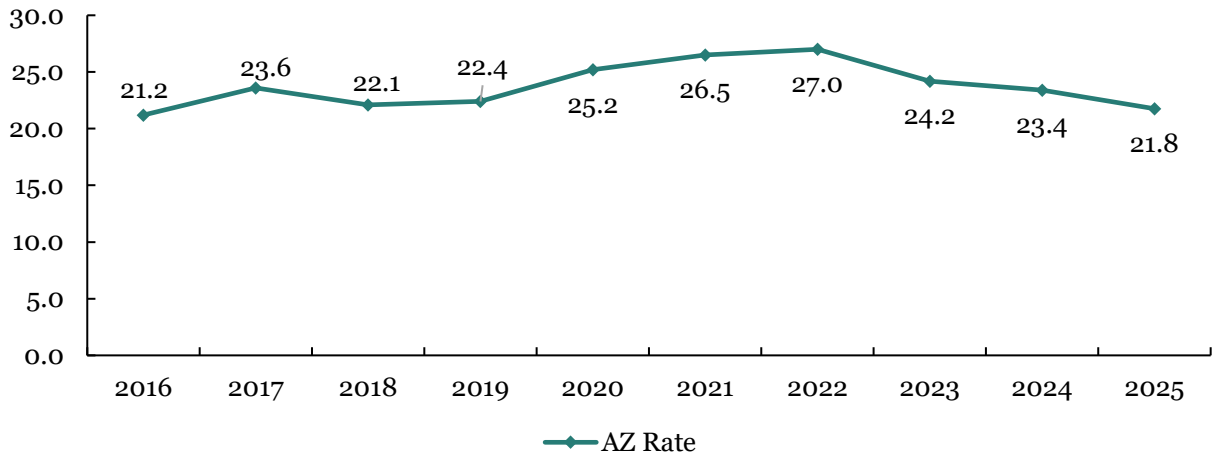
^More than one risk factor may have been identified for each death.

Prematurity Death Prevention Recommendations:

- Increase availability of the full spectrum of reproductive care, including: [110-113]
    - Preconception care, including family planning services and access to chronic disease management, to lower risks and to increase the chances of a healthy pregnancy.
    - Prenatal care, which can help prevent complications and inform about the necessary steps to take to protect infants and ensure a healthy pregnancy.
    - Postpartum care and interconception care to address physical and mental recovery immediately after birth and optimize health between pregnancies to lower future risks and support family well-being
- Increase education and community awareness of the risks of smoking nicotine, drinking alcohol, and using marijuana and illicit drugs during pregnancy because these substances increase the risk of preterm birth or other complications. [114]
    - Those who smoke tobacco should be referred to the Arizona Smokers Helpline (ASH Line/1-800-556-6222)
    - Those with substance use disorder should be referred to the Opioid Assistance Referral Line (OAR Line)
- Emphasize the importance of prenatal care and increase the availability and accessibility of affordable, quality mental health and substance use treatment services during pregnancy, including coordination of care so that those who need mental health and substance use treatment get appropriate follow-up after delivery. [115-116]
- Families interested in seeking care via midwives should utilize the ADHS Consumer Information Page for more information about midwife licensing requirements, scope of practice, and how to verify a midwife's credentials and licensing history through Arizona Care Check. Consumers can also learn about enforcement actions and how to submit complaints using the Department's Online Complaint Form. This ensures that: [117-119]
    - Care is provided by midwives who have received education on high-risk pregnancies, recognizing and responding to obstetric emergencies, and when to call 911.
    - American College of Obstetricians and Gynecologists (ACOG) and ADHS guidelines are followed regarding the scope of midwife services and home births, including safe criteria for home birth and when patients should not be managed at home.

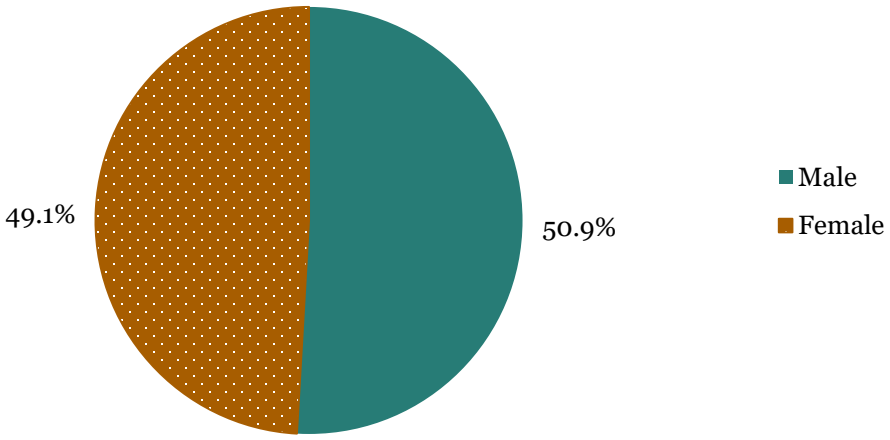
The prematurity mortality rate includes those who were identified as dying of prematurity (<37 weeks' gestation) but also includes infants who died of other perinatal conditions that led to premature births. Arizona's prematurity mortality rate (less than 1 year of age) decreased by 6.8 percent over the past year, falling from 23.4 deaths per 1,000 premature births in 2024 to 21.8 deaths per 1,000 premature births in 2025 (Figure 63).

Figure 63. Prematurity Mortality Rate (per 1,000 Premature Births, Less than 1 Year of Age), Arizona, 2016-2025 [24-33]



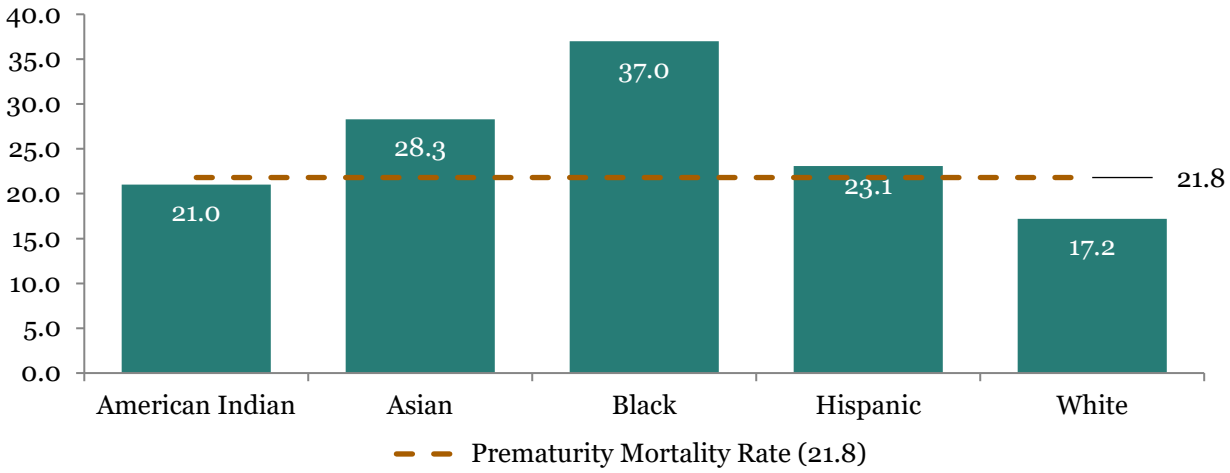
Among prematurity deaths by sex, 50.9 percent were male, while 49.1 percent were female (Figure 64).

Figure 64. Percentage of Prematurity Deaths by Sex (Less than 1 Year of Age), Arizona, 2025 (n = 175)



When stratified by race/ethnicity, Asian, Black, and Hispanic infants had higher mortality rates than the 2025 Arizona prematurity mortality rate (21.8 deaths per 1,000 premature births), at 28.3, 37.0, and 23.1 deaths per 1,000 premature births, respectively. American Indian and White infants had lower mortality rates (Figure 65).

Figure 65. Prematurity Mortality Rate (per 1,000 Premature Births) by Race/Ethnicity (Less than 1 Year of Age), Compared to the Prematurity Mortality Rate, Arizona, 2025 (n = 175) [24]



While numerous risk factors contribute to prematurity deaths, having preterm labor was the most prominent, identified in 53.7 percent of the fatalities (94 deaths). This was followed by having premature rupture of the membrane (PROM) at 51.4 percent (90 deaths) and poverty at 43.4 percent (76 deaths) (Table 39).

Table 39. Risk Factors for Prematurity Deaths (Less than 1 Year of Age), Arizona, 2025 (n = 175)

Risk Factors^	Number	Percent
Preterm Labor	94	53.7%
Premature Rupture of Membranes (PROM)	90	51.4%
Poverty	76	43.4%
No Prenatal Care	35	20.0%
Multiple Births (such as Twins, Triplets, etc.)	34	19.4%
Maternal Infection	33	18.9%
Maternal Hypertension	28	16.0%
Advanced Maternal Age (35+)	28	16.0%
Previous Preterm Birth	19	10.9%
Incompetent Cervix	18	10.3%
Parent Substance Use History	17	9.7%
Placental Abruption	16	9.1%
Substance Exposed Newborn (SEN)	15	8.6%
Maternal Diabetes	10	5.7%
Eclampsia/ Pre-eclampsia	7	4.0%
Smoking during Pregnancy	7	4.0%
Obesity	6	3.4%

^More than one risk factor may have been identified in each death.

Substance Involved-Related Deaths

Death where the child or any individual involved in the death of the child used or abused substances, and this was a direct or contributing factor in the child's death. See the Glossary for further explanation.

