

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: 170825-DSP-WOOD-749 **Agency:** Wood County Human Services Department

Child Information (at time of incident)

Age: 3 Months Gender: Female Male

Race or Ethnicity: Caucasian/White

Special Needs: None

Date of Incident: 08/25/2017

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

On August 25, 2017, the agency received a report regarding a 3-month-old unresponsive at her home and pronounced deceased at the hospital. Law enforcement was contacted and initiated a criminal investigation into the infant's unexplained death. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. The cause of death is undetermined; toxicology results were normal. No criminal charges have been filed in this case and the investigation remains open.

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 agency found a preponderance of the evidence to substantiate maltreatment of neglect to the infant by the father. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. The cause of death is undetermined; toxicology results were normal. The infant's 7-year-old paternal half-sibling primarily resides with her mother and does not have regular contact with her father. The agency closed the case upon completion of the Initial Assessment.

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):

At the time of the incident, the infant resided with her mother and father. The infant's 7-year-old paternal half-sibling primarily resides with her mother and does not have regular contact with her father.

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:

At the time of the incident, the agency was investigating the July 14, 2017 CPS Report alleging physical abuse to the infant by the father. The agency attempted to make contact with the family on July 20, 2017, July 24, 2017 and August 1, 2017, however no one was home on those dates. The agency requested assistance from law enforcement, and law enforcement was able to make face-to-face contact with the father on August 4, 2017.

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 July 14, 2017, the agency screened-in a CPS Report alleging physical abuse to the infant by the father. An assessment was completed by the agency and the allegation of physical abuse was unsubstantiated. The infant died during the assessment period, and the case was closed upon completion of the Initial Assessment.

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 July 14, 2017, the agency screened-in a CPS Report alleging physical abuse to the infant by the father. An assessment was completed by the agency and the allegation of physical abuse was unsubstantiated. The infant died during the assessment period, and the case was closed upon completion of the Initial Assessment.

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 and medical personnel to complete the assessment. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect to the infant by the father. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. The cause of death is undetermined; toxicology results were normal. The infant's 7-year-old paternal half-sibling primarily resides with her mother and does not have regular contact with her father. The agency closed the case upon completion of the Initial Assessment.

B Children residing in out-of-home care (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.)

- | | |
|---|--|
| <input checked="" type="checkbox"/> Screening of Access report | <input type="checkbox"/> Attempted or successful reunification |
| <input type="checkbox"/> Protective plan implemented | <input 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 checked="" 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 type="checkbox"/> Other (describe): |

FOR DSP COMPLETION IF RECORD OR ON-SITE REVIEW WAS UNDERTAKEN:

Summary of policy or practice changes to address issues identified based on the record or on-site 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 an initial review of the agency's practice for each case reported under the Act. A further practice review has been completed for case 170825-DSP-WOOD-749. As a result of this review process, the DSP determined the agency has implemented efforts to improve the consistency and quality of safety practices, including continued and updated training of CPS supervisors.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues based on the record or on-site review:

None

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

