DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

90-Day Summary Report for Child Death, Serious Injury or Egregious Incident

Case Tracking Number: 100206DSP-PN-1

Child Information: Age: 5 Gender: ☐ Female ☒ Male Race: Caucasian
Special needs: None

Description of the child's family:
At the time of the report and throughout the investigation, the child was living with his mother and two siblings. The parents are divorced but are considering remarrying. The children's father does not live with the family.

Child's Residence: ☒ In-home ☐ Out-of-home care placement

Date of Incident: 2/6/10

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On February 6, 2010 a 911 call was placed from a hotel in Tomah, Wisconsin about a child that drowned in the hotel swimming pool. CPR was being administered by bystanders in the pool area. When law enforcement arrived on the scene, the child was breathing, crying and had vomited after being resuscitated. Parents and bystanders were questioned. The child was in the pool with both parents where he could stand with the water just below his shoulders. The parents watched the siblings go down the slide in the kiddie pool and a bystander noticed that the child was floating upsidedown. The parents were five feet from the child and removed him from the pool, and a bystander began to administer CPR. Reportedly, the parents were not watching the child for approximately 1-2 minutes.

Findings by agency, including material circumstances leading to incident:
On February 8, 2010 the Monroe County Dept. of Human Services received a report of alleged neglect of this child. The agency interviewed the family, hotel staff, reviewed medical reports and contacted law enforcement about its investigation. Law enforcement indicated that the parents' explanation of the circumstances was plausible and there would be no further police department involvement in this case. Two physician consultations were sought, and the agency received conflicting opinions from the doctors in regards to the length of time the child was underwater. A third consultation was sought with the University of Wisconsin Children's Hospital. This physician believed that the average five-year-old child would have 1-2 minutes of struggling underwater, and parents near the scene would have seen this. The doctor's opinion is that this was significant neglect, and the parents' explanation was not consistent with how the child was found. The agency substantiated neglect, lack of supervision, by both parents based on the medical opinion that the child was not observed for over two minutes.

Additional information for children in home:

☐ **Yes** ☒ **No** **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, 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 under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:
N/A

Summary of actions taken by the agency under ch. 48, including any investigation of a report or referrals to services:
N/A

Summary of any investigation conducted under ch. 48 or ch. 938 and any services provided to the family since the date of the incident:
The agency substantiated neglect by both parents in regards to the child's near drowning. The parents were very remorseful and it appears that this was an unintentional, first-time occurrence. It is likely that the parents left the child unattended longer than they indicated. A child in need of protection and services court order was not sought due to the isolated nature of this incident. The children were determined to be safe in their mother's care. The family was provided information

about community services and resources.

Additional information for children 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 actions taken by agency in response to the incident:**

The agency investigated the allegations and assessed the family as described above. The agency intends to continue its work with law enforcement to ensure that reporting of alleged maltreatment occurs on a timely basis and continue to educate law enforcement regarding child protective services investigative standards for different types of caregivers and assessments.

***Summary of policy or practice changes to address identified issues:**

A local multi-disciplinary team will continue to meet quarterly and will address the issue of immediate reporting of alleged maltreatment to child protective services.

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

None at this time.

Statement of Completion:

☒ Yes ☐ No This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

* If a full report including agency actions, changes in policies or practices and recommendations for further changes was not completed within 90 days, the DSP will complete and submit the final summary report within 6 months.