Total Substance Involved-Related Deaths

127

(16.4% of Child Deaths)

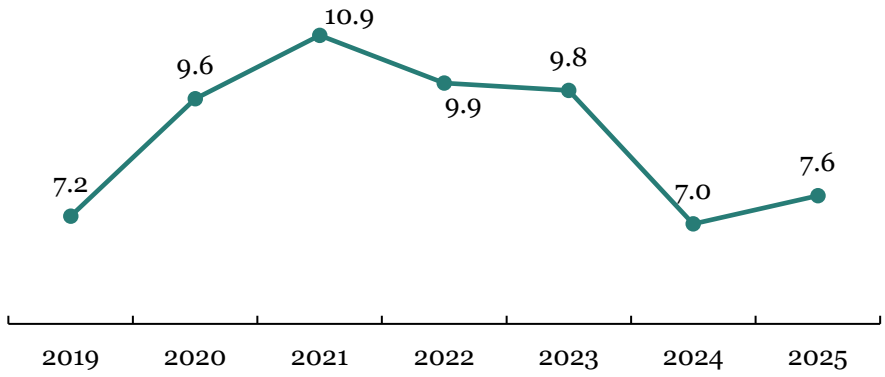
8.6% ↑

in the mortality rate from 2024

100.0%

of Substance Involved-Related Deaths were Preventable

Substance Involved-Related Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2019-2025 [4-10]

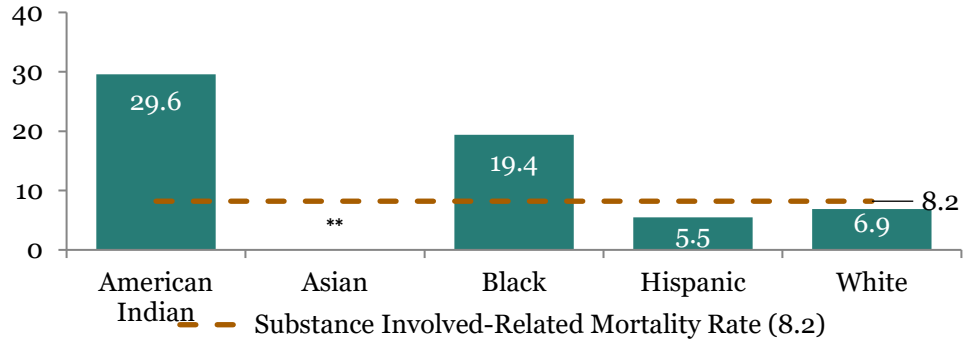


Leading Causes of Substance Involved-Related Deaths:

Motor Vehicle Crash	Firearm Injury	Poisoning	Suffocation	Prematurity
28.3% (36 deaths)	15.0% (19 deaths)	14.2% (18 deaths^)	12.6% (16 deaths)	10.2% (13 deaths)

^12 were opiate overdoses. Fentanyl was responsible for 9 of these opiate poisonings.

Substance Involved-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Substance Involved-Related Mortality Rate, Arizona, 2025 [4]



**Data for Asian children were suppressed because the count was less than 6.

42.5%

of Substance Involved-Related Deaths occurred in adolescents aged 15-17 years

61.4%

of Substance Involved-Related Deaths were among males

Leading Risk Factors of Substance Involved-Related Deaths^:

Parent Substance Use History	CPS History with Family	Poverty	History of Trauma/Violence	Child Relationship Issues
61.4%	60.2%	40.9%	26.8%	24.4%

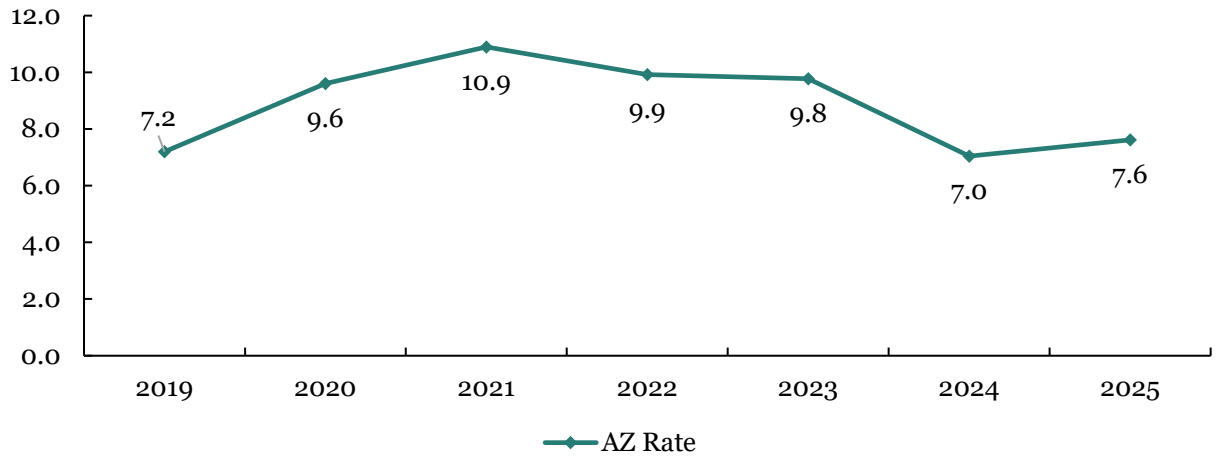
^More than one risk factor may have been identified for each death.

Substance Involved-Related Death Prevention Recommendations:

- Community leaders should advocate for increasing the availability and accessibility of affordable, quality mental health and substance use treatment services, including coordination of care so that those who need mental health and substance use treatment get appropriate follow-up after delivery. [115-116]
- Increase availability, accessibility, affordability, and appropriate use of naloxone among youth, families, caregivers, healthcare providers, and community members through strategies including: [120-126]
    - Promoting education on naloxone, including when and how to recognize and administer naloxone for an opioid overdose and administer naloxone, with age-appropriate education for adolescents.
    - Encouraging healthcare providers to co-prescribe or offer naloxone, especially when prescribing medications that may result in an opioid overdose.
    - Educating pharmacists about the importance of offering naloxone to patients of all ages when appropriate.
    - Increasing awareness that naloxone is available without a prescription and that many community organizations provide naloxone at no cost, including Naloxone Arizona, Sonoran Prevention Works Arizona, and the Substance Awareness Coalition Leaders of Arizona.
    - Encouraging parents and caregivers who use illicit opioids or other drugs, or who live with or socialize with individuals who use illicit drugs, to keep naloxone readily accessible in the event of an opioid overdose.
    - Educating families and caregivers that naloxone is safe to administer to children and adolescents when an opioid overdose is suspected.
    - Encouraging hospitals and healthcare facilities to provide or ensure access to naloxone at discharge for patients and their families when appropriate.
    - Expanding community access to naloxone statewide by encouraging community providers and organizations to ensure naloxone is readily available in their communities and to promote resources for obtaining naloxone through the ADHS Request Link.
- Increase community awareness of the risks of operating vehicles while under the influence of any legal/illicit substances that could cause impairment. Encourage the use of rideshares, designated drivers/public transportation. [127]
- Increase awareness and educate parents/caregivers on the risk of substance use while caring for/supervising children. [128-131]
- Increase parent/caregiver, school personnel, youth, and community knowledge of signs and risks of underage alcohol and drug use, including marijuana, and where/how to seek support/treatment.[123]
- Healthcare providers, pharmacists, and agencies that work with children should educate parents and caregivers about proper storage and disposal of medications and how to keep alcohol, drugs, and medications out of the hands of children and adolescents. [132]

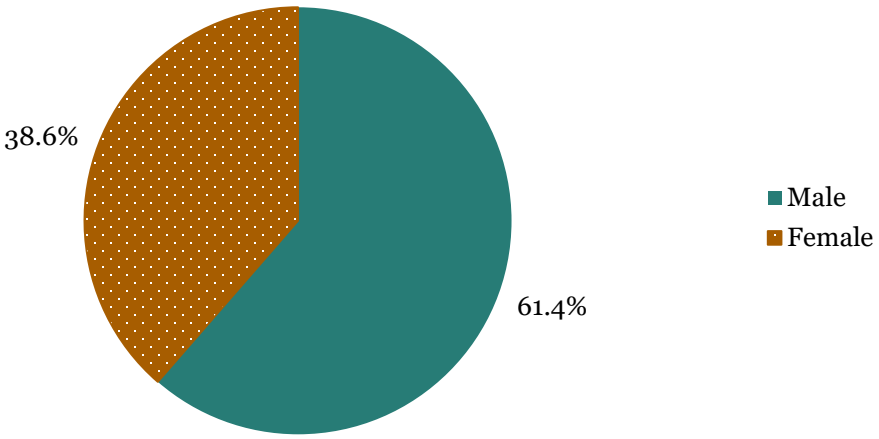
Arizona's substance involved-related mortality rate (ages 0 to 17 years) increased by 8.6 percent over the past year, increasing from 7.0 deaths per 100,000 children in 2024 to 7.6 deaths per 100,000 children in 2025 (Figure 66).

Figure 66. Substance Involved-Related Mortality Rate (per 100,000 Children, Ages 0 to 17 Years), Arizona, 2019-2025 [4-10]



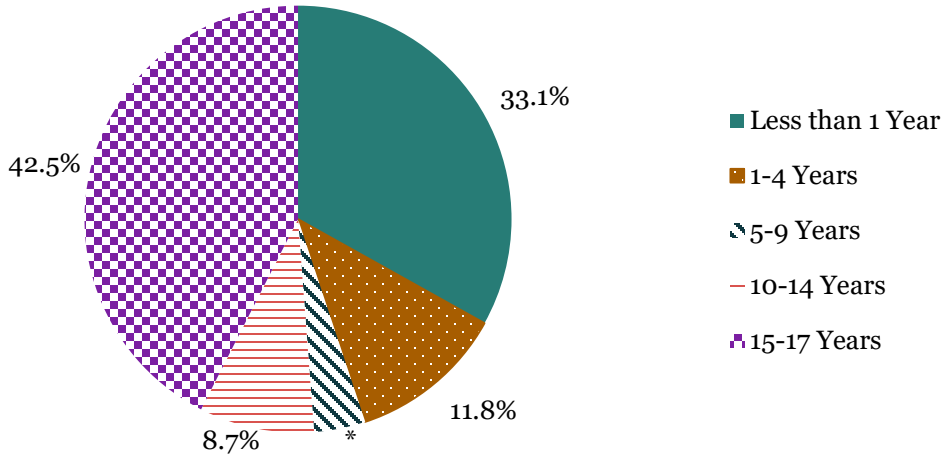
Among substance involved-related deaths by sex, 61.4 percent were male, while 38.6 percent were female (Figure 67).

Figure 67. Percentage of Substance Use-Related Deaths by Sex (Ages 0 to 17 Years), Arizona, 2025 (n = 127)



Substance involved-related deaths most frequently occurred among adolescents aged 15 to 17 years (42.5 percent), followed by infants less than one year (33.1 percent) (Figure 68).

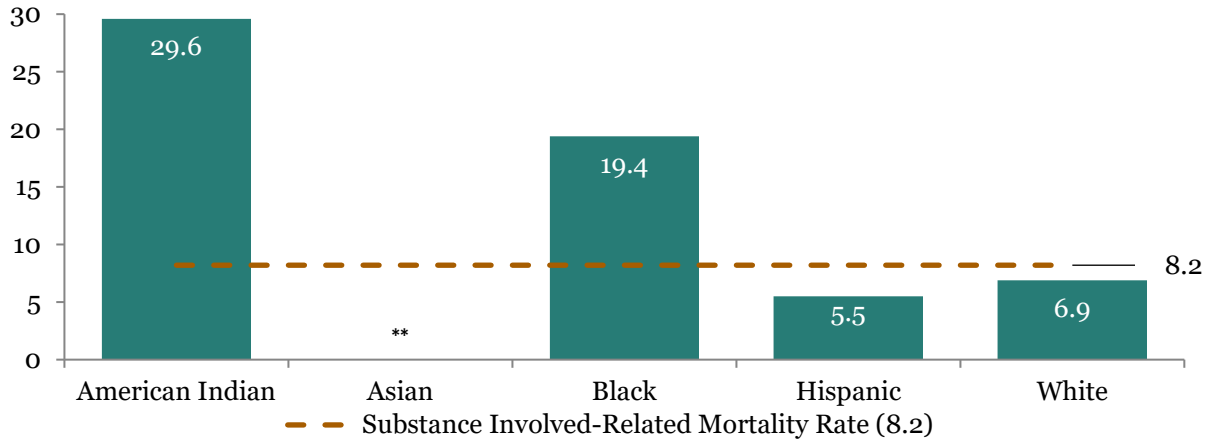
Figure 68. Percentage of Substance Involved-Related Deaths by Age Group (Ages 0 to 17 Years), Arizona, 2025 (n = 127)



*The percentage was suppressed because the count was less than 6.

