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: 130704DSP-Milw-340 **Agency:** Bureau of Milwaukee Child Welfare

Child Information (at time of incident)
Age: 4 months Gender: ☐Female ☒Male
Race or Ethnicity: Caucasian
Special Needs: None known

Date of Incident: July 4, 2013

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

On July 4, 2013, the agency received a report regarding the unexpected death of a four-month-old infant at home from possible neglect. The father reported he put the infant on the couch and sat at the other end of the large couch. The father stated when he woke up, the infant's head was buried in the couch cushions and he wasn't breathing. The parents called 911, but the paramedics were unable to revive the infant and he was pronounced deceased. Law enforcement initiated an investigation into the circumstances surrounding the infant's death. There were no underlying medical conditions or indications of physical trauma found to the child. The medical examiner determined the infant's death was due to accidental asphyxiation. No criminal charges were filed as a result of law enforcement's investigation.

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

The agency collaborated with law enforcement and medical professionals to complete the assessment. The Initial Assessment completed by the child welfare agency found insufficient evidence to substantiate the allegation of neglect to the infant. The information gathered did not find the father was under the influence of any illegal drugs or alcohol at the time of the incident. The mother returned home from work in the early morning hours of July 4, 2013. She woke the father to care for the infant and the infant's two-year-old sister so she could sleep. The father woke the mother when he discovered the infant was not breathing. The parents called 911 and paramedics responded, but the infant could not be revived. Law enforcement's investigation determined the father's account of events was consistent with findings by the Medical Examiner's Office. The Medical Examiner concluded physical indicators found to the deceased infant were consistent with accidental asphyxiation as the manner and cause of the infant's death.

☒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):

At the time of the incident, the infant lived with the mother, the father and the infant's two-year-old sister.

☐ **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.)

On March 22, 2011, the agency screened in a report alleging neglect to the deceased infant's one-year-old (now 2-year-old) sister by the parents. The agency completed an assessment and determined the infant's older sister safe. The allegation of neglect to the older sister by the parents was unsubstantiated. The family was referred to community resources and the

agency closed the case.

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.)

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On March 27, 2011, and March 29, 2011, the agency screened out two reports.

On July 8, 2012, the agency screened out a report.

On February 19, 2013, the agency screened in a report alleging neglect to the infant (now deceased) by the parents. The agency completed an assessment, which determined the infant and the infant's older sister safe, and unsubstantiated the allegation of neglect.

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 and assessed the allegation of neglect to the infant related to the infant's unexpected death. The agency completed an assessment in collaboration with law enforcement and medical personnel. The Initial Assessment completed by the child welfare agency found insufficient evidence to substantiate the allegation of neglect to the infant. The information gathered did not find the father was under the influence of any illegal drugs or alcohol at the time of the incident. There were no underlying medical conditions or indications of physical trauma found to the child. The medical examiner determined the infant's death was due to accidental asphyxiation. The agency determined the infant's surviving sibling safe. The family was provided referrals to grief counseling and other community resources.

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
- ☐ 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 DSP did not identify practice issues during the review of the incident.

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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: RobertB.Williams@wisconsin.gov