**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:** 140111DSP-Milw-406 **Agency:** Bureau of Milwaukee Child Welfare

**Child Information** (at time of incident)
Age: 4 Months Gender: ☒Female ☐Male
Race or Ethnicity: Black/African American
Special Needs: None known

**Date of Incident:** January 11, 2014

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

On January 14, 2014, the agency received a report regarding a 4-month-old infant admitted to the hospital in critical condition. The infant presented with altered mental status and severe, untreated dehydration due to vomiting and diarrhea. The mother reported she arranged for a family friend and the family friend's mother to care for the infant overnight and dropped her off at their home on January 11, 2014. The friend later called the mother to advise she felt ill and wanted the mother to pick up the infant. Because it was a cold night and the mother did not have enough gas in her car, she decided the infant should remain at the friend's home; however, she did not make the friend aware of her decision and instead went to sleep. The friend made her own arrangements to bring the infant back to the mother's house. The infant was left in the care of a minor relative, who left a short time later without telling any household member the infant was there. The grandmother returned home from work shortly after 7:00am and discovered the infant still in her car seat, fully clothed, along with her outside wear, and a blanket over the top of the car seat. The infant was unresponsive and sweating profusely; she was also soaked in urine and diarrhea. The grandmother called the paramedics, who advised the infant was coming down with a cold and recommended she be given Tylenol. The grandmother attempted to treat the infant's high temperature with Tylenol and changing her into cool clothes. As the day progressed, she noticed the infant was unable to swallow liquids and appeared to have diminished neck and body control. The grandmother and the mother transported the infant to the emergency room and the infant was subsequently admitted to the pediatric ICU. Medical personnel's assessment of the infant determined she suffered a stroke due to overheating, severe dehydration and hypovolemia (low blood volume).

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

The agency collaborated with medical professionals to complete the assessment. Based on information gathered, the Initial Assessment completed by the agency found a preponderance of the evidence to substantiate the allegation of neglect to the infant by the mother. The mother failed to communicate with the caregiver her intended plan for the infant's care overnight. This led to the infant being left unattended for several hours while covered with multiple layers of clothing and blankets in her car seat. The infant became overheated, dehydrated and suffered hypovolemic shock. Medical professionals diagnosed the infant with acute ischemic stroke and secondary complications. During the infant's hospitalization, the mother did not demonstrate sufficient understanding of her daughter's special medical needs and care requirements. The agency's Assessment determined the infant to be unsafe in the mother's care, was taken into temporary physical custody, and placed in out-of-home care. The agency filed a Child in Need of Protection or Services petition in juvenile court. The case remains open to provide the family with ongoing case management services.

☐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):

Prior to the incident, the infant lived with the mother (a minor), the infant's grandmother, and the mother's 16-year-old and 13-year-old siblings. The identity of the infant's father has not been determined.

☐ **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.)
In February 2009, the agency opened the case for BMCW Safety Services after completing an Assessment regarding a screened-in CPS Report (please refer to next section for further information regarding prior agency actions). BMCW Safety Services were provided to the family until the agency closed the case in July 2009, as outcomes were successfully achieved.

**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.)
The current automated child welfare information data base indicates prior agency history regarding the maternal grandmother and her children (now adults) between 1993 and 2002and the following information is available on this history:

On September 9, 1993, the agency screened in for assessment a CPS Report alleging neglect by the maternal grandmother of two of the infant's mother's older siblings (then age 5 and 10 years). The child welfare data base indicates these older siblings were placed in out-of home-care at that time. Petitions were filed alleging the two siblings to be Children in Need of Protection or Services, and the case remained open with the agency to provide the family with Ongoing case management services.

On May 12, 1997, the agency screened in for assessment a CPS Report alleging neglect by the maternal grandmother to the infant's mother's younger sibling at the time of that sibling's birth.

On December 6, 1999, the agency screened in for assessment a CPS Report alleging neglect to the infant's mother and two of her siblings.

On June 14, 2002, the agency screened out a CPS Report while the case was open with the agency for ongoing case management services.

On February 3, 2009, the agency screened in a CPS Report alleging neglect to the mother by the maternal grandmother as well as physical abuse to the mother by an adult older sibling. An Assessment was completed and the allegations of neglect and physical abuse were unsubstantiated. The case remained open and the family was referred to in-home safety services.

On March 6, 2009, the agency screened out a CPS Report while the case was being served in the family home. The case was open with the agency for Safety Services at the time so the worker was made aware of the information for follow-up.

On May 1, 2009, the agency screened out a CPS Report while the case was open with the agency for in-home safety services.

On July 24, 2013, the agency screened out a CPS Report.

On September 13, 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 medical professionals to complete the assessment. Based on information gathered, the Initial Assessment completed by the agency found a preponderance of the evidence to substantiate the allegation of neglect to the infant by the mother. The mother failed to communicate with the caregiver her intended plan for the infant's care overnight. This led to the infant being left unattended for several hours and she became overheated and dehydrated. Medical personnel advised the infant suffered hypovolemic shock and an acute ischemic stroke as a result of the incident.

During the infant's hospitalization, the mother did not demonstrate sufficient understanding of her daughter's special medical needs and care requirements. The agency's Assessment determined the infant unsafe and the infant was taken into temporary physical custody and placed in out-of-home care. The agency filed a Child in Need of Protection or Services petition in juvenile court. The case remains open to provide the family with ongoing case management services.

**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:**
N/A

**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.
N/A

**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 Bureau of Performance Management (BPM) completed a record review in case # 140111DSP-Milw-406.

In order to ensure timely completion of screening and response time decisions at Access, the BMCW updated its Child Welfare Access/Initial Assessment Quality Assurance Plan to include updating a policy requiring Access Report review by Program Evaluation Mangers. In addition, BMCW restructured staffing patterns after-hours at Access, which was implemented on July 1, 2014.

**Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:**
None at this time.

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