When stratified by race/ethnicity, American Indian and Black children had higher mortality rates than the 2025 Arizona substance involved-related mortality rate (8.2 deaths per 100,00 children), at 29.6 and 19.4 deaths per 100,000 children, respectively. Hispanic and White children had lower mortality rates (Figure 69).

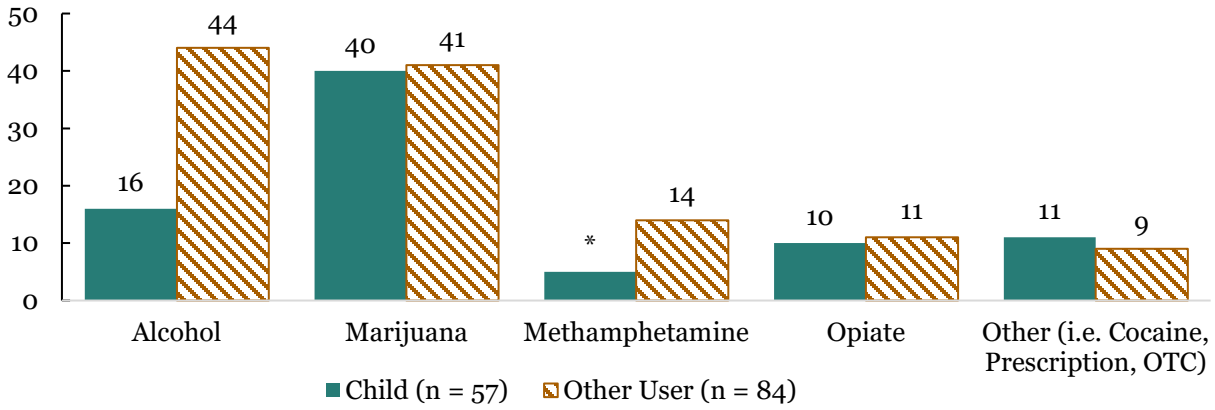
Figure 69. Substance Involved-Related Mortality Rate (per 100,000 Children) by Race/Ethnicity (Ages 0 to 17 Years), Compared to the Substance Involved-Related Mortality Rate, Arizona, 2025 (n = 127) [4]



**Data for Asian children was suppressed because the count was less than 6.

Marijuana was the most common substance identified by local review teams as causing or contributing to the substance involved-related death, followed by alcohol. When the child was identified as the user, marijuana was the most frequently noted substance, whereas alcohol was the most common substance when another individual was identified as the user (Figure 70). It is important to note that, in poisoning deaths of infants/toddlers, the child is not identified as the user.

Figure 70. Number of Substances Identified as Causing or Contributing to Death, by the Child or Other User (Ages 0 to 17 Years), Arizona, 2025 (n = 127)^



*The number was suppressed because the count was less than 6.
^More than one substance and/or more than one user may have been identified in each death.

While numerous risk factors contribute to substance involved-related deaths, a parental history of substance use was the most prominent, identified in 60.2 percent of the fatalities (78 deaths). A family history with CPS closely followed this at 61.4 percent (71 deaths), poverty at 40.9 percent (52 deaths), and a history of trauma/violence at 26.8 percent (34 deaths) (Table 40).

Table 40. Risk Factors of Substance Involved-Related Deaths (Ages 0 to 17 Years), Arizona, 2025 (n = 127)

Risk Factors^	Number	Percent
Parent Substance Use History	78	60.2%
CPS History with Family	71	61.4%
Poverty	52	40.9%
History of Trauma/ Violence	34	26.8%
Child Relationship Issues	31	24.4%
Child's Chronic Conditions	31	24.4%
Lack of Supervision	26	20.5%
Criminal Activity	23	18.1%
Inadequate Treatment	14	11.0%
Mental Health/ Substance Use Disorder	9	7.1%
Recent Crisis	6	4.7%

^More than one risk factor may have been identified in each death.

Among substance involved-related deaths (ages 0 to 17 years), MVC-related fatalities were the leading cause, accounting for 28.3 percent (36 deaths) of substance involved-related fatalities. This was followed by firearm injury fatalities at 15.0 percent (19 deaths), and poisoning at 14.2 percent (18 deaths) (Table 41).

Table 41. Causes of Substance Involved-Related Deaths where a Substance was a Direct or Contributing Factor (Ages 0 to 17 Years), Arizona, 2025 (n = 127)

Causes of Death	Number	Percent
MVC-Related	36	28.3%
Firearm Injury	19	15.0%
Poisoning	18	14.2%
Suffocation	16	12.6%
Prematurity	13	10.2%
Blunt Force Injury	6	4.7%
Other Infection	<6	*
Undetermined	<6	*
Drowning	<6	*
Strangulation	<6	*
Fall/Crush	<6	*
Influenza	<6	*
Other Injury	<6	*
Other Medical Condition	<6	*
Stabbing	<6	*

*The number/percentage was suppressed because the count was less than 6.

Of the 18 poisoning deaths, 12 were opiate overdoses (Table 42). Fentanyl was responsible for 9 of these opiate poisonings. Of the 9 fentanyl poisonings, 8 were among children aged 10 to 17 years (not shown).

Table 42. Number and Percentage of Poisoning Deaths by Types of Poisoning (Ages 0 to 17 Years), Arizona, 2025 (n = 18)

Types of Poisoning Deaths^	Number	Percent of Poisoning Deaths
Opioid	12	66.7%
Marijuana	<6	*
Prescription Drug	<6	*
Methamphetamine	<6	*
Over-the-counter (OTC) Drug	<6	*
Cocaine	<6	*
Alcohol	<6	*
Other (such as Synthetic Drug)	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one substance may have been identified in each death.

Sudden Unexpected Infant Deaths (SUIDs)

Death of an infant for which no underlying medical condition was identified as a cause of death. See the Glossary for further explanation.

Total SUIDs

55

(7.1% of Child Deaths)

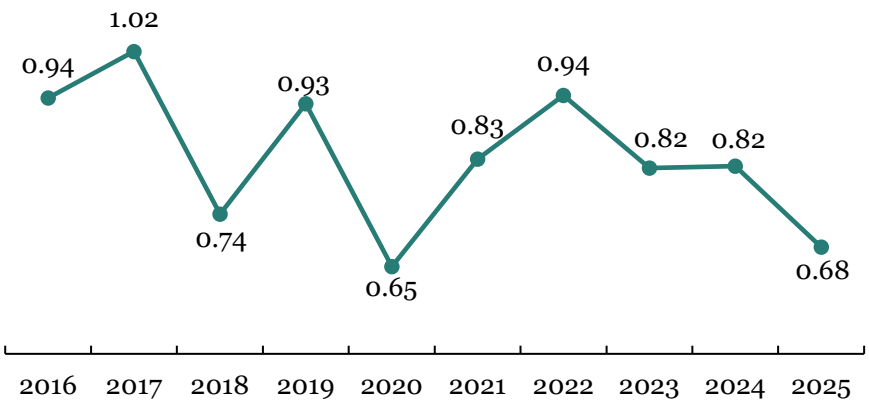
17.1% ↓

in the mortality rate from 2024

96.4%

of SUIDs were Preventable

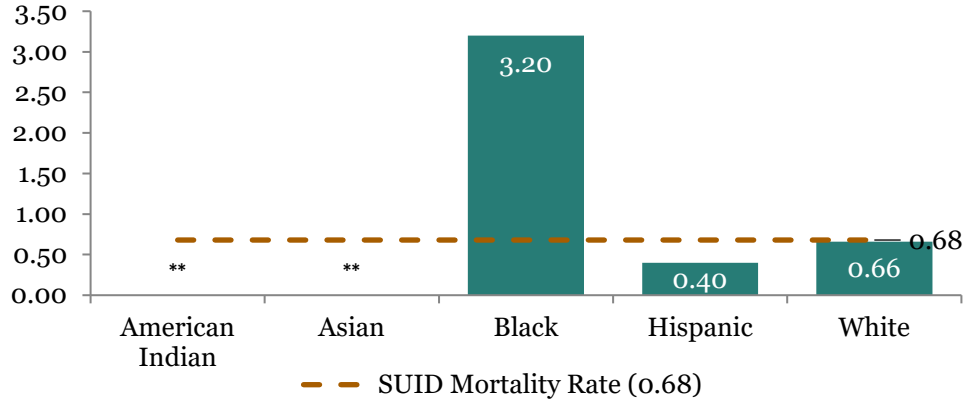
SUID Mortality Rate (per 1,000 Live Births, Less than 1 Year), Arizona, 2016-2025 [24-33]



Leading Causes of SUIDs:

Suffocation	Undetermined
85.5% (47 deaths)	14.5% (8 deaths)

SUID Mortality Rate (per 1,000 Live Births) by Race/Ethnicity (Less than 1 Year of Age), Compared to the SUID Mortality Rate, Arizona, 2025 [24]



**Data for American Indian and Asian infants were suppressed because the count was less than 6.

83.6%

of SUIDs occurred in post-neonates (infants 28 days and older but less than one year of age)

58.2%

of SUIDs were among males

Leading Risk Factors of SUID^:

Unsafe Sleep Environment	Objects in Sleep Environment	Poverty	Unsafe Sleep Location	Parent Substance Use History
96.4%	92.7%	81.8%	69.1%	61.8%

^More than one risk factor may have been identified for each death.

