

<b>Summary Report</b>	<b>Fatality</b>	<b>08/19/2024</b>
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**1. Victim:** Emoni-Rose Senegal – 2-month-old female

**2. Was the child residing in the child's home or in an out-of-home placement at the time of the fatality?**

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

On September 15, 2022, the Department of Child Safety received a report regarding 2-month-old Emoni-Rose Senegal, who was found deceased at home after co-sleeping with her mother and father, Allen Senegal. On July 9, 2024, the Department substantiated the allegation of neglect by Mr. Senegal.

**3. If the victim in the Preliminary Report involved a child residing in the child's home, the following information will be provided:**

**a. Services being provided to the child, a member of the child's family or the person suspected of the abuse or neglect at the time of the incident and the date of the last contact before the incident between the entity providing services and the person receiving services:**

No services were being provided to the family prior to the fatality incident. The family was being investigated for an open report dated July 8, 2022. Prior to the fatality incident, the last date of contact between the Department and the family was on July 8, 2022.

**b. Was the child, a member of the child's family or the person suspected of the abuse or neglect the subject of a report for investigation at the time of the incident?**

Emoni-Rose and her mother were subjects of the July 8, 2022 report.

**c. All involvement of the child's parents and of the person suspected of the abuse or neglect in a situation for which a report for investigation was made or in services provided pursuant to this chapter in the five years preceding the incident:**

DCS received the following prior reports involving the family:

On May 31, 2017, a report was received alleging neglect to a child by their mother. The allegation was unsubstantiated. The family was offered in-home services and daycare assistance. The case was closed on November 16, 2017.

On September 30, 2018, a report was received alleging neglect to a child by their mother. The allegation was substantiated. The family declined services from the

Department as they accepted services from the hospital. The case was closed on November 21, 2018.

On July 8, 2022, a report was received alleging neglect to Emoni-Rose Senegal by her mother. The case was open when the fatality report was received. Ultimately, the allegation was unsubstantiated. The family was provided with information on services in the community.

**d. Any investigation pursuant to a report for investigation concerning the child, a member of the child's family or the person suspected of the abuse or neglect or services provided to the child or the child's family since the date of the incident involving the fatality:**

The report regarding the fatality was investigated and the case was closed. The other children in the home were assessed as safe. The allegation of neglect to Emoni-Rose by Mr. Senegal was substantiated. The family was provided with information on services in the community.

A subsequent report involving Mr. Senegal and a child was received on October 14, 2022 alleging abuse. The report was unsubstantiated and the case was closed.

An additional subsequent report involving the child's mother and a newborn sibling was received on August 15, 2023. The child was assessed as safe and the allegation of neglect was unsubstantiated.

Another additional subsequent report involving the parents and siblings was received on February 2, 2024. The children were assessed as safe and the allegations were unsubstantiated.

**4. If the victim in the Preliminary Report involved a child residing in an out-of-home placement, the following information will be provided:**

**a. Licensing Agency:**

N/A

**b. Licensing history of the out-of-home placement, including the type of license held by the operator of the placement and the period for which the placement has been licensed:**

N/A

**c. Summary of all violations by the licensee:**

N/A

**d. Any other actions by the licensee or an employee of the licensee that constitute a substantial failure to protect and promote the health, safety and welfare of a child.**

N/A

**5. Actions taken by the Department in response to the case including any changes to policy or practice and/or recommendations for further changes in policies, practices, rules or statutes:**

The Department conducted a joint investigation with the Coolidge Police Department. The other children in the home were assessed as safe and the case was closed. The allegation of neglect to Emoni-Rose by Mr. Senegal was substantiated. The family was provided with information on services in the community.

The Department reminds all caregivers to practice safe sleep. For additional information please visit the DCS website at: <https://dcs.az.gov/Services/Safe-Sleep>.

Additionally, in accordance with the DCS Strategic Plan for State Fiscal Year 2016 (FY16), multidisciplinary team (MDT) reviews of fatality and near fatality cases were implemented during the first quarter of FY16. The MDT reviews fatality and near fatality cases with prior DCS involvement, which are a key feature of the Strategic Plan and supports the objective of increasing the accuracy of safety and risk assessments in investigations.

Cases are reviewed by the MDT in order to identify any systemic factors, both internal and external to the Department that may have had an impact. The Department uses the aggregate data gathered through all of the MDT reviews to assess and guide future changes and/or recommendations to policies, practices, rules or statutes. Findings from these reviews are compiled into an annual report to be shared on the DCS website. The target date for release of the next report is December 1, 2024.