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: 161123-DSP-MILW-665 **Agency:** Division of Milwaukee Child Protective Services

Child Information (at time of incident)
Age: 2 Months Gender: ☐ Female ☒ Male
Race or Ethnicity: Black/African American
Special Needs: None

Date of Incident: 11/23/2016

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On November 23, 2016, the agency received a report regarding a 2-month-old infant pronounced deceased in his home. Law enforcement was contacted and initiated a criminal investigation into the infant's unexplained death. The Medical Examiner's Office report noted no signs of trauma to the infant, but noted the death did appear to be related to co-sleeping. As a result of law enforcement's investigation, the infant's mother was arrested and criminally charged with 2nd Degree Recklessly Endangering Safety. A criminal charge is merely an allegation and a defendant is presumed innocent until proven guilty.

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 a preponderance of the evidence to substantiate neglect to the infant by the infant's mother. The Medical Examiner's Office report noted no signs of trauma to the infant, but noted the death did appear to be related to co-sleeping. The infant's mother was referred to community services focused on trauma, grief, and alcohol and other drug abuse treatment services. The case remained open for ongoing case management services.

☒ Yes ☐ No Criminal investigation pending or completed?
☒ Yes ☐ No Criminal charges filed? If yes, against whom? The infant's mother.

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 mother. Paternity has not been established for 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:
At the time of the incident, the family was receiving ongoing case management services from the agency. The last contact by the agency to the infant and the infant's mother was a home visit on November 17, 2016.

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 April 21, 2013, the agency screened-in a CPS report alleging neglect resulting in the death of the infant's then 2-month-old brother by the infant's mother. An assessment was completed by the agency and the allegation of neglect was unsubstantiated. The sibling in the home was determined to be safe in the care of his mother and the case was closed upon completion of the initial assessment.

On February 5, 2014, the agency screened-in a CPS report alleging neglect to the infant's now 3-year-old and 7-year-old brothers by the infant's mother. An initial assessment was completed by the agency and the allegation of neglect was unsubstantiated for the infant's now 3-year-old brother; the allegation of neglect was substantiated for the infant's now 7-year-old brother. Both children were taken into Temporary Physical Custody and the case remained open for ongoing case

management services.

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.)

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On April 21, 2013, the agency screened-out a CPS report.

On February 5, 2014, the agency screened-in a CPS report alleging neglect to the infant's now 3-year-old and 7-year-old brothers by the infant's mother. An assessment was completed by the agency and the allegation of neglect was unsubstantiated for the infant's now 3-year-old brother; the allegation of neglect was substantiated for the infant's now 7-year-old brother. Both children were taken into Temporary Physical Custody and the case remained open for ongoing case management services.

On September 12, 2016, 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 a preponderance of the evidence to substantiate neglect to the infant by the infant's mother. The Medical Examiner's Office report noted no signs of trauma to the infant, but noted the death did appear to be related to co-sleeping. The infant's mother was referred to community services focused on trauma, grief, and alcohol and other drug abuse treatment services. The case remained open for ongoing case management services.

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.)

- ☒ 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 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 DSP completes a 90-Day review of the agency's practice in each case reported under the act. A further practice review has been completed for case # 160227DSP-MILW-665. As a result of this review process, the DSP determined the agency is implementing action steps to improve upon the internal procedures regarding case transition staffing at various points in the case process.

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

Based on the agency's effort and response to this incident and DSP review, no further policy, practice, or statutory changes are recommended.

☒ Yes ☐ No ☐ Not Applicable This 6-Month final summary report completes the Division of Safety and Permanence (DSP) action on this case.