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: 131203DSP-Waup-387 **Agency:** Waupaca County Department of Health and Human Services

Child Information (at time of incident)
Age: 2 years Gender: ☐ Female ☒ Male

Race or Ethnicity: White

Special Needs: None

Date of Incident: 12/03/2013

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:

On December 3, 2013, the agency received a report regarding a two year old child presented at a local hospital with unexplained injuries. Medical professionals examined the child and the child was transported via ambulance to a Children's Hospital to assess and diagnose the injuries. Medical professionals at the Children's Hospital diagnosed the child with subdural hemorrhages, massive brain injury, retinal hemorrhages, and bruising to the face diagnostic of inflicted injury. The child was pronounced deceased on December 9, 2013. Medical professionals diagnosed the injuries as indicative of abusive head trauma and fatal physical abuse.

Law Enforcement and the agency initiated an investigation and the mother of the child reported she did not know how the child was injured. The mother reported the child went to bed on December 2, 2013, at 10:00 p.m. and woke the next morning at 6:45 a.m. The child cuddled in a blanket while the other children in the home got ready for school. The mother stated the child ate breakfast and continued to cuddle on the couch while she took the other children to school. The mother stated she returned and made breakfast for herself and the father of the child. The mother reported the child sneezed during breakfast and there was blood in the mucus but the child was not actively bleeding. The mother stated she left for work leaving the child with his father in the residence. The mother stated she received a text message from the child's father stating the child was sick because he sounded congested. The mother stated she received a second text from the father that the child vomited and the father was going to put the child to bed. The mother stated she left work at 2:00 p.m. and arrived at the residence at 2:10 p.m. The mother stated she immediately checked on the child and found him sleeping in his bed. The mother reported lying down to sleep with the father when a noise was heard from the child. The mother reported the father went in to check on the child and the noises stopped. The mother reported a few minutes later she heard the same noises and went herself to check on the child and found the child clenching his fist, stiff, and would not wake up. The mother reported she called the child's physician who instructed the mother to take the child to the emergency room. The mother reported that medical professionals advised her, after a CT scan, that the child had bleeding on the brain. The child was transferred to a second hospital and arrived at 6:30 p.m. The mother stated the child was transferred a second time to the Children's Hospital and arrived at 11:30 p.m. The mother reported that the week before Thanksgiving, 2013, she returned to the residence from work and discovered the child had a bruised lip. The father of the child reported, to the mother, that the child tripped while going up the stairs with the father. The mother reported the father of the child was the only caregiver for the child when she was at work. The mother denied any physical abuse to any of the children in her home.

The father of the child refused to provide any details pertaining to the incident.

The Medical Examiner's completed report was concurrent with medical professional's diagnosis of head trauma and fatal physical abuse to the child. The father was arrested on a parole violation and remains incarcerated. The criminal investigation remains open. No further criminal charges have been filed.

Findings by agency, including maltreatment determination and material circumstances leading to incident:

The agency collaborated with medical personnel and law enforcement to complete the assessment. Based on the information gathered, the Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of physical abuse to the child by the father. Medical records and collateral contacts provide illustration that the injuries inflicted to the child were indicative of physical abuse and the timeline established by medical professionals and the mother provide evidence that the maltreatment was inflicted by the father. The other children in the home were assessed as safe and

the family was referred to community resources.

☒Yes ☐No Criminal investigation pending or completed?
☒Yes ☐No Criminal charges filed? If yes, against whom?

The child's father was criminally charged with 2nd Degree Reckless Homicide, a class D felony, Wisconsin Statutes 940.06(1). He was found guilty and sentenced to state prison for 15 years.

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:

At the time of the incident, the child resided with his biological mother, father, and his two step-siblings ages twelve and nine.

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):

☐ **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.)

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. (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 June 29, 2006, the agency screened-in a CPS Report and completed an Initial Assessment and unsubstantiated the allegations.

On June 24, 2013, the agency screened-out a CPS Report.

On June 24, 2013, the agency screened-in a Services Report to offer the family community 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 collaborated with medical personnel and law enforcement to complete the assessment. Based on the information gathered, the Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of physical abuse to the child by the father. Medical records and collateral contacts provide illustration that the injuries inflicted to the child were indicative of physical abuse and the timeline established by medical professionals and the mother provide evidence that the maltreatment was inflicted by the father. The other children in the home were assessed as safe and the family was referred to community resources.

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
- ☒ 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.), the Department of Children and Families' (DCF) Division of Safety and Permanence (DSP) completes in an initial review the agency's practice for each case reported under the Act. A further practice review has been completed for case #131203DSP-WAUP-387. As a result of this review process, the DSP determined to agency implemented action steps to improve the consistency and quality of safety assessment and decision-making practices.

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

Based on the agency's effort and response to this incident and DSP review, no further policy, practice, or statutory changes are recommended.

☒ Yes ☐ No ☐ Not Applicable This 6-Month final summary report completes the Division of Safety and Permanence (DSP) review of this case.