OFFICE OF INSPECTOR GENERAL

Illinois Department of Children and Family Services

REPORT TO THE GENERAL ASSEMBLY

Pursuant to Public Act 88-0007

January 1997

Denise Kane
Inspector General

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LETTER FROM THE INSPECTOR GENERAL

To the Governor and Members of the General Assembly:

In *Childhood and Society*, Erik Erickson formulated an evolutionary blueprint for human life stages and institutions. For Erickson, each stage of life theoretically builds on the capabilities of the last stage. Erickson also recognized each stage of life has its unique struggles capable of producing a virtue or strength within the individual. The last stage of his human development theory called forth the value of integrity and the strength of wisdom. Recognizing that we all can learn from our elders I asked for guidance from a respected retired public servant who had experienced the vicissitudes of service in leading a major public institution. The trouble with asking for help from our elders is that they often do not give simple answers. Rather, they prod the questioner to think about the right question. The question posed to me was, what did I think the Office of the Inspector General should do to make a difference: Focus on the life of an individual child or focus on the system? I, of course, thought that one would not preclude the other, but in his wisdom he reminded me there is only so much time and hands are few. I would have to set a priority. I chose the life of the individual child since it was the tragic death of a three year old that created the Office of the Inspector General. He supported this answer. It is DCFS' responsibility to oversee the functioning of the Illinois' Child Welfare System, but, the individual child needs more than this broad overview, lest the individual child get lost among the many. The value and focus of the Office of the Inspector General has to be the individual child.

Here are the stories of some of the children whom our office works for and where they are today. Six-year-old "Gus" who I wrote about last year had been removed precipitously from a caring foster parent and placed in a residential program. After a struggle with the larger child welfare systems, he returned to his foster home. With the help of his foster mother, our office worked with the State Police to open a criminal investigation on the man who had sexually assaulted him. The man, a convicted murderer, was apprehended. He is charged and is awaiting prosecution.

Three years ago this past Thanksgiving, a three-year-old, weighing less than twenty pounds and covered with belt marks, was removed from his abusive home. Today, he lives with his brother and grandparents in Mississippi due to the professionalism of the Adoption Panel and the perseverance of our Office. I am not telling their stories for sentimental reasons but to convey the value of each child. We, as public or private servants, serve; and the duty we have is to work with each child -- and not as a statistical entity. The totalities of children's lives cannot be a statistical average or an outcome indicator that is easily manipulated. While struggling with the bureaucracies within the system, each child can be lost among the many.

I believe that I was given wise advice when I was made to critically think of the focus of this office. It has to be the individual child. This focus can be criticized as anecdotal and dismissed as statistically insignificant; or it can be seen in more Shakespearean terms - at times "wisdom cries out from the streets; and no man regards it." (Henry IV; part 1) It is this wisdom my office seeks.

Respectfully Submitted,

Denise Kane
Inspector General

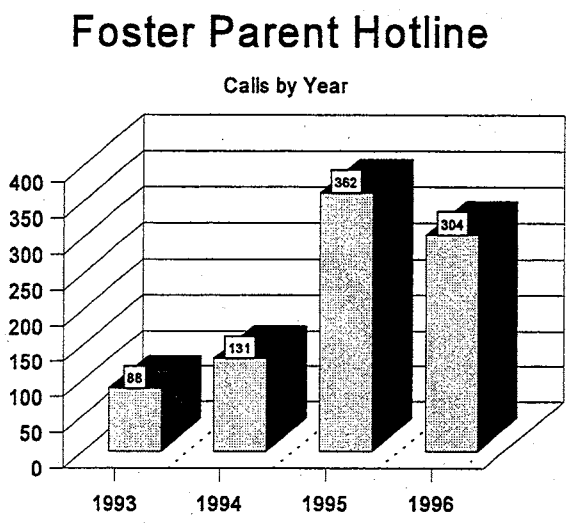
INTRODUCTION TO THE OIG

On June 24, 1993, Governor Jim Edgar signed Public Act 88-0007 into law, thus creating the Office of the Inspector General for the Illinois Department of Children and Family Services. The OIG fulfills a number of mandated responsibilities. The OIG investigates allegations of misconduct, misfeasance, malfeasance and violations of rules, procedures or laws by any employee, foster parent or contractor of DCFS.

The office responds to and investigates complaints filed by the judiciary, foster parents, biological parents, attorneys, and the general public. Additionally, the OIG investigates deaths of all Illinois children with whom DCFS or a private agency had prior involvement. At the request of the Director or when the OIG has noticed a particularly high level of complaints in a specific division of DCFS, the OIG will conduct a systemic review of a division of DCFS or a private agency or area of practice. Investigations yield recommendations specific to the case and generic recommendations for systemic reform. The OIG monitors compliance with all recommendations.

The Office of the Inspector General can be reached by telephone at **(312) 433-3000** and is located at **2240 West Ogden Street** in **Chicago,** directly across from the Cook County Juvenile Court building. The location, apart from other DCFS offices, promotes independence and objectivity and increases the OIG's ability to monitor efficiently investigations that are related to Cook County Juvenile Court. An adjunct Springfield Office is located at 406 East Monroe Street. The Springfield Office houses the OIG Foster Parent Hotline as well as two OIG investigators who handle downstate cases. The OIG Foster Parent Hotline number is **1-800-722-9124.**

FY 96 OIG/DCFS Vital Statistics



- State Central Register Child Abuse Hotline call volume was 352,629.*
- DCFS and private agencies monitored over 37,000 licenses to private agencies and private homes.*
- The total DCFS and private agency caseload included 54,144 children in substitute care. *
- DCFS received 174 child death reports. This was a 21 percent decrease from FY95. (See Child Death Report in Appendix.)
- The Foster Parent Hotline received 304 calls.
- The OIG completed over 100 drivers license checks on DCFS employees to determine whether employees had valid licenses and a record indicating they could safely transport children.

*Statistics from DCFS Executive Statistical Summary and DCFS Child Abuse and Neglect Statistics

II. OIG INVESTIGATIVE PROCESS

The OIG investigative process begins with intake and screening. If a complaint is accepted, the OIG will initiate an investigation including a full records review and interviews of relevant witnesses. When the investigation is complete, the OIG prepares a report to the Director of DCFS with recommendations for discipline, systemic changes, or sanction against private agencies. The OIG then monitors the implementation of recommendations.

Confidentiality

While conducting investigations, care is taken to conceal the identity of the complainant. Any request for disclosure of information, reports or results outside of the OIG, in connection with a referral or otherwise, must be approved by a supervisor. The OIG's reports are not generally distributed outside of the agency and are shared within the agency only with the Director and those involved in implementation of the recommendations. The employee or private agency subject of the report may review the Report (with confidential information deleted) and have an opportunity to respond to it, prior to the imposition of any discipline or sanction, except where circumstances demand immediate action. In addition, the OIG has prepared several reports with confidential information deleted, for use as teaching tools both within the department and for private agencies. private agency or Department employees involved in implementing or responding to recommendations.

Impounding

The OIG is charged not only with investigating misconduct but also with the responsibility of conducting investigations "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." In order to conduct thorough investigations, investigators often must impound files to ensure the integrity of records. Impounding involves the immediate securing and retrieval of records by the OIG.

Once an investigator determines it is necessary to impound relevant DCFS or private agency case files, the investigator will consult with the OIG supervisor and legal counsel. When files are impounded, the investigator leaves a receipt for impounded files with the office or agency. Additionally, individuals with a need for information contained in files may make copies of the necessary portions of the files in the presence of the investigator. Impounded files are returned as soon as practicable.