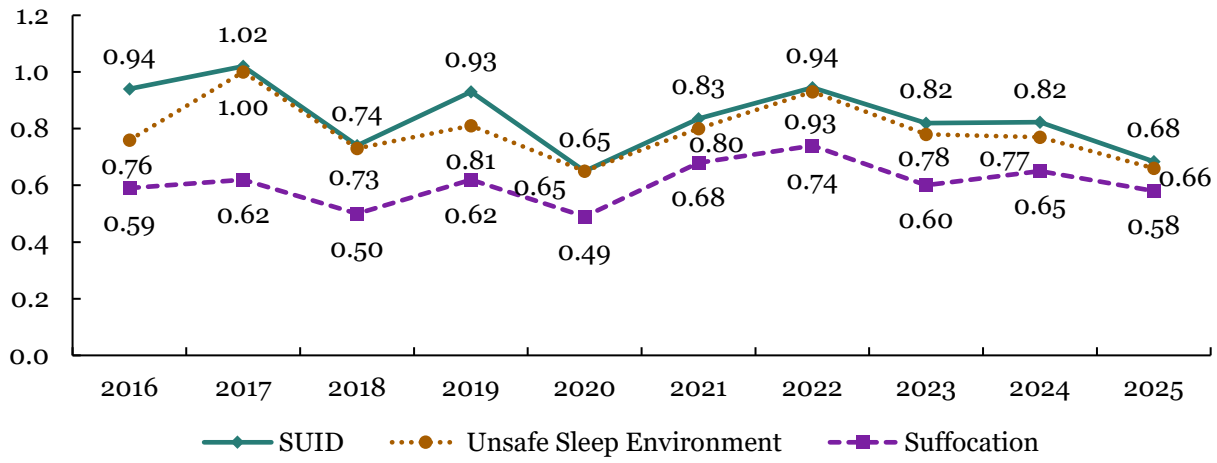
Sudden Unexpected Infant Death (SUID) Prevention Recommendations:

- Anyone providing services to families with children under the age of 1 should educate parents on safe sleeping environments in multiple languages, including: [133-136]
    - Infants should be placed on their backs to sleep on a firm, flat, non-inclined sleep surface until they are one year old.
    - An infant's ideal safe sleep environment requires a firm sleeping surface with only a fitted sheet and no additional bedding or items.
    - Dangers associated with using sleep products not explicitly marked for infants include rocking sleepers, nursing pillows, and infant loungers.
    - That they should stop swaddling as soon as their infant starts trying to roll and not use weighted swaddles.
- Increase home visiting programs statewide for infants from birth to one year, and educate home visitors on the importance of discussing safe sleep at every visit. [133-135, 82]
- Provide parents with education, support, and information on parenting strategies, including information and guidance on: [128-131]
    - The Centers for Disease Control and Prevention (CDC)'s Positive Parenting Tips
    - Proper and constant supervision of infants and children, and awareness of the dangers of caring for children and infants while under the influence of alcohol, marijuana, sedatives, and any medication that impairs alertness. Parents and caregivers should ensure there is a sober caregiver when supervising infants and children, and encourage the presence of support when using necessary medications that may cause impairment.
    - Typical developmental milestones and appropriate expectations for their child's abilities and risks as those skills develop (such as rolling over, etc.)
- Encourage Arizona policymakers to prioritize and invest in families' financial well-being, including increasing access to coordinated support for healthcare, food, housing, employment, and childcare. [86-87]
- Establish a coordinated community support framework that proactively identifies and provides wraparound services for high-risk families. This should include: [77-81]
    - Family Support Hubs that create or expand local centers where families can access case management, parenting programs, and immediate support for basic needs (food, housing, employment, mental health services) in one location.
    - Multi-Agency Collaboration to encourage cooperation between schools, healthcare providers, child protection, and community organizations to share relevant information and form joint care plans tailored to each family's circumstances.
    - Early identification and referrals by training frontline workers (teachers, nurses, community liaisons, social workers) to recognize early risk indicators and to refer families through a clear, supportive pathway—not a punitive one.
    - Peer and community mentorship to engage local volunteers, family mentors, and cultural leaders to provide social support and reduce isolation, particularly for marginalized communities.
- Increase the availability and accessibility of affordable, quality mental health and substance use treatment services that are supportive for families with children to receive care. Especially in rural and tribal areas.[76]
- Community partners/organizations and employers should support policies and programs that expand access to paid maternity and parental leave to strengthen postpartum support for mothers and families to promote infant and parent/caregiver health and safety. [137-139]

- Ensure availability and accessibility of adult, child, and infant cardiopulmonary resuscitation (CPR) training for parents/caregivers. [65]
- Increase connections to, and expand funding for, community organizations to strengthen post-reunification support. [140]
- Families and caregivers of children and adolescents should familiarize themselves with the AAP Schedule of Well-Child Care Visits and schedule appointments accordingly. [89-90]

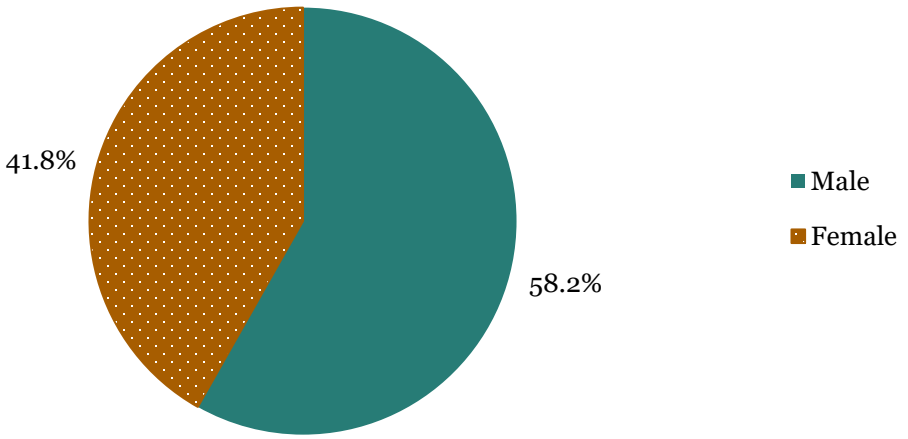
Arizona's SUID mortality rate (less than 1 year of age) decreased by 17.1 percent over the past year, falling from 0.82 deaths per 1,000 live births in 2024 to 0.68 deaths per 1,000 live births in 2025. From 2024 to 2025, the unsafe sleep environment mortality rate decreased by 14.3 percent (from 0.77 to 0.66 deaths per 1,000 live births), while the suffocation mortality rate decreased by 10.8 percent (from 0.65 to 0.58 deaths per 1,000 live births) (Figure 71).

Figure 71. SUID, Unsafe Sleep Environment, and Suffocation Mortality Rate (per 1,000 Live Births, Less than 1 Year of Age), Arizona, 2016-2025 [24-33]



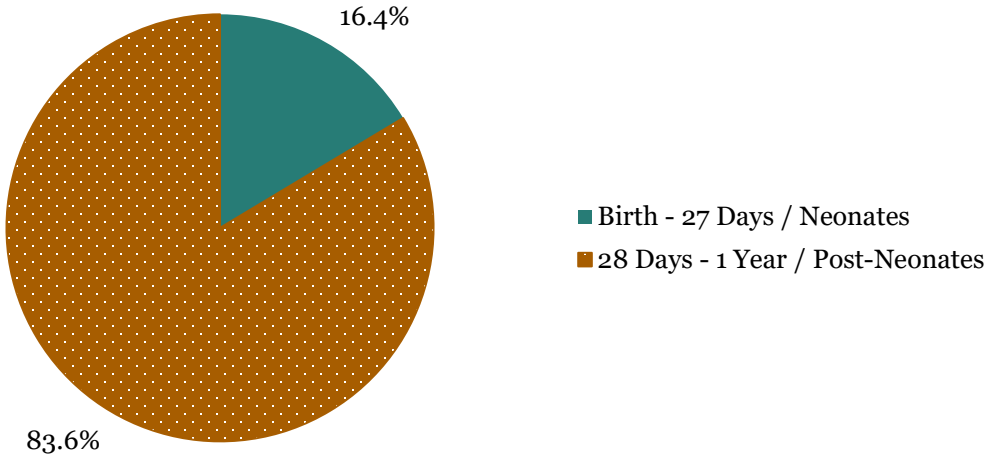
Among SUIDs by sex, 58.2 percent were male, while 41.8 percent were female (Figure 72).

Figure 72. Percentage of SUIDs by Sex (Less than 1 Year of Age), Arizona, 2025 (n = 55)



The majority of SUIDs occurred among post-neonatal infants aged 28 days to less than 1 year (83.6 percent), followed by neonatal infants younger than 28 days old (16.4 percent) (Figure 73).

Figure 73. Percentage of SUIDs by Age Group (Less than 1 Year of Age), Arizona, 2025 (n = 55)



The highest percentage of SUIDs occurred during the second month of life, accounting for 18.2 percent of these fatalities (10 deaths) (Table 43).

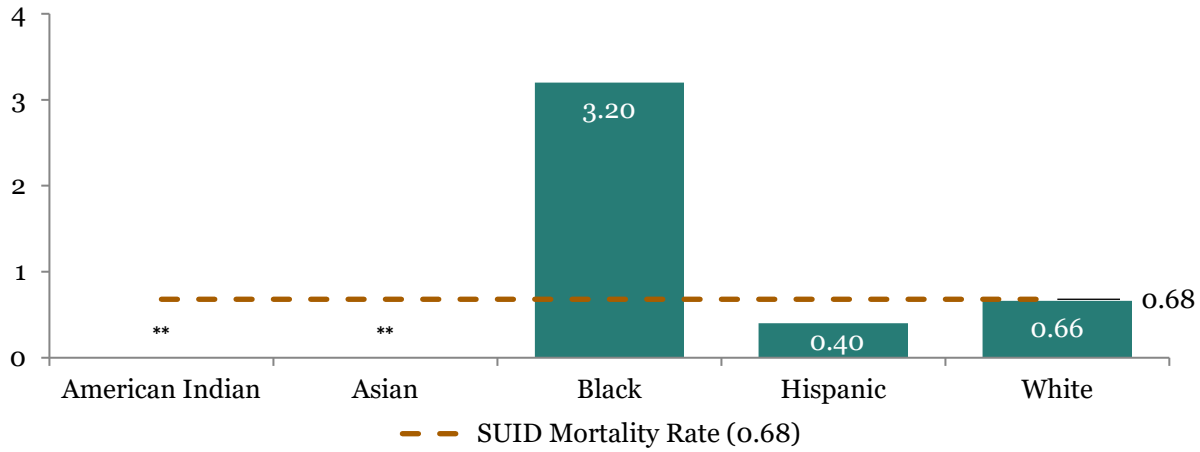
Table 43. Number and Percentage of SUIDs by Age in Months (Less than 1 Year of Age), Arizona, 2025 (n = 55)

Age in Months	Number	Percent
Less than 1 month	9	16.4%
1 Month	8	14.5%
2 Months	10	18.2%
3 Months	9	16.4%
4 Months	7	12.7%
5 Months	<6	*
6 Months	<6	*
7 Months	<6	*
8 Months	0	0.0%
9 Months	0	0.0%
10 Months	0	0.0%
11 Months	0	0.0%

*The number/percentage was suppressed because the count was less than 6.

