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: 110925DSP-Milw-150 **Agency:** Bureau of Milwaukee Child Welfare

Child Information: Age: 11 months Gender: ☒ Female ☐ Male
Race or Ethnicity: African American
Special needs: Hyperthyroidism and Albright's Osteodystrophy

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

Date of Incident: 9/26/11

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
The child was taken by ambulance to the hospital where she was admitted with significant injuries. She had rib fractures in various stages of healing, subarachnoid and subdural hemorrhages, a pulmonary contusion, bite marks, and significant bruising to her face, arms, chest and abdominal region. The mother reported that she left the infant in the father's care while she went to the home of one of his relatives. When she returned 3 hours later, the infant was lying on the floor unresponsive. The father was standing in the room and appeared to have blood on his neck. The parents attempted CPR and contacted 911. The infant was briefly revived but determined "non-salvageable," and the decision was made not to escalate her care. She was pronounced dead. The cause of death was multiple blunt force injuries. The father denied injuring the child while she was in his care, offering different explanations as to the events of the evening. He has been criminally charged with 1st Degree Intentional Homicide.

Findings by agency, including material circumstances leading to incident:
The agency substantiated physical abuse to the child by her father. Safety was not assessed because there were no other children in the home. The couple reported spending the day at the home of a relative of the father. Upon returning home, they forgot the child's diaper bag, and the mother returned for it. She spent a few hours with the relative and returned to find her daughter on the floor bruised and unresponsive. The father offered different explanations, including someone else entering the home while he was out of the room, and the child falling from the couch where she was laying with him. He admitted to biting and hitting her, reportedly to wake her up after finding her unconscious. The couple has a history of domestic violence, and the mother admitted that the father had been physically abusing the baby since she was 6 months old.

Additional information for children in home:

Description of the child's family:
The child lived with her mother and father.

☒ **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:
The family was receiving in-home services at the time of the incident. The service provider had face-to-face contact with the mother, father and child on 9/19/11.

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:
See following section.

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:
On 8/25/11, the agency screened in a report alleging medical neglect to the infant, which was assessed and unsubstantiated. The mother and child were referred to services. The case was opened for Ongoing Services.

On 11/29/10, the agency screened in a report alleging neglect to the infant, which was assessed and unsubstantiated. The mother and infant were referred to services. The case was closed when the family could not be located by the agency.

In 2006, the agency received two reports alleging neglect to the deceased child's half-sibling. Neglect was substantiated, and the child was removed from her mother's care. The family received Ongoing Services from the agency until the mother's parental rights were terminated in 2008, and the child was adopted.

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 substantiated physical abuse to the child by the father. The child was in the care of her father when the fatal injuries occurred. There were no other children in the home, and the agency closed the case at the end of the assessment.

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 the report of serious injuries, the resulted in the death of the child. Physical abuse to the child by the father was substantiated. The agency collaborated with law enforcement and medical professionals during the initial assessment. The case was closed due to there being no other children in the family or home.

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

See following section

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

The DSP conducted a full, on-site review of this case that was open at the time of the child's death. The OPQA is working with the agency on past practice issues identified in the review.

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.