

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: 131109DSP-Dane-383 **Agency:** Dane County Department of Human Services

Child Information (at time of incident)

Age: 3 month Gender: Female Male

Race or Ethnicity: African American

Special Needs: None

Date of Incident: 11/09/2013

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

On November 9, 2013, the agency received a report regarding a three month-old infant pronounced deceased at a local hospital. Law Enforcement responded to a 911 call from the home of the child and initiated an investigation into the child's unexplained death. The mother reported that the night of November 8, 2013, she left home at 7 p.m. to visit a friend. She left the infant with his father. The father contacted a babysitter to watch the infant. He left the residence and returned between 2 a.m. and 3 a.m. on November 9, 2013. The father dismissed the babysitter, fed the infant a bottle, and placed the infant in the bed with him. The father reported watching television before falling asleep. The mother reported trying to call the father at 7:30 a.m. but received no response. The mother took the 8:30 a.m. bus to the residence and at approximately 9:00 a.m. she found the father asleep in the bed and infant face down in the bed, not breathing. The mother reported she began yelling and slapping the father and a call was made to 911 at 9:04 a.m. Law Enforcement was first on the scene and attempted CPR on the infant for approximately 20 minutes. The EMTs arrived and transported the infant via ambulance to a local hospital, continuing efforts to resuscitate the infant without success. The child was pronounced deceased at the hospital.

The father reported to Law Enforcement he consumed an alcoholic drink the evening of November 8, 2013, and also consumed illegal drugs during the day and evening of the same day. The father voluntarily submitted to a toxicology test for alcohol and the illegal substance. The father reported he did not recall anything happening to the infant while they slept and both parents stated the infant always slept in the bed with them.

On November 11, 2013, the Medical Examiner's office completed their report and found no signs of abuse or neglect to the infant. The death was ruled accidental and the criminal investigation was closed with no charges 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 county agency has insufficient evidence to substantiate the maltreatment by the mother or the father to the infant. The infant's death was ruled accidental and the parents reported that the infant routinely slept in the bed with them. Collateral sources described the parents as caring and attentive toward the infant and his one year old sister. Both children were described as healthy and on track developmentally. During the course of the investigation, the agency initially determined the one year old sibling of the infant UNSAFE and implemented a Protective Plan for the child to stay temporarily with a relative while safety information was assessed. This plan was amended to allow the older sibling to have supervised contact with her mother and the infant's father. The Protective Plan was terminated on November 20, 2013, and the child was determined SAFE. The family was referred to a community agency for counseling and the agency closed the initial assessment and no further referrals were made.

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
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child and / or in the child's family home):

Prior to the incident the infant resided at home with his parents, and his one year old half-sibling. The mother has two older children, adopted by a relative in 2009. The mother continues to have regular contact with these children through the relative.

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.)

In February of 2007, the agency placed the mother's two older children with a relative. The agency monitored the children's placement, provided case management services, and referred the mother to services to address her alcohol and drug abuse issues. The mother was also referred for parenting education services, and was provided with supervised family interactions. The relative was provided with in-home family therapy services to assist her in meeting the children's needs. The mother was unable to maintain stability in her life, and consented to a voluntary termination of parental rights in September of 2009.

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 March 20, 2005, the agency screened out a report.

On October 15, 2006, the agency screened in a services report due to concerns regarding a loaded gun being in the residence. The mother did not respond to requests for a meeting and no services were provided.

On February 17, 2007, the agency screened in a report with concerns that the mother left her one and three year old children home, alone. The mother was arrested and the officer left the children with the maternal grandmother who was responsible for protecting the children. This report was screened in with a 5 day response time and the first agency contact is documented to have occurred on March 7, 2007. It is unclear if the agency implemented a formal protective plan prior to the documentation of the first Safety Plan dated April 7, 2007. The agency substantiated the allegations of child neglect and filed a Child In-Need-of Protection or Services petitions and opened a case for on-going case management services. At the time of the CHIPS dispositional hearing on May 31, 2007, the children were formally placed into out-of-home care with their maternal grandmother. The agency provided services for this family for two and a half years, until the mother voluntarily Terminated her parental rights on September 17, 2009 and the children were subsequently adopted by their maternal grandmother.

On May 6, 2013, the agency screened in a report with concerns that the mother was using illegal substances while pregnant and was arrested on outstanding charges of manufacturing and delivering an illegal substance. The agency assessed these concerns and determined the incident leading to the mother's arrest occurred in 2010. The agency found no indications the mother was engaged in illegal, drug-related behaviors. There was no evidence that the mother's current use of marijuana was impacting her ability to safely parent her infant, nor was it negatively impacting the development of her unborn child. Observations and collateral information indicated the mother was appropriately attentive and caring toward her infant daughter. The Initial Assessment completed by the county agency found insufficient evidence to substantiate the maltreatment to the unborn by the mother.

On May 7, 2013, the agency screened in a report that the mother's newborn tested positive for marijuana at birth. The agency assessed the concerns and found no evidence that the mother's use of marijuana was affecting her ability to safely parent her children. Collateral sources indicated the children were healthy and on track developmentally. The Initial

Assessment completed by the county agency found insufficient evidence to substantiate the maltreatment of neglect to the infant by the mother.

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 county agency has insufficient evidence to substantiate the maltreatment by the mother or the father to the infant. The infant's death was ruled accidental and the parents reported the infant routinely slept in the bed with them. Collateral sources described the parents as caring and attentive toward the infant and his one year old sister. Both children were described as healthy and on track developmentally. During the course of the investigation, the agency initially determined the one year old sibling of the infant UNSAFE and implemented a Protective Plan for the child to stay temporarily with a relative while safety information was assessed. This plan was amended to allow the older sibling to have supervised contact with her mother and the infant's father. The Protective Plan was terminated on November 20, 2013, and the child was determined SAFE. The family was referred to a community agency for counseling and the agency closed the initial assessment and no further referrals were made.

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.)

- | | |
|---|--|
| <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 checked="" 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 checked="" 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 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. The DSP did not identify practice issues during the review of the incident.

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

None

Yes No Not Applicable This 90-day 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