6-Month Final Summary Report for Child Death, Serious Injury or Egregious Incident

Reports submitted to the Division of Safety and Permanence (DSP) that do not include all of the required information will be returned to the agency for proper completion. Do not identify individuals by name when completing this report. Individuals may be referenced by relationship or position; e.g., mother, father, child, sibling, physician, detective, etc.

Case Tracking Number: 120717DSP-Doug-224 **Agency:** Douglas County Department of Human Services

Child Information (at time of incident)
Age: 6 months Gender: ☒Female ☐Male
Race or Ethnicity: Caucasian
Special Needs: Child was born premature. She had a heart murmur acid reflux requiring the child to sleep at an incline.

Date of Incident: 7/14/2012

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:

On July 17, 2012, the agency received a report of a 6-month-old child found deceased in her home. The child was born premature and had been under the care of a physician for a heart murmur and had been diagnosed with acid reflux. The mother had been instructed by the physician and a physical therapist to lay the child to sleep on an incline to help with the acid reflux issue. The night before, the mother had placed the child in her crib and propped her up on a horseshoe shaped pillow. The mother had propped a bottle for the child's nighttime feeding as well. The next morning, the mother found the child with vomit in her mouth and in the bed. There appeared to be blood in the vomit. Law enforcement and the medical examiner responded to the home. The child's death was classified as undetermined and attributed to undetermined causes. Law enforcement concluded their investigation and no criminal charges were filed in this case.

Findings by agency, including maltreatment determination and material circumstances leading to incident:

The agency screened in and assessed the allegation of neglect to the child. The agency collaborated with law enforcement and the medical examiner to complete the assessment. Neglect was unsubstantiated. Based on information from the medical examiner as well as the Child Death Review Team, the child's death was determined to be an accidental death. The conditions of prematurity, acid reflux, a heart murmur and sleeping environment/position contributed to the unexpected death of the child. The family has four other children living in the home and they were determined safe in the care of the parents.

☒Yes ☐No Criminal investigation pending or completed?
☐Yes ☒No Criminal charges filed? If yes, against whom?

Child's residence at the time of incident: ☒ In-home ☐ Out-of-home care placement

Complete the appropriate following section (A. or B. based on the child's residence at the time of the incident).

A. Children residing at home at the time of the incident:

Description of the child's family (includes household members, noncustodial parent and other children that have visitation with the child and / or in the child's family home):

The child lived with her mother, father, 6-month-old twin sister, 2-year-old half-brother, 4-year-old half-brother, and 6-year-old half-brother.

☐ **Yes** ☒ **No** **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, any member of the child's family or alleged maltreater at the time of the incident, including any referrals received by the agency or reports being investigated at time of incident?

If "Yes", briefly describe the type of services, date(s) of last contact between agency and recipient(s) of those services, and the person(s) receiving those services:
N/A

Summary of all involvement in services as adults under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years: (Does not include the current incident.)
None

Summary of actions taken by the agency under ch. 48, including any investigation of a report or referrals to services involving the child, any member of the child's family living in this household and the child's parents and alleged maltreater. (Does not include the current incident.)
(Note: Screened out reports listed in this section may include only the date of the report, screening decision, and if a referral to services occurred at Access. Reports that do not constitute a reasonable suspicion of maltreatment or a reason to believe that the child is threatened with harm are not required to be screened in for an initial assessment, and no further action is required by the agency.)

On 2/2/10, a neighboring county screened in a report alleging physical abuse to the now 4-year-old and the now 6-year-old. Physical abuse was unsubstantiated and the agency closed the case.

On 7/28/11, the agency screened out a report alleging neglect to the now 2-year-old, the now 4-year-old and the now 6-year-old.

Summary of any investigation involving the child, any member of the child's family and alleged maltreater conducted under ch. 48 or ch. 938 and any services provided to the child and child's family since the date of the incident:
The agency screened in and collaborated with law enforcement to assess the allegation of neglect to the child. The agency, in conjunction with law enforcement, determined the death of the child was accidental and was classified by the medical examiner as undetermined and attributed to undetermined causes. The remaining children were determined safe in the home and the family was referred to supports and services to assist with grief over the loss of the child. The family was also supported through extended family to help care for the other children during this time. The agency closed the case.

B. Children residing in out-of-home (OHC) placement at time of incident:

Description of the OHC placement and basis for decision to place child there:
N/A.

Description of all other persons residing in the OHC placement home:

Licensing history: Including type of license, duration of license, summary of any violations by licensee or an employee of licensee that constitutes a substantial failure to protect and promote the welfare of the child.

Summary of any actions taken by agency in response to the incident: (Check all that apply.)

- ☒ Screening of Access report
- ☐ Protective plan implemented
- ☒ Initial assessment conducted
- ☐ Safety plan implemented
- ☐ Temporary physical custody of child
- ☐ Petitioned for court order / CHIPS (child in need of protection or services)
- ☐ Placement into foster home
- ☐ Placement with relatives
- ☐ Ongoing Services case management
- ☐ Attempted or successful reunification
- ☒ Referral to services
- ☐ Transportation assistance
- ☒ Collaboration with law enforcement
- ☒ Collaboration with medical professionals
- ☐ Supervised visitation
- ☐ Case remains open for services
- ☒ Case closed by agency
- ☐ Initiated efforts to address or enhance community collaboration on CA/N cases
- ☐ Other (describe):

FOR DSP COMPLETION ONLY:

Summary of policy or practice changes to address issues identified during the review of the incident:
Under the Child Welfare Disclosure Act (Section 48.981(7)(cr), Stats.), the DSP completes a 90-day review of the agency's practice in each case reported under the Act. In accordance with the DCF memo Series 2010-13, dated December 7, 2010 pertaining to the Child Welfare Case Review Protocol, the DSP completed an on-site review in case # 120717DSP-DOUG-224. The review found: The CPS reports pertaining to this incident received by Douglas County Department of Health and Human Services were screened within the appropriate timeframes and were in compliance with the Wisconsin Access Standards. The Initial Assessments completed by the agency were not completed within the required statutory timeframes. The Initial Assessment completed by the agency did not contain sufficient information gathered or documented in the Surrounding

Circumstances, Adult Functioning, Parenting Practices and Family Functioning. While general information exists about family functioning, questions remain about daily life management, especially related to the concerns regarding domestic violence, there was insufficient information in all areas of the Initial Assessment pertaining to Impending Danger Threats, and the interviews with the mother were insufficient.

Douglas County Department of Health and Human Services revised its Quality Assurance Plan. A focus of the quality assurance plan is to ensure the timeliness and quality of information collection, analysis, and decision making from the point of access through initial assessment completion. This plan, its strategies, and the quality review results are discussed monthly at agency executive management meetings with CPS Supervisors and staff. Douglas County Department of Health and Human Services will also participate in the Supervisors as Safety Decision Makers Training.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:

None

☒ Yes ☐ No ☐ Not Applicable This 6-month summary report completes the Division of Safety and Permanence (DSP) review of this case.

The agency must submit an electronic copy of the completed 90-Day Summary Report to: RobertB.Williams@wisconsin.gov