Criminal Investigations

If evidence indicates that a criminal act may have been committed, the OIG will notify the Illinois State Police, Attorney General or other appropriate law enforcement agency. If another law enforcement agency elects to investigate, the OIG will close that portion of the OIG case referred but retain the case on monitor status. If the law enforcement agency declines to prosecute, the OIG file will be reopened.

OIG Reports

The OIG's reports are submitted only to the Director of DCFS, pursuant to statute. The OIG report contains a summary of the complaint, an historical perspective on the case including a case history and detailed information about prior DCFS contact with the family. An analysis of the findings is provided along with recommendations. Private agencies that contract with the Department are given an opportunity to respond to recommendations.

Monitoring

The OIG monitors implementation of all recommendations. Results of monitoring of many of the OIG recommendations are contained in this Annual Report.

Death Review

The OIG investigates all cases in Illinois in which a child has died where the child was a ward of DCFS, the subject of an open investigation or family case, or the subject of a closed abuse and neglect report within the last twelve months. In FY96 there were 69 such child deaths. (*See Death Review Report in Appendix I*)

III. OIG FOSTER PARENT HOTLINE

In October 1993, the OIG established a statewide, toll-free telephone number **(1-800-722-9124)** for foster parent access (in accordance with Public Act 88-007). Foster parents have called the hotline to request assistance in addressing the following concerns:

The Foster Parent Hotline received 304 telephone calls in FY 96.

- Child Abuse Hotline information;
- Child support information;
- Foster parent board payments;
- Youth College Fund payments;
- Problems accessing medical cards;
- Complaints regarding DCFS case workers and supervisors ranging from breaches of confidentiality to general incompetence;
- Requests for clarification of the statutory language, "best interest of the child;"
- Licensing questions; and
- General questions about the OIG.

For FY 96, the OIG Foster Parent hotline has received 304 calls. Of those, 232 calls were either directed to other agencies or referred to various offices within DCFS. The remaining 72 calls resulted in OIG investigations.

The Foster Parent hotline is an effective tool that enables the OIG to: communicate with concerned persons; respond to the needs of foster children; and address the day-to-day problems that foster care providers often encounter.

OMBUDS OFFICE

This year marks the second year that the OIG has supervised the Ombuds Office. The primary purpose of the Ombuds Office is to maximize client and public accessibility to DCFS services and offices. The Ombuds Office receives its inquiries through a toll-free number **1(800) 232-3798.** The Ombuds Office also investigates and responds to inquiries, complaints, and concerns that relate to child

welfare issues. The Ombuds Office ensures that recurring complaints or problems are addressed by the appropriate DCFS offices, bureaus, divisions, or staff. The OIG monitors the Ombuds Office through monthly meetings and case reports. The offices share case information and refer appropriate cases to each other. The OIG has been working with Ombuds to formalize responses to recurrent complaints, thus freeing Ombuds staff to respond to more complex problems.

In December 1995, Sharon Dawson, the first Administrator of the Ombuds office, retired after 20 years of service with the Department. Alma Mandeville, a highly qualified ombuds veteran, was recently appointed to succeed her.

RECOMMENDATION PROCESS: Changes in FY96

The OIG has changed its recommendation process to concentrate on implementation of recommendations to improve efficiency. Previously, as described above, completed reports were sent to the Director and the OIG awaited response. The purpose of the prior procedure was to maximize departmental input to ensure the soundness of recommendations. The OIG found, however, that the procedure focussed too much time and energy into developing the recommendations and not enough time and energy into implementing the recommendations. Currently, reports are submitted to the Director for discussion of recommendations. When recommendations are agreed upon, the Director identifies a contact person within the Department to implement the recommendations. The OIG will then monitor implementation of the agreed upon recommendations directly with the contact person.

The recommendations for FY96 are divided into four major categories: Major Report Recommendations, Private Agency Reform (recommendations involving private agencies that are contracted by the Department to provide child welfare services), DCFS Employees, and Systems Reform (recommendations involving child welfare policies and procedures). Not all of the OIG recommendations from FY96 are included. Only recommendations that address important systemic issues and employee discipline are listed.

RECOMMENDATIONS

Major Report Recommendations

Death Review Report

In May, the OIG submitted a detailed report concerning death investigations to the State Legislature entitled **Special Investigations of Child Deaths.** The report detailed the OIG death investigation process, included case specific and systemic recommendations that were made after completed investigations to prevent future child deaths, and listed the OIG abuse prevention initiatives.

The full report is included in Appendix I.

Private Agency Redesign

In FY 96 the Department embarked on a redesign of the delivery of case management services by private agencies that are contracted to provide case management services. The redesign shifted primary case management responsibility to many private agencies. Simultaneously, the OIG received increased allegations regarding private agency activities. The OIG investigations revealed problems that were exclusive to private agencies and problems that were related to DCFS Licensing and Contract procedures.

The Inspector General expressed strong reservations to the Director of DCFS about the wholesale transfer of case responsibility to private agencies under the "Private Agency Redesign" program. Rather than a wholesale transfer, the OIG recommended that transfer of functions begin with targeted, selected agencies which have demonstrated competency in service delivery. Such a staggered approach would both minimize risk to DCFS wards and allow DCFS and the agencies to identify and address unanticipated problems. Since some licensed private agencies had been identified as deficient by the OIG, the OIG noted that delegation of full case responsibility to them would be unethical. The "Private Agency Redesign" proceeded without incorporating the OIG's recommendations.

Child Welfare Agency Licensure and Contracts Report

In March 1996, the OIG submitted a report to the Director entitled **Child Welfare Agency Licensure and Contracts and Grants** to address a growing number of complaints against private agencies and to provide recommendations for reforming DCFS Licensing and Contracts procedures. The report suggested that the Department violated its fiduciary duties by licensing and contracting with agencies that are not capable of effectively caring for children. The report called for major reforms to reverse the trend of issuing licenses and large contracts to new organizations that do not have the organizational infrastructure necessary to support a service delivery system.

Principal Findings of the Report

- DCFS utilizes an inadequate set of standards as the basis for licensing organizations to operate as child welfare agencies. Agency compliance with current standards do not foster operations excellence or ensure protection of our children, and the provision of quality care and beneficial services.

- The manner in which contracts have been awarded places inexperienced agencies at greater risk of failure. The issuance of large contracts and significant programmatic growth within private agencies' first few years of operation undermines responsible management and quality service delivery.

- Non-enforcement of licensing and contract requirements has become the norm rather than the exception, while poor communication and coordination of information exists between licensing and contract units.

The report is included in Appendix II.

Based on the review of the Child Welfare Agency Licensure and Contracts and Grants report, the Child Welfare Ethics Advisory Board passed two resolutions. One recommended establishing strict regulations governing the composition of agency boards of directors. The second pointed out serious ethical failures of the Contracts and Licensing process and recommended a moratorium on funding increases for agencies with significant problems.

Ethics

The OIG Ethics staff, organizers and participants with the Child Welfare Ethics Advisory Board (a list of members appears on the next page), has worked on several projects which are designed to promote ethical decision-making with child welfare practice. In December 1995, the Director of DCFS approved a Code of

Ethics for Child Welfare Professionals. The Code was drafted by a broad-based committee of experts and practitioners in child welfare and ethics whose work was coordinated by the Ethics staff. The Code of Ethics defines the professional responsibilities of child welfare caseworkers, supervisors, and administrators to clients, colleagues, agencies, foster parents, the courts, and society. The Ethics staff is also working with a committee to develop a training manual to accompany the Code of Ethics.

The OIG Ethics staff assists both DCFS and private agencies in incorporating the values reflected in the Code into their training programs. It also conducts consultations and in-service trainings for individuals and groups of child welfare professionals who are interested in ethical decision-making and its application to difficult practice dilemmas.

