DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

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: 130416DSP-Winn-315 **Agency:** Winnebago County Department of Human Services.

Child Information (at time of incident)
Age: 8 months Gender: ☐ Female ☒ Male

Race or Ethnicity: Asian/Hmong

Special Needs: None Reported

Date of Incident: April 16, 2013

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

On April 16, 2013, the agency received a report of an infant fatality. The parents report they found the child unresponsive in a pack and play. Through the course of the investigation, it was determined the parents used pillows and blankets to prop the child on his side, as well as to prop a bottle in the child's mouth. An autopsy was completed and cited the cause of death as asphyxiation due to smothering and high risk sleeping environment. The mother was charged with Neglecting a Child (Consequence is Bodily Harm) and entered into a deferred prosecution agreement.

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

The agency collaborated with law enforcement and medical personnel to complete the assessment. The Initial Assessment completed by the county agency found a preponderance of evidence to substantiate neglect to the child, by the child's parents. The agency determined the parents recognized that the child was not on target developmentally and was placed in an unsafe sleeping environment. Additionally, the parents were inconsistent in scheduling necessary medical appointments, obtaining appropriate services and assessments, and cooperating with providers regarding these delays. The agency determined that the home was safe for the siblings as the father would protect them. The agency filed Child in Need of Protection or Services petitions with Juvenile Court for the infant's two surviving siblings. The agency opened the case for on-going case management services.

☒ Yes ☐ No Criminal investigation pending or completed?
☒ Yes ☐ No Criminal charges filed? If yes, against whom? The mother

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 child resided with his mother, father, and siblings, ages 18 months and three years.

☐ **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 12/13/2011, a CPS report was screened out.

On 12/20/2012, the agency screened in and assessed allegations of neglect to the oldest child, by the mother. The agency found insufficient evidence to substantiate the allegations of neglect to the child.

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 Initial Assessment completed by the county agency found a preponderance of evidence to substantiate neglect to the child, by the child's parents. The agency determined the parents recognized that the child was not on target developmentally and was placed in an unsafe sleeping environment. Additionally, the parents were inconsistent in scheduling necessary medical appointments, obtaining appropriate services and assessments, and cooperating with providers regarding these delays. The agency determined that the home was safe for the siblings as the father would protect them. The agency filed Child in Need of Protection or Services petitions with Juvenile Court for the infant's two surviving siblings.

On 7/19/2013, the mother gave birth to a child, and the agency took temporary physical custody of that child and placed her in a foster home. The agency filed a Child in Need of Protection or Services petition with Juvenile Court regarding the newborn. The agency opened the case for on-going 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:
N/A

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

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.
N/A

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 Department of Children and Families' (DCF) Division of Safety and Permanence (DSP) completes in an initial review the agency's practice for each case reported under the Act. A further practice review has been completed for case #130416DSP-Winn-315. As a result of this review process, the DSP determined the agency implemented efforts to improve the consistency and quality of intake procedures and safety assessment and decision-making practices.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:
Based on the agency's effort and response to this incident and DSP review, no further policy, practice, or statutory changes are recommended.

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