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: 131230DSP-Doug-397 **Agency:** Douglas County Department of Health and Human Services

Child Information (at time of incident)
Age: 1 month Gender: ☒Female ☐Male
Race or Ethnicity: Caucasian
Special Needs: None

Date of Incident: December 30, 2013

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

On December 30, 2013, the agency received a report regarding a 1-month-old infant pronounced deceased in the home of a family friend. Law enforcement and the Medical Examiner responded the same day to initiate an investigation into the infant's sudden, unexplained death. The mother left the infant in the family friend's care the prior evening. The family friend reported he fell asleep in bed after supper while the infant was asleep on his chest. He said he woke up to find the infant crying on the floor next to his bed. He believed she fell onto a carton of canned soda located on the floor next to his bed. The family friend stated he picked up the infant to comfort her and assess for any injuries. He heard a "clicking sound" and the infant's breathing sounded congested so he thought something might be wrong. The family friend said he asked his mother to check the infant, and after they fed the baby she seemed content. He said he sent a text message to the infant's mother telling her the infant fell and may need to go to the hospital. He wrapped the infant's ribs with gauze, then placed the infant next to him on the bed and went back to sleep. When he woke up the next morning around 9:45 am, he found the infant unresponsive and she was not breathing. The family friend reported he ran downstairs with the infant and his mother told him to call 911.

When interviewed by law enforcement and the agency, the mother indicated she trusted the family friend to care for the infant as he had cared for her older children in the past. She admitted to knowing the family friend co-slept with the infant prior to the infant's death but said she told him to stop once she learned this information.

The cause of the infant's death was initially deemed the result of accidental suffocation. Upon examining the infant, the Medical Examiner determined the infant sustained a skull fracture as well as fractured ribs, one of which showed healing to indicate the injury occurred prior to the infant's other rib fractures. The Medical Examiner's final report is not complete pending toxicology results. The mother stated she had no knowledge as to how the infant sustained the previous rib fracture. 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 agency found insufficient evidence to substantiate the allegation of neglect to the infant by the family friend. However, the Assessment determined a preponderance of the evidence existed to substantiate physical abuse to the infant by the family friend. The Medical Examiner determined the infant sustained a skull fracture as well as fractured ribs. The Medical Examiner's final report is not complete pending toxicology results. The agency deemed the infant's two half-siblings safe in the mother's care and the family was referred to community resources. The family relocated to another county and the agency 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):

At the time of the incident, the infant resided with her mother, her 2-year-old half-sister, and her 3-year-old half-brother.

The infant's father lived in a separate residence where the infant's other half-sister (age 2) and other half-brother (age 4) resided part-time during visitation.

☒ **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 November 27, 2013, the agency screened in a CPS report alleging unborn child abuse by the mother while pregnant with the infant. The report also stated the mother was not prepared to care for the infant and was homeless. An Initial Assessment by the agency was in process at the time of the infant's death. Prior to the incident, the last contact between the agency and family members occurred on December 18, 2013, when agency staff accompanied the infant, the mother and the infant's 2-year-old sister to a well-baby medical check for the infant.

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 December 14, 2009, the agency screened in a Services Report to offer the family referrals to services. Agency attempts to contact the family were unsuccessful, so community resource information was sent to the family and the case was closed.

On January 21, 2010, the agency screened in a CPS Report alleging physical abuse to the infant's half-brother (then 10-months-old) by the father. An Assessment was completed and the allegation of physical abuse was unsubstantiated.

On October 17, 2011, the agency screened in a CPS Report alleging physical abuse to the infant's half-sister (then 1-year-old) by an unknown maltreater. During the course of the agency's Assessment for this report, the agency screened in another report (see below).

On December 6, 2011, the agency screened in a CPS Report alleging physical abuse to the infant's half-brother (then 2-years-old) by the father. An Assessment was completed and physical abuse was unsubstantiated for this report as well as the previous report (see above).

On August 22, 2013, the agency screened in a CPS Report alleging neglect to the infant's half-brother (then 4-years-old) by the father. An Assessment was completed and the allegation was unsubstantiated.

On September 26, 2013, the agency screened out a CPS Report.

On September 27, 2013, the agency screened out a CPS Report.

On October 1, 2013, the agency screened out a CPS Report.

On November 27, 2013, the agency screened in a CPS Report alleging unborn child abuse by the mother while pregnant with the infant. The mother tested positive for THC at the time of the infant's birth. The report also stated the mother was not prepared to care for the infant and was homeless. An Initial Assessment was completed and the allegation of unborn child abuse was unsubstantiated. At the time of the infant's death, this Initial Assessment was in progress, and the agency was helping the family to access community services.

On January 17, 2014, the agency screened out a CPS Report.

On February 25, 2014, 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 agency found insufficient evidence to substantiate the allegation of neglect to the infant by the family friend providing care at the time of the infant's death. However, the Assessment determined a preponderance of the evidence existed to substantiate physical abuse to the infant by the same family friend. The Medical Examiner determined the infant sustained a skull fracture as well as fractured ribs. The Medical Examiner's final report is not complete pending toxicology results. The infant's two half-siblings were assessed as safe in the mother's care and the family was referred to community resources. The family relocated to another county and the agency closed the case. Following case closure, another county agency received a CPS Report which was screened out on January 17, 2014. A subsequent CPS Report was received by the agency which was screened out on February 25, 2014.

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):

FOR DSP COMPLETION ONLY:

Summary of policy or practice changes to address issues identified during the review of the incident:
Under 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 Department has determined no further review is needed. This completes the DSP actions related to this incident.

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

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