The Ethics staff also serves as a resource to the Inspector General for consultation on ethics issues which arise in OIG investigations and provides administrative support for the operations of the Child Welfare Ethics Advisory Board. The Ethics Board is an advisory body which was created by the Inspector General in March, 1996 to fulfill two functions. First, the Board provides advice to the Inspector General regarding individual issues arising in particular investigations or systemic issues identified from investigations. Second, the Board is available to answer inquiries from any child welfare professional subject to the Code of Ethics and to provide confidential advice regarding practice dilemmas. *A copy of the Code of Ethics is included in Appendix III.*

Child Welfare Ethics Board Members

Name	Title
Phyllis Johnson, Ph.D.	Associate Director, DCFS Office of Quality Assurance
David Ozar, Ph.D.	Director, Loyola University Center for Ethics
Esther Jenkins, Ph.D.	Chairman, Chicago State University Department of Psychology
Michael Bennett, Ph.D.	Assistant Professor, Jane Addams College of Social Work University of Illinois at Chicago
Gene Svebakken, M.S.W.	Executive Director, Lutheran Child & Family Services
Betty Williams, M.A.	Senior Vice President, Metropolitan Family Services
Katherine Ryan, J.D.	*Partner*, Ryan Miller & Trafelet

Name	Title
Jim Connelly	Foster Parent
Judge Joseph Schneider	Retired B.H. Monitor
Tom Geoghegan, J.D.	*Partner*, Despres Schwartz & Geoghegan
Ada Skyles, J.D., Ph.D.	Research Fellow, Chapin Hall Center for Children

CASE RECOMMENDATIONS

PROBLEM ISSUE	**A three-month-old child died as a result of starvation due to parental neglect. At the time of the child's death, the child's mother had an open intact family case with DCFS based on substance abuse. The case was being serviced by a private agency that was unable to address the family's problems because it lacked expertise in substance abuse. The supervisor at the agency lacked the child welfare background necessary to effectively supervise and monitor workers in his unit. The two caseworkers at the private agency lacked sufficient clinical knowledge of substance abuse issues in order to provide adequate services to the mother. The DCFS unit assigned to the case did not adequately monitor the private agency's intact family unit.**
RECOMMENDATION	*(1) DCFS should no longer refer substance abuse cases to the agency. (2) Present funds currently allocated to generic intact family service programs should be reconfigured to those child welfare providers who also have substance abuse treatment programs, specifically the Project Safe program. (See Appendix IV for full investigative report.)*
STATUS	**The Department accepted both recommendations in concept. The Department will audit current providers to distinguish those with substance abuse expertise from those without such expertise. Those without expertise will be required to collaborate with substance abuse experts for servicing cases where substance abuse is the primary problem. The Department and the OIG and others will work together to implement the recommendations.**

PROBLEM ISSUE	**The OIG investigated a private agency after an adult living in a foster home sexually assaulted a foster child. The private agency had not performed a criminal background check on members of the household. In addition, the child had an unusually high number of placements in a short period of time. The OIG investigation revealed that in the majority of similar cases, children had been placed in homes without adequate criminal background checks. The investigation also indicated a lack of credentials for supervisory personnel and that the agency lacked a local Board of Directors.**
RECOMMENDATION	*(1) The Department should review agency records to identify supervisors with insufficient credentials and ensure that all supervisory positions are staffed by qualified people , review foster care licensing records to address those homes requiring criminal background checks, and identify cases involving multiple placements for review and attention. The agency's corrective action plan based on the Department's findings should be submitted in writing to the Department for review. The Department should monitor implementation of the plan. (2) A local Board of Directors must be established to provide oversight and accountability for the agency.*
STATUS	**The Department agreed with the required recommendations and is working with the agency to implement OIG recommendations.**

PROBLEM ISSUE	**Employees of a private agency informed the OIG that the executives of the agency hired unqualified relatives for agency positions, failed to pay employees and failed to pay foster parents for providing room and board for foster children. The OIG investigation confirmed that foster parents had not been paid. In addition, the investigation revealed that the executive director had hired her husband as a half-time maintenance person for the three room agency, had failed to exercise fiscal control, and did not have a basic understanding of financial principles of management. The Board did not provide genuine oversight.**
RECOMMENDATION	*(1) The Department should not contract with this private agency. (2) The Department should develop and require minimal standards of fiscal competency for agency directors to ensure their ability to manage or oversee sound fiscal operations of the agency. (See Child Welfare Agency Licensure Report.)*
STATUS	**The Department agreed with the recommendations. The Department did not renew its contract with the agency in FY 97. The Department is developing minimal standards of fiscal competency for agency directors in conjunction with its implementation of the OIG Child Welfare Agency Licensure and Contracts and Grants Report.**

PROBLEM ISSUE	**A child who had a well-documented sexual abuse history was placed in a foster home by a private agency that failed to inform the foster parents of the child's history. An incident occurred in which the foster child had fondled one of the biological children. The failure to inform the foster parents of the child's history placed their biological children at risk for harm.**
RECOMMENDATION	*The private agency should address the caseworker's failure to share information with the foster parents about the history of their foster child in a timely manner. The agency should also address the caseworker's failure to direct the foster parents to secure informational resources and to provide them with guidelines on how to deal with sexually abused children. DCFS and the private agency should ensure that all foster parents who are willing to accept sexually abused children receive the necessary training and support assist them in addressing the issues involved with sexually abused children. Relevant training resources or consultation should be made available on an ongoing basis.*
STATUS	**The Department agreed with all of the OIG recommendations and met with the agency and developed a corrective action plan. The OIG received a letter from the private agency outlining appropriate improvements instituted by the agency that involved policy and training. DCFS Licensing is monitoring implementation of the Corrective Action Plan.**

PROBLEM ISSUE	**The OIG investigated a private agency that had numerous allegations including: confidential personnel records were unsecured; employee documents were frequently lost; an employee improperly represented himself as having a master's degree and concurrently held a number of positions; the payroll was not met on a timely basis; records lacked case entries and client service plans; and case monitoring was nearly non-existent. The investigation confirmed most of these allegations and uncovered additional serious problems within the agency.**
RECOMMENDATION	*The Department should no longer contract with the private agency. The case was referred to the Illinois State Police for criminal investigation.*
STATUS	**The Department agreed with the OIG recommendations. The Department did not renew its contract with the private agency. All cases serviced by the agency were removed and transferred to other private agencies.**

PROBLEM ISSUE	**A licensed, single foster parent complained that her private agency caseworker informed her that no other children would be placed in her home because of her hours of employment. The OIG investigation revealed that the foster mother's work hours made her substantially unavailable to foster children. In addition, the foster parent had transferred her foster care license several times .**
RECOMMENDATION	*(1) DCFS should develop policy and protocol to address multiple transfer of a foster home license. It is recommended that foster home transfer and application forms require full disclosure of foster care history by the applicant and that there be a records check and evaluation of the foster parent's history with prior supervising agencies after a minimum number of license transfers. (2) DCFS should reevaluate the status of the foster parent's license. (3) The Department should develop licensing guidelines on the issue of employed foster parents whose work schedules result in their unavailability to the children in their care.*
STATUS	**The Department agreed to implement the recommendations. The private agency reevaluated and confirmed the continuation of her foster parent's license.**

