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: 110818DSP-Milw-191 **Agency:** Bureau of Milwaukee Child Welfare

Scope of DSP Review of Incident

☐ No Review. The information contained in this report was provided by the agency.
☒ 90-Day Review

Child Information (at time of incident)

Age: 8 months Gender: ☐ Female ☒ Male

Race or Ethnicity: African American

Special Needs: None

Date of Incident: 8/18/11

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

On April 4, 2012 the agency received a report regarding the baby's death in 2011. When the baby died on August 18, 2011, the suspected cause of death was an unsafe sleeping condition. Reportedly, the baby was sleeping, and his mother placed him in a reclining chair with pillows underneath to catch him. The mother checked on the baby around 6:00 a.m. and found him not breathing and face down in the recliner. The parents called 911, and a relative in the home attempted CPR, but the baby was deceased when the paramedics arrived. Toxicology reports received in April 2012 found that there was Oxycodone in the baby's last bottle, his blood and urine. The cause of death was determined a homicide due to acute drug intoxication. The parents deny having prescriptions for Oxycodone, which was confirmed. The mother's relative where the child resided had a prescription for Percocet, which contains Oxycodone. The criminal investigation is pending.

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

The agency substantiated neglect to the baby by an unknown maltreater. The day before the child died, the mother and child spent most of the day at home with several relatives visiting throughout the day. The baby's father came to the mother's home around 8:00 p.m., and the mother, father and baby walked to the father's home between 10-11:00 p.m. to spend the night there. Upon arrival at his father's residence, the baby was sleeping. The mother placed him into the recliner, where he often slept while at his father's home. Reportedly, the mother checked on him around 3:00 a.m. and described that he was in a "deep sleep" and "snoring." When she checked on him at 6:00 a.m., she found him face down in the recliner and not breathing. The individual who administered the drug has not been identified.

☒ 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):

The baby resided with his mother in the home of a relative. The relative is the Kinship Care caregiver for the mother, who was a teen/minor at the time of the baby's birth and death. The father resides with a relative at a different residence. The father has six other children, half-siblings of the baby, who do not reside with their father.

☐ **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.)

See following section

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.)

8/18/11 Services report is screened in to assist the family with grief and counseling following the death of the baby.

6/10/10 CPS Report alleging maltreatment of the mother (minor) is screened out.

5/20/04 CPS Report alleging maltreatment of the mother (minor) is screened in and unsubstantiated.

10/8/02 Report screened in for Kinship Care. The mother is placed with a relative, where she continues to reside after the birth of her child and until his death in 2011.

8/7/01 CPS alleging maltreatment of the mother and three other children by their foster parent. The maltreatment determination is not available in eWiSACWIS.

7/16/01 & 7/26/01 Two CPS Reports alleging maltreatment of the mother as a foster child in the foster home are screened out.

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 screened in the 4/4/12 report on the toxicology findings for the deceased infant who died in 2011. Neglect to the infant by an unknown maltreater was substantiated. The mother does not have any other children, and the father does not reside with his children. The agency provided information regarding community resources to assist the family, and the case was closed.

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:

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 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 initial assessment is not in compliance with the CPS Access and Initial Assessment Standards. The DSP worked with the agency on identified issues.

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 PaulaL.Brown@wisconsin.gov