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: 120413DSP-Milw-194 Agency: Bureau of Milwaukee Child Welfare
Scope of DSP Review of Incident No Review. The information contained in this report was provided by the agency. 90-Day Review
Child Information (at time of incident) Age: 15 years Gender: ☑ Female ☐ Male
Race or Ethnicity: Hispanic
Special Needs: None
Date of Incident: 4/13/12
Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On April 20, 2012, law enforcement was contacted regarding the discovery of a dead body in a nearby abandoned home. The minors who discovered the body led law enforcement to the its location.
Law enforcement, after initial investigative activity, learned the now deceased victim accompanied another youth to the abandoned house on April 13, 2012. The youth allegedly stabbed the victim, several times, with a knife, in addition to stomping and choking the victim. The youth allegedly asked a friend to assist him in carrying the victim's body into the bathroom of the abandoned home.
Apparently, several teenagers provided a tour of the home to other minors who later made the disclosure to a mandated reporter. Some of those teenagers were taken into custody by police; one has been charged with First Degree Intentional Homicide and Hiding a Corpse.
Findings by agency, including maltreatment determination and material circumstances leading to incident:
Because the homicide was not reported to the agency as an alleged maltreatment incident requiring a child protective services response, there is no maltreatment finding for this case, at this time. As per Wisconsin Statue 48.981(3), which establishes reciprocal communication requirements for counties and law enforcement, the agency collaborated with law enforcement and the medical examiner's office by sharing information and records regarding the victim's prior contact with the agency.
Specifically, the now deceased victim, prior to April 13, 2012, was residing in out-of-home care placement. The victim was reported missing on April 7, 2012 and was considered Absent without Leave (AWOL). Efforts by out-of-home care placement staff to locate the victim were ongoing when notification of her death on April 23, 2012, occurred. According to agency records, prior to April 7, 2012, agency staff arranged for the victim's transportation to and from school; however, despite the agency's attempts to account for the victim, she would leave the placement to return after several days. During efforts to track her location following reporting her missing on April 7, 2012, the agency received information that the now deceased victim was taken to another state by her boyfriend. However, in retrospect, that information was invalid because the victim was actually deceased at the time the information was received.
 ✓ Yes ✓ No ✓ Criminal investigation pending or completed? ✓ Yes ✓ No ✓ Criminal charges filed? If yes, against whom? 17-year-old youth, no relation
Child's residence at the time of incident:
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:

child and / or in the child's family home):

Description of the child's family (includes household members, noncustodial parent and other children that have visitation with the

	☐ 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 recipier	t(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: (Does not include the current incident.) 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. (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 service 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.)		
Summary of any investigation involving the child, any member of the child's family and alleged maltreater conducted under 48 or ch. 938 and any services provided to the child and child's family since the date of the incident:			
В.	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 now deceased victim was most recently placed at St. Rose Youth and Family Services, a stabilization center		
	specializing in the provision of services and supports to teenagers with runaway tendencies. Prior to April 7, 2012, the		
	center was assessing the victim's current level of need, with intent to locate an appropriate long-term placement.		
	Description of all other persons residing in the OHC placement home:		
	The teen and two other teenaged girls were residing at the center.		
	Licensing history: Including type of license, duration of license, summary of any violations by licensee or an employee of licensee the constitutes a substantial failure to protect and promote the welfare of the child.		
	St. Rose Youth and Family Services is licensed as a Resident Care Center (RCC) for children and youth. The license was		
	issued on 11/30/66, and their current licensing period is 4/1/11-3/31/13. The Center is currently under a minimum		
	monitoring plan, which means there are no substantial noncompliance issues. On 7/13/07 the Center was issued an order and forfeiture (\$3500.00) due to a suicide at the facility. Noncompliance issues identified at that time were supervision, staff training in suicide prevention, and not following their own procedures for		
possible suicidal residents. There have been no other citations related to failure to protect.			
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Sur	Summary of any actions taken by agency in response to the incident: (Check all that apply.)	unification	
H	Screening of Access report Attempted or successful relative plan implemented Referral to services	unincation	
Ħ	Initial assessment conducted Transportation assistance		
	☐ Safety plan implemented ☐ Collaboration with law enfo	rcement	
	Temporary physical custody of child Collaboration with medical	professionals	
	Petitioned for court order / CHIPS (child in need of Supervised visitation		
	protection or services Case remains open for services	/ices	
님	☐ Placement into foster home ☐ Case closed by agency ☐ Placement with relatives ☐ Initiated efforts to address of the control	or enhance community	
H	Ongoing Services case management collaboration on CA/N case		
	Other (describe):		

FOR DSP COMPLETION ONLY:

Summary of policy or practice changes to address issues identified during the review of the incident:

Case review by the Bureau of Performance Management is pending.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues: Review pending.			
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 PaulaL.Brown@wisconsin.gov			