

## 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:** 120717DSP-Doug-224      **Agency:** Douglas County Dept. of Health and Human Services

**Child Information** (at time of incident)

Age: 6 months      Gender:  Female    Male

Race or Ethnicity: Caucasian

Special Needs: Child was born premature. She had a heart murmur and acid reflux requiring the child to sleep at an incline.

**Date of Incident:** 7/17/12

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

On 7/17/12, the agency received a report of a 6-month-old child found deceased in her home. The child was born premature and had been under the care of a physician for a heart murmur and had been diagnosed with acid reflux. The mother had been instructed by the physician and a physical therapist to lay the child to sleep on an incline to help with the acid reflux issue. The night before, the mother had placed the child in her crib and propped her up on a horseshoe shaped pillow. The mother had propped a bottle for the child's nighttime feeding as well. The next morning, the mother found the child with vomit in her mouth and in the bed. There appeared to be blood in the vomit. Law enforcement and the medical examiner responded to the home. The child's death was classified as undetermined and attributed to undetermined causes. Law enforcement concluded their investigation and no criminal charges were filed in this case.

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

The agency screened in and assessed the allegation of neglect to the child. The agency collaborated with law enforcement and the medical examiner to complete the assessment. Neglect was unsubstantiated. Based on information from the medical examiner as well as the Child Death Review Team, the child's death was determined to be an accidental death. The conditions of prematurity, acid reflux, a heart murmur and sleeping environment/position contributed to the unexpected death of the child. The family has four other children living in the home and they were determined safe in the care of the parents.

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):

The child lived with her mother, father, 6-month-old twin sister, 2-year-old half-brother, 4-year-old half-brother, and 6-year-old half-brother.

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 2/2/10, a neighboring county screened in a report alleging physical abuse to the now 4-year-old and the now 6-year-old. Physical abuse was unsubstantiated and the agency closed the case.

On 7/28/11, the agency screened out a report alleging neglect to the now 2-year-old, the now 4-year-old and the now 6-year-old.

**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 collaborated with law enforcement to assess the allegation of neglect to the child. The agency, in conjunction with law enforcement, determined the death of the child was accidental and was classified by the medical examiner as undetermined and attributed to undetermined causes. The remaining children were determined safe in the home and the family was referred to supports and services to assist with grief over the loss of the child. The family was also supported through extended family to help care for the other children during this time. The agency closed the case.

**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:**

**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 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 checked="" 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 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 DSP completes a 90-day review of the agency's practice in each case reported under the Act. In accordance with the DCF memo Series 2010-13, dated December 7, 2010 pertaining to the Child Welfare Case Review Protocol, the DSP will complete a records and on-site review in case #120717DSP-Doug-224.

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

None

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 [Tara.Muender@wisconsin.gov](mailto:Tara.Muender@wisconsin.gov)