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

Case Tracking Number: 110428DSP-Milw-104 **Agency:** Bureau of Milwaukee Child Welfare

Child Information: Age: 10 months Gender: ☐ Female ☒ Male

Race or Ethnicity: African American

Special needs: none known

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

Date of Incident: April 28, 2011

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

On April 28, 2011, a relative found the child unresponsive in the morning after the child slept on a mattress with his sibling and the relative The relative had been caring for the child overnight and awoke to find him positioned at the end of the mattress with a puddle of vomit on the floor. The relative went to a neighbor's home to call 911, and paramedics responded. Paramedics found no heartbeat, and some lividity was present. There did not appear to be any signs of trauma to the child. Paramedics, and later the medical examiner, pronounced the child deceased. Autopsy toxicology test results received in June showed significant amounts of oxycodone and morphine in the child's system and in the bottle he drank from prior to his death. The relative has been criminally charged with 1st Degree Reckless Homicide in connection with the child's death. A criminal charge is an allegation, and the defendant is presumed innocent until or unless proven guilty.

Findings by agency, including material circumstances leading to incident:

The agency substantiated neglect to the child and his sibling by the mother and the relative. A sibling was determined unsafe in the care of the mother. The mother left the child and his sibling with the relative on numerous occasions, despite knowing of the relative's heavy use of prescription narcotic medications. The relative used medications to the extent that the relative was often extremely drowsy and unable to be awakened when sleeping. She also failed to use safe sleeping practices with the children.

Additional information for children in home:

Description of the child's family:

Prior to his death, the child resided with his mother, 2-year-old sibling, and maternal grandmother in the home of the mother's friend and the friend's two children.

☐ **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 as adults under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:

The agency screened in and attempted to investigate a report of maltreatment in February 2011. The agency was unable to locate the family and the case was closed.

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 living in this household and the child's parents and alleged maltreater at the age of 18 years or older:

See previous section

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 screened in the report of maltreatment dated April 28, 2011 and substantiated maltreatment to the child and his sibling by the mother and the relative. The agency determined the sibling was unsafe in the care of the mother, and the child was placed in the home of a relative. At the court hearing, the court returned the child to the care of the mother and

ordered services to ensure the child's safety.

In June 2011, the agency received five reports of alleged maltreatment regarding the child's sibling. The family was already receiving services from the agency during this time. Three of the reports were screened out, and two of the reports were screened in and investigated. The first of these reports was dated June 6, 2011. The agency substantiated neglect to the sibling by the mother, and the child was determined unsafe. In-home services were provided to address the safety threat, and the agency continued to provide ongoing services to the family.

The second report was dated June 23, 2011. As a result of the investigation the agency assessed the sibling to be unsafe in the care of the mother and placed the child in foster care. The mother's contact with the sibling is supervised. The agency continues to provide services to the family.

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 dated April 28, 2011. Neglect of both children by the mother and the relative was substantiated. The child's sibling was assessed to be unsafe in the care of the mother and was placed with a relative. The court ordered the child returned to the mother with services in place to ensure the child's safety. The family's case was opened for services with the agency. While receiving ongoing services from the agency, subsequent allegations of maltreatment to the surviving sibling were reported, screened in and investigated in June, 2011. The family was assessed, and the child was removed from the mother's care and placed into foster care. The agency continues to provide ongoing case management services, including supervised visitation between the mother and the sibling.

***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.