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

Case Tracking Number: 100520DSP-PN-23 **Agency:** La Crosse County Department of Human Services

Child Information: Age: 5 months Gender: ☒ Female ☐ Male

Race or Ethnicity: Caucasian

Special needs: None

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

Date of Incident: 5/20/10

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

On 5/20/10, the Sheriff's Dept. responded to a domestic disturbance where a woman was screaming that her baby is dead. Attempts were made to revive the baby who was then transported by ambulance to the hospital where she died due to cardiorespiratory arrest. The parents reported that earlier this day the baby was observed to be in "good spirits" and "content." Her father placed the baby on top of a small bean bag chair and was left sleeping there while her father went into his bedroom and fell asleep for a few hours. When he awoke to check on the baby, he found her underneath the bean bag chair. The father has been criminally charged with Neglecting a Child (Consequence is Death).

Findings by agency, including material circumstances leading to incident:

The allegation of neglect to the baby by her father was substantiated. See above section for material circumstances.

Additional information for children in home:

Description of the child's family:

The baby lived with her parents.

☐ **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:

In the past five years, the child's mother was involved with child protective services in two different counties on five occasions and received child welfare services on one occasion. See the following section for more information about the 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 or alleged maltreater:

Nine child protective services reports on this mother and her family were screened in and investigated 2003-2008, followed by the recent report of the child's death in 2010 (ten total). Another report in 2007 was screened in for child welfare services (i.e., no investigation). Two investigations, including the child's death, resulted in substantiated maltreatment, two determined that maltreatment was likely to occur (a finding that is no longer used in CPS maltreatment determinations), one resulted in no determination because workers were unable to locate the family, and five reports were unsubstantiated. In all of the 2003-2008 investigations the mother was the alleged maltreater. During this period, the agency referred the father of their children to Family Court.

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 agency substantiated neglect to the baby by her father. There are no other children in the home. Weekend visitations between the mother are her other children were supervised during the assessment.

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 screened in and investigated the report of the child's death and assessed the safety of the older children who have weekend visitation with their mother. There is a no contact order between the baby's father and the mother's older children. The agency also implemented supervised visitation between the older children and their mother during the initial assessment. At the close of the case, the agency referred the family to Family Court.

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

The DCF review finds that some of the screened out CPS reports were incorrectly screened out by the other county agency previously involved with this family. No practice changes are needed because the agency has since participated in Access training that addressed similar issues in another case in 2008.

***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.