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: 100306DSP-PN-5

Child Information: Age: 1 month Gender: ☒ Female ☐ Male

Race: American Indian

Special needs: Born prematurely with medical complications

Description of the child's family:

The mother of the infant was living at home with her mother and siblings. After the baby's birth, the mother returned to her home and the infant remained hospitalized.

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

Date of Incident: 3/6/10

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

This baby was born prematurely in February to a teenaged (minor) mother. The baby was born with serious medical complications, including organ failure and infection. She did not respond to medical treatment and died on March 6, 2010.

Findings by agency, including material circumstances leading to incident:

The agency substantiated neglect to the infant by her mother and neglect to both the minor mother and infant by the grandmother.

The mother did not receive prenatal care nor did she promptly seek medical care when she began leaking amniotic fluids in January. The mother was admitted to the hospital at the end of January and the baby was born prematurely in February.

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:

The agency received a report of alleged maltreatment by the mother and grandmother following the baby's birth in February 2010. The agency was investigating these allegations and assessing the family at the time of the baby's death in March.

Summary of all involvement in services under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:

This family intermittently received child welfare services from Jackson County Dept. of Health and Human Services starting in 2005 and ending in 2009 prior to this incident. The family received child protective services in 2005, 2008, and 2010. They received juvenile justice services in 2007, 2008 and 2009.

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 or alleged maltreater:

Prior to this incident, the CPS Reports (i.e., 2005 and 2008) that were screened in were unsubstantiated and the children were determined to be safe at home. In these cases the children received medical and dental services.

During the period 2007-2009, four reports were screened in as Juvenile Justice (JJ) cases. In three of the cases, the agency offered services to the family but the cases were dismissed. In the fourth instance, there were continued issues with truancy and the agency provided services to the family until the court order ended in 2009.

Summary of any investigation conducted under ch. 48 or ch. 938 and any services provided to the family since the date of the incident:

In February 2010 the agency screened in a report regarding the birth of the medically fragile infant. During the course of the investigation, additional allegations for the mother's siblings were identified. Shortly after the initial report, the agency received and screened in another CPS Report and three JJ reports on the mother's family. All of the CPS allegations regarding the mother (neglect), baby (neglect), and the mother's siblings (neglect, sexual contact and emotional abuse) were substantiated. The family has refused services. The JJ reports currently are in the Intake process.

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 filed a Child in Need of Protection and Services (CHIPS) petition for the minor mother and her siblings. Since the filing of the petition, the teen mother has turned 18-years-old, and the agency offered counseling services to her. Three younger siblings have been removed from the home and temporarily placed with their biological father. Another sibling was placed into treatment foster care.

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

The case record documentation indicates that the agency did not screen this report within 24 hours as required by statute and the CPS Access and Initial Assessment Standards. The agency explained that they did screen and respond to this report as required and that the date in the case record is in error. The agency needs to correct the case record in eWiSACWIS.

The agency substantiated neglect to the infant by the teen mother and grandmother for not seeking medical or prenatal care during the pregnancy. Statutes do not allow for a child maltreatment finding during pregnancy except in cases of Unborn Child Abuse, which is specifically for substance abuse by the pregnant woman and does not pertain to this case. The agency needs to correct these findings in the initial assessment in eWiSACWIS.

The agency understands and agrees with these case review findings and has initiated correcting these errors in practice and in the record. The DCF will provide technical assistance where needed.

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

None

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.