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: 120607DSP-Wood-212 **Agency:** Wood County Human Services Department

Child Information (at time of incident)
Age: 4 months Gender: ☐ Female ☒ Male
Race or Ethnicity: American Indian
Special Needs: None

Date of Incident: 6/7/12

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On 6/7/12, the agency received a report regarding a child death. The infant had been transported from his home to a local hospital where he was pronounced dead. The father was home caring for the infant and the mother's 2-year-old and 8-year-old daughters while the mother was at work. The father placed the infant face down in the middle of the parents' bed for a nap. When the mother returned home from work, she found the infant not breathing and limp. The parents immediately transported the infant to the hospital. The hospital found no physical signs of trauma. Law enforcement conducted an investigation into the infant's death. The final autopsy report concluded that the infant died of a probable cardiac arrhythmia (irregular heartbeat) due to myocarditis (inflammation of the heart muscle). 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 allegations of physical abuse to the children. The agency collaborated with law enforcement during the assessment. The agency unsubstantiated physical abuse. The father reported that on 6/7/12 he was home with the children. He decided to clean the house. The father said that the infant woke up from a nap about 4:00 PM and was brought into the living room and propped on the couch. The father made the infant a bottle and tried to continue cleaning, but the infant became fussy. He did eventually fall asleep on the couch, so the father moved him into the bedroom. The father said he tried to take a shower, but the infant started to cry. He turned the infant and he started sucking on the bottle. The father went into the bathroom and when he came out the infant was biting the bottle, so the father took it out and set it on the dresser. The father then took a shower. While in the shower, the 8-year-old came in and told him that the infant was crying. The father told her to pat him on the back to help him go to sleep. After the father showered, he looked in and saw the infant sleeping on his stomach. He then continued to clean the house and make dinner until the mother got home. When she got home, she went to check on the infant and found him not breathing. They immediately left for the hospital, where the infant was pronounced dead. The autopsy determined the infant's death was caused by undetected medical reasons and not as the result of abuse or neglect. The 2-year-old and 8-year-old were determined safe in the care of their mother and the infant's father.

☒ 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 his mother, father, and his 2-year-old and 8-year-old half-sisters.

☒ **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:
A report was received by the agency on 4/26/12 and the assessment was pending at the time of the infant's death. The last contact with the family prior to the infant's death was on 5/22/12.

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.)

See below

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 8/18/10, a report was screened out for No Threatened Harm or Maltreatment.

On 8/30/10, a Services Report was screened in due to supervision concerns for the now 8-year-old. The mother was connected with community services.

On 3/30/11, a Services Report regarding housing issues was screened out.

On 11/29/11, a Services Report regarding the mother often leaving the now 8-year-old with relatives was screened out.

On 4/26/12, a report was screened in for concerns of violence in the home and the mother's boyfriend leaving the children home alone. The assessment was pending at the time of the infant's death. The agency ultimately substantiated Neglect by the mother's boyfriend. The children were determined safe in the home.

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 allegations of physical abuse to the children. The agency ultimately unsubstantiated physical abuse. The autopsy determined the infant's death was caused by undetected medical reasons and not as the result of abuse or neglect. The 2-year-old and 8-year-old were determined safe in the care of their mother and the infant's father. The family was offered referrals for grief services; however, the family declined services and the case was closed by the agency.

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
- ☒ 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): Collaboration with tribal agency

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 DSP completed an on-site review in case #120607DSP-Wood-212. The review found: Wood County Human Services Department practice in Access was in compliance with CPS Access and Initial Assessment Standards, but practice in Initial Assessment was not in compliance with CPS Access and Initial Assessment Standards. The Initial Assessments completed in April of 2012 and June of 2012 did not include sufficient information regarding domestic violence in the home and safety of the children. In addition, there was a general lack of information and analysis regarding the functioning of individual family members, parenting practices, and family functioning.

The Quality Improvement plan implemented by the county agency included training for all workers completing the Initial Assessment function for the agency and the CPS Supervisor discusses safety assessment during regular intervals with employees who complete protective or safety plans within their scope of work, and all employees performing the function of CPS completed the confirming safety environments training offered by the Training Unit.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:
None

☒ Yes ☐ No ☐ Not Applicable This 6-month report completes the Division of Safety and Permanence (DSP) review of this case.

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