201 East Washington Avenue , Room G200
P.O. Box 8916
Madison, WI 53708-8916
Telephone: 608-422-7000
Fax: 608-422-7161

Governor Tony Evers
Secretary Emilie Amundson

Secretary's Office

February 22, 2019

Jeffrey Renk
Senate Chief Clerk
State Capitol, B20 SE
P.O. Box 7882
Madison, WI 53707

Patrick Fuller
Assembly Chief Clerk
Risser Justice Center
17 West Main Street, Suite 401
Madison, WI 53703

Dear Mr. Renk and Mr. Fuller:

In compliance with the 2009 Wisconsin Act 78, the Child Welfare Public Disclosure Act, please accept the attached summary report prepared by the Department of Children and Families on February 22, 2019.

In accordance with Wisconsin Statutes section 48.981(7) (er) 3.b., the Department is required to "transmit to... the appropriate standing committees of the legislature under s 13.172(3)" summary reports prepared by the Department concerning incidents of death or serious injury to a child that results from suspected abuse or neglect or incidents of egregious abuse or neglect of a child. The summary reports are also made available to the public on the Department's public website.

Danielle Melfi
Assistant Secretary

cc: Governor Tony Evers

Attachments

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: 181119-DSP-TREMP-880 **Agency:** Trempealeau County Department of Human Services

Child Information (at time of incident)
Age: 5 months Gender: ☒ Female ☐ Male
Race or Ethnicity: White/Caucasian
Special Needs: None

Date of Incident: 11/19/2018

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On November 19, 2018, the agency received a report regarding an infant brought to the hospital unresponsive and subsequently pronounced deceased. Law enforcement was contacted and initiated a criminal investigation. The Medical Examiner's Office determined the death was due to accidental asphyxiation. No criminal charges were filed and the case was closed.

Findings by agency, including maltreatment determination and material circumstances leading to incident:
The agency collaborated with law enforcement and medical personnel to complete the assessment. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect to the infant by the child care provider. The Medical Examiner's Office determined the death was due to accidental asphyxiation. At the time of the incident, the infant was residing in a licensed foster home and was in the care of a child care provider. The agency determined the infant's biological sibling and foster siblings to be safe in the care of the infant's foster parents and the children remained in that home. The case remained open for continued ongoing case management services for the infant's sibling.

☒ 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):
N/A

☒ **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.)
N/A

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.)
N/A

Summary of any investigation involving the child, any member of the child's family and alleged maltreater conducted under ch. 48 and any services provided to the child and child's family since the date of the incident:
N/A

B. Children residing in out-of-home care (OHC) placement at time of incident:

Description of the OHC placement and basis for decision to place child there:
At the time of the incident, the infant was residing in a licensed foster home. The infant was originally placed in out-of-home care on June 7, 2018, after she was taken into Temporary Physical Custody due to physical abuse by her mother.

Description of all other persons residing in the OHC placement home:
At the time of the incident, the infant resided with her foster mother, foster father, 6-year-old sister, 8-year-old foster sibling, and 5-year-old foster sibling.

Licensing history: Including type of license, duration of license, summary of any violations by licensee or an employee of licensee or other actions that constitute a substantial failure to protect and promote the welfare of the child.
The foster parents have been licensed as a Level 2 foster home since May 23, 2018. There is no history of licensing violations by the foster parents that would constitute a substantial failure to protect and promote the welfare of a 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 IF RECORD OR ON-SITE REVIEW WAS UNDERTAKEN:

Summary of policy or practice changes to address issues identified based on the record or on-site 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 will conduct a further review in this case.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues based on the record or on-site review:
None at this time.

☐ Yes ☒ No ☐ Not Applicable This 90-day summary report completes the Division of Safety and Permanence (DSP) action on 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.