When stratified by race/ethnicity, Black infants had a higher mortality rate than the 2025 Arizona SUID mortality rate (0.68 deaths per 1,000 live births), at 3.20 deaths per 1,000 live births. Hispanic and White infants had lower mortality rates (Figure 74).

Figure 74. SUID Mortality Rate (per 1,000 Live Births) by Race/Ethnicity (Less than 1 Year of Age), Compared to the SUID Mortality Rate, Arizona, 2025 (n = 55) [24]



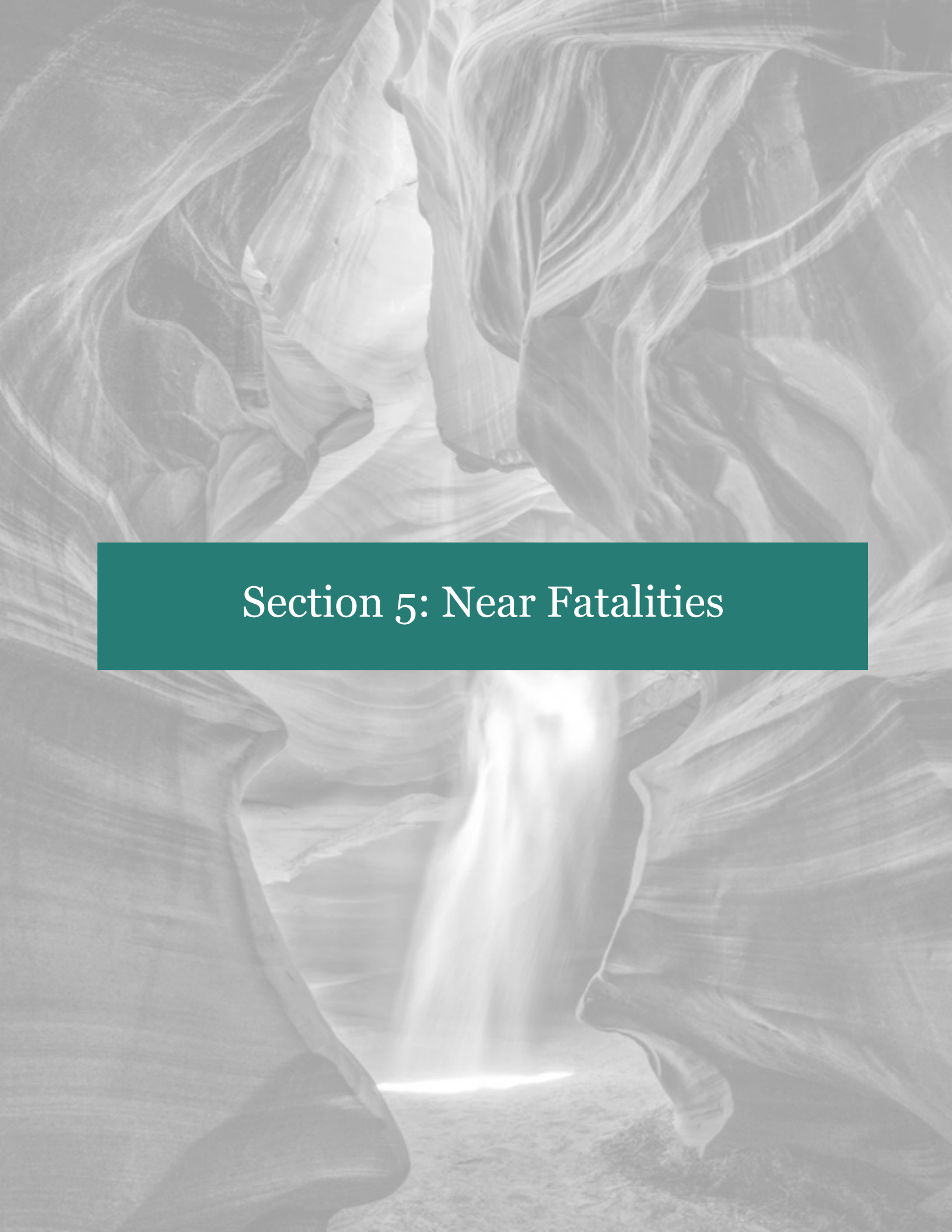
**Data for American Indian and Asian children were suppressed because the counts were less than 6.

While numerous risk factors contribute to SUIDs, a child having an unsafe sleep environment was the most prominent, identified in 96.4 percent of fatalities (53 deaths). This was closely followed by having objects in the sleep environment at 92.7 percent (51 deaths) and poverty at 81.8 percent (45 deaths). Six deaths (10.9 percent of fatalities) were linked to the use of a consumer product not meant for sleep, including the use of a U-shaped nursing pillow (Table 44).

Table 44. Risk Factors for SUIDs (Less than 1 Year of Age), Arizona, 2025 (n = 55)

Risk Factors^	Number	Percent
Unsafe Sleep Environment	53	96.4%
Objects in Sleep Environment	51	92.7%
Poverty	45	81.8%
Unsafe Sleep Location	38	69.1%
Parent Substance Use History	34	61.8%
Bedsharing	33	60.0%
CPS History with Family	27	49.1%
Substance Use	19	34.5%
Propping Bottle	14	25.5%
Unsafe Sleep Position	14	25.5%
Smoking During Pregnancy	7	12.7%
Lack of Supervision	7	12.7%
Consumer Product Problem (such as U-shaped nursing pillow)	6	10.9%
Child's Chronic Condition	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.



Section 5: Near Fatalities

Starting in the 2025 Annual Report is the inclusion of near fatality case reviews, as required by statute 36-3501-12: "Beginning January 1, 2025, conduct an annual statistical report on the incidence and causes of child fatalities and near fatalities identified by the Department of Child Safety (DCS) pursuant to section 8-807.01 for the past year." Near-fatal cases are identified using information published on the Arizona DCS Information Release webpage [141], where DCS reports cases determined to meet the statutory definition of near-fatalities under A.R.S. 8-807.01, following a comprehensive investigation. Because DCS investigations are extensive and may take six months to two years to complete before cases are publicly released, the CFRP can include only near-fatality cases that have been fully investigated and officially designated as such by DCS at the time of data collection. As a result, not all near-fatal cases for a given review year may be captured. For 2025, 6 near-fatality cases were identified by the June 30th deadline for case reviews.

How DCS identifies near-fatality cases:

- State law mandates DCS to release information in cases where children have died or nearly died as a result of abuse, abandonment, or neglect by a parent or caregiver.
- If DCS receives a report that a child has died or nearly died as a result of abuse, abandonment, or neglect, the preliminary information will be posted online.
- DCS strives to provide timely information until it is determined that a child died or nearly died because of abuse, abandonment, or neglect by a parent, guardian, or caregiver.
- DCS may only post on a death or near-death if it has been determined that it was caused by abuse, abandonment, or neglect, if:
    - The perpetrator is charged with an offense related to the incident;
    - A superior court finds a child dependent based on the allegations of abuse or neglect leading to the death or near-death; or
    - DCS, through its own internal review and administrative appeal process, substantiates findings linking the allegations of abuse or neglect to the death or near-death.
    - Further, if the posting is on a near-death, a medical professional must determine that the child was in serious or critical condition.

Near Fatality Cases

Defined by DCS as a case that was caused by abuse, abandonment, or neglect. See the Glossary for further explanation.

Total Near Fatalities^	100.0% of Near Fatalities were Preventable	100.0% of Near Fatalities occurred in Children <9 Years of Age
6		

^6 near fatality cases were identified by the June 30th deadline for case reviews using the Arizona DCS information release webpage.

Table 45. Causes of Near Fatalities (Ages 0 to 9 Years), Arizona, 2025 (n = 6)

Causes of Near Fatalities	Number	Percent
Blunt Force Injury	<6	*
Poisoning	<6	*
MVC-Related	<6	*
Firearm Injury	<6	*

*The number/percentage was suppressed because the count was less than 6.

Table 46. Risk Factors for Near Fatalities (Ages 0 to 9 Years), Arizona, 2025 (n = 6)

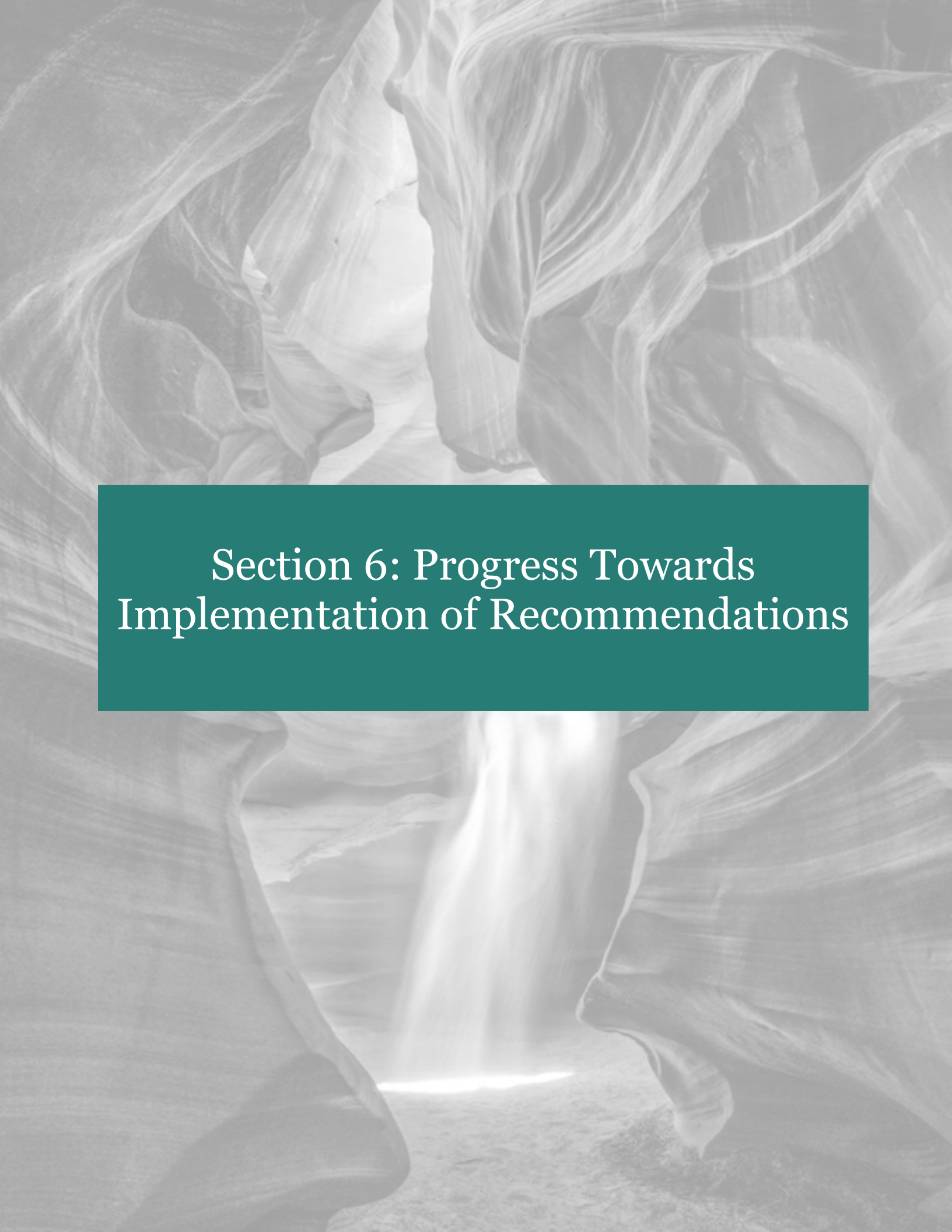
Risk Factors^	Number	Percent
CPS History with Family	<6	*
Child Relationship Issues	<6	*
Family Discord	<6	*
History of Trauma/Violence	<6	*
Parent Substance Use History	<6	*
Substance Use	<6	*
Poverty	<6	*
Child's Chronic Condition	<6	*
Lack of Supervision	<6	*
Unsecured Firearm	<6	*

*The number/percentage was suppressed because the count was less than 6.
^More than one risk factor may have been identified in each death.

