DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

Child Death, Serious Injury or Egregious Incident Summary Report

Type of Report: ☒ 90-Day ☐ Final

Case Tracking Number: 100312DSP-PN-8 **Agency:** Dane Co. Dept. of Human Services

Child Information: Age: 4 1/2 months Gender: ☒ Female ☐ Male
Race or Ethnicity: Caucasian
Special needs: Premature birth

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

Date of Incident: 3/12/2010

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
The child's parents called Emergency Medical Services (EMS) due to the child being unresponsive. The father performed CPR until EMS arrived, but the child was pronouced dead on the way to the hospital. Preliminary autospy results showed that there were "child abuse issues" but there was no conclusive cause of death. It was reported to Dane County Dept. of Human Services that the child had several fractured ribs, a fractured arm (all of unknown age) and a "new" fracture to the area above the child's mouth, below the nose, but the agency subsequently was unable to confirm this first report.

Findings by agency, including material circumstances leading to incident:
Allegations of Physical Abuse and Neglect were unsubstantiated for this child at the end of the 60-day Initial Assessment period. The initial report of injuries to the infant and "child abuse issues" could not be confirmed. A second autopsy was performed, and critical pieces of information about the child's death and alleged injuries were are not available during the Dane Co. DHS investigation. The criminal investigation is ongoing.

Additional information for children in home:

Description of the child's family:
The child lived at home with her parents and two half-siblings.

☒ **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:
In November 2009 the Dane Co. Dept. of Human Services began an initial assessment on the family after receiving a report of alleged neglect following the child's birth. The agency connected the family to in-home support services with three different agencies over the next four months in addition to referring the parents to treatment services. The last contact with the family by the agency social worker occurred in February, two weeks prior to the baby's death.

Summary of all involvement in services under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:
In 2005 and 2008 the agency received and screened in two reports with concerns regarding the father and his children. During the initial assessment the agency referred the family to services and assisted them with resources to address some health problems. Services received in 2009 are described above.

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:
During the period 2004-2008, the agency received and screened in several reports on the father and his children. Four of the reports were unsubstantiated and the children were determined safe. One allegation was substantiated and the father was identified as the maltreater. Another report alleged neglect allegations and emotional/behavioral problems, which were unsubstantiated. The family received assistance with housing resources and counseling services.
The November 2009 report alleging neglect following the baby's birth was screened in, but the initial assessment was not

concluded until after the child's death. The 2009 allegations were unsubstantiated in May 2010. The family continually received in-home support services starting in 2009 through the present. The mother also received assistance related to issues reported at the time of the child's birth.

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

Maltreatment to the baby was unsubstantiated due to the lack of critical medical and criminal investigation information regarding the reported maltreatment. The CPS case will remain open with the agency, and family will continue to receive voluntary parenting services.

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 CPS investigation based on reported allegations of neglect and physical abuse. The older siblings were immediately removed from the home and placed with their biological mother. After assessing child safety, the father was allowed supervised visits with the children. DCDHS determined that the children are safe and their father has sufficient protective capacities, so they were allowed to return to their home. The agency referred the family for voluntary in-home services to assist the older children in dealing with the loss of their sister and the disruption in their family. The agency attempted to collaborate with law enforcement on this case, but information regarding the criminal investigation, the child's injuries or cause of death was not available during the assessment. The CPS case will remain open with the agency to provide continuing support and services as needed.

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

The initial assessment was not completed within 60 days and there is no evidence that the agency completed a formal safety assessment. The initial assessment and safety assessment must be conducted, entered into eWiSACWIS and approved by the supervisor in compliance with Standards. The agency agrees with these findings and must submit a Corrective Action Plan to the DSP that addresses these findings.

Supervisor-worker case consultation occurred weekly prior to this incident. The supervisor now requires that in addition to the regular meetings, all face-to-face contacts are documented immediately into eWiSACWIS to further enhance case monitoring and consultation. The DCF concurs with this practice change.

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

The DCF will continue its review of the case regarding the 3/12/10 Access report about the baby's injuries and death and the subsequent initial assessment.

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.

☐ This final summary report completes the DSP review of this case.