

6-Month Final Summary Report for Child Death, Serious Injury or Egregious Incident

Reports submitted to the Division of Safety and Permanence (DSP) that do not include all of the required information will be returned to the agency for proper completion. Do not identify individuals by name when completing this report. Individuals may be referenced by relationship or position; e.g., mother, father, child, sibling, physician, detective, etc.

Case Tracking Number: 120527DSP-Lang-208 **Agency:** Langlade County Department of Social Services

Child Information (at time of incident)

Age: 1 month Gender: Female Male

Race or Ethnicity: American Indian

Special Needs: None

Date of Incident: 5/27/12

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

On 5/27/12, the agency received a report of a deceased infant. Law enforcement reported that the initial findings indicated the infant died due to co-sleeping with his mother and mother's boyfriend in their bed. The mother's one-year-old daughter from a previous relationship was staying with her father at the time of the incident. The mother's boyfriend stated that on the night of the death, he had gotten in bed with the mother and had the infant in his arms at approximately 11:15 PM. The boyfriend woke up at approximately 2:30 AM and found the infant was not breathing and had some blood on the left shoulder of his onesie. The boyfriend woke the mother and two friends who were staying at the home and they called 911. The mother stated that they did not normally let the infant sleep with them, but on the night of the death the infant was fussy so they put him in bed with them. The cause of death was asphyxiation due to co-sleeping. No criminal charges were filed in this case.

Findings by agency, including maltreatment determination and material circumstances leading to incident:

The agency screened in and assessed an allegation of neglect to the child by his mother and mother's boyfriend. The agency collaborated with law enforcement during the assessment. The allegation of neglect was unsubstantiated by the agency. The mother also has a one-year-old daughter who was with her father at the time of the incident and remained with her father for a period of time during the assessment. The mother questioned whether the infant's death was caused by co-sleeping and believed it had to do with a medical issue the child was having since birth. The infant had been having problems since birth with grunting. The infant recently had two episodes of turning purple and had stopped breathing while he was grunting. The mother took the infant to see a doctor who prescribed Florajen3 two days before the infant's death. The cause of death was determined to be asphyxiation due to co-sleeping.

Yes No Criminal investigation pending or completed?

Yes No Criminal charges filed? If yes, against whom?

Child's residence at the time of incident: In-home Out-of-home care placement

Complete the appropriate following section (A. or B. based on the child's residence at the time of the incident).

A. Children residing at home at the time of the incident:

Description of the child's family (includes household members, noncustodial parent and other children that have visitation with the child and / or in the child's family home):

The infant lived with his mother, mother's boyfriend, and his one-year-old sister. The one-year-old visits with her father every other week.

Yes **No** **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, any member of the child's 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:

On 5/2/12, the agency received a report alleging neglect to the infant and the one-year-old by the mother. The mother and her children were living in the home of the maternal grandmother. The home environment was determined unsafe and unhealthy for the children and the allegation of neglect was substantiated. The mother moved with her children into her own apartment and the agency assessed no concerns with the cleanliness of that home. The last contact with the family was on 5/23/12. The mother is an enrolled member of an Indian tribe and the tribe will be continuing to work with the family.

on a weekly basis on parenting education and other resources.

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: (Does not include the current incident.)

On 5/2/12, a CPS Report was screened in regarding concerns of neglect due to unhealthy living conditions. Neglect was substantiated and the family was referred for services through the mother's Indian tribe.

On 7/6/11, a Services Report was screened in due to concerns that the father of the now one-year-old did not have the supplies or skills to care for the child. Contact was made with the father and it was determined that services were not needed.

On 6/22/11, a CPS Report was screened in regarding concerns of neglect due to the condition and the amount of animals in the home where the mother was staying with the now one-year-old. Neglect was unsubstantiated 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. (Does not include the current incident.)

(Note: Screened out reports listed in this section may include only the date of the report, screening decision, and if a referral to services occurred at Access. Reports that do not constitute a reasonable suspicion of maltreatment or a reason to believe that the child is threatened with harm are not required to be screened in for an initial assessment, and no further action is required by the agency.)

See above

Summary of any investigation involving the child, any member of the child's family and alleged maltreater conducted under ch. 48 or ch. 938 and any services provided to the child and child's family since the date of the incident:

The agency screened in and assessed the allegation of neglect after the infant's death. The agency collaborated with law enforcement to complete the assessment. The agency unsubstantiated neglect. The cause of death was determined to be asphyxiation due to co-sleeping. The one-year-old was determined safe and continues to alternate weekly between her parents. The mother and mother's boyfriend continue to receive services through the mother's Indian tribe.

B. Children residing in out-of-home (OHC) placement at time of incident:

Description of the OHC placement and basis for decision to place child there:

NA

Description of all other persons residing in the OHC placement home:

NA

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.

NA

Summary of any actions taken by agency in response to the incident: (Check all that apply.)

- | | |
|---|---|
| <input checked="" type="checkbox"/> Screening of Access report | <input type="checkbox"/> Attempted or successful reunification |
| <input type="checkbox"/> Protective plan implemented | <input checked="" type="checkbox"/> Referral to services |
| <input checked="" type="checkbox"/> Initial assessment conducted | <input type="checkbox"/> Transportation assistance |
| <input type="checkbox"/> Safety plan implemented | <input checked="" type="checkbox"/> Collaboration with law enforcement |
| <input type="checkbox"/> Temporary physical custody of child | <input type="checkbox"/> Collaboration with medical professionals |
| <input type="checkbox"/> Petitioned for court order / CHIPS (child in need of protection or services) | <input type="checkbox"/> Supervised visitation |
| <input type="checkbox"/> Placement into foster home | <input type="checkbox"/> Case remains open for services |
| <input type="checkbox"/> Placement with relatives | <input checked="" type="checkbox"/> Case closed by agency |
| <input type="checkbox"/> Ongoing Services case management | <input type="checkbox"/> Initiated efforts to address or enhance community collaboration on CA/N cases |
| | <input checked="" type="checkbox"/> Other (describe): Referred to mother's Indian tribe for continued services as needed. |

FOR DSP COMPLETION ONLY:

Summary of policy or practice changes to address issues identified during the review of the incident:

Under the Child Welfare Disclosure Act (Section 48.981(7)(cr), Stats.), the DSP completes a 90-day review of the agency's practice in each case reported under the Act. In accordance with the DCF memo Series 2010-13, dated December 7, 2010

pertaining to the Child Welfare Case Review Protocol, the DSP completed an onsite review in case #120527DSP-Lang-208. The review determined: Child Protective Services (CPS) Reports from 2011 and 2012 were screened-in in accordance with statute and standards; however, one CPS report from May of 2012 was not screened within 24 hours as required by statute. The Initial Assessments completed for the family in 2011 and 2012 were in compliance with standards pertaining to response times for face to face contact with all family members but documentation was insufficient in the areas of adult function, parenting practices, disciplinary approaches, and parental protective capacities.

The Quality Improvement plan implemented by the county agency included: training for all workers completing the access function for the agency, all afterhours workers are required to complete the necessary training pertaining to Access and Initial Assessment before placement on the work schedule, and the CPS Supervisor discusses proper documentation for Initial Assessments for employees performing this function.

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

None

Yes No Not Applicable This 6-month summary report completes the Division of Safety and Permanence (DSP) review of this case.

The agency must submit an electronic copy of the completed 90-Day Summary Report to RobertB.Williams@wisconsin.gov