PROBLEM ISSUE	**The OIG investigated allegations that a DCP investigator designated as a specialist in sexual abuse investigations placed children at risk of harm and made inappropriate and unprofessional comments to clients. It was also alleged that the DCP investigator helped a mother and her three children obtain plane tickets to leave the court's jurisdiction prior to the date on which the State's Attorneys was to petition the court to take temporary custody of her children. The investigation could not confirm the allegation regarding assisting the parent in obtaining airplane tickets. Several comments and actions by the worker, however, as reported by outside professionals, demonstrated a lack of objectivity and failure to adequately assess harm. Despite several unresolved complaints from professionals, the worker's evaluations were consistently positive.**
RECOMMENDATION	*(1)The worker should be transferred from her current unit, reassigned and retrained. (2) Employee performance appraisals need to accurately reflect the substance and the quality of work. (3) The DCP Deputy Director and the OIG will convene a meeting of DCP administrators and representatives of the professionals who had complained about the worker's performance of duties to establish a system for addressing complaints.*
STATUS	**The Department transferred the DCP worker out of the sexual abuse unit. Department will address concerns presented in the OIG report with the worker.**

PROBLEM ISSUE	**Outside professionals reported that a DCP investigator assigned to the Sexual Abuse Unit made several comments suggesting a bias in favor of alleged perpetrators. The investigator did not deny the comments but disputed the context in which they were made and denied that the comment demonstrated any bias. The OIG determined that regardless of the existence of actual bias, the comments to outside professionals evidenced a significant lack of professional judgement expected from a sexual abuse investigator.**
RECOMMENDATION	*The investigator should be transferred immediately from the Sexual Abuse Unit of DCP and no longer be allowed to represent the Department in the role of a Child Protection Investigator. Instead the investigator should be returned to a child welfare I position. (2) The worker should be referred to employee assistance program to assist him in issues of stress and anger management.*
STATUS	**The worker has been transferred from the Sex Abuse Unit and the Department will address the concerns presented in the OIG report with the worker.**

PROBLEM ISSUE	**The OIG investigated complaints against a foster home that included a complaint that a worker placed children in the foster home over the home's licensed capacity. The investigation confirmed the allegations and found that the employee was unaware of the number of children placed in the home.**
RECOMMENDATION	*(1)The worker assigned to the foster home should receive a written reprimand. (2) Upon placing a child in a foster home, the DCFS worker should notify the foster parent's licensing representative.*
STATUS	**1) The Department agrees that the worker should receive a written reprimand. 2) The Department will amend Procedure 300.160(b) so that the Licensing Representatives are included as persons to be notified of foster home placements.**

PROBLEM ISSUE	**A caseworker deposited an emergency assistance check from the Illinois Department of Public Aid in the amount of $597 in her personal account. When the biological mother cooperated with services, the caseworker said she would give her the money. When the caseworker was transferred to another DCFS office, she left a personal check payable to the biological mother for $597 in the case record. The check was never given to the mother. A year passed before a newly assigned worker discovered that the check in the case file. The caseworker's coercive use of the biological mother's entitlement funds demonstrated abuse of power, conduct unbecoming a state employee, and inappropriate behavior.**
RECOMMENDATION	*Disciplinary proceedings should be initiated against the worker. The parent should be compensated.*
STATUS	**Department agreed to implement the recommendations. The mother was presented with a check for $597 and discipline proceedings are pending.**

PROBLEM ISSUE	**A DCFS attorney was alleged to have performed professional services for a private client while on State time.**
RECOMMENDATION	*General Counsel along with the State Ethics Panel should convene discussion among Department attorneys addressing the permissible scope of outside representation.*
STATUS	**The Department has addressed this concern. DCFS attorneys abide by the Attorney General's Code of Ethics that prohibits them from outside practice.**

PROBLEM ISSUE	**A minor's biological parents alleged that a DCFS worker placed one of their children in an unlicensed foster home and improperly conducted an investigation of abuse and neglect. This resulted in the removal of their children from their home. The investigation revealed that upon hearing allegations from a teenager of physical abuse by his father, the worker assumed them to be true without initiating an appropriate investigation into the allegations. The worker also failed to review the family history, which documented an identical allegation two years prior that had been unfounded after an investigation.**
RECOMMENDATION	*(1)The DCFS worker and his supervisor should be disciplined. (2) The Department should determine how to respond to delinquency court orders requiring placement in unlicensed homes.*
STATUS	**(1) The Department agreed to discipline both caseworker and supervisor. (2) The Department issued policy guides to remind workers that they may not place children in unlicensed homes and directing workers to respond appropriately when ordered to do so by a court and to immediately notify DCFS Legal Counsel for appropriate resolution.**

Systems Reform

PROBLEM ISSUE	**The OIG investigated why an extremely vulnerable six-year-old child who had been sexually abused was removed from a foster home and subsequently placed in a residential placement. The OIG investigation revealed that a conflict between the private public guardian and the foster parent had escalated to a level on which the conflict took precedence over the best interest of the child. At the time of the change of placement, the child had been living in the foster home for nearly 1½ years and had not demonstrated any behaviors in the foster home that warranted residential placement. His foster mother wanted him back. The child spent over nine months in a residential placement that cost $9,315 monthly and totaled $83,835. In addition, the Department had failed to ensure criminal prosecution of the child's abuser, even though the child had consistently disclosed the identity of his attacker.**
RECOMMENDATION	*(1) The child should be returned to the foster home. (2) Caseworkers should coordinate a staffing with all professionals involved with the family's case to help determine the appropriateness of residential placements.*
STATUS	**As a result of the OIG investigation, the foster child was returned to the original foster home. The OIG worked with the Illinois State Police to locate and prosecute the child's abuser. The perpetrator was arrested and the States Attorney is now prosecuting him. The Department has instituted a Placement Review Team to ensure the appropriateness of every residential placement or assist the caseworker in developing alternatives to residential placement.**

PROBLEM ISSUE	**Six years prior to becoming a relative foster parent, the subject of this investigation gave birth to a child who tested positive for controlled substances. During the OIG investigation, the relative foster parent stated that substance abuse was no longer a problem since she had voluntarily entered a detoxification program and had tested clean. Through a LEADS check, the OIG learned that the foster parent had a recent felony conviction for heroin possession and was placed on probation with mandatory drug treatment. While the foster parent was currently testing negative for drugs, she failed to inform DCFS of her recent drug conviction.**
RECOMMENDATION	*The child should be removed from the foster parent's care.*
STATUS	**The child was removed and placed in another relative foster home. The investigation raised the systemic issue of how DCP should respond to first-time substance-exposed infants is being examined by DCFS and some of its contractors. The OIG is currently reviewing literature toward developing a draft protocol for Department response to substance-exposed infants.**

OIG Investigation Interim Reports

Periodically, before investigations are completed, the OIG releases investigation interim reports that provide preliminary recommendations to address issues that require immediate attention. Included here are summaries of FY 96 interim reports and recommendations.

INTERIM REPORT A

The OIG conducted an investigation of a private agency with the involvement of a new partner, the Illinois State Board of Education (ISBE). The investigation involved a residential center that prevented one of its residents from attending mainstream education classes despite having no reported behavior problems which would have prevented her from attending classes. The nine-year-old resident was confined to the residential cottage during a period of "extended shut down" for 24 days in the month of April. During this same period, the minor was not permitted to visit with her foster family off campus, or visit with her sibling. The local school where the child was mainstreamed reported no classroom behavioral

problems, and were concerned about her sporadic attendance at school.

The OIG determined that the private agency was in violation of DCFS Rules and Procedures Education Policy, Section 384.30 Discipline and Behavior management in Child Care Facilities, and Section 384.80 Confinement. The ISBE Special Education Unit agreed with the OIG finding that school suspensions of residents for cottage behaviors is illegal. The OIG convened a meeting with the private agency's CEO, and the ISBE Grants Administrator of the Orphanage Act to discuss school suspensions in order to remedy the violations.

The child was removed from residential placement and placed in a pre-adoptive foster home with her brother where she attends mainstream classes.

