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: 111023DSP-EauCl-160 **Agency:** Eau Claire County Department of Human Services

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: 16 Days Gender: ☒ Female ☐ Male
Race or Ethnicity: Caucasian
Special Needs: None identified

Date of Incident: 10/23/11

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
The local police department responded to the death of a sixteen-day-old female child. The infant was reported to have significant bruising on the head and inside of her mouth. Reportedly, after tending to the baby after she awoke around 12:30 a.m., the father remembers taking her into the living room and "dozing off," falling asleep on the couch. Around 8:30 a.m., the father found the baby in her bouncer seat, purple but still warm. He called 911 and started CPR. Preliminary autopsy results found no evidence of trauma or maltreatment. The bruising was noted to be normal lividity occuring following death. Final results of the autopsy indicate the cause and manner of death of this infant are undetermined. The parents believe that the child's death was due to a medical or genetic cause rather than co-sleeping. No criminal charges were filed in connection with the baby's death.

Findings by agency, including maltreatment determination and material circumstances leading to incident:
Based on the information gathered on this case, there did not appear to be a preponderance of evidence to suggest that the child was a victim of physical abuse (unsubstantiated). The child's older sibling was determined safe in the care of the parents. The parents had taken the infant to the doctor several days earlier due to concerns about her eating, sleeping and possible jaundice. The doctor indicated she was healthy and within the normal range for a newborn. Reportedly, after a 10:00 p.m. feeding, the baby awoke around 12:30 a.m."screaming away" on October 23. The father picked her up and took her into the living room, falling asleep on the couch. He remembers "dozing off" during her feeding. The father does not recall sleeping with the infant on the couch and remembers placing her into her bouncer seat. The parents awoke atround 8:30 a.m. When her father checked on her, he found her in the bouncer seat, purple but still warm. The parents believe that the current infant's death was due to a medical or genetic cause rather than co-sleeping.

The parents had another child that died in 2010 due to accidental positional asphyxia, which occurred when the parent was co-sleeping with the infant. The parents believe that the current infant's death was due to a medical or genetic cause rather than co-sleeping. The infant was found to have congested lungs during the autopsy and no indication of trauma or maltreatment.

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 parents had their one-year-old daughter and newborn residing in their home. No other people were residing within the home.

☐ **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.)
The family was opened to the agency on 2/23/10 for an offer of service due to concerns of the parents being immature and not bonding with their children (twins). The agency responded to the referral by scheduling a meeting with the family which did not occur. The family then did not respond to other attempts for contact from the agency. Referral information for community services was provided to the family. On April 1, 2010, the agency was notified that one of the twins passed away, likely an accident due to her father rolling over on her while co-sleeping. The Child Welfare case was closed and a Initial Assessment was opened for both children on April 1, 2010. The older child was placed on a CHIPS Order and was in out of home care from 4/23/11 until 10/2/11. The family successfully completed services through the agency and cooperated with other community services. The CHIPS order for the older child was closed on 7/11/11.

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. (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 belief of maltreatment or threatened are not required to be screened in for an initial assessment, and no further action is required by the agency.)
02.23.10 - Services report while twins @ hospital screened-in for offer of services.
04.01.10 - Unsubstantiated I.A. - father accidentally rolled over on one of the infants @ age six weeks. Child deceased.
07.08.10 - CPS Report - screened-out - Information shared with Ongoing CPS Worker
10.15.10 - CPS Report - screened out - Information shared with Ongoing CPS Worker.
11.22.10 - CPS Report - screened out - Information shared with Onoing CPS Worker
01.12.11 - CPS Report - screened out - shared with Ongoing CPS Worker
Family was open for CHIPS Jurisdiction until 7/11/11. The child was deemed safe and the family was working with the local Dept. of Public Health.

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:
Based on the information gathered on this case, there did not appear to be a preponderance of evidence to suggest that the deceased child was a victim of physical abuse. There was not evidence after further interviewing and autopsy testing to suggest there was trauma or maltreatment to the child.
Following the death of this infant, the parents participated in supervised visitation with their older child. Program staff indicated no concerns over child safety during all interactions. Program staff noted the parents seemed extremely attached to the child and made adequate provisions for her care. The family successfully completed the program in January of 2012. This successful completion, along with the preliminary autospy information led to the parents and child reunifying on 2/9/12. The family has continued to work with nursing services through the Eau Claire County Health Department and counseling services through their Pastor.
No new incidents have been reported to the Agency regarding the family.

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
☒ Attempted or successful reunification

- ☒ 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
- ☒ 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:
N/A

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

☐ 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