Near-Death Fatality Prevention Recommendations:

- Increase the availability and accessibility of affordable, quality mental health and substance use treatment services that are supportive for families with children to receive care. Especially in rural and tribal areas.[76]
- Increase availability, accessibility, affordability, and appropriate use of naloxone among youth, families, caregivers, healthcare providers, and community members through strategies including: [120-126]
    - Promoting education on naloxone, including when and how to recognize and administer naloxone for an opioid overdose and administer naloxone, with age-appropriate education for adolescents.
    - Encouraging healthcare providers to co-prescribe or offer naloxone, especially when prescribing medications that may result in an opioid overdose.
    - Educating pharmacists about the importance of offering naloxone to patients of all ages when appropriate.
    - Increasing awareness that naloxone is available without a prescription and that many community organizations provide naloxone at no cost, including Naloxone Arizona, Sonoran Prevention Works Arizona, and the Substance Awareness Coalition Leaders of Arizona.
    - Encouraging parents and caregivers who use illicit opioids or other drugs, or who live with or socialize with individuals who use illicit drugs, to keep naloxone readily accessible in the event of an opioid overdose.
    - Educating families and caregivers that naloxone is safe to administer to children and adolescents when an opioid overdose is suspected.
    - Encouraging hospitals and healthcare facilities to provide or ensure access to naloxone at discharge for patients and their families when appropriate.
    - Expanding community access to naloxone statewide by encouraging community providers and organizations to ensure naloxone is readily available in their communities and to promote resources for obtaining naloxone through the ADHS Request Link.
- Increase community awareness of how and when to report suspected child neglect or abuse so that any individual who suspects a child who is being neglected or abused can act by calling 911 in an emergency or, in non-emergency cases, call the Arizona Child Abuse hotline (1-888-SOS-CHILD). This includes increasing awareness among professionals about mandated reporting laws (A.R.S. § 13-3620), who is a mandated reporter, and training requirements for identifying and reporting suspected neglect/abuse. [107]
- Establish a coordinated community support framework that proactively identifies and provides wraparound services for high-risk families. This should include: [77-81]
    - Family Support Hubs that create or expand local centers where families can access case management, parenting programs, and immediate support for basic needs (food, housing, employment, mental health services) in one location.
    - Multi-Agency Collaboration to encourage cooperation between schools, healthcare providers, child protection, and community organizations to share relevant information and form joint care plans tailored to each family's circumstances.
    - Early identification and referrals by training frontline workers (teachers, nurses, community liaisons, social workers) to recognize early risk indicators and refer families through a clear, supportive pathway—not a punitive one.
    - Peer and community mentorship to engage local volunteers, family mentors, and cultural leaders to provide social support and reduce isolation, particularly for marginalized communities.

- Increase availability of the full spectrum of reproductive care, including: [110-113]
    - Preconception care, including family planning services and access to chronic disease management, to lower risks and to increase the chances of a healthy pregnancy.
    - Prenatal care, which can help prevent complications and inform about the necessary steps to take to protect infants and ensure a healthy pregnancy.
    - Postpartum care and interconception care to address physical and mental recovery immediately after birth and optimize health between pregnancies to lower future risks and support family well-being
- Increasing the availability of home visiting programs throughout the state. [82]
- Increase availability of domestic violence screening and resources by all healthcare providers for victims of domestic and interpersonal violence, including raising awareness of available resources and support, and how and where to find help. [106]
- Encourage Arizona policymakers to prioritize and invest in families' financial well-being, including increasing access to coordinated support for healthcare, food, housing, employment, and childcare. [86-87]
- The Governor's Office of Highway Safety (GOHS) and the Arizona Department of Education (ADE) should implement education campaigns and initiatives to promote safe, sober, distraction-free defensive driving for young drivers and their parents/caregivers, with a focus on education on proper supervision of teen drivers and the risks of driving while intoxicated/under the influence (youth and adults). [93-94]
- Healthcare providers, pharmacists, and agencies that work with children should educate parents and caregivers about proper storage and disposal of medications and how to keep alcohol, drugs, and medications out of the hands of children and adolescents. [132]
- Implement education, campaigns, and initiatives for gun owners to reduce firearm deaths; strategies include: [70-74]
    - Healthcare providers and community agencies that serve families and children should promote safe storage of firearms, which requires keeping the gun unloaded and locked in a safe separate from the ammunition.
    - Businesses that sell firearms should distribute lock boxes to promote safe storage and provide information on safety classes with all firearm purchases.
    - Strengthen firearm ownership and purchase restrictions on those with serious mental illness diagnoses and domestic violence perpetrator history, and continue to promote and support prohibited possessor laws.
    - Community agencies serving children, adolescents, and families should increase awareness of firearm safety guidance and what to do if you find a firearm.



Section 6: Progress Towards Implementation of Recommendations

Progress Towards Implementation of Recommendations

In accordance with A.R.S. § 36-3501(C)(12), beginning in January 2025, this section provides information on progress toward implementing recommendations made by the Arizona CFRP. These recommendations are developed to address preventable factors identified through the review of child deaths in Arizona.

This section highlights the actions ADHS has taken to support the implementation of these recommendations. The summaries below describe ADHS initiatives, policy developments, and programmatic activities that align with identified prevention priorities and demonstrate ongoing efforts to reduce child fatalities and improve child well-being across the state.

Suicide Recommendation Implementation:

- Through funding from the Arizona Department of Education (ADE) and in partnership with Cochise County Education Services, the Bureau of Chronic Disease and Health Promotion (BCDHP) is developing and implementing the Bright Futures Project—a comprehensive suicide prevention toolkit for K-12 schools, with a planned launch in 2027. The toolkit will help schools strengthen early identification of suicide risk, improve staff preparedness and response, connect students to behavioral health resources, and promote protective factors such as connectedness, resilience, and help-seeking. It also provides guidance for responding to suicide deaths and reducing the risk of suicide contagion, supporting a coordinated, school- and community-based approach to preventing youth suicide. For more information about the toolkit, contact preventsuicide@azdhs.gov.
- Bureau of Women and Children's Health (BWCH) partners with County Health Departments and Community-Based Organizations across the state to deliver Youth Mental Health First Aid training, an evidence-based early intervention program that teaches adults how to identify, understand, and respond to signs of mental health and substance use challenges in adolescents.
- BWCH provides referral pathways through evidence-based home visiting programs that offer direct education and support on child development, nutrition, breastfeeding, oral health, and navigating community resources, available here.
- BCDHP participates in the Four Corners conference collaboration with the Suicide Prevention program to strengthen coordination.
- BWCH conducts eight youth councils across the state. Councils build positive experiences, relationships, and environments where young people are given the space to be leaders, take initiative, and create innovative ideas and solutions to public health issues youth face daily.
- BWCH partners with County Health Departments and Community-Based Organizations to implement the Teen Outreach Program, an evidence-based initiative that provides teens with the tools and opportunities to build life and leadership skills, strengthen relationships, and avoid risky behaviors.
- Through a collaborative effort among ADHS, ADE, and AHCCCS, a Youth Mental Health Steering Committee is convened to coordinate programs, practices, and procedures that increase resilience and improve mental health outcomes for youth, adolescents, and young adults. Through this partnership, a parent/caregiver youth mental health digital media toolkit was developed and is available to any organization interested in using the assets. The toolkit is designed to support parents, caregivers, and trusted adults in promoting youth mental health by encouraging everyday conversations and consistent

emotional check-ins. The toolkit offers a collection of ready-to-use digital and printable materials that can be shared anywhere caregivers connect with youth.

- In collaboration with Brad Snyder, a nationally recognized bullying prevention expert, a Bullying Prevention webinar series is offered, focusing on bullying prevention and youth mental health and providing practical strategies and insights for anyone who interacts with young people.
- BCDHP also supports suicide prevention recommendations through several statewide and community-driven initiatives focused on increasing access to crisis resources, promoting safe messaging, and strengthening youth connection and resilience. Key activities include:
    - Student ID Card Crisis Messaging (A.R.S. § 15-160) - statewide campaign with ADE/Teen Lifeline, to maximize compliance with statutory requirements mandating crisis touchpoints on Grades 9–12 student ID cards (Teen Lifeline / 988) to lower help-seeking barriers.
    - Youth Innovation Lab & Influencer Campaign - Establishes a participatory, youth-driven co-design engine to generate digital safe-messaging that peer champions and social media influencers deploy directly to Arizona youth.
    - Native Voices Storytelling Initiative through the American Indian and Alaska Native Workgroup, in conjunction with the Inter-Tribal Council of America (ITCA). A structured initiative designed to gather, archive, and share resilience and strength-based narratives - combining traditional cultural/creation oral histories with contemporary, lived-experience recovery stories - with a central focus on reaching and including Native youth councils through ITCA.

