Summary Report	Child Fatality	7/9/15

1. Victim: Isabel Ledo Herrera – 7-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 at the time of the fatality.

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

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

No services were being provided to the family by the Department of Child Safety.

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:

The child and her parents have no prior involvement with the Department of Child Safety.

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 June 25, 2015. The allegation of neglect to the child by her father was substantiated. No subsequent reports of abuse or neglect have been received.

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

a. Licensing Agency: N/A

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

c. Summary of all violations by the licensee: N/A

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

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) reviewed the case and determined that although this was a tragic accident and not a case of intentional neglect, the fatality was preventable. The family has had no prior contact with the Department and the team found that the investigation was handled appropriately.

The Department reminds all caregivers to always double check for kids in cars. For more information, please visit the DCS website at: https://dcs.az.gov/news/double-check