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

Division of Safety and Permanence

### 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	: 130824DSP	-Milw-360	Agency:	Bureau of Milwaukee Child Welfare
Child Information (at tire Age: 2 months	ne of incident)	Gender: 🛛 Fe	emale 🗌 N	Male
Race or Ethnicity: Cau	ıcasian			
Special Needs: None	known			
Date of Incident: Au	gust 24, 2013			
On August 24, 2013, mother reported she p mother stated she wol infant with blood arou and began CPR. Para	the agency recellaced the infant we up at 2:30 and her mouth, umedics could not igation into the	ived a report regin an adult bed to feed and channesponsive. To trevive the infant	garding a to sleep, and ange the indicate in the mother on the mother on the was	wo-month-old infant pronounced deceased in her home. The d then went to sleep in her two-year-old daughter's room. The fant. When she got up again a few hours later, she found the called for her two older children, ages 12 and 14, to call 911 pronounced dead at the scene. Law enforcement was notified Law enforcement's investigation is pending, and no criminal
The agency collabora the official cause of the The Initial Assessment abuse and neglect by	ted with law end ne infant's death t completed by he mother to the , the agency did	forcement and man was undeterming the county agent infant and the infant find a preport of the force of the find a preport of the fi	nedical personed by the acy has instant's surponderance of	erial circumstances leading to incident: sonnel to complete the assessment. As of November 8, 2013, Medical Examiner's Office; toxicology results were pending. afficient evidence to substantiate the maltreatment of physical reviving two-year-old sister. Based on information gathered for of the evidence that the mother failed to provide necessary care
mother and alleged far domestic violence inc Intensive In-Home Se agency determined th The infant's 12-year-	ther were drinking the state of	ng. There were of mother. Addition mother did not of ving two-year-ol old half-sibling	concerns re onally, the lisclose head d half-siste s returned	the infant on the night before the infant's death, and both the egarding the alleged father's presence in the home, due to prior family had an open, on-going case with the agency, receiving a pregnancy or the infant's birth to the assigned worker. The er unsafe and placed the two-year-old into out-of-home care, to their father's care on the day after the infant's death. The ase management services.
∑ Yes				
Child's residence at the	e time of inciden	t: 🛛 In-home	Out-of-ho	me care placement
Complete the appropriat  A. Children residing	-	•		residence at the time of the incident).
child and / or in the At the time of the	child's family hom incident, the in	e): fant lived with tl	he mother	oncustodial parent and other children that have visitation with the and the infant's two-year-old half-sister. The infant's 14-year-with their father, but had visitation with the mother.
				48 or ch. 938 being provided to the child, any member of the child's referrals received by the agency or reports being investigated at time
If "Yes", briefly de	scribe the type o	f services, date(s	) of last co	ntact between agency and recipient(s) of those services, and the

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person(s) receiving those services:

The family was being provided Intensive In-Home Services at the time of the incident. The assigned worker's last contact with the mother was a telephone call on August 19, 2013 about scheduling a home visit. It was agreed they would speak again on August 27, 2013 to schedule a home visit for that week.

## 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.)

In August 2011, a petition was filed in juvenile court alleging the infant's now two-year-old sister was a Child in Need of Protection or Services. The agency opened the case for on-going case management services. The infant's sister returned to the mother's care on a Trial Reunification in February 2013, which transitioned to full reunification two months later. The case remained open and the family was receiving Intensive In-Home Services at the time of the infant's death.

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 3/19/09, another agency screened in a report of physical abuse and neglect by the mother to the deceased infant's seven-year-old (now 12-year-old) and 10-year-old (now 14-year-old) half-siblings. An assessment was completed by the other agency. The allegation of physical abuse was unsubstantiated as there were no injuries found. The allegation of neglect was unsubstantiated as the children were not endangered and there was a protective adult in the home. The family was referred to community resources and the case was closed.

On 7/23/11, the agency screened in a report alleging physical abuse to the infant's six-month-old (now two-year-old) sister by their alleged father during a domestic violence incident. On 8/09/11 another report alleging neglect to the six-month-old (now two-year-old) sister by the parents was screened out and the initial assessment worker was made aware of the referral. The allegation of physical abuse in the 7/23/11 report was unsubstantiated, as there was no evidence of inflicted injury found by medical professionals. Neglect to the infant's sister by the mother was substantiated, as the mother failed to provide adequate supervision and care for her child's special needs. The infant's sister was determined unsafe and placed into out-of home care. A Child in Need of Protection or Services petition was filed in juvenile court, and the case was opened for ongoing case management services.

# 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 collaborated with law enforcement and medical personnel to complete the assessment. As of November 8, 2013, the official cause of the infant's death was undetermined by the Medical Examiner's Office; toxicology results were still pending. The Initial Assessment completed by the county agency has insufficient evidence to substantiate the maltreatment of physical abuse and neglect by the mother to the infant and the infant's surviving two-year-old sister. Based on information gathered for the Initial Assessment, the agency did not find a preponderance of the evidence that the mother failed to provide necessary care so as to seriously endanger the physical health of the children. However, the agency learned the infant's alleged father cared for the infant on the night before the infant's death, and both the mother and alleged father were drinking. There were concerns regarding the alleged father's presence in the home, due to prior domestic violence incidents with the mother. Additionally, the family had an open, on-going case with the agency, receiving Intensive In-Home Services, but the mother did not disclose her pregnancy or the infant's birth to the assigned worker. The agency determined the infant's surviving two-year-old half-sister unsafe and placed the two-year-old into out-of-home care. The infant's 12-year-old and 14-year-old half-siblings returned to their father's care on the day after the infant's death. The case remains open and the family continues to receive on-going case management services.

### B. Children residing in out-of-home care (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.

Sumi	mary of any actions taken by agency in response to the incident:	(Che	Check all that apply.)					
$\boxtimes$	Screening of Access report		Attempted or successful reunification					
$\overline{\boxtimes}$	Protective plan implemented	$\overline{\boxtimes}$	Referral to services					
$\overline{\boxtimes}$	Initial assessment conducted	$\boxtimes$	Transportation assistance					
Ħ	Safety plan implemented	$\boxtimes$	Collaboration with law enforcement					
$\square$	Temporary physical custody of child	$\boxtimes$	Collaboration with medical professionals					
	Petitioned for court order / CHIPS (child in need of	Ħ	Supervised visitation					
	protection or services)	$\boxtimes$	Case remains open for services					
$\square$	Placement into foster home	H	Case closed by agency					
$\square$	Placement with relatives	H	Initiated efforts to address or enhance community					
$\forall$	Ongoing Services case management	ш	collaboration on CA/N cases					
	Crigoria Corvices ease management	$\Box$						
		ш	Other (describe):					
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 and found: The Initial Assessment does not include the mother's two oldest children as household members and there was no documented Safety Assessment, Analysis and Plan for the two oldest half-siblings following the infant's death.								
Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues: $None$								
⊠ Y	es No Not Applicable This 90-day summary report complet case.	es th	e 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.								
The agency must submit an electronic copy of the completed 00 Day Summary Penart to Beharth Williams @wiccopsin.gov								

The agency must submit an electronic copy of the completed 90-Day Summary Report to <a href="RobertB.Williams@wisconsin.gov">RobertB.Williams@wisconsin.gov</a>