DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

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: 130115DSP-LaCr-288 **Agency:** La Crosse County Human Services Department

Child Information (at time of incident)
Age: 3 Years Gender: ☒ Female ☐ Male

Race or Ethnicity: Caucasian

Special Needs: None

Date of Incident: January 15, 2013

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On January 17, 2013, the agency received a report regarding a three-year-old child, admitted to the hospital two days prior. The child, seen by a physician on 1/15/13 because of concerns of weight loss, hair loss, and lethargy, was examined and admitted to the hospital for further evaluation. Upon admission, a skeletal survey was completed, which revealed five fractures in the child's left hand and two in the right hand. Medical personnel also discovered fractures in both feet, as well as a broken toe. The child's preliminary lab work showed signs of Celiac Disease and Diabetes Insipidus, which the treating physician felt could explain the weight loss, hair loss and lethargy. Medical professionals determined these conditions did not cause the fractures and alleged non-accidental trauma as the cause. Law enforcement was contacted to investigate the cause of the child's injuries. The child's father and the father's girlfriend denied causing harm to the child. Since the initial hospitalization, the child received a biopsy which ruled out Celiac Disease. Medical records indicate the child was in the 85th percentile for weight in June 2012 and, by January 2013, the child was in the 6th percentile.

The father and the father's girlfriend were criminally charged with one count each of Causing Mental Harm to a Child and Neglecting a Child (Consequence is Bodily Harm). The father and the father's girlfriend were both found guilty of one count of Neglecting a Child (Consequence is Bodily 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. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of physical abuse and neglect to the child by the father and the father's girlfriend. Both caregivers denied any knowledge of how the injuries occurred or that they caused the injuries to the child; however, the agency and law enforcement determined the father and the father's girlfriend were the only individuals to care for the child. Medical personnel also determined physical abuse was the only plausible explanation for the child's injuries. Law enforcement and the agency obtained information from collateral sources; which revealed concerns regarding the treatment and care of this child. Extreme and harsh disciplinary measures were used by the caregivers and several sources referenced discipline involving the child's hands. The agency determined this child was targeted by the caregivers and not given the same treatment as other children in the home. The father's girlfriend was the primary person targeting this child; however, collateral sources revealed the father made no attempts to intervene or provide safety for his daughter. The child was held to a different set of standards and restricted from physical affection, love or even positive touch. The child was also determined to have unmet medical needs. The family was involved with the agency because of a serious and significant skull fracture to the child in 2011. The father and the father's girlfriend did not follow through with the child's medical care and were not keeping appointments with medical providers. The child was determined unsafe and placed in foster care. The girlfriend's two children were also determined unsafe and placed in the home of a relative. The family's case remains open for court-ordered ongoing case management services with the agency.

☒ Yes ☐ No Criminal investigation pending or completed?
☒ Yes ☐ No Criminal charges filed? If yes, against whom? The father and the father's girlfriend.

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 her father, her father's girlfriend, a six-month-old half-sister, the girlfriend's three-year-old son, the girlfriend's mother, the girlfriend's nine-year-old brother, and the girlfriend's mother's boyfriend. The child did not have regular contact with her biological mother at the time of the incident.

☒ **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:

The family's case was open with the agency for ongoing case management services at the time of the incident. The case has been open with the agency since July of 2011. The last contact between the agency and the family was on January 8, 2013. On that date, the caregivers were directed by the agency to have the child seen by a medical professional. Agency practice is to make contact with the family, at a minimum, once per month and more frequently if necessary.

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 agency filed a Child in Need of Protection or Services petition and opened the case for ongoing case management services in July 2011 after the child sustained a skull fracture; traumatic brain injury; bruising to her abdomen and behind her ear; and a torn frenulum. The agency substantiated neglect against the father's girlfriend and she was criminally charged with Neglecting a Child - Consequence is Great Bodily Harm; however, the charge was dismissed by the prosecutor. The child was determined unsafe and placed in the home of her biological mother. The child was subsequently placed in out-of-home-care from 1/19/12 until 6/18/12; at which time she was returned to the care of her father and the father's girlfriend. The case was open for ongoing case management services at the time of the current incident.

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.)

Several reports, received by numerous counties, were received regarding this family. Some reports involved the child and some involved children from another relationship who live with the biological mother. They are as follows:

On 12/7/10, Vernon County screened in a CPS Report. Neglect was unsubstantiated and the agency closed the case.

On 2/18/11, Monroe County screened out a CPS Report.

On 3/14/11, Vernon County screened in a Services Report. The mother was referred to community services.

On 4/18/11, La Crosse County screened out a CPS Report.

On 6/3/11, Monroe County screened out CPS Report.

On 7/13/11, La Crosse County screened in a CPS Report (previous serious incident in the father's household). Neglect was substantiated and the case was opened for ongoing case management services.

On 7/15/11, La Crosse County screened out a CPS Report.

On 11/19/11, La Crosse County screened out a CPS Report.

On 2/10/12, Trempealeau County screened out a CPS Report.

On 2/14/12, Trempealeau County screened out a CPS Report.

On 12/28/12, La Crosse County screened out a CPS Report. The agency sent the information to the ongoing services worker to address the concerns.

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. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of physical abuse and neglect to the child by the father and the father's girlfriend. The agency determined the child and two other children in the home were unsafe and placed in out-of-home care. The family's case remains open for court-ordered, ongoing case management services with the agency.

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. 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 and records review in case #130115DSP-LaCr-288.

The review found: Child Protective Services (CPS) Reports from November of 2011 and December of 2012 were screened out in error. Agency practice in Access related to response time and safety determinations were not in accordance with Wisconsin Child Protective Services Access and Initial Assessment Standards and Safety Intervention Standards.

Agency practice in Ongoing Services related to safety assessments and determinations were not in accordance with Safety Intervention Standards.

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

The DSP is working with the agency to address the practice issues identified during the review. Actions will consist of training and technical assistance for the CPS supervisors and staff.

☒ Yes ☐ No ☐ Not Applicable This 6-Month Final 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.