INTERIM REPORT B

Another OIG investigation revealed that caseworkers had knowledge that a Department ward had fired a gun in his bedroom. Though the ward reported to the caseworkers that he had disposed of the weapon, the caseworkers did not report the incident to the police or ensure disposal of the weapon. The investigation identified as a critical problem the failure of Department workers, administrators, foster parents, and private agencies to effectively and consistently address the issue of Department wards in possession of weapons.

To address this lack of consistency, the OIG recommended the distribution of the interim report to each of the Child and Adolescent Local Area Networks to develop a community protocol because they foster communication and collaboration among the various community resources. The interim report recommended the inclusion of the possession of weapons in the list of behaviors warranting an unusual incident report. The report also suggested a protocol for responding to minors in possession of firearms. Major elements of the protocol proposed that:

> DCFS should collaborate with the law enforcement youth officer in determining the action that is best suited to the circumstances of the minor, the foster family, and the community. The Department worker or contracting agency will cooperate with the youth officer and DCFS in obtaining relevant information pertaining to the circumstances surrounding the minor's possession of the weapon and the minor's background.

The Department and the OIG are working together to implement the above protocol.

INTERIM REPORT C

The OIG provided the Director's office with an interim report of an investigation of a private therapist who contracts with DCFS. The therapist, reportedly, displayed inappropriate behavior with a client. The client, employed by a bakery in a large department store, was required by his therapist to bring pies to each visit. The supervisor of the bakery reported to the OIG that the therapist had called, asked "personal" questions, and divulged confidential information regarding the client. During the investigation, the OIG discovered that the therapist misrepresented himself as being a Licensed Clinical Social Worker (LCSW). The investigation also revealed that the therapist was assigned two DCFS provider numbers. This allowed the therapist to circumvent Departmental oversight that would have been required for contracts over $5,000.

The OIG recommended that DCFS should not contract with this therapist for any services, and that DCFS should review its resource databases to ensure that providers do not have more than one identification number.

The Department has notified all regions not to contract with the therapist for services. The Department is working on resolving the multiple identification number problem.

FOLLOW-UP REPORT: Recommendations Contained in Previous Annual Reports

Since the first OIG annual report a number of recommendations have yielded substantive changes within Departmental procedures and private agency operations. Other recommendations may take longer to implement. Contained below are select recommendations that have appeared in previous annual reports that were not fully implemented at the time that the annual reports were issued. Prior recommendations have also been presented where subsequent OIG experience has revealed fine tuning necessary in the implementation process. For instance, a corrected policy statement might have been issued, but new allegations demonstrate that the policy change has not filtered down to line workers. In these cases, the OIG will work with the Department to identify the problem and recommend a solution.

Report Recommendations from FY 1994

DATA COLLECTION

-In cases involving allegations of physical or sexual abuse, investigators should be required to collect medical and psychiatric hospital records from all hospitals within a reasonable vicinity. This recommendation requires the appropriation of funds for facsimile machines in each office conducting investigations. The equipment must be designated exclusively for investigative purposes in order to keep lines open for this vital documentation.

The Cook County Child Death Review Team also endorses this recommendation. The Department is upgrading its telefax equipment to have the capability of broadcast faxing.

LEADS ACCESS

-Investigators should check criminal histories of alleged perpetrators of physical and sexual abuse by utilizing the Law Enforcement Agency Data System (LEADS) network.

While LEADS access has been achieved, the OIG learned that the use of LEADS was restricted to "Priority 1" cases. This restriction resulted in children and workers being unnecessarily exposed to risk of harm. The OIG has developed a Draft protocol for the use of LEADS to ensure that it is used in all cases involving violence, sexual abuse, and substance abuse. The Department has agreed to implement the protocol. (*See Appendix V*)

PERSONNEL

The OIG investigated allegations of false credentials presented in job applications. In addition to investigating specific allegations, the OIG conducted a random review of 105 personnel files and discovered several instances of false credentials. As a result, the OIG recommended that a sealed copy of the transcript from the most recent institution be submitted with the application.

The OIG made this recommendation when most workers were employed by DCFS. The Department implemented the recommendation. This recommendation has been extended to private agencies as well. The Department has notified private agencies and contractors of the necessity of verifying credentials of staff and contractors and will perform an onsite review to determine compliance with the directive.

Report Recommendations from FY 1995

LICENSING REFORM

-Licensing should review any home that is the subject of two or more unfounded hotline investigations.

While the Department agreed to implement this recommendation, subsequent allegations have cast doubt on the extent of implementation. The OIG will work with the Department and continue to monitor implementation of this important recommendation.

CASE PLANNING AND STAFFINGS

-When a family is receiving services through more than one DCFS office, case records and information subsequently learned must be consistently shared between caseworkers. Staffings should be utilized to enhance case planning and decision making.

The Department will incorporate this recommendation into case planning initiatives currently under review.

OVERBURDENING FOSTER PARENTS

OIG investigations revealed that elderly foster parents were frequently overburdened with the number of children and the special needs of children placed in their homes. Prior to placement of children in foster homes, workers should assess the demands placed on the foster parent by current foster and natural children and determine whether the parent is capable of caring for another child.

While policy has changed to implement these agreed upon recommendations, there is evidence that not all line workers and supervisors have integrated the change into daily practice. In addition, the OIG learned that the Department does not maintain the age of the caretaker in its database of caretaker information. The OIG will continue to work with and monitor the Department's implementation of the recommendation and to develop procedures to keep track of caretaker age to assist workers in determining caretaking capabilities.

ADDITIONAL REVIEW FOR MULTIPLE ALLEGATIONS

Several OIG investigations involved families that had more than two prior allegations of abuse or neglect. While there may be explanations for prior allegations, the existence of prior allegations is often an indicator of problems with the family that need to be addressed. In addition, the OIG learned that multiple allegations against a family (more than 2) amounted to only 22% of all child protection investigations. Therefore, the OIG recommended that the Department audit all multiple allegation cases and hold specialized staffings. In addition, the OIG recommended that DCFS training focus on the necessity of attending to multiple allegation cases.

DCFS agreed to retrain investigators and follow up workers on existing policy regarding reviewing all prior family investigations as part of Child Endangerment Risk Assessment Protocol Training.

OIG INITIATIVES

SEXUAL ABUSE/ DIVORCE TASK FORCE

From its inception, the OIG received several complaints from parents alleging that sexual abuse allegations against a parent had been improperly unfounded or improperly indicated. The investigations were some of the most difficult to resolve for several reasons. By their nature, sexual abuse investigations are often the most difficult investigations because there may be no physical evidence and the only witnesses may be the perpetrator and the very young victim. When the allegations are against a non-family member, investigations are often resolved by de-emphasizing the determination of whether the abuse occurred and simply prohibiting contact between the child and the alleged abuser. When the allegations are against a parent, however, the issues are more complicated.

The risk of a bad decision increases, since a wrongly indicated report may mean that a child's relationship with a biological parent is compromised or destroyed and a wrongly unfounded report may mean that the perpetrator has unsupervised access to the victim. When the allegations are against a parent during or after divorce proceedings, the issues are further complicated. Since a complex and antagonistic relationship often exists between the two parents, motivations of the outcry witness may be subject to question. Moreover, the naturally close relationship between the child and the complaining parent may influence the child in subtle ways. To complicate matters further, the cases involve joint jurisdiction of both divorce and child custody court systems, each with their own rules and procedures. Within the context of these complex interpersonal relationships, truth is often difficult to discern. To add to the complexities initially presented, by the time a complaint was made to the OIG, there was an increased possibility of irretrievably distorted memories through prior interviews. As a result, even small numbers of these complaints can consume a large amount of time and resources.

