

6-Month Final 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: 130107DSP-Brown-281 **Agency:** Brown County Human Services Department

Child Information (at time of incident)

Age: 2 Years Gender: Female Male

Race or Ethnicity: American Indian and Hispanic

Special Needs: None

Date of Incident: January 7, 2013

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

On January 8, 2013, the agency received a report regarding the death of a two-year-old child, which occurred the previous evening. The child was brought to the hospital on January 7, 2013 by the mother's boyfriend. The mother's boyfriend was watching the child and the child's 3-year-old sister while the mother was at work. The mother left for work at approximately 5:00 p.m. on January 7, 2013. The mother's boyfriend took the child to the hospital at approximately 7:30 p.m. and indicated to hospital staff he noticed the child was ill. Medical personnel observed the child had a cut on his chin, old bruising the mother reported was from falling on a toy, lower abdominal bruising, which appeared fresh, and a protruding bowel. The child died between 9:30 p.m. -10:00 p.m. Law enforcement was contacted to investigate the cause of the child's injuries. An autopsy determined the child sustained bruising on several parts of his body (arms, legs, abdomen, head, back and face) in different stages of healing, as well as a subdural hematoma between his skull and brain, and bleeding in his brain tissue; he was missing two teeth, which appeared to have been lost during a traumatic event; and, his bowel was perforated which appeared, upon preliminary findings, to be caused by a non-accidental blunt force trauma to his abdomen, resulting in disrupted blood flow to the bowels, causing the bowels to die. Preliminary autopsy findings determined that the child died from multiple injuries and was ruled a homicide.

The mother's boyfriend was criminally charged with one count of 1st Degree Reckless Homicide, one count of Neglecting a Child (Consequence is Death), one count of Neglecting a Child, and two counts of Child Abuse-Recklessly Cause Harm. The mother's boyfriend was found guilty of one count of 2nd Degree Reckless Homicide and two counts of Child Abuse-Recklessly Cause Harm.

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. Physical abuse to the child was substantiated by an unknown maltreater. In addition, neglect to the child and his three-year-old sister by the mother was substantiated. Per the Medical Examiner's report, the child died as a result of infection from a perforated bowel, which was caused by multiple blunt force traumas. During the course of the assessment, the agency determined the mother left her young children home alone on numerous occasions. In the days prior to the child's death, the mother was aware he was vomiting, which was green in color, and he was lethargic. The mother did not seek medical care for the child despite advice received to the contrary. The three-year-old child was determined unsafe and placed in the home of relatives. The agency filed a Child in Need of Protection or Services petition and the family continues to receive ongoing case management services.

Yes No Criminal investigation pending or completed?

Yes No Criminal charges filed? If yes, against whom? The mother's boyfriend.

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 child resided with his mother and his three-year-old sister. The mother's boyfriend did not live in the home, but provided childcare in the home. The children's biological father lives out of state, having little contact with the children prior to the child's death.

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.)

On June 6, 2011, the agency screened-out a CPS report alleging neglect to the now three-year-old child.

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 collaborated with law enforcement and medical personnel to complete the assessment. Physical abuse to the child by an unknown maltreater was substantiated. Neglect to the child and the three-year-old sister by the mother was also substantiated. The three-year-old child was determined unsafe and placed in the home of relatives. The agency filed a Child in Need of Protection or Services petition and the family continues to receive ongoing case management services.

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.)

- | | |
|--|--|
| <input checked="" type="checkbox"/> Screening of Access report | <input type="checkbox"/> Attempted or successful reunification |
| <input type="checkbox"/> Protective plan implemented | <input checked="" type="checkbox"/> Referral to services |
| <input checked="" type="checkbox"/> Initial assessment conducted | <input type="checkbox"/> Transportation assistance |
| <input type="checkbox"/> Safety plan implemented | <input checked="" type="checkbox"/> Collaboration with law enforcement |
| <input checked="" type="checkbox"/> Temporary physical custody of child | <input checked="" type="checkbox"/> Collaboration with medical professionals |
| <input checked="" type="checkbox"/> Petitioned for court order / CHIPS (child in need of protection or services) | <input checked="" type="checkbox"/> Supervised visitation |
| <input checked="" type="checkbox"/> Placement into foster home | <input checked="" type="checkbox"/> Case remains open for services |
| <input checked="" type="checkbox"/> Placement with relatives | <input type="checkbox"/> Case closed by agency |
| <input checked="" type="checkbox"/> Ongoing Services case management | <input type="checkbox"/> Initiated efforts to address or enhance community collaboration on CA/N cases |
| | <input type="checkbox"/> 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. In accordance with the DCF memo Series 2010-13, dated December 7, 2010 pertaining to the Child Welfare Case Review Protocol, the DSP completed an on-site review in case # 130107DSP-Brown-281. The review found agency practice in Access was compliant with standards. Agency practice in Initial Assessment and safety determinations were not in accordance with the Wisconsin Child Protective Services Access and Initial Assessment Standards and Safety Intervention Standards.

The Quality Improvement plan implemented by the agency included restructuring the unit responsible for Child Protective Services, community outreach, staff and supervisory training, internal policy improvement and participation in initiatives

focused on improving child welfare. The agency reorganized and increased staff responsible for CPS work. The agency created an emergency line to receive Access reports and communicated with Mandated Reporters in an attempt to make improvements around reporting and receipt of reports. Staff completed all the necessary trainings related to Access, Initial Assessment and Safety. All supervisory staff participated in the Supervising Safety training provided by the state. The agency reviewed and improved internal policy and procedures related to CPS. Additionally, the agency participates in various initiatives aimed at improving practice related to child welfare.

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

None

Yes No Not Applicable This 6-month summary report completes the Division of Safety and Permanence (DSP) review of this case.