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: 130227DSP-Milw-298 **Agency:** Bureau of Milwaukee Child Welfare

Child Information (at time of incident)
Age: 2 months Gender: ☒ Female ☐ Male
Race or Ethnicity: African American
Special Needs: None

Date of Incident: 2/27/13

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On 3/1/13, the agency received a report alleging physical abuse of a 2-month-old infant, on which multiple facial bruises were observed. The mother reported she did not know how the infant got the bruises. The mother stated she noticed the bruises on 2/27/13; however, she did not seek medical attention for the infant due to inclement weather. The infant was seen in the emergency room on 3/1/13 for a physical abuse exam, which included a CT scan and Skeletal Survey. Medical personnel found bruises to the infant's face, arm, back, and buttocks. Medical findings also confirmed the infant had healing fractures to her wrist, rib, and ankle. There were signs of possible additional fractures. Medical personnel determined these injuries were diagnostic of physical abuse to a reasonable degree of medical certainty. Law enforcement was contacted to investigate the cause of the injuries to the infant. The mother and father were determined to be the primary caregivers for the infant; however, several other individuals also provided care to the infant at various times. No criminal charges have been filed in this case.

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. Physical abuse and neglect to the infant by the mother and father was substantiated. Physical abuse by an unknown maltreater was also substantiated. The infant sustained multiple injuries which medical personnel determined were diagnostic of child physical abuse. Medical personnel also stated the infant's fractures were consistent with being squeezed, yanked, pulled and/or shaken. The mother and father were the primary caregivers to the infant; however, several other individuals provided care to the infant. The mother initially denied knowing how the infant received the injuries, but later provided multiple explanations for how the infant could have been injured; including dropping the infant and the mother falling with the infant on multiple occasions. The father also reported that he "smashed" the infant's arm into the wall as he fell with her in his arms. The mother and father both admitted they knew the infant was injured, but did not seek any medical attention. The infant was determined to be unsafe and was placed in out-of-home care. The agency filed a Child in Need of Protection or Services Petition.

☒ 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 resided with her mother, maternal grandmother, and cousins. The infant's father had frequent contact with the mother and infant. The mother has three other children who were removed from her care in October 2012 and were living in the home of a relative. The mother and infant had frequent contact with the three children.

☒ **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:
The agency became involved with the family in October 2012 after the mother's 11-month-old (now 1-year-old) child

received severe burns to her face by the mother's boyfriend. The mother's three children were determined to be unsafe and were placed in out-of-home care with a relative. The agency filed Child in Need of Protection or Services Petitions and opened the case for ongoing case management services. The infant was born in January 2013 and the agency continued to provide monitoring and services to the mother while the infant remained in her care. The case manager had contact with the mother and infant on 2/28/13. The case manager observed the bruising to the infant's face on 2/28/13, which prompted the infant to be taken for medical attention on 3/1/13.

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.)

The family has been receiving ongoing case management and foster care services since 10/17/12.

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 9/21/12, the agency screened in a report alleging physical abuse to the mother's 11-month-old child by the mother's boyfriend. Physical abuse by the mother's boyfriend was substantiated. The mother's three children were removed from the home and placed in the care of a relative.

On 2/25/13, the agency screened out a report alleging neglect to the mother's four children.

On 3/5/13, the agency screened in a report alleging physical abuse to the mother's four children. The maltreatment allegations involving the three children living in out-of-home care were unsubstantiated. The children continue to reside in out-of-home care and the case remains open for ongoing case management services.

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 allegations of physical abuse to the infant, as well as additional allegations of physical and sexual abuse involving the children living in out-of-home care. Physical abuse to the infant by the mother, father and an unknown maltreater was substantiated. Neglect to the infant by the mother and father was also substantiated. Allegations of physical and sexual abuse to the children living in out-of-home care were unsubstantiated. The infant was determined to be unsafe and was placed in out-of-home care. The agency filed a Child in Need of Protection or Services petition and the family continues to receive ongoing case management services.

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:

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 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 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.), DSP completes a 90-day review of the agency's practice in each case reported under the Act. In accordance with the DCF memo Series 2010-13, dated December 7, 2010 pertaining to the Child Welfare Case Review Protocol, the Bureau of Performance Management (BPM) completed an on-site review in case # 130227DSP-Milw-298. The review found: BMCW practice in Access was not in accordance with Access standards related to review and reporting of relevant CPS history for one of the two Access reports under review. Practice in Initial Assessment was not in accordance with standards in the areas of information gathering, collateral contacts, protective planning documentation and monitoring, timely completion of Initial Assessment, and lack of compliance with BMCW policies concerning locating fathers, case transfer, and timely data entry of placement changes into the eWiSACWIS system.

The Ongoing Services Agency practice was not in compliance with standards in the areas of timely completion of case/permanency plans, location and inclusion of non-custodial parents in the case/permanency planning process, determination of the need for professional evaluations in the assessment process, and Safety Planning to include development/monitoring/adjustment and documentation of safety plans.

BMCW revised its Quality Assurance Plan. A focus of the quality assurance plan is to ensure the timeliness and quality of information collection, analysis, and decision making from the point of access through initial assessment completion. This plan, its strategies, and the quality review results are discussed monthly at agency executive management meetings. The BMCW Quality Assurance Plan will be updated to incorporate a review of the referral to Fatherhood Advocacy Services, protective planning, case transfer and eWiSACWIS data entry to ensure compliance with standards and internal policies in these areas.

The Ongoing Services agency updated and continues to refine Quality Improvement Department monitoring in the areas of practice that were not in compliance with Standards, focusing on safety assessment and intervention and case planning. Additionally, efforts have been made in training staff and supervisors both within the organization and through the Milwaukee Child Welfare Training Partnership in the area of case planning and safety assessment and intervention. The agency Supervision Protocol was updated and the agency is in the process of developing an Integrated Case Plan content guide. The agency also developed a case manager desk reference guide that cues case managers to critical areas of practice related to case planning and safety assessment and intervention.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:
None

☒ Yes ☐ No ☐ Not Applicable This 6-month 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