To develop procedures for handling these cases, the OIG hired a licensed clinical social worker to review current literature and prepare a report outlining the issues. **The report is provided in Appendix VI .** In addition, the OIG convened a task force, composed of the supervisor of Assistant Public Guardians in Cook County Domestic Relations Court, a vice president of a private hospital that specializes in the evaluation of sexual abuse, a licensed clinical social worker, the Director of Cook County Clinical Services, representatives of the OIG and a representative of the Child Advocacy Centers, funded by DCFS. The task force was asked to develop recommendations regarding improving the general process employed to initially investigate the hotline allegations. The task force has been meeting regularly for the past year and expects to issue recommendations during the next fiscal year.

Mental Health Task Force: Parenting Assessment Team (PAT)

Referrals:

For FY 96, 109 referrals have been made to PAT by child welfare workers and the Juvenile Court.

Eighty-three were accepted for assessment by PAT.

In August 1993, to help address systemic problems with accurate assessment of parenting capacities, case management, and coordination of services to parents with mental health issues, the Governor and the OIG convened a Mental Health Task Force. One of the Task Force recommendations was to develop a Parenting Assessment Team (PAT) to perform comprehensive, methodologically sound assessments of parenting capabilities for use by the courts and DCFS in cases where mental illness was an issue.

The Team began accepting referrals in the fall of 1995. Through the joint effort of the Thresholds Mother's Project and the University of Illinois at Chicago (UIC), Department of Psychiatry, DCFS allocates funds, and its Division of Clinical Services (DCS) provides oversight and general guidance to the project. The purpose of the project is to assist DCFS and the Juvenile Court in a non-adversarial evaluation of mentally ill parents who are alleged perpetrators of child abuse or neglect. The objectives are to (1) improve the accuracy, comprehensiveness and relevance of parenting assessment, (2) substantially decrease the time it takes to adjudicate these cases, (3) prevent a "backlash" against mentally ill mothers who are nonetheless adequate parents, (4) improve communication among clinicians, DCFS workers and judges, and (5) educate professionals about the components of a valid assessment.

These assessments involve parent/child observations, developmental/attachment assessments, intensive forensic evaluations, collateral interviews, records reviewed and individual contacts with the clients (the average number of contacts between the Team and each individual is six.)

During the first two quarters in FY 96, the number of referrals nearly tripled compared to the number of referrals for all of the previous year. By the end of FY 96 there was a backlog of referrals to this single team. The Task Force's previous recommendation to create an additional team stands due to the overwhelming demand for the Team's services.

Tools for Improving Child Welfare Services: Case Studies

The OIG began preparing special versions of completed investigations and reports with confidential information removed to private agencies. This practice follows the tradition of law as well as clinical social work that distributes case studies as learning tools. The intent is for child welfare workers ranging from administrators to caseworkers to review the facts and applications of issues that were revealed in OIG investigations. The overall goals of this exercise are to improve the operations of agencies and to address complex issues to ultimately provide better care to Illinois children.

One report that was distributed to private agencies is included as Appendix IV. Appendix VII contains an investigation report concerning a complex private agency case involving substance abuse and child safety issues.

OIG Adoption Initiatives

Many of the initial complaints that came into the Office of the Inspector General (OIG) when it was established in the spring of 1993 centered on the Department's adoption practices. In the summer of 1994, the OIG released a study recommending several ways the Department could improve its adoption practices. Several of these recommendations have been implemented. Adoption continues to be a priority of the OIG and the office has piloted several projects that have contributed to shaping the Department's focus on permanency.

Kinship Permanency Planning Project

This project addresses the concern that children linger in foster case when there may be other permanency options. In 1993 Mark Testa, at the University of Chicago, reported that 67 percent of the home of relative foster parents stated that they might be interested in adopting their foster children but no one had mentioned the possibility to them. At that time it was not the practice of the Department to take specific consents from birth parents so that adoption to the caregiver could bypass the lengthy wait for termination of parental rights hearings.

In an effort to bring permanency to families and help them make plans for their children's lives, the OIG along with Northwestern University Legal Clinic, Resource

Alliance (a mediation firm), and the Department initiated the Kinship Permanency Planning Project. The prime component of the Project is a family conference, facilitated by a specially trained mediator, that is designed to encourage discussion between the birth parents, relatives, caretakers, and significant others about the appropriate permanent plan for the child. Specially trained staff also are available to take a specific consent when appropriate. Prior to a family conference, all interested representatives--state's attorney, public defender, guardian ad litem--are notified of the anticipated mediation and have an opportunity to attend, or to object to the case being referred for mediation. The mediation will not go forward if there is an objection. (An example of an objection would be a situation where the state's attorney wants to build a record for termination because of other siblings in the system or anticipated future cases that may involve the family.)

In the almost two years of this pilot project, 718 referrals have proceeded to mediation. The conferences have resulted in adoption agreements for 124 children (mediation is continuing for 323 children), and agreed long-term placement with relatives for 38 children; and for the remaining 233 children, it was determined that the facts concerning the abuse or neglect of the child, or the identified caretaker made an uncontested adoption inappropriate.

This pilot project has increased recognition of the need for families to come together to create a plan for the children, and for taking specific consents for adoption. This is now considered the preferred practice. The characteristics of the Kinship Permanency Planning Project are being instituted within the child welfare system. Twenty-five adoption supervisors and workers from the Department and private agencies recently were trained and mentored in Kinship mediation and will begin to handle these cases. In addition, the expanded initiative will include relative and non-relative foster parents.

Case example 1: Three children ages 11, 7, and 3 had lived with their maternal grandmother since birth. The 11- and 7-year-olds were performing well in school. The biological mother was unable to care for the children. The biological father of the 7-year-old traveled from Panama to attend the mediation session. Many family members were supportive of the grandmother's adopting the children. Following the mediation, the parents signed specific consents for the grandmother to adopt all three children.

Case example 2: The biological mother had two children living with two different relatives and was 8 months pregnant when the case first came to mediation. The biological mother was concerned that the bad relationships and the lack of communication she had with the caregivers of her two children would only get worse after adoption. The biological mother wanted to maintain the relationship she had with her children and also did not want their names to be

changed. Three mediation sessions were held to go over the issues and concerns of all those involved. In the meantime, the biological mother delivered a healthy baby boy. It was after the birth of her third child that the biological mother realized how important it was for her two other children to have the comfort of a loving family. At the fourth mediation she signed the specific consent for all the respective families to adopt the children who had been living with them.

Diligent Search Center

The length of time that the termination of parental rights process takes delays the adoption of children. One particular step in this process that has caused unnecessary delay is the diligent search for the biological parents. A diligent search is required to ensure the integrity of a termination hearing. This process can be difficult for those unfamiliar with it and tedious for caseworkers who are ill-equipped to search phone books across the country, public aid terminals, or send out certified mail. The OIG, with Northwestern University Legal Clinic, realized that searches could be performed more efficiently with a national data base and staff trained in computer searches. The OIG applied for, and received, a grant from the Department of Health and Human Services to begin the Diligent Search Center. The Department sub-contracted with Illinois Action for Children (IAFC) to run the Center. IAFC volunteers staff the Center under the direction of a paid program director. The Juvenile Court provides space and DCFS contributes 10 percent matching funds.

All parties involved-- the courts, the State's Attorney Office, DCFS and advocacy groups--have welcomed the Center. Since January of 1996, the Center has received 800 referrals and completed 400 searches. Intake has increased to an average of 40 requests per week statewide. The Center has been funded for the second and final year of the grant. The OIG is exploring funding options to add an additional computer and work station in order to meet the growing demand, and to retain the Center when the federal funding ends.

