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: 1109221	OSP-Walw-149 Agency:	Walworth County Dept. of Health & Human Services
Child Information: Age: 11-mo Race or Ethnic Special needs	city: African American	Gender: Female Male
Child's Residence: In-home	Out-of-home care placement	
Date of Incident: 9/22/11		
The children were found unresported by ambulance to the loof the twins in the bathtub with hit twin with her into the bedroom who roommate who found both twins in	asive in the bathtub by a roomn ocal hospital where they were p is older sibling. She ran some b here she sat down with the child in the bathtub. The mother exp	nate of their parents. CPR was attempted, and they were pronounced deceased. Reportedly, the mother had placed one bathwater into the tub, then turned it off. She took the other d. The mother fell asleep and awoke to the cries of the plained that she was exhausted and intended to lay down briefly, in two counts of Neglecting a Child - Consequence is Death.
two surviving children were deter described herself as extremely exl working these hours. The father of at work, an older sibling was at so the twins in the morning while an children baths but fell asleep shor home and found the twins in the f of the children's deaths, they foun	to all four children in the home mined unsafe in the care of the nausted. She also explained that of the twins and a roommate also shool and the roommate was away ther sibling watched televisionally after running a small amount illed bathtub with the water rund the condition of the home enveloped.	by their mother and the father of three of the children. The mother and father. The mother was working 3 rd shift and at the condition of the home deteriorated after she began so lived in the home. At the time of the incident, the father was vay. Reportedly, the mother fed and then briefly napped with in. After awaking from the nap, she intended to give two of the int of water into the bathtub. The roommate returned to the ming. When law enforcement and CPS responded to the report vironment unsafe for the children. The mother and father are andition of the home at the time of the incident.
Additional information for children	in home:	
the parents. Another half-si	ne twins resided with their preg	gnant mother, father, sibling, half-sibling and an adult friend of a separate residence and has regular visits with their father. 's deaths.
		. 48 or ch. 938 being provided to the child, family or alleged maltreater gency or reports being investigated at time of incident?
If "Yes", briefly describe the ty person(s) receiving those serv N/A		ontact between agency and recipient(s) of those services, and the
Summary of all involvement in previous five years: None	services as adults under ch. 48	or ch. 938 by child's parents or alleged maltreater in the
Summary of actions taken by the child, any member of the child seems or older: None	he agency under ch. 48, includir nild's family living in this housel	ng any investigation of a report or referrals to services involving hold and the child's parents and alleged maltreater at the age of

incident:

Summary of any investigation conducted under ch. 48 or ch. 938 and any services provided to the family since the date of the

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The agency substantiated neglect to all four children by the mother and father living in the home. The surviving children were determined unsafe in the care of these parents and placed with relatives. While assessing the family, the agency found the condition of the family's home to be unsafe for the children. Visits with the children by the twin's parents and the half-sibling's father are supervised at this time. The two older children and their parents have been referred to services. The mother gave birth to another child, which was taken into custody by the agency and placed with relatives. The family and relatives are receiving Ongoing Services case management from the agency.

Additional information for children in out-of-home	(OHC) placement at time of incident:
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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 screened in and investigated the report of the children's deaths, collaborating with law enforcement during the initial assessment. Neglect to all four children was substantiated, and the surviving siblings were determined unsafe. The siblings were taken into temporary physical custody and placed with relatives. Following the birth of another child, the agency took custody of the baby and placed it with relatives. The agency is working with the mother and fathers of the siblings to provide services and assure visitation, which is supervised. The children, parents and relatives have been referred to services. They continue to receive Ongoing Services from the agency.

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

None

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

None

\bowtie	Yes	No	This 90-day	summary re	oort complete	es the Division	of Safety	and Permanence	(DSP) review of this case.
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^{*} 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.