DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

90-Day 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: 130320DSP-Dunn-303 **Agency:** Dunn County Department of Human Services

Child Information (at time of incident)
Age: 3 months Gender: ☐ Female ☒ Male
Race or Ethnicity: White/Hispanic
Special Needs: None

Date of Incident: March 20, 2013

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On March 20, 2013, the agency received a report alleging physical abuse to the infant by an unknown maltreater. The reporter stated the three-month-old infant was brought to a local medical clinic by his parents because he was not acting like himself. His right leg presented with bruising and swelling. X-ray results revealed a spiral fracture to his leg involving the tibia and fibula bones. He was undergoing further x-rays and evaluation at the time of the report. The reporter advised it is rare for a 3 month old to sustain this type of fracture.

The reporter contacted the agency later the same day with additional information. X-ray results indicated the infant sustained a fracture to the left clavicle (shoulder) and a healing fracture to his left femur (upper leg). The parents and child were located at another pediatric hospital to cast the baby's leg when the additional x-ray results arrived. The parents had no explanation for the infant's spiral fracture; but the mother did report their daughter, almost age two, is very rough with the baby. The older sister gets into the bouncy seat or excer-saucer with the infant, but the mother provided no specific incidents to explain the spiral fracture.

A medical evaluation and consultation was completed at the pediatric hospital by a child maltreatment pediatrician. The consulting pediatrician reported the infant sustained numerous fractures which included: an acute left clavicle fracture; classic metaphyseal fractures of the right distal femur, the right proximal tibia, the right proximal fibula, the right distal tibia, the right distal fibula, the left distal femur, the left proximal tibia, the left distal fibula, and the right proximal humerus (upper arm).

The pediatrician described the child's presentation as "clinically diagnostic of child abuse" and expressed that the child's ongoing safety must be a primary concern. The pediatrician further concluded that without intervention, the infant "should be considered at great risk for ongoing abuse with potentially fatal outcomes." Following this consultation, the infant was admitted to the pediatric trauma unit. The following day, the infant was sufficiently stable to be released.

Both parents denied causing the injuries to the infant or having knowledge as to how they occurred. The criminal investigation by law enforcement is pending with no criminal charges filed.

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 agency substantiated physical abuse to the infant by an unknown maltreater. The parents stated that the only person they observed be rough with the infant is his older sister, almost age two. The child maltreatment pediatrician advised it is not possible for a toddler to have caused the injuries to the infant. The physician said the injuries are considered to be "acute," occurring within the last seven to 10 days and not yet healing. According to the child maltreatment pediatrician, the type of fractures the infant sustained is strongly associated with physical abuse. Such fractures are caused when a baby is pulled or jerked very hard or if a baby is shaken and the extremities flop back and forth. In addition, the infant presented with bruising on both cheeks and on the backside of one thigh. The physician indicated that bruising is highly suspicious for physical abuse in an infant who is not yet "cruising" or moving while standing upright and holding onto furniture. Neither parent admitted to causing these injuries. Only the parents provided care for the infant during the time frame indicated through medical evaluation. A protective plan for the sibling was implemented by the agency on the date of the report, remaining in place until the infant was discharged from the hospital at which time the agency took the infant and his sister into temporary physical custody. The agency filed Child in Need of Protection or Services petition on the infant and his sister. The agency is providing ongoing case management

services.

☒ 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):

At the time of the incident, the infant resided with his mother, his father, and his two-year-old sister.

☐ **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.)

N/A

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 agency substantiated physical abuse to the infant by an unknown maltreater. A protective plan was implemented by the agency on the date of the report to arrange for the infant's older sister to stay with a relative while the child was in the hospital. This plan remained in place until the infant was discharged from the hospital two days later at which time the agency took the infant and his sister into temporary physical custody. The agency filed Child in Need of Protection or Services petitions in Juvenile court on both the infant and his sister. The infant has been referred to Birth to Three early intervention services. The parents have been referred for psychological evaluations and counseling. The parents are able to have regular contact with the infant and his sister that is supervised by relatives approved by the agency. The agency is providing ongoing case management services to the family.

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
☐ Attempted or successful reunification
☒ Referral to services
☐ Transportation assistance

- ☐ 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
- ☒ 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. The DSP found the initial assessment documentation included the required information but was not completed and approved within timeframes required by Wisconsin's Child Protective Services Access and Initial Assessment Standards. Consultation was provided by the DSP to support the agency's case practice and compliance with timeframes as required per Standards.

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

None

☒ Yes ☐ No ☐ Not Applicable This 90-day 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.

This 90-Day Summary Report was previously delayed. DSP did determine that releasing the summary report would jeopardize an ongoing criminal/civil investigation/proceeding, and delayed posting as provided under Wis. Stat. § 48.981(7)(cr)7.