DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

90-Day Summary Report for Child Death, Serious Injury or Egregious Incident

Case Tracking Number: 110121DSP-Milw-75 **Agency:** Bureau of Milwaukee Child Welfare

Child Information: Age: 18 months Gender: ☒ Female ☐ Male
Race or Ethnicity: African American
Special needs: None

Child's Residence: ☒ In-home ☐ Out-of-home care placement

Date of Incident: 1/21/11

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On January 21, 2011 the child was taken to the hospital after her father reportedly found her unresponsive on the floor and called 911. The child was found to have a massive injury to the brain. She was diagnosed with subdural hemorrhage, abdominal trauma including multiple liver lacerations, and bruising on her abdomen, back, and thigh. On January 24, 2011 the child was found to have no brain activity and was pronounced dead. Initially, the father explained that he left the child sleeping on the bed while he showered. He stated when he returned to the room, he found her on the floor, which he later changed to finding her between the wall and mattress. He later admitted to shaking the child so hard that her head went backwards striking her buttocks, lifting her by one arm, striking her on the head with his hand and knocking her to the floor where she hit her head. The father has been arrested and charged with 1st Degree Reckless Homicide. A criminal charge is an allegation, and the defendant is presumed innocent until and unless proven guilty.

Findings by agency, including material circumstances leading to incident:
The agency substantiated physical abuse to the child by her father. The child was in the care of her father, who had been providing weekday care for her approximately 3 times each week per his request since October 2010. He admitted to inflicting the injuries described above because she wouldn't sleep and was running around the house, which upset him. The child's mother noticed that when the child returned from visits with her father, she would have some bumps and bruises, but she did not suspect he was hurting the child. A relative of the mother began taking pictures of the child's injuries following these visits, because she believed the injuries were too frequent and the explanations did not make sense. None of these injuries were reported to child protective services.

Additional information for children in home:

Description of the child's family:
The child lived with her mother, two half siblings and other related adults and children in a relative's home. The child's father cared for the child during the week since October 2010 when paternity was established. The child also had a half-sibling that lived at a different residence with her mother, a former girlfriend of her father. This half-sibling by the father also spent time at the father's house.

☐ **Yes** ☒ **No** **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, 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:
None

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 at the age of 18 years or older:
None

Summary of any investigation conducted under ch. 48 or ch. 938 and any services provided to the family since the date of the

incident:

The agency screened in and investigated the 1/21/11 report of maltreatment, substantiating physical abuse to the deceased child by her father. Later on the same day, the agency screened in another report of possible maltreatment to the half sibling living in a different household. Maltreatment to this half-sibling was unsubstantiated, and the child was determined safe in the care of her mother. The family where the child resided with her mother was provided with information about community resources, including grief counseling for adults, relatives and children. Both of these cases were closed following the initial assessments.

Additional information for children in out-of-home (OHC) placement at time of incident:

Description of the OHC placement and basis for decision to place child there:

Description of all other persons residing in the OHC placement home:

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.

*** Summary of actions taken by agency in response to the incident:**

The agency screened in and investigated two reports on this incident. The agency substantiated physical abuse to the deceased child by her father. The agency unsubstantiated maltreatment to a child of the father who resided in a different household, determining that the half-sibling was safe in her mother's care. The agency offered services to the mother's family. Both cases were closed following the initial assessments.

***Summary of policy or practice changes to address identified issues:**

The initial assessment on the mother's household is not in compliance with the CPS Access and Initial Assessment Standards. The DSP is working with the agency on the practice issues.

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

None

Statement of Completion:

☒ Yes ☐ No This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

* If a full report including agency actions, changes in policies or practices and recommendations for further changes was not completed within 90 days, the DSP will complete and submit the final summary report within 6 months.