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: 120918DSP-Monro-249 **Agency:** Monroe County Department of Human Services

Child Information (at time of incident)
Age: 2 years Gender: ☐ Female ☒ Male

Race or Ethnicity: Caucasian

Special Needs: Diagnosed with growth deficiency and hypothyroidism

Date of Incident: 9/18/12

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

On 9/20/12, the agency received a report regarding a child who had been hospitalized on 9/18/12 after suffering cardiac arrest. Medical professionals were suspicious of maltreatment since it is not normal for a young child to experience cardiac arrest. The child lived part-time in the home with his father, father's girlfriend, his 6-month-old half-sister and the girlfriend's two female children, ages 3 and 5. On the day of the incident, the father's girlfriend was home with the 2-year-old, 3-year-old and 6-month-old children while the father was at work. The father's girlfriend reported the child awoke and was given his thyroid medication and toys to play with until he could eat 30 minutes after taking his medication. The father's girlfriend went downstairs to tend to the other children. When she returned to the child 45 minutes later, she found the child with a blanket over him and observed the child to be extremely pale. The father's girlfriend picked up the child under both of his arms and he was limp. The child slid out of her arms and hit his forehead on a small table next to the crib. The child was struggling to breathe and gasped for air. The father's girlfriend stated she couldn't think straight at the time and couldn't remember how to do CPR. She took the child downstairs and sat him up in a position she thought would make it easier for him to breathe. The father's girlfriend then called a family member not knowing what to do. The family member advised her call 911, which she did. Emergency medical responders arrived and started CPR. The child was transported to the hospital. The child was later transferred to another hospital and placed on life support. On 9/26/12,life support was removed and the child was pronounced dead. Medical professionals have been unable to determine a cause for the child's sudden cardiac arrest or find any indication of maltreatment. The final autopsy results are still pending. Law enforcement determined they would not be opening an investigation after no indication of foul play was found. No criminal charges will be 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 physical abuse to the 2 year-old by his father's girlfriend. Physical abuse by the father's girlfriend was unsubstantiated. The agency determined that small bruises on the outside of his left thigh were consistent with minor injuries due to the child's crawling technique and normal toddler play. A bruise on the left side of the child's forehead appears to have been caused when the child fell out of the father's girlfriend's arms and hit his head on the small table next to the crib. Medical professionals found no signs of maltreatment which could have led to the child's sudden cardiac arrest. The bruise on the forehead was determined minor and no associated head trauma was found. A skeletal survey was negative for any signs of fractures, a CT scan of the child's head was negative for intracranial hemorrhaging and a CT scan of the neck and spine was negative for fractures. An examination by an ophthalmologic consultant revealed no retinal hemorrhages. A cause of the child's sudden cardiac arrest was not determined. The child was diagnosed with growth deficiency and hypothyroidism. Genetic testing had revealed the child had a 13.6 Mb micro deletion on chromosome 13; however genetic specialists indicated this would not have led to the child's condition. The other children were determined safe in the home and the agency has closed the case.

☐ 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's parents had joint custody and placement. The child lived with his mother Friday morning to Sunday evening. The child lived with his father Sunday evening to Friday morning. Residing in the father's home is the father, father's girlfriend, father's girlfriend's two female children, ages 3 and 5, and the child's half-sister, age 6 months.

☐ **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 5/18/12, the agency screened out a CPS report regarding neglect of the 1-year-old child (now 2-year-old deceased child) while in the care of his father.

On 7/13/12, the agency screened in a report alleging physical abuse of the 2 year-old child (now deceased) while in the care of his father. Physical abuse was unsubstantiated and the agency closed the case.

On 8/3/12, the agency screened in a report alleging physical abuse of the 2 year-old child (now deceased) while in the care of his father. Physical abuse 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 completed an assessment regarding the allegation of physical abuse to the deceased 2-year-old child. Physical abuse by the father's girlfriend was unsubstantiated. Medical professionals were unable to determine what caused the child's sudden cardiac arrest. Extensive medical testing did not show any signs of maltreatment. Results from autopsy are not yet available; however initial results, which are not conclusive, have shown no indication of foul play or a cause of death. The other children were determined safe in the home and the agency has 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.)

- ☒ 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):

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 completed an on-site review in case #120918DSP-Monr-249 and prior reports involving the family. The report found: Phone calls taken on September 18 and 19, 2012 were erroneously documented as case notes and not taken as CPS Reports as required by Wisconsin statute and standards. The CPS Report dated September 20, 2012 was screened within 24 hours as required by statute and standards and screened-in for an Initial Assessment in accordance with statute and standards.

The Initial Assessments completed in conjunction with the September 20, 2012 CPS report contained sufficient information in the areas of maltreatment, child functioning, adult functioning, disciplinary approaches, family functioning, and parenting practices. All children in the household were not interviewed during the Initial Assessment as required by Wisconsin standards and the non-custodial father of the other children in the household was not contacted or interviewed in accordance with standards.

The Quality Assurance and Improvement plan implemented by the county agency included the assurance of timely and quality information collection, analysis, and decision making from the point of access through initial assessment and completion. This plan included the incorporation of monthly discussion of statute and standards at team meetings.

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.

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