DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

90-Day Summary Report for Child Death, Serious Injury or Egregious Incident

Case Tracking Number: 100211DSP-PN-3

Child Information: Age: 8 months Gender: ☐ Female ☒ Male Race: African American
Special needs: None identified

Description of the child's family:
The child lived at home with his parents and siblings.

Child's Residence: ☒ In-home ☐ Out-of-home care placement

Date of Incident: 2/11/10

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On February 11, 2010, the child was fed and placed on an air mattress to sleep in his parent's bedroom at approximately 1:00 a.m. At 6:30 a.m. the father found the baby stiff and nonresponsive. The parents called 911 and the child was pronounced dead at the hospital. There were no apparent external injuries or other trauma. In January, the child had been seen and treated by his pediatrician and at Urgent Care for wheezing.

Findings by agency, including material circumstances leading to incident:
Allegations of Physical Abuse and Neglect were unsubstantiated for this child by the Dane County Department of Human Services. The child had been exhibiting symptoms of respiratory illness and was sleeping on an air mattress. The child's death has been ruled accidental.

Additional information for children in home:

☐ **Yes** ☒ **No** **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, 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 under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:
The mother was a Kinship Care provider for a two-year period; otherwise, the family was never involved in formal services under Ch. 48 or Ch. 938.

Summary of actions taken by the agency under ch. 48, including any investigation of a report or referrals to services:
On September 30, 2009 the agency received and screened out a report that did not allege child abuse or neglect. The agency referred the family to a local service provider. A social worker followed up with the mother who declined to meet with her.

On November 19, 2009 a report was received and screened in with concerns that the children were being neglected. The agency contacted law enforcement who visited the family on November 20 and found no concerns for the children. The assigned initial assessment social worker made several home visits, announced and unannounced, and found no evidence to support concerns of neglect or possible physical abuse of the children. Collateral contacts were made with a probation officer, medical providers, and daycare staff who reported no concerns for these children. The social worker offered assistance to the family, but the family was aware of and using community resources. No other significant service needs were identified. This assessment was completed and approved on February 4, and the case was closed on February 5, 2010.

Summary of any investigation conducted under ch. 48 or ch. 938 and any services provided to the family since the date of the incident:
On February 11, 2010 the agency received and screened in a report regarding the death of this child. The social worker responded the same day by meeting with the family, observing the siblings, requesting all medical records, interviewing a day care provider for the children and gathering information from law enforcement. Throughout the investigation, the

assigned worker continued to meet with family members, conduct home visits, and gather additional information from collateral contacts with law enforcement, daycare, and medical providers. There were no indications of concerns around parenting or discipline, and the parents demonstrated ability to meet the children's basic needs. The preliminary autopsy found no indications of abuse, and the suspected cause of death is possible respiratory illness or the air mattress. The agency assisted the parents in connecting with community resources for help with rent and other financial expenses related to the child's burial. The parents were notified on April 15, 2010 that their case with the agency will be closed. No criminal charges were filed regarding the child's death.

Additional information for children in out-of-home (OHC) placement at time of incident:

Description of the OHC placement and basis for decision to place child there:

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 actions taken by agency in response to the incident:**

The agency conducted a child protective services investigation in response to the child's death. The agency assisted the family with obtaining community resources, including assistance to arrange the child's burial.

***Summary of policy or practice changes to address identified issues:**

The initial assessment was not completed within 60 days in compliance with the CPS Access and Initial Assessment Standards. The agency identified this as an issue that they are currently addressing.

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

The agency must assure compliance with the CPS Access and Initial Assessment Standards, completing initial assessments in a timely manner and documenting the assessment within the eWiSACWIS.

Statement of Completion:

☒ Yes ☐ No This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

* If a full report including agency actions, changes in policies or practices and recommendations for further changes was not completed within 90 days, the DSP will complete and submit the final summary report within 6 months.