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: 231104DSP-Sheb-1270 **Agency:** Sheboygan County Health and Human Services Department

Child Information (at time of incident)
Age: 6 months Gender: ☒ Female ☐ Male
Race or Ethnicity: White
Special Needs: None

Date of Incident: 11/04/2023

Description of the incident, including the suspected cause of death, injury or egregious abuse or neglect:
On November 4, 2023, the agency received a report regarding a 6-month-old infant pronounced deceased in her home. Law enforcement was contacted and initiated a criminal investigation. The Medical Examiner's Office determined the death was due to an unsafe sleep environment. 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 professionals to complete the assessment. The Medical Examiner's Office determined the death was due to an unsafe sleep environment. The Initial Assessment completed by the agency found insufficient evidence to substantiate neglect by the mother and the father. The infant's siblings remained in the home under a Safety Plan. An Informal Disposition Agreement was filed, and the case remained open for ongoing case management.

☒ 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 her mother, father, 2-year-old sibling, 4-year-old sibling, 7-year-old siblings, and 8-year-old sibling.

☒ **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 providing voluntary case management services. The last contact by the agency was with the mother on October 25, 2023.

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 February 21, 2023, the agency screened-in a CPS Report alleging physical abuse to the infant's now 7-year-old sibling by the father. An assessment was completed by the agency, and the allegation of physical abuse was unsubstantiated. At the conclusion of the assessment, the family agreed to voluntary services with the department and the case remained open to provide those services. The infant died during the period of time when the agency was providing services to the family.

On August 12, 2021, the agency screened-in a CPS Report alleging neglect to the infant's now 2-year-old, 4-year-old, 7-year-old, and 8-year-old siblings by the mother and the father. An assessment was completed by the agency, and the allegations of neglect were 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 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 August 12, 2021, the agency screened-in a CPS Report alleging neglect to the infant's now 2-year-old, 4-year-old, 7-year-old, and 8-year-old siblings by the mother and the father. An assessment was completed by the agency, and the allegations of neglect were unsubstantiated. The case was closed upon completion of the Initial Assessment.

On July 23, 2017, 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 professionals to complete the assessment. The Medical Examiner's Office determined the death was due to an unsafe sleep environment. The Initial Assessment completed by the agency found insufficient evidence to substantiate neglect by the mother and the father. The infant's siblings remained in the home under a Safety Plan. An Informal Disposition Agreement was filed, and the case remained open for ongoing case management.

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): Informal Disposition Agreement

FOR DSP COMPLETION IF FURTHER REVIEW WAS UNDERTAKEN:

Summary of policy or practice changes to address issues identified based on the 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 #231104DSP-Sheb-1270. 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 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 summary report completes the Division of Safety and Permanence (DSP) action on this case.