

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

Case Tracking Number: 100904DSP-PN-46 Agency: Bureau of Milwaukee Child Welfare

Child Information: Age: 3 months Gender: Female Male
Race or Ethnicity: African American
Special needs: Seizure disorder

Child's Residence: In-home Out-of-home care placement

Date of Incident: 9/4/10

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

The three-month-old infant was pronounced dead at his home at 1:48 am on September 4, 2010. The child regularly slept on a mattress that was placed next to the couch where his mother slept. The mother awoke to find her infant face down and wedged between the mattress and the couch. The child was not breathing and his hands were cold. She attempted cardiopulmonary respiration and called 911. The medical examiner determined the death was accidental due to positional asphyxia.

Findings by agency, including material circumstances leading to incident:

The agency unsubstantiated neglect to the infant by his mother. The family was assessed and the siblings in the home were determined to be safe. The evening of the incident the mother was home with her two youngest children while two older siblings spent the night with a relative. The infant was given his formula and seizure medication, and his mother rocked him to sleep. The child was placed on the mattress on the floor, and the mother and sibling slept on the couch. The child was found not breathing by his mother. The medical examiner determined the death was accidental due to positional asphyxia.

Additional information for children in home:

Description of the child's family:

The child lived with his mother and three siblings.

Yes No **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, 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 under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:

In September 2009 the agency received and screened in a report alleging physical abuse to mother's then eight-month-old child. Physical abuse by an unknown maltreater was substantiated. The family was referred to community services 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 or alleged maltreater:

None noted for these children or other members of this family unit as adults.

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 agency screened in the report of the child's death and conducted an initial assessment. Neglect to the infant by the mother was unsubstantiated. The medical examiner determined the death was accidental due to positional asphyxia. The other children in the home were determined to be safe. The mother was provided with information on grief services. The case was closed without further assistance from the BMCW.

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 screened in the report of the child's death and conducted an initial assessment. Neglect to the infant by the mother was unsubstantiated. The other children in the home were determined to be safe. The mother was provided with information on grief services. The case was closed without further assistance from the BMCW.

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

None

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

None

Statement of Completion:

Yes No This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

* 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.