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: 120101DSP-Burn-259 **Agency:** Burnett County Health and Human Services Department

Child Information (at time of incident)
Age: 5 weeks Gender: ☐ Female ☒ Male
Race or Ethnicity: American Indian
Special Needs: None

Date of Incident: 1/1/12

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On 10/10/12, the agency received notification of the death of a 5-week-old infant which occurred ten months prior, on 1/1/12. At the time of death, the infant was cared for by his father who had been staying at the mother's home for a few days. On 1/1/12, tribal law enforcement and emergency medical personnel responded to the home after receiving a call of an infant not breathing. Law enforcement observed the infant presented with a blood encrusted upper lip, a bruise and red mark over his right eyebrow, and several scratches on both legs. The infant was transported to the local hospital and pronounced dead. Both parents admitted to drinking alcohol during the night of the incident, but were unable to provide an explanation for the infant's condition. The father later admitted to dropping the child during the night, but was unable to provide a consistent recollection of events. An autopsy was completed and determined the cause of death was homicide related to blunt force cranial and cerebral injury. The autopsy results revealed the following injuries: broken left femur, small bruise on the right side of his forehead above the eye, minor scratches on his legs, bleeding from his inner and upper lip, rib fractures (possibly attributable to CPR efforts), and his head sustained a contused and lacerated upper frenulum, a thin subdural hemorrhage, a subarachnoid hemorrhage, a hypoxic-ischemic brain injury, retinal hemorrhages in both eyes, bilateral optic nerve sheath hemorrhaging, and a spinal root nerve hemorrhage. The father was criminally charged with one count of 1st Degree Reckless Homicide. A criminal charge is merely an allegation and a defendant is presumed innocent until and unless proven guilty.

Findings by agency, including maltreatment determination and material circumstances leading to incident:
Due to the time lapse between the date of the incident and date the report was received by the agency, the majority of the information for the assessment was gathered from the criminal complaint and comprehensive file kept by the District Attorney's office. The agency substantiated physical abuse to the infant by the father. Based on the autopsy results and the father's inconsistent recollection of events, it was determined more likely than not that the infant experienced physical abuse at the hands of his father, which resulted in death.

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

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 infant was residing with his mother, 3-year-old brother, 7-year-old sister, 13-year-old sister, and maternal grandparents. The father recently united with the infant and resided temporarily at the home to provide care to the infant.

☐ **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.)

In August 2009, Washburn County assessed allegations of neglect by the mother due to drug use when caring for the children. Neglect was substantiated and the case was opened for ongoing case management services. The children were removed from the home on 8/12/09. Two of the children were returned home on 11/25/09 and the third child was returned home on 1/29/10. Washburn County closed the case on 8/23/10.

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 12/13/05, the agency screened out a services report. A referral was made to the tribal child welfare department.

On 9/22/08, the agency screened out a services report.

On 10/3/08, the agency screened out a services report. A referral was made to the tribal child welfare department.

On 1/12/09, the agency screened out a services report.

On 1/22/09, the agency screened out a services report. A referral was made to the tribal child welfare department.

On 1/23/09, the agency screened out a services report. A referral was made to the tribal child welfare department.

On 3/5/09, Washburn County screened in a services report. The family was referred to community services.

On 6/24/09, Washburn County screened in a services report. The family declined an offer of services.

On 8/11/09, Washburn County screened in a report alleging neglect to the children. Neglect was substantiated and the family received ongoing case management services until 8/23/10.

On 6/5/12, the agency screened out a report alleging neglect by the mother.

On 6/21/12, Washburn County screened out a report alleging neglect by the mother.

On 8/6/12, the agency screened out a services report.

On 9/13/12, Washburn County screened out a report alleging neglect by the mother.

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:

On 8/13/12, the agency screened in and assessed an allegation of neglect by the mother. Neglect was substantiated and the agency filed a Child in Need of Protection or Services Petition in juvenile court. The agency removed the children from the home on 10/2/12 and placed them in the home of relatives. The agency received a report on 10/8/12 alleging the mother was pregnant and using drugs. The allegation of unborn child abuse was unsubstantiated. On 10/10/12, the agency received notification of the infant's death which occurred ten months prior on 1/1/12. Based on information from the criminal complaint and contact with the family, the agency substantiated physical abuse to the infant by his father. The children remain in out-of-home care with relatives and the family is receiving 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:

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

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.

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 #120101DSP-Burn-259 and prior reports involving the family. The report found: A Child Protective Services (CPS) Report from 2012 was screened-out in error and not in accordance with the Wisconsin Child Protective Services standards, the screening decisions for Child's Status as Indian and biological Family History documents were incomplete and inaccurate and not in accordance with the Wisconsin Department of Children and Families, Division of Safety and Permanence Informational Memo 2010-08, August 19, 2010, a safety determination was made erroneously at the conclusion of the Initial Assessment and not in accordance with the Wisconsin Child Protective Services Safety Intervention Standards, and the agency does not have a memoranda of understanding with local law enforcement jurisdictions in accordance with the Wisconsin Child Protective Services Access and Initial Assessment Standards.

The Burnett County Health and Human Services Department executive management reviewed with all CPS staff the requirements in the Wisconsin Child Protection Services standards pertaining to the Access screening process including informational gathering at Access. BCHHSD created a Memorandum of Understanding (MOU) with local law enforcement jurisdictions covering cooperation during business hours and after-hours. BCHHSD management provided Safety Foundation Training for current CPS staff and new employees beginning in the CPS Unit.

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

None

☒ 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 RobertB.Williams@wisconsin.gov