

90-Day 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: 111231DSP-Milw-171 **Agency:** Bureau of Milwaukee Child Welfare

Scope of DSP Review of Incident

- No Review. The information contained in this report was provided by the agency.
 90-Day Review

Child Information (at time of incident)

Age: 2 months old Gender: Female Male

Race or Ethnicity: African American

Special Needs: None known

Date of Incident: 12/31/11

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

On December 31st, the agency received a report regarding a 2-month-old baby who was found unresponsive in her father's home. On the evening the incident occurred, the mother and the baby were visiting the home of the baby's father. The father's adult sister and 10-year-old sister (i.e., baby's aunts) were also in the home. The mother and father went to bed, leaving in the infant in the care of the adult sister. The adult sister in turn gave the infant to the 10-year-old sister, who fell asleep on a mattress in the living room with the baby in her arms at approximately 7am. The adult sister reportedly entered the room at approximately 9am and found the baby to be cold and unresponsive. The family attempted CPR and called 911. The paramedics were unable to revive the baby and transported her to the hospital where she was pronounced dead. No criminal charges were filed in connection with the child's death.

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

The 12/31/11 referral alleging neglect to the infant by the mother was screened in and assessed. The allegation was unsubstantiated as the autopsy results indicated the infant's death was a result of sudden/accidental death, and the infant showed no sign of trauma upon investigation. The mother's other children (infant's half-siblings) were determined unsafe in their mother's care. Due to the mother's request for assistance in relocating to Milwaukee and concerns about other identified needs, the mother and her children are currently participating in intensive in home services to ensure the safety of the children.

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 had been residing with a relative, the relative's girlfriend, and the girlfriend's adult daughter for the two weeks leading up to the incident. Prior to that, the father had been the infant's primary caregiver, and they resided together with his mother and his younger sibling. The household also included the father's adult sister and her three children.

The infant was born in Illinois and resided there with her mother and four half-siblings before coming to stay with her father in Wisconsin.

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.)

A 7/5/11 referral alleging neglect by the mother to the 1-year-old (now 2-year-old) was screened out.

A 6/9/11 referral alleging physical abuse by the mother to the 6 year-old (now 7-year-old), 4-year-old (now 5-year-old), 3-year-old (now 4-year-old) and 1-year-old (now 2-year-old) was screened in. The case was forwarded to Illinois for assessment, as the family had fled there and was residing with relatives. In response, the agency received a mandated reporter letter from Illinois stating it was determined that the family was not in need of services.

A 5/18/11 services report was screened in as a failed safety plan, due to the mother missing a medical appointment for the 3-year-old (now 4-year-old) and fear that she would flee the state with the children. The initial assessment worker made contact with the mother, who expressed willingness to continue working with the safety services program. The case was open with safety services until June of 2011, at which time the mother fled with the children to Illinois and the case was closed in Wisconsin as a failure to participate in services.

A 4/5/11 referral alleging medical neglect by the mother to the 3-year-old (now 4-year-old) and 1-year-old (now 2-year-old) was screened in, assessed and unsubstantiated as there was no evidence that the children's health was seriously endangered. The case was, however, referred to Safety Services due to concerns about mother's ability to safely meet her children's basic needs.

A 12/17/08 services report was screened in as a request for a courtesy interview from the state of Illinois, due to concerns of physical abuse by the mother to the 4-year-old (now 7-year-old). The initial assessment worker made several attempts but was unable to locate the family, therefore 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 living in this household and the child's parents and alleged maltreater at the age of 18 years or older. (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 belief of maltreatment or threatened harm may not be screened in for an initial assessment, and no further action is required by the agency.)

See previous section

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 screened in and assessed the allegation of neglect to this child by the mother. The agency unsubstantiated the allegation as the autopsy results indicated the child's death was of an accidental nature and no evidence of intentional harm or negligence was found. The other children continue to be placed in the home, and the family is currently participating in intensive in home services to ensure safe parenting practices and skills.

Companion cases were opened for the two relatives as a result of the incident. The children were assessed and found to be safe.

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.)

DEPARTMENT OF CHILDREN AND FAMILIES

Division of Safety and Permanence

- 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:

None - No DSP Review

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

None - No DSP Review

Yes No Not Applicable This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

If the case review was not completed within 90 days, the DSP will complete and submit the final summary report within 6 months.

The agency must submit an electronic copy of the completed 90-Day Summary Report to PaulaL.Brown@wisconsin.gov