Drowning Recommendation Implementation:

- Facilitation of quarterly Injury Prevention Advisory Council (IPAC) meetings to bring together state and local agencies and community partners to advance injury prevention recommendations, including motor vehicle crashes, drowning, and firearm injuries, into actionable strategies, coordinated initiatives, and community-based prevention efforts.
- Bureau of Chronic Disease and Health Promotion partners with ADE on drowning prevention efforts.
- Produced Arizona Drowning Data Report in collaboration with the CDC Foundation and hosted a webinar on the CDC Foundation Arizona drowning report produced by a CDC Fellow or Epidemiologist. The report provides a comprehensive assessment of the drowning landscape in Arizona, highlighting key data, trends, risk factors, and opportunities to strengthen statewide drowning prevention efforts.
- BCDHP develops and disseminates bilingual (English and Spanish) water safety awareness messaging through social media campaigns and educational blog content on the ADHS website to promote water safety and drowning prevention.
- The Bureau of Infectious Disease and Services (BIDS) conducts outreach to improve knowledge, such as the Healthy Swimming Educational Campaign, which includes a poster contest and site visits to pools to provide health education on swimming.

Firearm Injury Recommendation Implementation:

- Facilitation of quarterly IPAC meetings to bring together state and local agencies and community partners to advance injury prevention recommendations, including motor vehicle crashes, drowning, and firearm injuries, into actionable strategies, coordinated initiatives, and community-based prevention efforts.

- BWCH supports a coordinated community support framework through evidence-based home visiting programs that provide direct education and support on child development, nutrition, breastfeeding, oral health, and navigating community resources, found here.
- Through funding from ADE and in partnership with Cochise County Education Services, BCDHP is developing and implementing the Bright Futures Project—a comprehensive suicide prevention toolkit for K-12 schools, with a planned launch in 2027. The toolkit promotes lethal means safety by guiding families on safe firearm storage, medication security, and reducing access to other potential hazards to prevent youth suicide.

Motor Vehicle Crash (MVC) Recommendation Implementation:

- Facilitation of quarterly IPAC meetings to bring together state and local agencies and community partners to advance injury prevention recommendations, including motor vehicle crashes, drowning, and firearm injuries, into actionable strategies, coordinated initiatives, and community-based prevention efforts.
- BCDHP leads multiple national car seat certification trainings in rural and tribal communities each year.
- Collected and analyzed e-bike injury data in Maricopa County in collaboration with epidemiologists, translating findings into actionable information to educate community partners and inform public awareness and injury prevention efforts.

Neglect/Abuse Recommendation Implementation:

- Conducts and publishes a quarterly statewide Treatment Capacity Survey Report that illustrates substance use treatment capacity in Arizona to increase public awareness of available treatment resources and help individuals, families, and community partners identify access to care across Arizona.
- ADHS overdose prevention programs promote the AHCCCS Opioid Service Locator tool.
- BWCH supports a coordinated community support framework through evidence-based home visiting programs that provide direct education and support on child development, nutrition, breastfeeding, oral health, and navigating community resources, found here.
- BWCH implements evidence-based and evidence-informed home visiting programs that provide parent education and support to pregnant women and families with children under age five. These programs promote healthy child development, strengthen parent–child relationships, and support emotional well-being. Families receive education on child development, positive parenting, social and emotional regulation for both parent and child, and injury prevention, while also completing screeners and assessments related to parental mental health, substance use, and child development.
- ADHS' home visitors are mandatory reporters who receive training from DCS on how and when to report suspected child abuse and neglect.

Infectious Disease Recommendation Implementation:

- BIDS aims to maintain and enhance surveillance activities, outbreak response, laboratory capacity, and collaborations with stakeholders to continue providing comprehensive vaccine-preventable and respiratory disease surveillance, statewide situational awareness, the ability to detect and respond to outbreaks or novel events, and to mitigate the public health impact of vaccine-preventable and respiratory disease and related conditions in Arizona.
- BIDS worked closely with the Bureau of Immunizations (BIZS), local/tribal and community partners (such as The Arizona Partnership for Immunization, known as TAPI) to promote vaccinations and vaccine confidence. This is accomplished through

various strategies, including trend and data analysis, collaborative vaccine communications, evaluation and approval of relevant materials (such as flyers and the Ask the Experts Newsletter), and consistent dissemination of messages to providers, communities, and stakeholders for further distribution.

- BWCH supports vaccine education, the AAP Schedule of Well Child Care Visits, and the streamlining of support services for families of children with complex medical needs through evidence-based home visiting programs that provide direct education and support on child development, nutrition, breastfeeding, oral health, and navigating community resources.
- BIDS conducts educational outreach and community engagement to increase public awareness and prevent infectious diseases through the following activities:
    - Valley Fever Education: Hosts a student poster contest to increase awareness and education about Valley Fever.
    - Infectious Disease Prevention Outreach: Participates in the Game and Fish Expo to educate the public on rabies, mosquito-borne diseases, and food- and waterborne disease prevention.
    - Rocky Mountain Spotted Fever Prevention: Partners with Tribal communities to prevent the spread of Rocky Mountain Spotted Fever through dog tick inspections and treatment, community outreach, data collection, and pesticide application around homes.
- The Bureau of Emergency Medical Services and Trauma System (BEMSTS), through the 5- Year Rural Health Transformation Program (RHTP), is collaborating with Arizona's four Arizona EMS Regional Councils to award RHTP funding to eligible Arizona individuals and organizations to provide scholarships for Initial training courses and Continuing Education courses to increase the number of Emergency Medical Care Technicians (EMCT) at each of the four certification levels (EMT, Advanced EMT, Paramedic, Critical Care Paramedic) who work for Arizona EMS agencies (fire services, ground ambulance services) and healthcare facilities (qualifying urgent cares, and acute care hospital emergency departments) operating in Arizona rural areas.
- BEMSTS is working towards increasing availability and access to EMS by increasing the workforce of EMCTs working for rural-operating EMS agencies and eligible healthcare facilities, enhancing prehospital response and transport times, enhancing the quality of care, and enhancing workforce levels in emergency department and urgent care facilities with additional physician extenders and delegated practitioners to fill assessment and treatment gaps.

Prematurity and Other Perinatal Conditions Recommendation Implementation:

- BWCH partners with Happy Birth Day to implement the Count the Kicks campaign to prevent stillbirth.
- BWCH implements family planning programs through nine county health department clinics and Valleywise Health Medical Center.
- BWCH promotes the Know the Signs social media campaign and resources.
- Arizona Revised Statutes (A.R.S.) § 36-699 directs ADHS to establish a program to distribute folic acid supplements to women of childbearing age, to provide women with counseling and proper usage information about folic acid, and authorizes ADHS to partner with community entities to carry out distribution and counseling. Power Me2 AZ is the folic acid education and distribution program that provides a free 3-month supply of multivitamins containing folic acid to people in Arizona who can get pregnant. Power

Me2 AZ also provides educational materials on pregnancy planning, planning for a subsequent pregnancy, and birth control options after having a baby.

- ADHS programs such as the Women, Infants, and Children (WIC) Program and Health Start partner with county health departments, community clinics, and community nursing teams to promote the ASH Line Pregnancy and Parenting Program and educate staff, community clinics, community nursing teams, and community-based partners about available services and incentives. These partnerships also provide opportunities to share program information and resources through maternal and child health workgroups and community outreach efforts.
- BCDHP conducts Linkages to Care Workgroups, where stakeholders from treatment centers, peer navigation services, community providers, county health departments, justice-involved organizations, and ADHS program managers engage in ongoing strategy sessions to improve substance use treatment services.
- BCDHP operates the ASH Line, which offers a Pregnancy and Postpartum Program providing tailored coaching, educational materials, nicotine replacement therapy (NRT) with provider consent, and financial incentives for completing coaching sessions. The Health Systems Change team supports clinics in implementing the Ask–Advise–Connect model to connect pregnant patients who use tobacco with cessation services. ADHS also provides ASH Line training to healthcare partners. ASH Line resources are also included on crib cards to increase awareness of tobacco cessation support among families.
- ADHS runs the OAR Line, a free, confidential, 24/7/365 helpline operated in partnership with the University of Arizona College of Medicine and Banner Health. The OAR Line provides information, consultation, and referrals to individuals seeking support for opioid and other substance use concerns, including pregnant and postpartum individuals, with an average of 10 consultations per month for pregnant and postpartum individuals.
- BWCH supports the Arizona Perinatal Access Line (APAL), which provides healthcare providers with clinical consultations, training, and evidence-based toolkits to strengthen perinatal care and support improved maternal and infant health outcomes.
- BWCH supports the implementation of the Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles on Substance Use Disorder and Perinatal Mental Health Conditions in 40 of 42 birthing hospitals.
- BWCH supports a coordinated community support framework through evidence-based home visiting programs that provide direct education and support on child development, nutrition, breastfeeding, oral health, and navigating community resources, found here.

Substance Use Recommendation Implementation:

- ADHS is resuming regularly scheduled Linkages to Care Workgroups, where stakeholders from treatment centers, peer navigation services, community providers, county health departments, justice-involved organizations, and ADHS program managers engage in ongoing strategy sessions to improve substance use treatment services.
- BCDHP conducts Linkages to Care Workgroups, where stakeholders from treatment centers, peer navigation services, community providers, county health departments, justice-involved organizations, and ADHS program managers engage in ongoing strategy sessions to improve substance use treatment services.
- Agency staff participate in the Substance Abuse Coalition Leaders of Arizona (SACLAz). SACLAz engages community organizations and county health departments, shares resources, and supports substance use awareness and prevention efforts. Through these

partnerships, SACLAz provides education, training, and outreach to youth, families, caregivers, healthcare providers, and community members.
- Supports statewide naloxone distribution and education through partnerships with the ADE, schools, and rural county partners. Efforts include providing free naloxone, encouraging schools to stock naloxone and train staff in its administration, reducing stigma, and promoting overdose prevention education through resources such as The STOP-IT toolkit, which has sample parent communication, including "What Every Parent and Caregiver Needs to Know about Fake Pills" and "Emoji Drug Code | Decoded". Efforts also include implementing Medication and Sharp Disposal Information Posters, Postcards, and safe disposal products to County Health Departments to distribute within their community.
- Launched a Heat and Drug Education Campaign in Summer 2026 to raise public awareness about the risks of using certain substances during extreme heat. The campaign included distributing educational messaging on pharmacy bags to reach the public with information on heat-related substance use risks and prevention.

