### **DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Safety and Permanence

# 90-Day Summary Report for Child Death, Serious Injury or Egregious Incident REVIEW DESIGNATION CORRECTED- 2/16/15

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 Tra	acking N	umber:	130420DSP-	-Milw-319	Agency:	Bureau of Milwaukee Child Welfare
Child Info		-	of incident)	Gender: F	Female ⊠N	Male
Race or E	Ethnicity:	Africa	an American			_
Special N	leeds:	None				
Date of I	ncident:	April	20, 2013			
Descript	ion of th	e incider	nt, including th	e suspected ca	use of death	n, injury or egregious abuse or neglect:
neglect. breathing the emer drainage visits wi mother a times. H (respirat	The mog. She argency re. The in the his pradmitted Hospital tory syncery	other broadso indicated on vision fant was imary placed she feed staff dia cytial vir	ught the infancated the infart. A chest x-rs noted to be whysician, first ds the infant wgnosed the inf	t to the emergent was born drugay showed the very thin appear when the infant whole milk and fant with pneur	ency room reg-affected. infant's left ring with sent was nine of table food, monia, MRS	emonth-old infant admitted to the hospital due to suspected eporting a three-day history of cough, congestion, and trouble The infant displayed a fever and breathing difficulty during t lung was collapsed so a chest tube was immediately placed for evere eczema. Pediatric records showed the infant had only two days old then again on the date of his hospital admission. The despite medical professionals directing against this numerous SA (Methicillin-resistant Staphylococcus aureus), RSV ant's condition, he was admitted to Pediatric Intensive Care for
Findings	s by ager	ncv. inclu	ıding maltreatr	ment determina	tion and ma	terial circumstances leading to incident:
mother v contact v electricit safe bed	was subs with the ty was to for the	stantiated family a urned off infant.	<ul><li>I. Neglect want home, the age and there want he agency de</li></ul>	s also substant gency found the s no food in the termined the cl	iated to the e children re e residence. hildren unsa	erals to complete the assessment. Neglect to the infant by the infant's five older half-siblings by the mother. Upon making esiding in hazardous and unsanitary conditions. The home's There were no infant supplies or clothing observed and no afe and placed them in out-of-home care. The agency filed rt and is providing ongoing case management services.
				nding or completor f yes, against wh		
Child's r	esidence	e at the ti	ime of incident	t: ⊠ In-home	Out-of-ho	ome care placement
		-	-	(A. or B. based		s residence at the time of the incident).
			<b>ild's family</b> (ind ild's family hom		d members,	noncustodial parent and other children that have visitation with the
			cident, the inf four and two		the mother,	the infant's 11-year-old half-brother, and the infant's four half
famil						48 or ch. 938 being provided to the child, any member of the child's y referrals received by the agency or reports being investigated at time
	on(s) re		ribe the type of hose services:		(s) of last co	ontact between agency and recipient(s) of those services, and the
				ices as adults u		or ch. 938 by child's parents or alleged maltreater in the

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 August 8, 2007, the agency screened in a CPS Report alleging neglect to the infant's three oldest half-siblings who were age one, three and five years at the time. The agency attempted to assess the allegations but was unable to locate the family and the case was closed.

On June 29, 2009, the agency screened in a CPS Report alleging neglect to the infant's four oldest half-siblings who were ages four months, three years, five years and seven years at the time. The agency completed an assessment and found the children's needs were being met. Neglect was unsubstantiated and the agency closed the case.

On April 27, 2012, the agency screened out a CPS Report.

On November 14, 2012, the agency screened in a CPS Report alleging neglect to the newborn infant by the mother. The agency completed an assessment and found the mother was not endangering the health of her child. Neglect was unsubstantiated and the agency closed the case.

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 the infant related to his serious medical condition and malnourished status. Neglect to the infant and to the infant's five older siblings was substantiated by the mother. The mother was not meeting the children's basic needs and they were living in hazardous and unsanitary conditions. The agency determined all six children unsafe and placed them in out-of-home care. The agency filed Child in Need of Protection or Services petitions in juvenile court and is providing ongoing case management services to the family.

#### B. Children residing in out-of-home (OHC) placement at time of incident:

Description of the OHO	placement and basis for	decision to	place child there:
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Summary of any actions taken by agency in response to the incident: (Check all that apply.)

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

$\boxtimes$	Screening of Access report		Attempted or successful reunification
$\boxtimes$	Protective plan implemented	$\boxtimes$	Referral to services
$\boxtimes$	Initial assessment conducted	$\boxtimes$	Transportation assistance
	Safety plan implemented		Collaboration with law enforcement
$\boxtimes$	Temporary physical custody of child	$\boxtimes$	Collaboration with medical professionals
$\boxtimes$	Petitioned for court order / CHIPS (child in need of	$\boxtimes$	Supervised visitation
	protection or services)	$\boxtimes$	Case remains open for services
$\boxtimes$	Placement into foster home		Case closed by agency
$\boxtimes$	Placement with relatives		Initiated efforts to address or enhance community
$\boxtimes$	Ongoing Services case management		collaboration on CA/N cases

## 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 Bureau of Performance Management (BPM) will complete a records

Other (describe):

review of case 130420DSP -Milw-319. Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues: None at this time. ☐ Yes ☒ No ☐ Not Applicable

This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this

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