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: 130624DSP-Craw-338 **Agency:** Crawford County Human Services Department

Child Information (at time of incident)
Age: 14 Gender: ☐ Female ☒ Male

Race or Ethnicity: Caucasian

Special Needs: Emotional, behavioral, and cognitive

Date of Incident: June 24, 2013

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On June 25, 2013 the agency received a report alleging physical abuse to a 14-year-old child while placed in a residential treatment facility. On June 24, the child was placed in a series of physical holds during which he was injured. He was not medically assessed after the hold. The child complained at various times throughout the day and evening of pain, numbness and weakness. Despite his complaints, no medical assessment was completed. The next morning the child told staff he could not move his legs and they were numb. The child was evaluated by medical staff and an ambulance was called.

The child was transported to a local emergency room where medical staff assessed the child's condition. The child was air-lifted to a larger hospital and admitted to pediatric intensive care. Medical evaluation of the child determined he sustained a serious injury. The child's attending physician informed this type of injury is caused by force such as whiplash or a wrestling "take-down" move. The physician advised the child's injuries are consistent with the physical hold/restraint used on the child by residential staff

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 allegations of physical abuse to the child by residential treatment staff were unsubstantiated. However, the agency found a preponderance of evidence to substantiate neglect to the child by four staff members. It was determined these staff members failed to provide adequate care for the child and did not seek necessary medical treatment in timely manner. Information gathered showed the child expressed multiple times having physical symptoms and he required assistance ambulating. The identified staff members believed the child refused to cooperate for behavioral rather than medical reasons. When staff noticed the child could not move his legs, an ambulance was not called immediately, which further delayed medical treatment for his injuries.

☒ 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):
N/A

☐ **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:

N/A

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:

The placement provides residential treatment for male and female children and adolescents. The child was placed there by another entity after prior placement settings were not successful.

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

The placement is licensed by the State of Wisconsin to accept children and adolescents under the following categories: Child in Need of Protection or Services, juvenile delinquency, developmental disabilities, emotional-behavioral disorders, short term, foster care respite, and transition from secure facilities.

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.

The placement is licensed as a residential care center for males and females from age 10 to 17, with a capacity of 105 residents. Their license has been in effect since August 1, 1977. The facility has a history of licensing violations, including one or more violations in each of the sixteen licensing visits in the past three years. On September 20, the Department of Children and Families revoked the Residential Care Center license issued to Wyalusing Academy for failing to protect and promote the health, safety, and welfare of children, youth, and young adults served. The revocation is effective October 21, 2013. In addition, Wyalusing may not accept any new placements as of September 20.

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): Contact with licensing authorities; Collaboration with placing entity.

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 did not identify practice issues during the review of the incident.

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.

The agency must submit an electronic copy of the completed 90-Day Summary Report to: RobertB.Williams@wisconsin.gov