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: 130728DSP-Fore-426 **Agency:** Forest County Department of Social Services

Child Information (at time of incident)
Age: 9 months Gender: ☐ Female ☒ Male
Race or Ethnicity: American Indian/Alaskan Native, native American
Special Needs: None

Date of Incident: July 28, 2013

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On July 28, 2013, the agency received a report regarding a nine-month-old infant brought to the emergency room to be examined for injuries. Law enforcement responded earlier the same day to a disturbance at the family's residence. The mother was highly intoxicated and allegedly "barricaded" herself and the infant in the bedroom. Prior to law enforcement's arrival, the mother reportedly dropped the infant into the crib causing him to bump his head. The mother then picked up the infant, lost her balance, and fell into a dresser. A relative standing nearby was able to catch the infant so he did not fall to the floor. The mother was observed pushing down on the infant and she refused to allow the relative to check on the baby. Law enforcement escorted the mother out of the home and local rescue personnel were called to check the infant for injuries. The infant was transported to a larger hospital and was admitted for further evaluation and treatment. Medical professionals assessed the infant and determined he sustained two skull fractures during the reported incident.

As a result of law enforcement's investigation, the mother was arrested and criminally charged with Child Abuse-Recklessly Cause Great Harm and Neglecting a Child (Consequence is Great Bodily Harm). A criminal charge is merely an allegation and a defendant is presumed innocent until and unless proven guilty.

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 the maltreatment of physical abuse to the infant by the mother. Medical professionals determined the child sustained two skull fractures as a result of non-accidental trauma. The agency determined the infant unsafe and placed him with his father upon release from the hospital. A Child in Need of Protection or Services petition was filed on the infant and the infant's older brother and the case remained open to provide ongoing case management services.

☒ Yes ☐ No Criminal investigation pending or completed?
☒ Yes ☐ No Criminal charges filed? If yes, against whom? The mother.

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 was residing with the mother. The infant's older half-sister, now two years old, was residing with a relative caregiver who is her legal guardian. The infant's older brother, now four years old, was placed with his father and had visitation with the mother every other week.

☒ **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 agency was providing ongoing case management services to the family when the incident occurred. The ongoing case resulted from a Child in Need of Protection or Services order due to substantiated neglect to the infant's older sister by the mother in December 2012. At the time of the current incident, legal guardianship of the older sister had just been transferred to a relative. Prior to the incident, the agency's last contact with the family occurred on July 8, 2013 at the transfer of legal guardianship hearing involving the infant's older sister and the sister's relative caregiver.

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 November 16, 2011, the agency screened in a CPS Report alleging medical neglect to the infant's older sister by the mother. An assessment was completed, and the allegation of neglect was unsubstantiated. The family was referred to community resources and the case remained open with the agency for voluntary ongoing services. The family received ongoing services from December 5, 2011 to December 29, 2011, at which time the case was closed and the family continued to receive services in the community.

On December 27, 2012, the agency screened in a CPS Report alleging neglect to the infant's older sister by the mother. An assessment was completed and the allegation of neglect was substantiated. The infant's older sister was determined unsafe and placed in out-of-home care with a relative. A petition was filed alleging the older sister was a Child in Need of Protection or Services. The case remained open for ongoing case management services. The relative caregiver for the older sister was eventually awarded legal guardianship of the sister.

While the case was still open with the agency for ongoing services, Vilas County Social Services Department screened in a CPS Report on June 14, 2013, which alleged neglect to the infant and the infant's older brother by the mother. Vilas County collaborated with the agency to complete an Assessment and the allegations of neglect were substantiated. The infant and the infant's older brother were determined safe in the care of the mother while the case remained open with the agency for ongoing services.

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 September 27, 2011, the agency screened out a Services Report.

On November 8, 2011, the agency screened out a CPS Report.

On November 16, 2011, the agency screened in a CPS Report alleging neglect to the infant's older sister by the mother. An assessment was completed, and the allegation of neglect was unsubstantiated. The family was referred to community resources and the case remained open a short time for voluntary ongoing services.

On January 5, 2012, the agency screened in a CPS Report alleging medical neglect to the infant's older sister by the mother and the older sister's father. An assessment was completed and the allegation of neglect was unsubstantiated. The agency determined the infant's older sister was safe in the home and was receiving all necessary medical care. The family continued to receive services in the community, so the agency closed the case.

On December 27, 2012, the agency screened in a CPS Report alleging neglect to the infant's older sister by the mother. An assessment was completed and the allegation of neglect was substantiated. The infant's older sister was determined unsafe and placed in out-of-home care with a relative. A petition was filed alleging the older sister was a Child in Need of Protection or Services. The case remained open for ongoing case management services.

On June 14, 2013, Vilas County Social Services Department screened in a CPS Report alleging neglect to the infant and the infant's older brother by the mother. Vilas County collaborated with the agency to complete an Assessment and the allegations of neglect were substantiated. The infant and the infant's older brother were determined safe in the care of the mother while the case remained open with the agency for ongoing services.

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:

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 to the infant by the mother. Medical professionals diagnosed the infant with two skull fractures resulting from non-accidental trauma. The agency determined the infant unsafe and placed him with his father upon release from the hospital. A Child in Need of Protection or Services petition was filed on the infant and his older brother, and the case remained open to provide ongoing case management services.

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:
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 or other actions that constitute 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 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. In accordance with the DCF memo Series 2010-13, dated December 7, 2010 pertaining to the Child Welfare Case Review Protocol, the DSP completed a records review in case # 131018DSP-Fore-426.

The review found agency practice in Access was compliant with screening standards, safety determinations and response time. The report was correctly screened-in for an assessment. Safety determinations and response time were made according to Standards. The agency practice in Access was not compliant with screening timeframes, information gathering and notifications required per Standards. The Access report was not screened within the required timeframes and did not meet the information gathering requirements per Standards. The required notifications were not made in relation to the Access report per Standards.

The review found agency practice in Initial Assessment was compliant with documentation and contact timeframes per Standards. The assessment was documented and approved within the required timeframes and the contact was made timely. Agency practice in Initial Assessment was not compliant with information gathering, contact requirements, safety determinations and notification requirements per Standards. The assessment contained insufficient information in multiple areas in order to meet Standards and make safety determinations. The required contacts and assessment of household members were not completed according to Standards. Multiple required notifications in relation to the Initial Assessment were not made according to Standards.

Agency practice in Ongoing Services was not compliant with standards in multiple areas. The case transition policy was not followed. Safety determinations were not in accordance with Standards. Case planning requirements were not followed according to Standards.

The agency has an improvement plan that requires training and technical assistance for both the supervisor and staff. The training is scheduled to occur in 2014 and 2015. The supervisor will attend Supervising Safety in Spring 2015 provided by the

state. The Supervisor and staff will attend Access, Initial Assessment, Safety Intervention, and Case Planning trainings provided by the child welfare training system. The DSP will provide technical assistance as requested by the agency in order to assist in improving practice in the areas identified.

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 6-month 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.