

## Child Death, Serious Injury or Egregious Incident Summary Report

Type of Report:  90-Day  Final

Case Tracking Number: 100609DSP-PN-28 Agency: Winnebago County Department of Human Services

Child Information: Age: 1 1/2 years Gender:  Female  Male  
Race or Ethnicity: Caucasian  
Special needs: None prior to the incident

Child's Residence:  In-home  Out-of-home care placement

Date of Incident: 6/9/10

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

The child fell from a second story window. Reportedly, there was a toy box under the window, and the child pushed out the screen, falling to the ground. He was transported to the hospital and then transferred to Children's Hospital in Milwaukee. A coma was induced to reduce brain-swelling. He was found to have a traumatic brain injury and collapsed lung. The child was hospitalized for several weeks.

### Findings by agency, including material circumstances leading to incident:

The agency unsubstantiated maltreatment to the child. The child's fall was determined to be accidental by law enforcement and the agency. The mother was sleeping with her child on the couch. The child awoke and proceeded to climb on the window ledge, pushing out the screen. The windows were open because it was a hot day, and there were no problems with the windows or screens.

### Additional information for children in home:

#### Description of the child's family:

The child lives with his mother and her boyfriend.

Yes  No **Statement of Services:** Were services under ch. 48 or ch. 938 being provided to the child, 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:

N/A

#### Summary of all involvement in services under ch. 48 or ch. 938 by child's parents or alleged maltreater in the previous five years:

In 2008 and 2009, Fond du Lac Co. Dept. of Social Services screened in two child protective services (CPS) reports and one report for child welfare services on the family. In 2008, the agency closed the case after connecting the family to several community resources. Later in 2008 and 2009, following the two CPS assessments, the family was referred to other resources and refused further services from the agency.

#### 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 or alleged maltreater:

During the period 2008-2009 the family lived in two counties other than Winnebago. Fond du Lac Co. Dept. of Social Services received nine reports on the family, screening out 6 of the reports. Two reports alleging neglect were screened in as child protective services reports, investigated and unsubstantiated. After each investigation, the case was closed and the mother and child were referred to other services. One report was screened in to provide child welfare services to the family, and the mother was connected to several resources

In 2009, Manitowoc Co. Human Services Dept. received and screened out one CPS report on the family.

In 2010, Winnebago County DHS received four reports on the family, screening in and investigating the report on this incident and screening out three subsequent reports. Following the child's discharge from the hospital, the agency implemented a plan requiring that the child and his mother live with a relative until their landlord secured the apartment windows. The child continues to receive medical care, and his mother continues to work with Ongoing Services receiving

**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Safety and Permanence

case management and parenting support.

**Summary of any investigation conducted under ch. 48 or ch. 938 and any services provided to the family since the date of the incident:**

The agency unsubstantiated neglect to the child, determining his fall from a window to be accidental. The agency implemented a plan, assuring that the mother and her boyfriend child-proofed their home prior to allowing the child to return there. The family voluntarily participates in services with agency support, including parenting and access to continued medical care and rehabilitation for the child.

**Additional information for children in out-of-home (OHC) placement at time of incident:**

**Description of the OHC placement and basis for decision to place child there:**

**Description of all other persons residing in the OHC placement home:**

**Licensing history:** Including type of license, duration of license, summary of any violations by licensee or an employee of licensee that constitutes a substantial failure to protect and promote the welfare of the child.

**\* Summary of actions taken by agency in response to the incident:**

The agency screened in, investigated and unsubstantiated the allegation of maltreatment to the child after he fell from a window. The agency collaborated with law enforcement, agreeing that the fall was accidental. The agency implemented a plan that required childproofing the home prior to the family returning there with their son following his discharge from the hospital. The family is voluntarily participating in services, and the agency is assisting them with the continuing medical needs of the child. The case continues to be open for voluntary services with the agency.

**\*Summary of policy or practice changes to address identified issues:**

The initial assessment was not completed within 60 days in compliance with Standards. The agency must complete the assessment and document the findings in eWiSACWIS in compliance with the CPS Access and Initial Assessment Standards.

**\*Recommendations for further changes in policies, practices, rules or statutes needed to address identified issues:**

None

**Statement of Completion:**

Yes  No This 90-day summary report completes the Division of Safety and Permanence (DSP) review of this case.

\* If a full report including agency actions, changes in policies or practices and recommendations for further changes was not completed within 90 days, the DSP will complete and submit the final summary report within 6 months.

This final summary report completes the DSP review of this case.