

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: 121107DSP-Monro-265 Agency: Monroe County Department of Human Services

Child Information (at time of incident)

Age: 6 weeks Gender: Female Male

Race or Ethnicity: Caucasian/African American

Special Needs: None

Date of Incident: 11/7/12

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

On 11/7/12, the agency received a report regarding the death of a 6-week-old infant. The mother reportedly went to sleep on the couch between 11:00 and 11:30 pm the night before with her 3-year-old and 4-year-old sons. The mother placed the 6-week-old infant in a swing in the same room. At approximately 1:00 to 1:30 am, the mother woke up due to the infant fussing. The mother gave the infant a bottle and placed her back in the swing. The mother did not wake up again until approximately 5:30 am. The mother discovered the infant was no longer in the swing. The mother checked the home and did not find the infant until she moved the 4-year-old on the couch. The mother saw the infant between the back of the couch and the seat cushion, underneath where the 4-year-old had been laying. The mother picked the infant up, but the infant did not respond. The mother attempted to revive the infant by giving her a bath in hopes the cold water would wake her up. The mother indicated she did not attempt CPR because the mother did not know the technique. The mother contacted 911 after the infant did not respond. Emergency medical personnel attempted to resuscitate the infant and transported her to the hospital, where the infant was pronounced dead. The 4-year-old told law enforcement he took the infant from her swing during the night and brought her to the couch to watch television. The mother admitted to law enforcement she used marijuana the evening of 11/6/12 and voluntarily submitted to a blood draw to test for the presence of drugs. Initial autopsy results indicate the infant died of positional asphyxiation without indication of maltreatment. No criminal charges have been filed at this time.

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

The agency screened in and assessed the allegation of neglect to the 6-week-old, as well as the 3-year-old and 4-year-old by the mother. Neglect by the mother was substantiated on all three children. The agency determined there was no indication the death of the infant was caused by any direct action by the mother. The death appears to be accidental after the 4-year-old sibling placed the infant on the couch sometime during the early morning hours of 11/7/12. Neglect was substantiated on all three children due to the mother's drug use while caring for her minor children. The mother admitted to recent use of marijuana, heroin, and morphine. The agency also determined the mother allowed a regular flow of individuals who use drugs and potentially sell drugs in and out of her residence. Due to the chaotic nature of the mother's household, her admitted drug use, and the drug use of individuals that frequent her residence, the children were determined unsafe in the care of the mother. The children were maintained in the home with an in-home safety plan and services. Child in Need of Protection or Services petitions was filed in juvenile court for the 3-year-old and 4-year-old.

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 her mother, 3-year-old half brother, and 4-year-old half brother in the maternal grandmother's home. Also living in this home was the maternal grandmother, the mother's 21-year-old half sister, and the mother's 24-year-old half brother. The infant's alleged father was incarcerated at the time of the incident.

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:

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: (Does not include the current incident.)

None

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.)

On 9/8/08, the agency screened in a report alleging physical abuse to the 8-month-old (now 4-year-old) while in the care of a babysitter. Physical abuse was unsubstantiated and the agency closed the case.

On 6/14/10, the agency screened out a report alleging neglect of the 10-month-old and 2-year-old (now 3-year-old and 4-year-old).

On 6/15/12, the agency screened out a report alleging neglect of the 10-month-old and 2-year-old (now 3-year-old and 4-year-old).

On 7/8/11, the agency screened in a report alleging neglect of the 2-year-old and 3-year-old (now 3-year-old and 4-year-old). Neglect was unsubstantiated and the agency referred the mother to community services.

On 7/14/11, the agency screened in a report alleging neglect of the 2-year-old and 3-year-old (now 3-year-old and 4-year-old). Neglect was unsubstantiated and the agency referred the mother to community services.

On 10/10/11, the agency screened out a report alleging physical abuse to the 3-year-old (now 4-year-old) while in the care of a babysitter.

On 10/18/11, the agency screened out a report alleging neglect of the 2-year-old and 3-year-old (now 3-year-old and 4-year-old).

On 11/23/11, the agency screened out a report alleging physical abuse to the 3-year-old (now 4-year-old) while in the care of a babysitter.

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 collaborated with law enforcement to complete the assessment. Neglect by the mother to all three children was substantiated. The agency determined the surviving children to be unsafe in the care of the mother. The children were able to be maintained at home with an in-home safety plan and services. Child in Need of Protection or Services petitions were filed in juvenile court and the case remains open for ongoing case management services.

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:

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

- Screening of Access report
- Protective plan implemented
- Initial assessment conducted
- Safety plan implemented
- Temporary physical custody of child
- Petitioned for court order / CHIPS (child in need of protection or services)
- Placement into foster home
- Placement with relatives
- Ongoing Services case management

- Attempted or successful reunification
- Referral to services
- Transportation assistance
- Collaboration with law enforcement
- Collaboration with medical professionals
- Supervised visitation
- Case remains open for services
- Case closed by agency
- Initiated efforts to address or enhance community collaboration on CA/N cases
- Other (describe):

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 on-site review in case #121107DSP-Monr-265 and prior reports involving the family. The report found: CPS Report dated November 7, 2012 accurately identified present and possible impending danger threats and was screened in according to statute and standards.

The Initial Assessments completed in conjunction with the November 7, 2012 CPS report contained sufficient information in the areas of maltreatment, child functioning, adult functioning, disciplinary approaches, family functioning, and parenting practices. All areas of the Initial Assessment were in compliance with statute and standards. The DSP did not identify practice issues during the review of the incident.

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