

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: 181207 DSP-MILW-884 **Agency:** Division of Milwaukee Child Protective Services

Child Information (at time of incident)

Age: 1 Year Gender: Female Male

Race or Ethnicity: African American/Black

Special Needs: None

Date of Incident: 12/07/2018

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

On December 7, 2018, the agency received a report regarding neglect of a 1-year-old infant brought to Children's Hospital unresponsive due to injuries allegedly sustained on December 5, 2018. The infant was subsequently pronounced deceased. Law enforcement was contacted and initiated a criminal investigation. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. No criminal charges were filed and the case was closed.

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 Initial Assessment completed by the agency found insufficient evidence to substantiate neglect of the infant by the relative primary care provider. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. The agency closed the case upon completion of the Initial Assessment.

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):

At the time of the incident, the infant resided with his father and a relative primary care provider.

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:

At the time of the incident, the agency was assessing the October 31, 2018 CPS report. The last contact by the agency was a visit with the infant and his 2-year-old half-sister in the home where their mother was staying on November 13, 2018.

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.)

On October 31, 2018, the agency screened-in a CPS Report alleging neglect to the infant by his mother. The infant died during the assessment period and an additional report was made to the agency on December 7, 2018. An assessment was completed by the agency and the initial allegation of neglect was unsubstantiated.

On June 11, 2018, the agency screened-in a CPS Report alleging neglect to the infant and his now 2-year-old half-sister by their mother. An assessment was completed by the agency and the allegation of neglect was unsubstantiated. The case was closed upon completion of the Initial Assessment.

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
On October 31, 2018, the agency screened-in a CPS Report alleging neglect to the infant by his mother. The infant died during the assessment period and an additional report was made to the agency on December 7, 2018. An assessment was completed by the agency and the initial allegation of neglect was unsubstantiated.

On October 4, 2018, the agency screened-out a CPS Report.

On August 21, 2018, the agency screened-out a CPS Report.

On June 11, 2018, the agency screened-in a CPS Report alleging neglect to the infant and his 2-year-old half-sister by their mother. An assessment was completed by the agency and the allegation of neglect was unsubstantiated. The case was closed upon completion of the Initial Assessment.

On March 6, 2018, the agency screened-out a CPS Report.

Summary of any investigation involving the child, any member of the child's family and alleged maltreater conducted under ch. 48 and any services provided to the child and child's family since the date of the incident:

The agency collaborated with law enforcement and medical personnel to complete the assessment. The Initial Assessment completed by the agency found insufficient evidence to substantiate neglect of the infant by the relative primary care provider. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. The agency closed the case upon completion of the Initial Assessment.

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:

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 or other actions that constitute 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.)

- | | |
|---|--|
| <input checked="" type="checkbox"/> Screening of Access report | <input type="checkbox"/> Attempted or successful reunification |
| <input type="checkbox"/> Protective plan implemented | <input 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 type="checkbox"/> Temporary physical custody of child | <input checked="" type="checkbox"/> Collaboration with medical professionals |
| <input type="checkbox"/> Petitioned for court order / CHIPS (child in need of protection or services) | <input type="checkbox"/> Supervised visitation |
| <input type="checkbox"/> Placement into foster home | <input type="checkbox"/> Case remains open for services |
| <input type="checkbox"/> Placement with relatives | <input checked="" type="checkbox"/> Case closed by agency |
| <input 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 IF RECORD OR ON-SITE REVIEW WAS UNDERTAKEN:

Summary of policy or practice changes to address issues identified based on the record or on-site review of the incident:

Under the Child Welfare Disclosure Act (Section 48.981(7)(cr), Stats.), the Department of Children and Families' (DCF) Division of Safety and Permanence (DSP) completes an initial review of the agency's practice for each case reported under the Act. A further practice review has been completed for case 181207DSP-Milw-884. As a result of this review process, the DSP learned that the agency had implemented a quality improvement plan aimed at assessing safety practice with the goal of ensuring consistency and quality in safety practice.

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues based on the record or on-site review:

None.

Yes No Not Applicable

This 6-Month summary report completes the Division of Safety and Permanence (DSP) action on this case.