DEPARTMENT OF CHILDREN AND FAMILIES

Division of Safety and Permanence

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

Case Tracking Number: 100514DSP-PN-21 Agency: D	unn County Dept. of Human Services				
Child Information: Age: 1½ months Race or Ethnicity: Caucasian Special needs: None	Gender: 🛛 Female 🔲 Male				
Child's Residence: ☐ In-home ☐ Out-of-home care placement					
Date of Incident: 5/14/10					
Description of the incident, including the suspected cause of death, injoin May 15, 2010 Dunn County Department of Human Services receabout the death of a one-month-old infant and criminal investigation out on the evening of May 13. They returned home at approximately May 14, the child was in bed with them and was cold to the touch. To suffocation.	ived a report from the Menomonie Police Department. The children were with a relative while the parents were v 10:30 p.m. When the parents awoke on the morning of				
Findings by agency, including material circumstances leading to incident: The agency concluded that the child's death was an accident. The child was laying between her parents with a large body pillow over her face obscuring her nose and mouth. The mother called 911 to summon emergency services and started resuscitation efforts on the child. The medical examiner pronounced the infant dead at her home. The parents had no recollection of waking up in the middle of the night to feed the baby or bring her into the bed. Conclusions from the law enforcement investigation and the autopsy were consistent with the agency's findings. No criminal charges were filed. Alleged neglect to the surviving siblings was unsubstantiated.					
Additional information for children in home:					
Description of the child's family: The baby lived with her parents and two siblings in their home.					
☐ Yes ☒ No Statement of Services: Were services under ch. 48 of at the time of the incident, including any referrals received by the agence					
If "Yes", briefly describe the type of services, date(s) of last contact person(s) receiving those services: N/A	t between agency and recipient(s) of those services, and the				

Summary of all involvement in services under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:

The family received Ongoing Services from the agency 2005-2007.

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 or alleged maltreater:

In 2005 the agency received and investigated a report of alleged maltreatment. Neglect to the two-month-old child by the parents was substantiated. The parents were unable to care for their child, and the baby was placed with a relative. The agency assisted the family with services, treatment and supervised visitation. The baby was returned to his parents' care in 2005. The family continued to receive Ongoing Services from the agency 2005-2007. The family's case with the agency was closed in February 2007.

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 investigation of alleged neglect to the surviving children was unsubstantiated. The parents were extremely remorseful and distraught over their daughter's death. It is likely that the father brought the infant into bed with him. The other children were determined to be safe in the care of their parents. The family was provided information about community

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resources for play therapy and grief counseling.

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 investigated and unsubstantiated allegations of neglect to the surviving children. The family was assessed, and the children were determined to be safe in their parents' care. The family was provided information about community resources for support following their child's death.

The agency developed internal tools to effectively handle and process cases of child death, serious injury or egregious incidents where maltreatment is suspected in compliance with the Disclosure Act (Act 78). Act 78 requirements and decision-making points in the case were reviewed with the management team as well with the Family and Children's Services Unit.

*Summary of policy or practice changes to address identified issues:

The agency must screen Access reports within 24 hours in compliance with the CPS Access and Initial Assessment Standards. Prior to this review, the agency had already addressed this issue which occurred in this case.

*Recommendations for further	r changes in policies	s, practices, rules	or statutes neede	d to address	identified is	ssues:
None						

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^{*} 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.