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: 100401DSP-PN-12 **Agency:** Eau Claire County Dept. of Human Services

Child Information: Age: 1 ½ months Gender: ☒ Female ☐ Male

Race: Caucasian

Special needs: Child was born prematurely

Description of the child's family:

The child resided with her sibling and parents in their home.

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

Date of Incident: 4/1/10

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

The agency received a report that the baby was pronounced dead resulting from an accidental co-sleeping incident with her father.

Findings by agency, including material circumstances leading to incident:

The agency concluded that the child's death was an accident and maltreatment was unsubstantiated. The father was comforting the fussy baby on the couch where both the father and baby feel asleep. Her mother found the baby on the couch with her father's arm across her and noticed she was not breathing. She woke the father, they attempted CPR and called for an ambulance. An autopsy determined that there was no evidence of trauma. No criminal charges will be filed.

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 referral on this family in February 2010 and screened it in for child welfare services. The agency made several attempts to engage the family, who would agree to meet but then would not be available for the scheduled appointment. The case was open for child welfare assessment, but no services were being provided at the time of 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:

The mother was involved in services as a minor in 2008 when she received juvenile justice services from the agency.

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 2006-2008, the agency received 5 referrals on the mother's family when she was a minor. Four of the reports were screened out and one was screened in for juvenile justice services. In 2010, the agency screened in a report for child welfare services to the family of the deceased child and her sibling. Services were attempted, but the parents did not participate.

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

The investigation in response to the child's death was unsubstantiated. On the same day that the agency received the referral that the baby died, a referral was also received with concerns about the sibling, who is medically fragile, and her parents' ability to properly care for her. The concerns and family were assessed, and the allegation of neglect to the child by the parents was substantiated. The child was removed from the home and placed into foster care. The parents have supervised visitation with their child, which will soon progress to unsupervised. The parents are working with the agency and are connected to resources (e.g., housing, employment) and several skill-building services, including in-home training and proper care of their child's health needs.

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 investigated allegations of maltreatment by the parents to their children. Maltreatment in the baby's co-sleeping death was unsubstantiated. A second report concerning the sibling and her parents' ability to care for her was received on the same day of the incident and investigated. Neglect to the sibling was substantiated and the child was placed into foster care. The parents continue to receive services and support from the agency and other community service providers. Visits with their child are supervised by the agency. The agency contacted the DCF to review the referrals received in February and April 2010. The case also was reviewed internally by Eau Claire County Dept. of Human Services management.

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

The agency found that it incorrectly screened in the child's co-sleeping death and implemented a process where supervisors will consult with each other when a referral is received that is unique or complicated.

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

The DCF review of this case finds that the CPS Report on this incident could not have been screened out. The agency's decision to screen in the report, assess the family and assess safety of the surviving sibling in response to the report of the baby's death was correct and appropriate. The DCF agrees that a consultation system for screening complicated reports will enhance the quality of the agency's screening process and decisions.

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.