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: 120501DSP-Wash-198 **Agency:** Washington County Human Services Department

Child Information (at time of incident)
Age: 3 years Gender: ☒ Female ☐ Male
Race or Ethnicity: Caucasian
Special Needs: Seizure Disorder

Date of Incident: 5/1/12

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On May 1, 2012, the agency received a report regarding a 3-year-old child who had been found in the apartment where she lived with her mother, two siblings and her mother's boyfriend, dead of what appeared to be other than natural causes. Law enforcement had received a call with concerns for the safety of this child. The caller stated that the mother had called them making statements about the child being unresponsive. Upon arrival of the police, they found the child's body covered with a towel. It was reported that the child had been discovered by the adults in the household cold and lifeless, two to three hours prior. She had what appeared to be injuries about her head and arms. This later turned out to be partially the result of a massive infection, Necrotizing Fasciitis. This is a rapidly progressive infection that primarily affects the subcutaneous connective tissue planes and may quickly spread to involve adjacent soft tissue leading to widespread necrosis or tissue death. The infection appears to have started in a finger on her left hand and had spread up the arm and eventually into the brain. The mother was aware of the injury to the child's finger and was treating it at home. The mother did not seek out medical treatment and did admit some concern that the children would be removed again by the agency. The child's two siblings were taken into custody by the agency and placed in a foster home. The mother and mother's boyfriend were both arrested and have been charged with Neglecting a Child (Consequence is Death) and were found guilty.

Findings by agency, including maltreatment determination and material circumstances leading to incident:
The agency screened in and assessed the allegations of physical abuse by the mother and the mother's boyfriend to the 3-year-old child. The agency substantiated neglect by the mother and the mother's boyfriend and unsubstantiated physical abuse. It was determined that child died from an infection which may have been treatable early on. Although mother denies any wrongdoing in the death of her daughter, she did admit during the assessment that she did not seek out medical treatment because she was concerned the children would be removed from her care. The child's two siblings were determined unsafe and were placed in foster care.

☒ Yes ☐ No Criminal investigation pending or completed?
☒ Yes ☐ No Criminal charges filed? If yes, against whom? Mother and mother's boyfriend

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 child lived with her mother, mother's boyfriend and two siblings. The child's biological father did not have access to his three children at the time of the incident due to mother's interference with visitation.

☒ **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:
An initial assessment had been completed on the family and was pending approval by a supervisor. The last contact with the family occurred within the month prior to the child's death. The agency had made a referral to community services and

was going to close the case.

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.)

All three children were removed from their parent's care in 2008 after one of the children had a bruise that could not be explained. A CHIPS petition was filed and guardianship was granted to a family member after both parents failed to meet the conditions of the CHIPS order for return of the children. In January of 2012, the guardian of the children died. No successor guardian had been named and the county of residence required the mother to take the children into her care. In February 2012, a referral was made to the agency with concerns about the mother's ability to care for the children. An assessment was completed and mother was determined to have a stable and safe household for the children. In April 2012, family court overturned the guardianship order and returned full parental responsibilities to both parents.

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 11/16/06 a service report with concerns that the father was possessive and verbally abusive towards mother was screened out.

On 12/14/06 a referral alleging physical abuse to the 1-month-old infant was screened in. Physical abuse was substantiated by an unknown maltreater. The child was determined safe in the home and the case was closed.

On 12/16/08 a referral alleging physical abuse to the 1-month-old infant was screened in. Physical abuse was substantiated by an unknown maltreater. The children were determined unsafe and were removed from the home.

On 4/27/11 a service report with concerns about the guardians' ability to care for the children was screened out.

On 2/16/12 a service report regarding the passing of the guardian was screened in.

On 2/7/12 a referral alleging neglect by the mother to her three children was screened out as No Threatened Harm or Maltreatment.

On 2/9/12 a referral alleging physical abuse by the grandfather to the 3-year-old child was screened out as No Threatened Harm of Maltreatment.

On 2/10/12 a service report notifying the county where the mother resides and that she would now be caring for her children was screened out.

On 2/13/12 a referral alleging neglect by the mother to her three children was screened in. Neglect was unsubstantiated and the case was pending approval from a supervisor for closure at the time of the incident.

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 the allegations of physical abuse by the mother and the mother's boyfriend to the 3-year-old child. The agency substantiated neglect by the mother and the mother's boyfriend and unsubstantiated physical abuse. It was determined that child died from an infection which may have been treatable early on. Although the mother denies any wrongdoing in the death of her daughter, she did admit that she did not seek out medical treatment because she was concerned the children would be removed from her care. The child's two siblings were determined unsafe and were placed in foster care. The children are currently placed in the care of their biological father 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:

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 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 DSP completed an on-site review in case # 120501DSP-Wash-198. The review found: all CPS reports pertaining to this incident received by Washington County Human Services Department were screened within the appropriate timeframes and were in compliance with the Wisconsin Access Standards. The Initial Assessments completed by the agency were not completed within the required statutory timeframes. The Initial Assessment completed dated May 1, 2012, pertaining to the child death found a preponderance of the evidence to substantiate neglect to both the mother and the boyfriend. The Initial Assessment contained all required collateral sources of information, there was sufficient information in all areas of the Initial Assessment pertaining to Impending Danger Threats, and the interviews with the mother were sufficient. The Initial Assessment did not include interviews with all members of the household in accordance with Standards.

Washington County Human Services Department 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 with CPS Supervisors and staff. Washington County Human Services Department will also participate in the Supervisors as Safety Decision Makers Training.

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