

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: 190906DSP-Keno-952 **Agency:** Kenosha County Department of Human Services

Child Information (at time of incident)

Age: 5 months Gender: Female Male

Race or Ethnicity: Black/African American

Special Needs: None

Date of Incident: 9/6/2019

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

On September 6, 2019, the agency received a report regarding a 5-month-old infant pronounced deceased in the home. 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 have been filed in this case, and the investigation remains open.

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 insufficient evidence to substantiate neglect of the infant by the mother. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. The infant's siblings were deemed safe and they remained in the care of the mother. Petitions for Protection or Services were filed for the infant's siblings and the case remained open to provide ongoing case management services.

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 child resided with her mother, alleged father, 5-year-old half-sister, 3-year-old half-sister, 2-year-old half-sister, and maternal grandmother.

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 May 5, 2019 Services Report. The agency had not been able to successfully make contact with the family.

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 5, 2019, the agency screened-in a Services Report. The infant died during the assessment period and an additional report was made to the agency regarding the infant's death on September 6, 2019.

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.)

The following history is related to the infant's mother, who resided in the home at the time of the incident:

On May 5, 2019, the agency screened-in a Services Report. The infant died during the assessment period and an additional

report was made to the agency regarding the infant's death on September 6, 2019. The agency provided the family with community crisis information.

On May 5, 2019, the agency screened-out a CPS Report.

The following history is related to the infant's grandmother, who resided in the home at the time of the incident:

On May 5, 2019, the agency screened-out a CPS Report.

On May 5, 2019, the agency screened-in a Services Report. The agency provided the family with community crisis information.

On August 11, 2017, the agency screened-out a CPS Report.

On June 30, 2014, the agency screened-out a CPS Report.

On March 4, 2014, the agency screened-out a CPS Report.

On March 25, 2013, the agency screened-in a Services Report. The agency provided the family with community resources.

On March 25, 2013, the agency screened-out a CPS Report.

On January 20, 2010, the agency screened-out a Services Report.

On October 13, 2009, the agency screened-out a Services Report.

On September 11, 2007, the agency screened-out a Services 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 insufficient evidence to substantiate neglect of the infant by the mother. The Medical Examiner's Office noted no signs of maltreatment or trauma to the infant. The infant's siblings were deemed safe and they remained in the care of the mother. Petitions for Protection or Services were filed for the infant's siblings and the case remained open to provide 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.)

- | | |
|--|--|
| <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 |

- 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

- 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 190906-DSP-KENO-952. As a result of this review process, the DSP did not determine policy or practice changes were needed.

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 Final summary report completes the Division of Safety and Permanence (DSP) action on this case.