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: 250807DSP-Milw-1407 **Agency:** Division of Milwaukee Child Protective Services

Child Information (at time of incident)
Age: 1 year Gender: ☐ Female ☒ Male
Race or Ethnicity: Black/African American
Special Needs: None

Date of Incident: 08/07/2025

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On August 7, 2025, the agency received a report regarding a 1-year-old infant with a serious injury. The infant subsequently passed away on August 14, 2025. Law enforcement was contacted and initiated a criminal investigation. The Medical Examiner's Office determined the cause of death was due to controlled substance toxicity. As a result of law enforcement's investigation, the infant's father was criminally charged with Neglecting a Child, Consequence is Death. 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:
The agency collaborated with law enforcement and medical professionals to complete the assessment. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect of the infant by the father. The infant's half-sibling remained in-home with a Safety Plan. The family's 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 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):
At the time of the incident, the infant resided with his mother and his 14-year-old half-sibling. The infant's father had regular 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:
At the time of the incident, the infant and the infant's 14-year-old sibling were under in-home Child in Need of Protection or Services orders related to the May 11, 2025, CPS Report. The last contact by the agency was at the family home with the mother, the infant, and the infant's 14-year-old half-sibling on July 25, 2025.

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 May 11, 2024, the agency screened-in a CPS Report alleging neglect of the infant by the mother. During the assessment period, an additional report was made to the agency regarding the infant sustaining a serious injury. The infant subsequently passed away on August 14, 2025. An assessment of the initial allegation was completed by the agency, and the allegation was unsubstantiated.

On April 12, 2024, the agency screened-in a Services Report. The family was opened for voluntary 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.)

On May 11, 2024, the agency screened-in a CPS Report alleging neglect of the infant by the mother. During the assessment period, an additional report was made to the agency regarding the infant sustaining a serious injury. The infant subsequently passed away on August 14, 2025. An assessment of the initial allegation was completed by the agency, and the allegation was unsubstantiated.

On April 12, 2024, the agency screened-in a Services Report. The family was opened for voluntary services.

On May 1, 2017, the agency screened-in a CPS Report alleging neglect to the infant's now 14-year-old half-sibling by the mother. An assessment was completed by the agency with the determination of unable to locate, and the case was closed.

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 professionals to complete the assessment. The Initial Assessment completed by the agency found a preponderance of the evidence to substantiate maltreatment of neglect of the infant by the father. The infant's half-sibling remained in-home with a Safety Plan. The family's case remained open for voluntary 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 a 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 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 #250807DSP-Milw-1407. No immediate changes to policy or practice were made based on review of the incident. The Division of Milwaukee Child Welfare will conduct a case review via the Citizen Review Panel (Critical Incident subcommittee).

Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues based on the record or on-site review:
The DSP did not make any recommendations for further changes based on this review process. (Note: The review process for an individual case may not result in a recommendation for policy or practice changes but may impact future recommendations as a result of the review of multiple cases and other related sources of information.)

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