

## 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:** 131113DSP-Keno-384      **Agency:** Kenosha County Department of Children and Family Services

**Child Information** (at time of incident)

Age: 3 Month      Gender:  Female    Male

Race or Ethnicity: Black

Special Needs: None

**Date of Incident:** 11/13/2013

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

On November 13, 2013, the agency received a report regarding the unexplained death of a three month old. Law Enforcement responded, the same day, to initiate an investigation into the child's sudden, unexplained death. The mother reported she and the father of the infant work second shift and the children attend a childcare facility while they work. Both parents reported the children were picked up from the childcare facility at approximately 12:30am and they all went to the residence of the mother. The mother put the other children back to bed but the infant was fussy so the mother placed her in the bed with both parents as well as a one year old sibling. The mother stated all of them were laying perpendicular in the bed. At approximately 5:30 a.m., the father woke and noticed the infant was not breathing. The father woke the mother and told her to call 911. EMTs responded to the residence of the mother but attempts to resuscitate were unsuccessful and the infant was pronounced deceased.

On November 14, 2013, the Medical Examiner's office's completed report noted no signs of abuse or neglect to the infant with toxicology reports pending. The criminal investigation determined both parents did not appear impaired and cooperated in submitting toxicology tests, the results of which were negative. Law Enforcement's investigation of the infant's death has concluded and no criminal charges were filed.

**Findings by agency, including maltreatment determination and material circumstances leading to incident:**

The agency collaborated with law enforcement and medical personnel to complete the assessment. Based on the information gathered, the Initial Assessment completed by the agency has insufficient evidence to substantiate the maltreatment by the mother or father to the infant. The criminal investigation determined both parents did not appear impaired and cooperated in submitting toxicology tests, which were negative. The mother denied rolling over on the infant and stated she has a bassinet for the infant but did fall asleep with the infant in the bed. The other children in the residence were assessed as unsafe and a protective plan was implemented with relatives. The agency provided co-sleeping education to the family and all other children in the home were observed and determined unsafe and the case was opened with an intensive, in-home safety services program.

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):

At the time of the incident, the infant resided with her mother and four siblings. The infant's father was active in her life but was not residing in the mother's residence.

**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:**

On September 25, 2013, the agency screened-in a CPS report alleging a two-year old child had three bruises on his lower back. The agency screened-in the report with a five day response time. The two-year old and siblings were observed on October 2, 2013, and assessed as safe. Subsequent home visits were attempted on October 4, 2013, October 29, 2013, November 4, 2013, and November 11, 2013.

**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 January 27, 2010, a Child Welfare report was screened-in for a severe diaper rash and dehydration to a child in the home. The Child Welfare report indicated services were not needed and the case was closed.

On February 2, 2012, a Child Welfare report was screened-in for a welfare check because a child had a second head laceration needing medical attention. The agency responded and assessed for safety, determined there was no need to offer services, and closed the case.

On February 18, 2013, the agency screened-out a CPS report.

On February 19, 2013, the agency screened-in a CPS report alleging that a two-year old child had three small bruises on his right cheek and one small bruise on his left cheek. The report was screened-in with a same day response time. The agency assessed the allegation and unsubstantiated abuse to the child. The case was closed and referred to community 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. Based on the information gathered, the Initial Assessment completed by the agency has insufficient evidence to substantiate the maltreatment by the mother or father to the infant. The criminal investigation determined both parents did not appear impaired and cooperated in submitting toxicology tests, which were negative. The mother denied rolling over on the infant and stated she has a bassinet for the infant but did fall asleep with the infant in the bed. The other children in the residence were assessed as unsafe and a protective plan was implemented with relatives. The agency provided co-sleeping education to the family and all other children in the home were observed and determined safe and the case was opened with an intensive, in-home safety services program.

**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.

**Summary of any actions taken by agency in response to the incident:** (Check all that apply.)

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

**FOR DSP COMPLETION IF RECORD OR ON-SITE REVIEW WAS UNDERTAKEN:**

**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 Department of Children and Families' (DCF) Division of Safety and Permanence (DSP) completes in an initial review the agency's practice for each case reported under the Act. A further practice review has been completed for case #131113DSP-Keno-384. As a result of this review process, the DSP determined the agency implemented efforts to improve the consistency and quality of safety practices, including continued and updated training of CPS staff surrounding safe sleep practices.

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

Based on the agency's effort and response to this incident and DSP review, no further policy, practice, or statutory changes are recommended.

- Yes    No    Not Applicable   This 6-Month final summary report completes the Division of Safety and Permanence (DSP) review of this case.