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: 111019DSP-Door-158 **Agency:** Door County Dept. of Social Services

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

Child Information: Age: 8 months Gender: ☒ Female ☐ Male
Race or Ethnicity: Hispanic
Special needs: None

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

Date of Incident: 10/19/11

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On October 19, 2011, the mother placed her 8-month-old daughter into a car seat that was strapped inside a running vehicle with the rear heat set on high. The mother returned to the house to get the diaper bag, laid down on a bed and went to sleep leaving the child in the vehicle for an unknown period of time. The child was discovered unresponsive in the vehicle around 5:00 p.m. and later pronounced deceased at the Door County Medical Center. The cause of death was environmental hypothermia. The mother was criminally charged with Homicide by Intoxicated Use of Vehicle and Neglecting a Child – Consequence is Death.

Findings by agency, including material circumstances leading to incident:
The agency substantiated neglect to the deceased child by her mother. Neglect to the child's sibling was unsubstantiated because she was at the home of relatives when the incident occurred. On October 10, 2011, the agency screened in and was investigating a report alleging that the mother was not appropriately supervising the children due to intoxication. The agency had an open case on the family and was investigating the report and assessing the family when the child died. The children's father lives at a separate residence and visited the children in their home the evening of October 18. The morning of October 19, a relative was at the family's home with the mother and children. The mother had an appointment at a day care center at 1:00 p.m., which she did not keep. After the relative was unable to reach the family in the afternoon, she contacted another relative who went to the home to check on the family. The mother and relative were unable to find the child and called 911. She was found unresponsive in the vehicle around 5:00 p.m.

Additional information for children in home:

Description of the child's family:
The child lived with her mother and sibling. The children's parents are married but separated. Their father lives at a different residence and had visits with the children.

☒ **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:
On October 10, 2011 the agency screened in a CPS Report alleging neglect of the children by the mother. The initial assessment was underway when the child died. Face-to-face contact with the mother and two children occurred on October 12 in their home.

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:
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 at the age of 18 years or older:
On October 10, 2011, a CPS Report was screened in alleging neglect of the two children by their mother. During the initial

assessment, the child died when left unattended in the vehicle. The October 10 allegations of neglect to the child and sibling were substantiated and the surviving sibling was determined unsafe in her mother's care. The allegations of neglect pertaining to the child's death are described later in this report in the section of the report that addresses the investigation of the incident.

On June 29, 2011, the agency screened in a request from the mother for child welfare services. The mother voluntarily contacted the agency to request assistance with her two infants. The agency opened the case and began working with the family.

On May 3, 2010, the agency screened in a CPS Report alleging neglect of the mother's infant (sibling of the deceased child). The allegation was unsubstantiated and the baby was determined safe in her mother's care. The family was referred to services, and the agency closed the case.

On February 17, 2007, the agency screened in a CPS Report alleging unborn child abuse. The agency began working with the then pregnant woman, but the pregnancy ended in miscarriage, and she moved out of state. The agency unsubstantiated maltreatment and closed the case.

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 to the deceased child by her mother. Neglect to the sibling was unsubstantiated, and the surviving child was determined unsafe in her mother's care. The sibling was placed with relatives during the assessment. The agency initially supervised both parents' contact with the sibling. The father moved to unsupervised visits, and the mother's visits remain supervised. The mother was incarcerated and conditionally released to participate in inpatient treatment. She transferred from treatment to a sober living facility to continue recovery and treatment. The case will remain open with the agency for Ongoing Services case management for at least six months, at which time it is anticipated the case will transfer to another county where the father resides.

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 screened in and investigated allegations of neglect. Neglect to the deceased child by her mother was substantiated. Neglect to the sibling was unsubstantiated, and the sibling was determined unsafe in her mother's care. The sibling was taken into custody and placed with relatives. The agency supervised visits between the parents and child, with the father moving to unsupervised visits. The case remains open, and the agency continues to assist the family with needed services. Agency staff collaborated with law enforcement during the initial assessment.

For DSP completion only:

Summary of policy or practice changes to address issues identified during review of the incident:

The DSP finds that the agency was not in compliance with the CPS Safety Intervention Standards. The DSP conducted an on-site review of this case and is working with the agency on issues identified during the review.

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

None

*This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

☒ Yes ☐ No ☐ Not Applicable

* If this case is undergoing a review that was not completed within 90 days, the DSP will complete and submit the final summary report within 6 months.