Sudden Unexpected Infant Death (SUID) Recommendation Implementation:

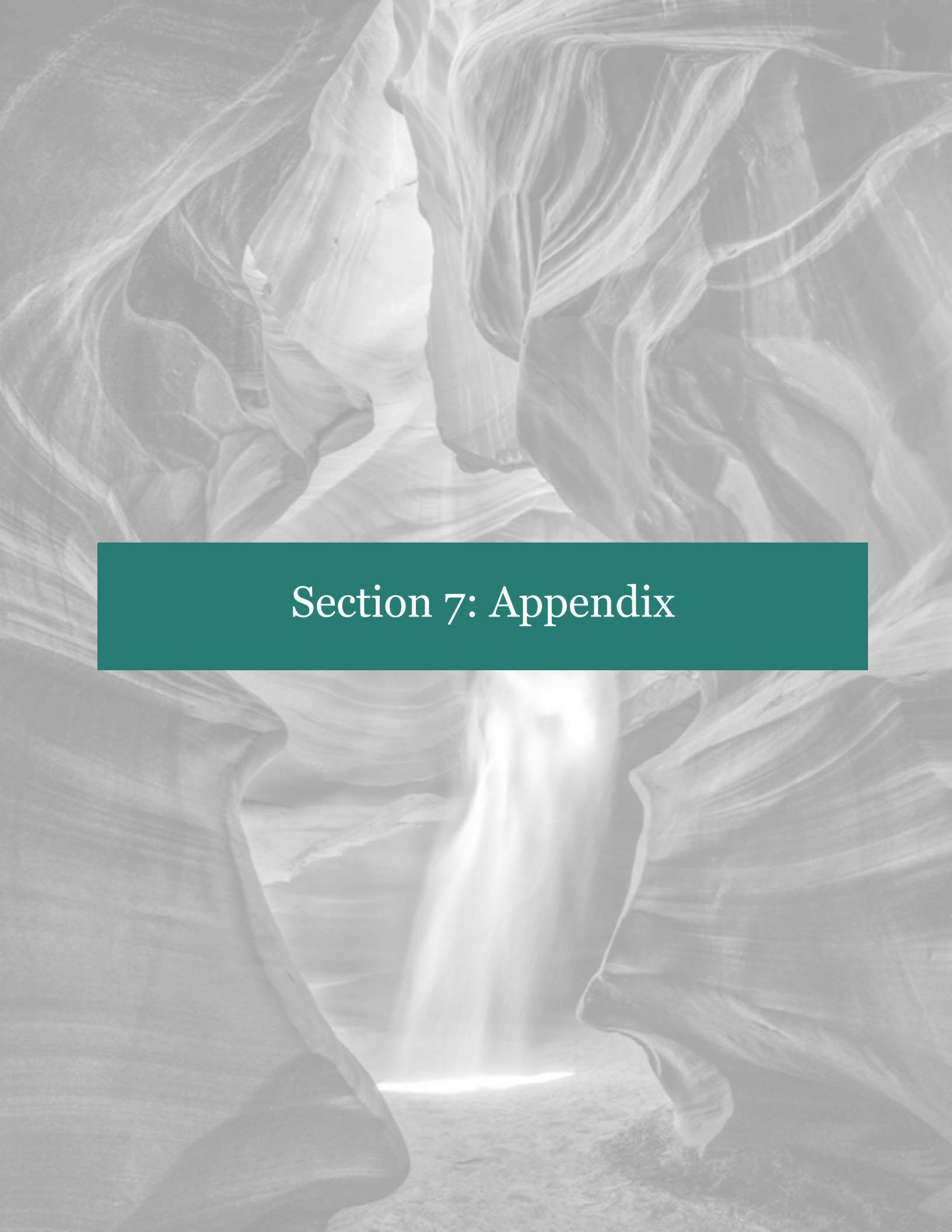
- The Safe Sleep task force meets to provide resources when able and connect with others when needed.
- BWCH hosts The Parenting Brief podcast, which features an episode on safe sleep that remains the most-streamed. The episode helps parents understand the importance of safe sleep environments, validates the challenges families face, and provides tools for implementing best practices to prevent sleep-related infant deaths.
- Strong Families promotes safe sleep practices through social media outreach and educational messaging to increase public awareness of infant safe sleep recommendations.
- Home visiting programs provide ongoing parent education on safe sleep practices, beginning in prenatal visits and continuing through the child's first birthday. Home visitors educate on safe sleep environments, reinforce key messages, and support families in creating safe sleep spaces at home.
- The Strong Families AZ Safe Sleep website offers safe sleep education, including a quiz that families can complete to receive a free sleep sack. The platform helps families increase their knowledge and confidence in practicing safe sleep every day.
- Safe sleep education is provided through evidence-based home visiting programs that provide direct education and support on child development, nutrition, breastfeeding, oral health, and navigating community resources, found here.

Near Fatality Recommendation Implementation:

- BCDHP implemented a Request for Grant Application (RFGA) for Counseling and Community Services for Southern Arizona. Provided $1,00,000 for expansion of comprehensive individual and family mental and behavioral health care, and financial support (such as grants for client utilities, medical expenses, rent or mortgage).
- Supports statewide naloxone distribution and education through partnerships with the ADE, schools, and rural county partners. Efforts include providing free naloxone, encouraging schools to stock naloxone and train staff in its administration, reducing stigma, and promoting overdose prevention education through resources such as the STOP-IT toolkit, which has sample parent communication, including "What Every

Parent and Caregiver Needs to Know about Fake Pills" and "Emoji Drug Code | Decoded".

- Facilitation of quarterly IPAC meetings to bring together state and local agencies and community partners to advance injury prevention recommendations, including motor vehicle crashes, drowning, and firearm injuries, into actionable strategies, coordinated initiatives, and community-based prevention efforts.
- BCDHP maintains the Dump the Drugs website, which provides safe drug-disposal materials to the public, including the groups listed.



Section 7: Appendix

Appendix A: Neglect/Abuse Data Disclaimers

Disclaimer for DCS/CPS:

- Local CFRP teams attempt to obtain records from child protective services (CPS) agencies, including the Department of Child Safety (DCS) and CPS agencies in other jurisdictions, such as tribal authorities and agencies in different states.
- Review teams consider a family as having previous involvement with a CPS agency if the agency investigated a report of Neglect/Abuse for any child in the family before the incident leading to the child's death.
- Unsubstantiated reports of Neglect/Abuse are also included in this definition; however, calls to DCS that did not meet the criteria to be made into a report and were taken as "information only" are not included in the CFRP annual report.

Department of DCS Definition of Neglect/Abuse:

Definitions of neglect and abuse as observed by DCS are outlined in Title 8 of the Arizona Revised Statutes. Child Safety 8-201; Section 2 and Section 25:

- Section 25: "Neglect" or "neglected" means:
    - The 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, except if the inability of a parent, guardian, or custodian to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services.
    - Permitting a child to enter or remain in any structure or vehicle where volatile, toxic, or flammable chemicals are found, or any person possesses equipment to manufacture a dangerous drug as defined in §13-3401.
    - A health professional determined that a newborn infant was exposed prenatally to a drug or substance listed in §13-3401 and that this exposure was not the result of a medical treatment administered to the mother or the newborn infant by a health professional. This subdivision does not expand a health professional's duty to report neglect based on prenatal exposure to a drug or substance listed in §13-3401 beyond the requirements prescribed under §13-3620, subsection E. The determination by the health professional shall be based on one or more of the following:
        - Clinical indicators in the prenatal period, including maternal and newborn presentation.
        - History of substance use or abuse.
        - Medical history.
        - Results of a toxicology or other laboratory test on the mother or the newborn infant.
    - Diagnosis by a health professional of an infant under one year of age with clinical findings consistent with fetal alcohol syndrome or fetal alcohol effects.
    - Deliberate exposure of a child by a parent, guardian, or custodian to sexual conduct as defined in §13-3551 or to sexual contact, oral sexual contact, or sexual intercourse as defined in §13-1401, bestiality as prescribed in §13-1411, or explicit sexual materials as defined in §13-3507.
    - Any of the following acts committed by the child's parent, guardian, or custodian with reckless disregard as to whether the child is physically present:
        - Sexual contact as defined in §13-1401.
        - Oral sexual contact as defined in §13-1401.

        - Sexual intercourse as defined in §13-1401.
        - Bestiality as prescribed in §13-1411.
- Section 2: "Abuse" means the infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior, and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody, and control of a child. Abuse includes:
    - Inflicting or allowing sexual abuse under §13-1404, sexual conduct with a minor under §13-1405, sexual assault under §13-1406, molestation of a child under §13-1410, commercial sexual exploitation of a minor under §13-3552, sexual exploitation of a minor under §13-3553, incest under §13-3608, or child sex trafficking under §13-3212.
    - Physical injury that results from permitting a child to enter or remain in any structure or vehicle in which volatile, toxic, or flammable chemicals are found, or any person possesses the equipment to manufacture a dangerous drug as defined in §13-3401.
    - Unreasonable confinement of a child.

Appendix B: State and Local CFRP Teams

State Team:

Chairperson:
Mary Ellen Rimsza, MD, FAAP
Arizona Chapter of the American Academy of Pediatrics

Members:
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Arizona Department of Health Services

Jakenna Lebsock, MPA
Rachael Salley, MPH (Proxy)
Arizona Health Care Cost Containment System

Vicki Copeland, MD
Division of Developmental Disabilities
Arizona Department of Economic Security

Rebecca Krumm
Julia Leight (Proxy)
Division of Children, Youth, & Families
Arizona Department of Child Safety

Tonya Hamilton
Amy Peep (Proxy)
Governor's Office for Youth, Faith, and Family

David K. Byers
Robert Shelley (Proxy)
Administrative Office of the Courts Parent Assistance Program

Douglas Sargent
Dr. Grant Phillips (Proxy)
Arizona Department of Juvenile Corrections

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Forensic Pathologist
Coconino County Medical Examiner

Susan Newberry, MEd
Maricopa County CFR Team

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Phoenix Indian Medical Center

Verna Johnson
InterTribal Council of Arizona

Amber-Rose Begay
Navajo Maternal and Child Health Projects
Diné College

Nicola Winkel, MPA
Arizona Coalition for Military Families

Dyanne Greer
Maricopa County Attorney's Office

Charles "Chuck" Miller
Law Enforcement Council
Arizona Peace Officer Standards and Training Board

Ryan Butcher, B.S.
Yuma County Public Health Services District

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Protective Services Child & Family Protective
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Phoenix Children's Hospital

Lindsay Kipersztok, LMSW
Arizona State Crisis Line

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Yomaira Castillo
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Britney Frederic
Injury Prevention Specialist, Phoenix Children's Hospital

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Tanya Dean
Child Protective Services

Suzi Dodt
Medicolegal Investigator
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Pattie Dremler
CASA Coordinator

Donald Engler
Payson Chief of Police

Tom Fife
Payson Fire Department

Joshua George
San Carlos Apache Health Care Nurse Manager

Thomas Greene
Arizona Department of Child Safety

Sherrie Harris
Chief Prosecutor

Von Harris
Child Safety Family Services
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Michael McAnerny
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Tonto Apache Tribe Payson

Shelly Soroka-Spence
Payson Child Help

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Shannon Claw
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Zeke Ziegler
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County Attorney Graham
County Attorney's Office

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Greenlee County Health Department

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Alysha Tucker, RN
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Jason Stein
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Melissa Loy
Department of Child Safety Coordinator

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Coordinator:
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Appendix C: References

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