DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

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: 131213DSP-Rock-390 **Agency:** Rock County Human Services Department

Child Information (at time of incident)
Age: 3 years Gender: ☐Female ☒Male

Race or Ethnicity: White, Hispanic

Special Needs: None

Date of Incident: 12/13/2013

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

On December 14, 2013, the agency received a report regarding the death of a three year old, presented at a hospital. Law Enforcement responded, the same day, to initiate an investigation into the child's death. Medical professionals examined the child in the emergency room on December 13, 2013, and diagnosed the child with complications from asthma. Medical professionals recommended the child be transferred and admitted to a hospital, which accepted pediatric patients. Medical professionals contacted a hospital able to accept the child as a transfer and the child's mother advised medical professionals she would transport the child. Medical professionals discharged the child at 10:45 p.m. and authorized the appropriate transfer paperwork for the mother. The child arrived at the transfer hospital at 11:30 p.m. Upon arrival, medical professionals diagnosed the child in cardio-respiratory arrest, administered CPR, and were unsuccessful. The child was pronounced deceased at 12:21 a.m. on December 14, 2013. Medical professionals reported that hospital personnel had to move the child's mother's car as it was blocking the door. They found the car filled with cigarette smoke and ashes.

The mother was interviewed in the joint investigation by Law Enforcement and the agency. The mother stated that on December 13, 2013, she gave the child several treatments for his asthma, but the child continued to wheeze, so she transported the child to the local hospital. The mother stated that medical professionals gave the child an asthma treatment, but the child continued to wheeze. She became upset with the care the child was receiving, so she told medical professionals she would transfer the child to another hospital. The mother reported she requested an ambulance transfer, but the medical professionals denied her request. The mother stated she left the hospital and went to her house, with the child, to gather her belongings and, while at the home, placed the child on the nebulizer for a small treatment. The mother stated while transporting the child to the hospital the child was talkative, but began crying as he struggled to breathe. The mother reported that a few minutes before arriving at the hospital the child fell forward and stopped crying. The mother denied smoking in the car in the child's presence and denied involvement with any illegal substances the day or night of the incident.

The Medical Examiner's completed report found no signs of abuse or neglect to the child with toxicology reports pending. The report concluded no head trauma or skull fracture existed, but a finding of acute asthma exacerbation did exist and the preliminary finding of the cause of death ruled acute bronchial asthma. The criminal investigation remains open with no charges filed.

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

The agency collaborated with law enforcement and medical personnel to complete the assessment. Based on the information gathered, the Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect to the child by the mother. Medical records and collateral contacts provide illustration that the mother did not follow medical advice for the child and placed the child in an unsafe environment.

☒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):

At the time of the incident, the child resided with his mother and one year old sibling. The father of the children resided in the home until a criminal arrest.

☒ **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:

The Department received a CPS report on November 11, 2013 regarding concerns associated with medical neglect to the child by his mother. The Department made contact with the mother and the two children on November 15, 2013. At the November 15, 2013 meeting the agency discussed the importance of attending the scheduled doctor's appointments for both children. The mother acknowledged that she understood.

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.)

From February of 2009 until June of 2012, the mother received Rock County Human Services CPS On-going Services for case management and community referrals. The mother participated in community services and did not have significant contact with the agency until March of 2010. The mother gave birth to a child in April, 2010. The agency received a CPS Report of neglect to the child by the mother because the child was born positive for a controlled substance and was actively displaying signs of withdrawal. The agency assessed the child as unsafe and Temporary Physical Custody was taken and the child was placed into out-of-home care with the on-going case remaining open.

In February 2011, the mother voluntarily terminated her parental rights to one of her children, but continued to work with the agency on reunification efforts for the child born in 2010. The child was returned to the care of the mother in December of 2011. The agency continued to monitor the case until the court order expired in June of 2012 and the agency closed the case.

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 November 19, 2009, the agency screened-in a Service Report requesting services for the mother and her unborn child. The agency provided the mother with community services. The agency closed the case after the mother stopped responding to agency attempts to refer for services.

On January 20, 2009, the agency screened-in a CPS report with allegations of neglect to a two month old infant. The report stated that mother was using heroin, exposing the infant to environmental hazard, and the infant was exposed to drug usage in the home. The concerns surrounding the neglect allegations included: maintaining a drug home; having a room used specifically for heroin; individuals frequenting the home under the influence of drugs and other substances; drug use by both parents; and the condition of the home. The infant was assessed unsafe and taken into Temporary Physical Custody; a Child in Need of Protection and Services petition was filed and the case was opened for on-going services. Allegations of neglect were substantiated by the agency.

On April 26, 2010, the agency screened-in a CPS report for a substance exposed infant with risk of substantial harm for the infant in the home environment and the infant was actively displaying signs of withdrawals; and, the infant born at a low birth rate. The agency assessed the infant unsafe and took Temporary Physical Custody and placed in out-of-home care. A Child in Need of Protection and Services petition was filed and the case was opened for on-going services. Allegations of neglect were substantiated by the agency.

On November 11, 2013, the agency screened-in a CPS report with concerns that the mother of a child was not following through with attending wellness appointments as well as referrals made to specialists. The CPS report stated the child

suffers with breathing issues and the mother has not followed scheduled appointments. This CPS report was open at the time of the current incident. The allegation regarding medical neglect to the child by the mother was unsubstantiated.

On December 9, 2013, the agency screened out a CPS Report.

On December 20, 2013, the agency screened out a CPS Report.

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 collaborated with law enforcement and medical personnel to complete the assessment. Based on the information gathered, the Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect to the child by the mother. Medical records and collateral contacts provide illustration that the mother did not follow medical advice for the child and placed the child in an unsafe environment.

On December 16, 2013, the agency screened-in a CPS report with concerns that the mother of the child was using drugs in the home with the child present and was providing no supervision or care for the child. The agency completed an Initial Assessment. Based on information gathered, the Initial Assessment completed by the agency found a preponderance of the evidence to substantiate neglect of the child by the mother. The child was assessed as unsafe, temporary physical custody was taken, and the child was placed in out-of-home care. A Child in Need of Protection or Services petition was filed and the on-going case remains open.

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 Department of Children and Families' (DCF) Division of Safety and Permanence (DSP) completed an initial review of the agency's practice for each case reported under the Act. A further practice review has been completed for case 131213DSP-Rock-390. As a result of this review process, the DSP determined the agency implemented steps to improve the consistency and quality of safety assessment and decision-making practice, including the development of a policy regarding the internal review process of Act 78 cases and a change to case practice surrounding the implementation of Protective Plans.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:
Based on the agency's effort and response to this incident and DSP review, no further statewide policy, practice, or statutory changes are recommended.

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