Adoption Clinical Review Panel

In January of 1995, a clinical review panel was created in response to an OIG recommendation regarding certain disputed adoption cases. This panel consists of psychologists and child welfare clinical experts (some of whom are also adoptive parents). These experts are independent of the Department and receive a small stipend to review case material and construct clinical recommendations for the Department.

Sometimes adoption raises difficult issues regarding the appropriateness of a placement or the best plan for a child. There may be competing parties--all of whom are connected to the child--who wish to adopt the child, or there may be conflict

about whether adoption is a viable option altogether. Sibling involvement is another factor that must be considered. Some children suffer from disabilities that require a certain level of care, and it may be unclear whether the caretaker who wishes to adopt can provide the necessary care. Case workers from the Department and private agencies are sometimes grounded in their own personal history in the case and therefore blind to alternative options for the child. Prior to the creation of the panel there was no independent clinical consideration of the issues in a case. The panel reviews the case, interviews professionals involved, and makes a clinical recommendation to the Department regarding the appropriate permanent placement for the child. To date panel members have heard and provided recommendations to the Department concerning 29 children. This service is available on a statewide basis.

Case example 1: One child who suffered from a growth retardant disease was severely abused by his mother and step-father. He was brought to a hospital on a holiday weekend. The case was highly publicized. The child lingered in the hospital for over six months and then was placed in a group home and several foster homes spanning a two year period. The child's paternal grandparents (out of state) came to Chicago when the child was taken to the hospital and offered to raise the child with his brother who is two years older and had already been living with the grandparents and doing well. The Department refused to consider the grandparents as an appropriate placement and instead were considering returning the child to the biological mother once she was released from prison where she was serving time for criminal child abuse. The grandparents continued their pursuit and the case was referred to the Adoption Panel. After reviewing the case, the adoption panel recommended that the child be placed with his grandparents in a timely fashion. Presently, the child is thriving with his brother, grandparents and other uncles and aunts.

Case example 2: A child, now three-and-a-half-years-old, had been with a foster mother since birth. Until recently, the biological mother was not involved in decision-making regarding her son, in part because of mental illness complicated by a serious physical illness. Four siblings were placed with the maternal grandmother with a plan of returning them to their biological mother. Serious concern existed on the part of some providers regarding the mother's parenting ability. Some providers were concerned about the appropriateness of the foster family home of the three-and-a-half-year-old, and considered placing the child with his four siblings in his grandmother's home. After meeting with all the workers involved in the case and reviewing case files and a psychological report on the mother, the Panel recommended that the child remain with the foster parent. Though the ultimate goal was for the foster parent to adopt the child, the Panel suggested that it was in the best interest of the child to maintain regular contact with his mother, siblings and grandmother (a plan with which the foster parent agreed).

Cook County Adoption Function Redesign

The OIG and the Department agreed there was a need to identify more children who are appropriate for adoption, and to move them more quickly to permanency. In March 1996, at the request of the DCFS Director, the OIG began to work with Cook County adoption supervisors to design a new system for facilitating adoption in the three DCFS Cook County Regions. As a result of this effort, the focus of the adoption workers' efforts will soon be to provide technical assistance to public and private agency workers to help them aggressively identify children appropriate for adoption, and to move the case toward implementation of the adoption plan. In those cases where a foster home will be converted to an adoptive home, the already assigned worker will retain primary responsibility for the case, but the adoption worker will work with the already assigned worker, the child, and if appropriate, the foster or relative care giver to explain adoption and prepare the child and adoptive family for adoption if it becomes the plan. In those cases where a child has been identified for adoption, but the current placement is not a viable adoption placement, the adoption worker will assume responsibility for actively recruiting an adoptive resource, and pursuing the steps needed to achieve an adoption.

Linkages with Law Enforcement to Ensure Better Cooperation and Coordination Between DCFS and Law Enforcement Agencies

The OIG continues to work actively with the Division of Child Protection and a number of law enforcement organizations. The goal of these efforts is to forge a closer link between DCFS workers and law enforcement personnel at the state and local level to improve cooperation and coordination between the agencies and to improve the child protection and criminal investigation processes. The OIG served as consultant on two separate projects involving DCFS and law enforcement.

A Joint Project On Child Abuse and Neglect Investigations was conducted by the Special Counsel to the Governor for Child Welfare Services, The Illinois Department of Children and Family Services, The Cook County State's Attorney Office, The Chicago Police Department (CPD), and the Illinois State Police (ISP). The collaborative project, focusing on joint child protection investigations, came from discussions among former Special Counsel to the Governor, Anne Burke, State Police Director Terrance Gainer, DCFS Director Jess McDonald, Chicago Police Superintendent Matt Rodriguez and DCFS Inspector General Denise Kane. Representatives from each office met to design a child protective investigative

project. As a result, an integrated unit of DCFS, ISP, and CPD personnel, designated the Child Protection Enforcement Group (CPEG) was formed to investigate all DCFS priority II abuse and neglect reports within a small geographic area in Chicago for 90 days. At the conclusion of the project, a report with findings and recommendations was completed. The CPEG demonstrated ways in which DCFS and law enforcement agencies can be complimentary and deliver benefits of increased efficiency and effectiveness.

The OIG also consulted on a project involving *Cross Training Between The Chicago Police Department and the Illinois Depratment of Children and Family Services Cook County Child Protection Division*. The Office of Special Counsel to the Governor for Child Welfare Services (OSC) convened a Child Protection Working Group consisting of representatives from the CPD, DCFS, and the OIG. The working group developed a training curriculum on child welfare for CPD officers. The curriculum provided uniform training on DCFS policies, procedures, and practices for officers who encounter child welfare issues. The CPD's Research and Development Division then developed a training curriculum on police procedures, organization and ways to obtain police assistance in child protection investigations for DCFS Cook County Child Protection Investigators. This was the first time that DCFS and the CPD attempted to cross train virtually all of their investigators and patrol officers in Chicago.

As a result of both projects, DCFS, the Chicago Police Department, and the Illinois State Police are committed to future cross training initiatives. Additionally, plans are being made to provide cross training to law enforcement personnel and Child Protection investigators statewide. The OIG will continue to participate in these initiatives.

Casework Best Practice: Best Practice for Permanency Project

The OIG, with casework supervisors and administrative case reviewers from DCFS and private agencies, continued developing innovative training based on principles of best practice for child welfare. The project includes a two-day, simulation-based training on skills for testifying in court. Over the course of the training, caseworkers get many opportunities to get "on their feet," practicing techniques of talking with attorneys out of court, presenting the case in court, and handling cross-examination. The feedback from workers has been overwhelmingly positive. To date, 75 workers and supervisors have been trained; an additional 160 workers will be trained during the next fiscal year.

In addition, the Project began field trials of practice strategies which show promise for reducing children's length of stays in foster care. Each field test involves a

limited number of caseworker and supervisor participants who receive hands-on training and are asked to put the new practice into action. The purpose of a field test is to make sure that what appear to be good ideas actually work in Illinois. When barriers to the new practices are identified, the OIG and participants work to address the barriers or revise the strategy. The result will be a better model of practice, a practical hands-on training model, and a set of reality-based recommendations for changes in policy. Described below are three field tests that are in progress.

The **Collaborative Service Planning Conference Model** is a series of interventions designed to produce better decisions for foster children whose parents have begun to make progress in substance abuse treatment. The target cases are typically complex; a number involve multiple children in foster care for varying lengths of time. The model was developed after a 1994 Inspector General study of such parents revealed that they often had multiple children in care, unrealistic views about what they needed to do (in addition to maintaining sobriety) to secure return of their children and, though they were involved in their substance abuse program, were often in poor contact with their children's caseworker.

