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: 100612DSP-PN-26 **Agency:** Kenosha Co. Dept. of Human Services, Division of Children and Family Services (DCFS)

Child Information: Age: 2 years Gender: ☒ Female ☐ Male

Race or Ethnicity: Hispanic-White

Special needs: None

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

Date of Incident: 6/12/10

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

The two-year-old child and her sibling were placed with their father. Supervised visitation between the mother and the children by a designated relative was required by court order. On the weekend of the incident, the children were visiting with their mother, and the family went swimming at a local hotel with other relatives. The relative designated to supervise the visits did not attend the family gathering. The child died by accidental drowning in the hotel's hot tub/whirlpool.

Findings by agency, including material circumstances leading to incident:

The child's death was determined an accidental drowning by law enforcement and the agency. The allegation of neglect to the child by the mother was unsubstantiated. The agency required supervised visitation by a designated relative. The relative made the decision without DCFS authorization to allow the child, her siblings and their mother to join relatives at the hotel without the relative's direct supervision. There were a number of people, including other families with their children in the pool at the time of the accident. No one directly observed the child either falling or entering the hot tub/whirlpool. It was determined that she had not been in the water for an extended period of time. Another person at the pool noticed the young child in the hot tub. She was pulled from the water and CPR was attempted, without success.

Additional information for children in home:

Description of the child's family:

The child and one of her siblings resided with their father in his home. Two other siblings are placed with another relative.

☒ **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 deceased child was living with one of her siblings and their father, and they were receiving Ongoing Services. The agency was working with the family on reunification of the other two siblings with their mother. The worker last had contact with the mother on 6/8/10, the deceased child's father on 5/24/10 and the siblings' household on 5/28/10.

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 2008, the agency served the pregnant mother and her three children, closing the case when the mother was connected to resources for herself and family. In 2010, the agency placed the four children with relatives and was providing services to all of the children and their relatives at the time of the incident.

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:

In 2002, the agency investigated and unsubstantiated maltreatment to the newborn infant. The agency provided services to the mother and her baby. The family was referred to community resources and the case was closed in 2003. In 2008, the agency screened in a child welfare report and provided support to the pregnant mother and her 3 children. The case was closed after the mother was connected to community services. In 2010, the agency substantiated neglect to the four children by their mother and the children were placed with relatives.

In 1996, the father and his family received services when he was a minor.

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 unsubstantiated maltreatment, concluding that the child's death was accidental and the children were not neglected. The two children placed with the relative that violated the supervision agreement were removed from that home and placed into a licensed foster home. The other sibling was determined to be safe in his father's care and remains with him. The siblings, their mother and other relatives have supervised visitation with each other. The agency is providing Ongoing Services to the family and has connected the father to other community 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 investigated the report and unsubstantiated maltreatment. Two of the siblings who were placed with a relative were removed from that home and placed into foster care. The other sibling remains with his father. Kenosha Co. DCFS continues to provide Ongoing Services, which includes supervised visitation and case management, and has referred the family to other resources in the community. The agency staffs the case frequently at the Transition Team, a process to seek clinical and professional oversight of identified cases. The agency is collaborating with the Department of Children and Families to conduct an on-site review of the case.

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

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

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.