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: 140703DSP-Dodge-457 **Agency:** Dodge County Human Services and Health Department

Child Information (at time of incident)
Age: 2 Years Gender: ☒ Female ☐ Male

Race or Ethnicity: Caucasian

Special Needs: Down's Syndrome

Date of Incident: July 3, 2014

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On July 3, 2014, the agency received a report regarding a two-year-old child pronounced deceased in her home. Law Enforcement was contacted and a criminal investigation was initiated. No criminal charges have been filed in this case, but the investigation remains open.

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. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect to the child by the mother. The official cause of the infant's death was undetermined by the Medical Examiner's Office; however, toxicology results determined the child had morphine in her system. The agency closed the initial assessment and no service referrals were made.

☒ 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 her mother and her step-father. The child's two half-brothers, ages six and eight years of age visited the family home periodically. The child's biological father did not have contact with the child.

☒ **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:
On July 1, 2014, the agency screened-in a Services Report. No contact was made with the family prior to the child's death and the agency was unable to provide services.

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.)
On September 2, 2008, another agency screened-in a CPS Report alleging neglect to the infant's now eight-year-old and six-year-old half-brothers by the mother and her significant other. An assessment was completed by the agency and the allegation of neglect was substantiated by an unknown maltreater. The children were deemed unsafe, taken into Temporary Physical Custody, and placed in out-of-home care. A Child in Need of Protection or Services petition was filed and the case remained open to provide ongoing case management services. The family was provided with services. The case was closed on October 12, 2010 when a Chapter 48 guardianship was completed.

On December 18, 2012, the agency screened-in a Services Report. The agency determined natural supports were meeting the needs of the family and the agency did not provide the family with additional services.

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 December 18, 2012, the agency screened-in a Services Report. The agency determined natural supports were meeting the needs of the family and the agency did not provide the family with additional services.

On December 18, 2012, the agency screened-out a CPS Report.

On March 19, 2013, the agency screened-out a Services Report.

On July 1, 2014, the agency screened-in a Services Report. No contact was made with the family prior to the child's death and the agency was unable to provide services.

Summary of any investigation involving the child, any member of the child's family and alleged maltreater conducted under ch. 48 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. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect to the child by the mother. The official cause of the infant's death was undetermined by the Medical Examiner's Office; however, toxicology results determined the child had morphine in her system. The agency closed the initial assessment and no service referrals were made.

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

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 or other actions that constitute 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 IF RECORD OR ON-SITE REVIEW WAS UNDERTAKEN:

Summary of policy or practice changes to address issues identified based on the record or on-site 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. A further practice review has been completed for case 140703DSP-Dodge-457. As a result of this review process, DSP determined the agency implemented steps to improve the consistency and quality of safety assessment and decision-making practice.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues based on the record or on-site review:
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) action on this case.