Summary Report	Fatality	02/01/2024

1. Victim: Natalia Gonzalez-Cuen – four-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 August 17, 2021, the Department of Child Safety received a report regarding the fatality of four-month-old Natalia Gonzalez-Cuen. The child was found unresponsive in an adult bed and was transported to the hospital, where she was pronounced deceased. It was determined that Natalia died of asphyxia due to the unsafe sleep environment. On October 30, 2023, the Department substantiated the allegation of neglect by the mother, Karen Gonzalez.

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:

There were no services being provided to the family by the Department of Child Safety at the time of the incident.

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

No.

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

There has been no prior involvement of the child’s parents with DCS.

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:

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The report regarding the fatality was investigated the allegation of neglect to Natalia by her mother, Karen Gonzalez, was substantiated. Following an assessment of child safety, the sibling in the home was assessed as safe with their parents. The family was provided with information on services available in the community and the case was closed. There have been no subsequent reports of abuse or neglect received regarding the family.

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

a. Licensing Agency:

N/A

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

N/A

c. Summary of all violations by the licensee:

N/A

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

N/A

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

The Department conducted a joint investigation with the Yuma County Sheriff's Office. The report regarding the fatality was investigated the allegation of neglect to Natalia by her mother, Karen Gonzalez, was substantiated. Following an assessment of child safety, the sibling in the home was assessed as safe with their parents. The family was provided with information on services available in the community and the case was closed. There have been no subsequent reports of abuse or neglect received regarding the family.

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

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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.

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