**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:** 130802DSP-Keno-350 **Agency:** Kenosha County Department of Human Services

**Child Information** (at time of incident)
Age: Six weeks Gender: ☐ Female ☒ Male
Race or Ethnicity: Caucasian, Hispanic/Latino
Special Needs: None Reported

**Date of Incident:** 08/02/2013

**Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:**
On August 2, 2013 the agency received a report regarding a six-week-old infant admitted to the hospital with a skull fracture. The mother stated the injury was the result of the infant scooting himself between the mattress and the headboard of an adult bed. The mother stated she caught the child before he fell off the bed, but instead hit his head on the headboard. Medical professionals stated the infant's injury was inconsistent with the mother's explanation of the incident. The infant was transferred to a larger hospital for evaluation and treatment of his injuries.

**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 county agency has insufficient evidence to substantiate the maltreatment of physical abuse by the mother. The infant and his five-year-old half-sister were placed in the home of a relative during the assessment period. The mother's explanation of the incident remained consistent throughout the assessment. Medical personnel had differing opinions regarding an infant's ability to scoot and were unable to conclusively state the injury was non-accidental. At the conclusion of the assessment, the infant and his half-sister were determined unsafe, however, returned to the home with an in-home safety plan and in-home safety services in place. The agency filed a Child in Need of Protection or Services petition and the case remains open for ongoing case management services and monitoring of the in-home safety plan. Law enforcement has concluded their investigation into the infant's death and no charges were filed.

☒ 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):
The infant lived with his mother and five-year-old half-sister. Both biological fathers of the two children had visitation with the children in the mother's home.

☐ **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 January 1, 2013 the agency screened in and assessed a report alleging neglect to a then four-year-old female and a then two-year-old male by the mother. The two-year-old male was deceased at the time the report was made. The Initial Assessment completed by the county agency has insufficient evidence to substantiate the maltreatment of neglect to both children. No criminal charges were filed against the mother. Grief services were offered by the agency to both biological parents, but were denied.

**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 physical abuse to the infant. The Initial Assessment completed by the county agency has insufficient evidence to substantiate the maltreatment of physical abuse by the mother. The infant and his five-year-old half-sister were placed in the home of a relative during the assessment period. At the conclusion of the assessment, the infant and his sibling were determined unsafe, but returned to the home with an in-home safety plan and in-home safety services in place. The agency filed a Child in Need of Protection or Services petition and the case remains open for ongoing case management and monitoring of the in-home safety plan.

**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 IF RECORD OR ON-SITE REVIEW WAS UNDERTAKEN:

**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 Department of Children and Families' (DCF) Division of Safety and Permanence (DSP) completes in an initial review the agency's practice for each case reported under the Act. A further practice review has been completed for case #130809DSP-Keno-350. As a result of this review process, the DSP determined the agency had implemented efforts to improve the consistency and quality of safety practices, including continued and updated training of CPS staff surrounding safe sleep practices.

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

Based on the agency's effort and response to this incident and DSP review, no further policy, practice, or statutory changes are recommended.

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