Summary Report	Fatality	09/23/25

1. Victim: Andres Ortega – 8-year-old male

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 his home when the following incident occurred:

On March 4, 2024, the Department of Child Safety received a report regarding 8-year-old Andres Ortega, who was involved in a motor vehicle accident. The child was unrestrained in the vehicle being driven by his father, Steven Ortega. The child was transported to the hospital, where he passed away on March 13, 2024, due to his injuries. On August 20, 2025, the Department substantiated the allegation of neglect to Andres by his father, Steven Ortega.

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 DCS involvement with the child's parents within the past five years.

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 fatality report was investigated and the other children in the home were assessed as safe in their parents' care. The allegation of neglect to Andres by his father was substantiated. The family was provided with information on services available in the

P.O. Box 6030 ♦ Site Code C010-23 ♦ Phoenix, AZ 85005-6030
Telephone (602) 255-2500

community and the case was closed. No subsequent reports of abuse or neglect were 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 Greenlee County Sheriff's Office. The fatality report was investigated and the other children in the home were assessed as safe in their parents' care. The allegation of neglect to Andres by his father was substantiated. The family was provided with information on services available in the community and the case was closed. No subsequent reports of abuse or neglect were received regarding the family.

The Department reminds all caregivers to always properly restrain children in vehicles.

For additional information please visit the Arizona Department of Health Services (ADHS) Office of Injury Prevention: A Safe Ride home at: http://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/index.php#safe-ride-home

Additionally, in accordance with A.R.S. § 8-469, cases with prior involvement with the Department within 3 years of the critical incident are reviewed by a multidisciplinary team (MDT). The team selects cases that present opportunities for systemic learning or that demonstrate opportunities for systemic change. The Department uses the aggregate data gathered through the MDT reviews to assess and guide future changes and/or recommendations to policies, practices, rules, or statutes to improve the quality of outcomes for children and families receiving services from the department. Findings from these reviews are compiled into an annual report which is shared on the DCS website. The target date for release of the next report is December 1, 2025.

P.O. Box 6030 ♦ Site Code C010-23 ♦ Phoenix, AZ 85005-6030
Telephone (602) 255-2500