DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

6-Month Final 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: 120504DSP-Milw-199 **Agency:** Bureau of Milwaukee Child Welfare

Child Information (at time of incident)
Age: 4-month-old Gender: ☒ Female ☐ Male
Race or Ethnicity: African American
Special Needs: None

Date of Incident: 5/4/12

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On May 4th, the agency received a report regarding an infant who had been pronounced dead at her home. The mother had found the infant unresponsive and called 911. The paramedics attempted CPR upon arrival, but were unsuccessful and the child was pronounced dead. The mother reported that her apartment had a roach infestation, so she had the infant sleep with her rather than in her pack-n-play to protect her from exposure. The police report indicates the infant fell from the bed and landed on the exposed metal of the baseboard heater and bed frame. The leg of the metal bed frame had pierced the plastic coating of an extension cord, which was plugged in and ran under the bed. Contact between the metal bed frame and heater created a circuit which electrocuted the child and caused her death. The mother had purchased the cord in December 2011 and had no reason to believe it was faulty or defective. The medical examiner ruled the infant's death a result of accidental electrocution. The mother's 6-year-old daughter, 5-year-old son, and 2-year-old daughter were found to be free from injury and well cared for. 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 by the mother to her infant daughter. The agency unsubstantiated the allegation of neglect, as there was no indication that the infant's death was due to the mother's negligence. The medical examiner ruled the infant died as a result of accidental electrocution. The mother had no reason to believe the extension cord was defective and was trying to protect her infant from a roach infestation by co-sleeping. The agency also unsubstantiated neglect by the mother to the other children. The mother had made numerous attempts to have the building management address the bug problem which was occurring throughout the building and not just in the mother's apartment. The children were determined to be unsafe due to the housing issues and mother's struggle to manage the children's behaviors. An In-Home Safety Plan was developed and the family was referred to Intensive In-Home Services to assist the mother in identifying appropriate housing and improve her parenting skills, which the family continues to receive.

☒ 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 infant lived with her mother, 6-year-old half sister, 5-year-old half brother, and two-year-old sister.

☐ **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 7/29/11 referral alleging physical abuse by the mother to her 4-year-old son was screened out as No Threatened Harm or Maltreatment.

A 5/13/11 referral alleging neglect by the mother to her 5-year-old daughter, 4-year-old son, and 1-year-old daughter was screened in and assessed. The allegation was unsubstantiated as the children's basic needs were being met. At the time of the referral, the mother had been working with Safety Services since February 2011 and continued to do so until June 2011, when she moved out of state and the case was closed.

A 2/16/11 referral alleging physical abuse by the mother to her 3-year-old son was screened in and assessed. The allegation was unsubstantiated, as the child denied any physical abuse and did not have any injuries indicative of abuse. The mother did request Safety Services to assist her with her parenting skills and was referred to the program.

A 4/15/10 referral alleging physical abuse by the mother to her 4-year-old daughter was screened in and assessed. The allegation was unsubstantiated as the children denied any physical abuse and no injuries were observed. The family was also provided with community assistance referrals.

A 4/15/10 service report was screened in as the mother requesting parenting assistance with her 4 year-old daughter and 2-year-old son. The mother was given the information to request assistance from Safety Services.

A 2/19/10 referral alleging neglect by the mother to her 4 year-old daughter and 2-year-old son was screened in and assessed. The allegation was unsubstantiated as the children's basic needs were being met.

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.)

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 by the mother to her infant daughter. The agency unsubstantiated the allegation of neglect, as there was no indication that the infant's death was due to the mother's negligence. The medical examiner ruled the infant died as a result of accidental electrocution. The mother had no reason to believe the extension cord was defective and was trying to protect her infant from a roach infestation by co-sleeping. The agency also unsubstantiated neglect by the mother to the other children. The mother had made numerous attempts to have the building management address the bug problem which was occurring throughout the building and not just in the mother's apartment. The children were determined to be unsafe due to the housing issues and mother's struggle to manage the children's behaviors. An In-Home Safety Plan was developed and the family was referred to Intensive In-Home Services to assist the mother in identifying appropriate housing and improve her parenting skills. The family is still receiving Intensive In-Home Services.

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.)

- ☒ Screening of Access report
- ☐ Protective plan implemented
- ☐ Attempted or successful reunification
- ☒ Referral to services

- [x] Initial assessment conducted
- [x] 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
- [x] Ongoing Services case management
- [ ] Transportation assistance
- [x] Collaboration with law enforcement
- [x] Collaboration with medical professionals
- [ ] Supervised visitation
- [x] 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:

Under the Child Welfare Disclosure Act (Section 48.981(7)(cr), Stats.), 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) completed an on-site review in case # 120504DSP-Milw-199. The review found that the Bureau of Milwaukee Child Welfare (BMCW) was not in compliance with the CPS Access and Initial Assessment Standards in the areas of information gathering and analysis at Access, and substantiation decision making and inclusion of non-custodial parents in Initial Assessment.

BMCW provided an in-service to its Access unit reviewing practice expectations to ensure practice is aligned with BMCW procedure, standards and statutes. Additional training related to decision making around substantiation of abuse and neglect was provided by the Bureau of Safety and Well-Being and BMCW legal counsel. Region Managers were briefed by Section Chief concerning the need to ensure inclusion of all household members as well as non-custodial parents in the Initial Assessment process, per standards.

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

None

☒ Yes ☐ No ☐ Not Applicable This 6-month 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 RobertB.Williams@wisconsin.gov