

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: 130704DSP-Milw-343 Agency: Bureau of Milwaukee Child Welfare

Child Information (at time of incident)

Age: 1 month Gender: Female Male

Race or Ethnicity: African American

Special Needs: None known

Date of Incident: July 4, 2013

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

On July 4, 2013 the agency received a report regarding a one-month-old infant admitted to the hospital with suspicious injuries. The teenage mother of the infant stated the infant woke up crying in the early morning and again two hours later. At that time, she said the infant's eyes rolled back in his head and he was arching his back. The teenage mother informed her foster mother of her concerns for the infant, at which time they took him to the hospital. The infant was found to have an injury to the head and soft tissue inflammation. These injuries are highly concerning for non-accidental trauma. Medical professionals stated the infant's symptoms likely started the previous day, but could not determine when the infant sustained the injuries. Both the mother and the foster mother cared for the infant during that timeframe but were unable to explain how he was injured. Law enforcement continues to investigate and no criminal charges have been filed.

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. The allegation of physical abuse to the infant by an unknown maltreater was substantiated. The infant's injuries were highly concerning for inflicted trauma; however, the agency was unable to establish a specific maltreater. The agency determined the infant unsafe and placed the infant in out-of-home care separately from the mother. The agency filed a Child in Need of Protection or Services petition on the infant in juvenile court. The case remains open and the agency continues to provide ongoing case management services to the family.

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):

N/A.

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.)

N/A.

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.)

N/A.

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:

N/A.

B. Children residing in out-of-home care (OHC) placement at time of incident:

Description of the OHC placement and basis for decision to place child there:

At the time of the incident, the infant and the teenage mother were living in a general foster home. The mother was placed in out-of-home care in October of 2012. The infant was not placed under court order prior to the serious incident. The foster mother was providing support and assistance to the mother in caring for her infant.

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

The infant resided with the mother, the foster mother, and the foster mother’s fiancé, and an unrelated 13-year-old female foster child.

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 foster mother has been licensed as a general foster home since August 2012. There is no history of licensing violations in the foster home prior to the serious incident. During the course of the agency’s Initial Assessment for the serious incident, it was learned the foster mother’s fiancé, who has a significant criminal history, was living in the foster home. The infant and the mother were moved from the foster home to different placements and the foster home’s license was placed on hold.

Summary of any actions taken by agency in response to the incident: (Check all that apply.)

- | | |
|--|--|
| <input checked="" type="checkbox"/> Screening of Access report | <input type="checkbox"/> Attempted or successful reunification |
| <input type="checkbox"/> Protective plan implemented | <input checked="" type="checkbox"/> Referral to services |
| <input checked="" type="checkbox"/> Initial assessment conducted | <input type="checkbox"/> Transportation assistance |
| <input type="checkbox"/> Safety plan implemented | <input checked="" type="checkbox"/> Collaboration with law enforcement |
| <input checked="" type="checkbox"/> Temporary physical custody of child | <input checked="" type="checkbox"/> Collaboration with medical professionals |
| <input checked="" type="checkbox"/> Petitioned for court order / CHIPS (child in need of protection or services) | <input checked="" type="checkbox"/> Supervised visitation |
| <input checked="" type="checkbox"/> Placement into foster home | <input checked="" type="checkbox"/> Case remains open for services |
| <input type="checkbox"/> Placement with relatives | <input type="checkbox"/> Case closed by agency |
| <input checked="" type="checkbox"/> Ongoing Services case management | <input type="checkbox"/> Initiated efforts to address or enhance community collaboration on CA/N cases |
| | <input type="checkbox"/> 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 Bureau of Performance Management (BPM) completed a review in case # 130704DSP-Milw-343 and found: BMCW practice in Access was compliant with standards in the area of screening decision and timeliness of screening decision. BMCW practice in Initial Assessment demonstrated compliance with standards in the areas of initial contact, identification of present danger threats and timely action to control for present danger, monitoring of protective plan, and identification of the need for an ongoing safety plan. Ongoing Services demonstrated compliance with standards in the areas of timely Case/Permanency Planning, and initial and ongoing case worker contacts.

BMCW practice in Access was not compliant with standards in the areas related to identification of impending danger threats and response time. BMCW Initial Assessment was not in compliance with standards in the areas related to modifying the Protective Plan, timely completion of the Initial Assessment, completing the Initial Assessment prior to case transfer to Ongoing Services, and completing necessary collateral contacts. The Ongoing Services Agency was not compliant with standards related to updating Family Interaction Plans and the process for re-confirming safe environments.

The Child Placing Agency was not compliant with foster home licensing standards in the areas of Criminal Background

Checks, notification to the ongoing services agency of placement of a third child in the foster home, and modification of a foster home license when a new adult moved into the household and provided care to the foster children.

The BMCW modified components of their Quality Assurance Plan to ensure compliance with standards related to identification of impending danger threats and appropriate response time at Access, monitoring and updating protective plans, appropriate collateral contacts, and timely completion of Initial Assessments. In addition, the BMCW modified its policy concerning case transfer, bringing the policy into compliance with recent changes in Ongoing Standards. The Ongoing Services agency reviewed all placements with the identified CPA to ensure child safety and compliance with the Confirming Safe Environments process. In addition, the Ongoing Services agency modified their Quality Assurance Plan related to monitoring family interaction plans, created a desk guide for case managers and supervisors related to practice standards for family interaction plans, and developed and provided training to all staff related to Safety Assessment and Domestic Violence.

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.

The agency must submit an electronic copy of the completed 90-Day Summary Report to RobertB.Williams@wisconsin.gov