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: 110609DSP-Milw-117 **Agency:** Bureau of Milwaukee Child Welfare

Child Information: Age: 1 year Gender: ☒ Female ☐ Male
Race or Ethnicity: African American
Special needs: None

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

Date of Incident: 6/9/11

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On June 9, 2011, the child was found unresponsive in her home by the mother's boyfriend. A relative called for emergency services and began cardiopulmonary resuscitation. Efforts to revive the child were unsuccessful, and the child was pronounced deceased. The cause of death was ruled homicide, blunt force trauma to the abdomen. The child had multiple rib fractures, liver lacerations, lung contusions, bruises on her face, back, ribs, injuries to her mouth and healed scars on her jaw/cheek area and right foot. The mother's boyfriend was criminally charged with 1st Degree Reckless Homicide in the child's death. A criminal charge is an allegation, and the defendant is presumed innocent until or unless proven guilty.

Updated 11/28/11 – The boyfriend was found "not guilty" following a jury trial.

Findings by agency, including material circumstances leading to incident:
The agency substantiated physical abuse to the child by the mother's boyfriend, neglect to the child by her mother and neglect to the child and a sibling by the relative caregiver who provided out-of-home care to the children. The boyfriend had been criminally charged with injuring the child in February 2011, but was not convicted. Two no-contact orders were issued following the February incident; however, the mother allowed the boyfriend back into her home. She allowed him to care for her children in her absence, withholding this information from workers assigned to her case. The mother's visits with the children were to be supervised by agency approved relatives and friends, but this was not consistently occurring. On the morning of the child's death, the boyfriend was watching her children while she ran an errand.

Additional information for children in home:

Description of the child's family:

☐ **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:

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:

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:

Summary of any investigation conducted under ch. 48 or ch. 938 and any services provided to the family since the date of the incident:

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:

In February 2011, maltreatment to the child by an unknown maltreater was substantiated. The child was determined unsafe in the mother's care, and the child was placed with a relative. The relative was already caring for 2 of the mother's other children at the time, and the child was placed with her half-siblings by request of the mother and relative caregiver.

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

The relative caregiver, an adult sibling of the mother, and three of the mother's children were residing in the placement home at the time of the child's death.

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 relative caregiver became licensed as a general foster home in February 2010 to take placement of her grandchildren. Prior to the child's death, the relative caregiver did not have any history of allegations of maltreatment or licensing violations. The relative caregiver was substantiated for neglect of the deceased child and a sibling for not complying with requirements to ensure supervision of the children during visits with their mother.

*** Summary of actions taken by agency in response to the incident:**

The agency screened in and investigated the report of the child's death. Physical abuse to the child by the mother's boyfriend, neglect to the child by her mother and neglect to the child and a sibling by the relative caregiver who provided out-of-home care to the children were substantiated. The agency collaborated with law enforcment and medical professionals during the initial assessment. Two of the child's half-siblings were determined unsafe and removed from the care of the relative. Visits with the children and their relatives are supervised. The mother's case remains open with the agency, and the family is receiving Ongoing Services case management.

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

The agency conducted an internal review of the case and implemented actions to address identified issues; e.g., making a personnel change and reviewing the collaborative practice between the BMCW and contracted providers' staff assigned to the case. The DSP conducted an on-site review of the case and found the agency not in compliance with the CPS Access and Initial Assessment, Safety Intervention, and Ongoing Services Standards.

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

The agency must develop an implementation plan to address the practice issues identified by the Independent Review Team during the on-site review. The Office of Performance and Quality Assurance will monitor the agency's plan.

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.