DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

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: 140101DSP-Milw-398 **Agency:** Bureau of Milwaukee Child Welfare

Child Information (at time of incident)
Age: 6 months Gender: ☐ Female ☒ Male
Race or Ethnicity: Black/African American
Special Needs: None known

Date of Incident: January 1, 2014

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

On January 1, 2014, the agency received a report regarding a 6-month-old infant pronounced deceased in his home. The report included concerns of neglect to the infant and the infant's 2-year-old sister due to conditions observed in the family's home. Law enforcement and the Medical Examiner's office were called and responded to the residence to investigate the infant's sudden, unexplained death. The mother reported she put the infant to bed in a dresser drawer on top of the bed, around 6:00 or 7:00 pm that night. She said she lay down in the bed with the infant's sister at approximately 8:40pm. At that time she observed the infant in the drawer and his eyes were partially open. She stated when she picked him up, he was limp and unresponsive so she called 911. The paramedics responded but were unable to revive the infant and he was pronounced deceased. At the time of the incident, there were multiple concerns noted in the residence: cold temperatures; extension cords strewn throughout the residence; an open can of turpentine, kitchen knives within reach of the 2- year old; and other dangerous and unhealthy environmental risks.

The following day, the Medical Examiner reported upon examining the infant, extensive bruising was found on the infant. Given the infant's age and lack of mobility, his injuries were deemed to be non-accidental, from physical abuse. No bone fractures or external head injuries were found to the infant. The mother lives with an adult male, who is a family friend. He reported he had never seen the infant sleep in a drawer; the children were both generally in bed with the mother. He also denied partaking in any caretaking duties for the children. The infant's alleged father maintained a separate residence but was also in the home on a regular basis and stayed overnight the date prior to the infant's death. All of the individuals who had access to the infant denied knowing how the infant sustained his injuries. No criminal charges were filed as a result of law enforcement's investigation.

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

The agency collaborated with law enforcement and medical professionals to complete the assessment. The Initial Assessment completed by the child welfare agency found a preponderance of the evidence existed to substantiate the allegation of physical abuse to the infant by an unknown maltreater. However, insufficient evidence existed to substantiate the allegation of neglect by the mother to the infant and the infant's sister. While there were concerns about the condition of the home at the time of the infant's death, there was no indication that the condition of the home or the mother's lack of care to the infant caused his death. The preliminary ruling by the Medical Examiner's office was Sudden Infant Death, pending receipt of further test results. Medical professionals determined the extensive bruising sustained by the infant was non-accidental, from physical abuse. Multiple caregivers had access to the infant during the timeframe his injuries were inflicted and all caregivers denied knowing how the injuries occurred. The agency determined the 2-year-old sister unsafe so she was taken into temporary physical custody and placed in out-of-home care. A petition was filed in juvenile court alleging the infant's sister to be a Child in Need of Protection or Services. The case remains open and the agency is providing the family with On-going case management services.

☒ 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 lived with his mother, his (alleged) 2-year-old sister, and an adult male friend of the infant's alleged father. The alleged father lived in a separate residence but was in the home on a regular basis.

☐ **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.)

N/A.

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 7/23/2013, the agency screened out a CPS Report.

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 professionals to complete the assessment. The Initial Assessment completed by the child welfare agency found a preponderance of the evidence existed to substantiate the allegation of physical abuse to the infant by an unknown maltreater. However, insufficient evidence existed to substantiate the allegation of neglect by the mother to the infant and the infant's sister. While there were concerns about the condition of the home at the time of the infant's death, there was no indication these conditions or any lack of care by the mother contributed to or caused the infant's death. The preliminary ruling by the Medical Examiner's office was Sudden Infant Death, pending receipt of further test results. Medical professionals determined the extensive bruising sustained by the infant was non-accidental, from physical abuse. Multiple caregivers had access to the infant during the timeframe his injuries were inflicted and all caregivers denied knowing how the injuries occurred. The agency determined the 2-year-old sister unsafe so she was taken into Temporary Physical Custody and placed in out-of-home care. A petition was filed in juvenile court alleging the infant's sister to be a Child in Need of Protection or Services. The case remains open and the agency is providing the family with On-going case management services.

B. Children residing in out-of-home care (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):

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 Medical Examiner determined that the child death was due to Sudden Infant Death Syndrome and not due to trauma and there was insufficient evidence to substantiate the maltreatment allegations of neglect. This concluded the Department's review.

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.