The critical component of the model is a case staffing which involves the parents, their extended families and support persons, the child welfare worker, and the substance abuse provider. The goals of the conference are to include extended family input into the case planning process in order to gain agreement on parental task requirements, and inform the parent about the status of his or her children. Emphasis is placed on the time frames for making a final decision on the child's permanent home.

A second field test, entitled **Partnering with Families for Permanency,** is a collaborative endeavor of DCFS, OIG, the Child Care Association, Volunteers of America (VOA), and Lifelink/Bensenville Home Society. It has been developed to test a series of best practice strategies for achieving a more timely permanent home in a less adversarial manner both for children who should be able to return home quickly and for children who are unlikely ever to be returned home.

A study group of children under the age of 12 who have been in foster care for one year or less will be assessed regarding the likelihood of reunification with their parent. Workers and supervisors will be trained in the use of two tools which have been developed by the Child Care Association -- an interview protocol which will supplement existing assessment tools, and a decision-making matrix which is designed to be used by the supervisor and worker together to differentiate cases. The tools will assist in the identification of families at both ends of the substitute care continuum: families whose strengths are such that children are likely to be able to be reunified with the family within a period of five to eight months from

time of entry into care, as well as families where the children are unlikely to be able to be reunified within a reasonable period of time, given the children's ages.

For the latter families, *contingency planning* is recommended. *Contingency planning,* sometimes referred to as concurrent planning, is a model of practice in which parents are offered time-limited services with a clearly stated preferred goal of return home. At the same time, other permanency options are explored with full knowledge and, if possible, participation of the parents. If the parent has not made reasonable progress within a six to nine month time frame, the alternative permanency option is pursued. During the period of service delivery, every attempt is made to place the child in a home which could become a permanent placement if the child cannot be returned to his/her parent.

When a child is identified as *unlikely* to be reunified, the worker and casework assistant will likewise schedule a permanency conference involving the parent, kin and, where appropriate, the child's non-related foster parent and key service providers. If the recommendation is for immediate pursuit of an alternative permanent home with an identified caretaker, the parent and the caretaker will be offered the opportunity to enter into mediation to explore the parent executing a specific consent for adoption. If this offer is accepted, the project will provide full mediation services through the agencies' trained mediators. (VOA's mediators will mediate Lifelink cases, and vice-versa, to assure objectivity.) If the parents do not wish to avail themselves of this less adversarial approach, the case will be screened for termination of parental rights and adoption planning.

When the agency's recommendation is for contingency planning, the goal of the family conference will be to inform the parties of the intention to pursue concurrent planning. The parties will be informed of the requirements of the parents' service plan and the time frames under which the parent's progress will be evaluated. If appropriate, the parents and family will be offered the opportunity to mediate a possible specific consent for adoption.

The project will provide training and ongoing consultation to workers and supervisors on the principles and techniques of concurrent planning and will provide tools to assist in the documentation of the parents' and caseworkers' efforts and progress.

Evaluation will be conducted on the application of the matrix, the process and outcome of the permanency conference and mediation sessions, and the process and outcome of concurrent planning efforts. In addition, where cases are referred for immediate termination of rights, the OIG will track these cases in the screening, Juvenile Court, and post-termination phases.

A third field test involves **Case Management Tools.** The field trials test the effectiveness of new informational tools in supporting decision-making. These tools enable workers and supervisors to chart progress in key elements of a case.

Best Practice for Permanency Advisory Group

In April, 1996, the OIG convened a group of university-based experts to serve as an Advisory Group for continuing work on the Best Practice Project. This advisory group will serve as a bridge between the OIG's best practice work and the efforts of the DCFS-University Training Partnership. Once the Training Partnership is firmly established and in the business of training, the Best Practice Advisory Group will disband. The OIG remains committed to the inclusion of the state's private child welfare agencies in this process; private agency caseworkers and supervisors need and want training opportunities to improve their practice.

OIG Partnerships

The OIG has coordinated investigative and research efforts with several organizations. The most frequently contacted agencies are the Attorney General's Office, the Department of Professional Regulations, the OIG of the Department of Public Aid and the Cook County State's Attorneys Office - Division of Public Integrity. The OIG also partners with law enforcement personnel from municipal, state, and interstate offices. The OIG initiatives previously detailed demonstrate partnerships with universities, hospitals, and other state human service agencies, including the Illinois State Board of Education (ISBE).

APPENDIX I

Death Report

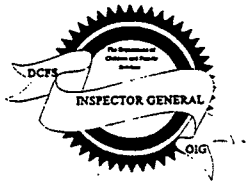
SPECIAL INVESTIGATIONS OF CHILD DEATHS

MAY 1996

ILLINOIS DEPARTMENT

OF

CHILDREN AND FAMILY SERVICES



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INTRODUCTION

This report has been prepared in response to a legislative request for information on investigations by the Office of the Inspector General following the recent death of a child.

The Office of the Inspector General (OIG) was created by the Legislature in June of 1993, after the death of a three year old child by his mother, soon after The Illinois Department of Children and Family Services (DCFS) had returned the child to his mother. The legislative mandate of the Office of the Inspector General is to investigate allegations of DCFS or private agency misconduct. In addition, the Inspector General is to perform other duties the Director of DCFS may designate. From its inception in June of 1993 until January of 1995, the OIG investigated only those deaths of DCFS wards pursuant to a specific request by the Director of DCFS, the Governor or a specific allegation filed by a member of the general public. In July of 1994, the newly appointed Director of DCFS, Jess McDonald, asked the OIG to replace the DCFS Administrative Review Team (ART). The ART had investigated selected deaths of DCFS wards to determine whether there was any wrongdoing on the part of DCFS or private agencies with which DCFS contracts.

In preparation for replacing the ART, the OIG determined that, rather than relying on a referral process, it was necessary to review all child deaths to determine which deaths implicated possible misconduct and should be investigated by the OIG. In January of 1995, the OIG began instituting procedures to review all initial reports of child deaths in Illinois from the State Central Register of DCFS. The State Central Register receives allegations of abuse or neglect of Illinois children, including all child deaths. Reports of child deaths represent approximately 2-3 percent of all allegations that DCFS must investigate. The Division of Child Protection of DCFS must investigate all allegations against the alleged perpetrator to determine whether the allegations are "indicated" or "unfounded." The DCFS investigation is separate and apart from the OIG investigation, which focuses on possible misconduct by child welfare professionals.

In line with the nationwide average, only approximately 1/3 of all death allegations are indicated by DCFS against the perpetrator. In other words, in nearly 2/3 of cases alleging that a child died as a result of abuse or neglect, DCFS determines abuse or neglect was not the cause of the death. In addition, of the 1/3 of death allegations that are "indicated," nearly 3/4 are first-time allegations, where there was no prior DCFS contact with the perpetrator.

Office of the Inspector General Death Investigations

The OIG investigates only those deaths which appear to have been the result of abuse or neglect and in which there was an open DCFS case or prior DCFS involvement within the last 12 months. For instance, if the medical examiner determines that a child died of natural causes, the OIG would not investigate. Sudden Infant Death Syndrome (SIDS) is a frequent cause of child deaths. The OIG does not investigate deaths due to SIDS since the Illinois Department of Public Health provides counseling and intervention statewide following a SIDS death and Loyola

Medical Center investigates all SIDS deaths in Chicago to compile information regarding the syndrome.

The OIG does not generally investigate child death reports where there has been no prior contact with the Department, since these deaths do not implicate any misconduct on the part of DCFS, its employees or private agencies. In addition, the OIG will not investigate child when there is no connection or too much time has passed between previous allegations and the child's death.

The OIG has initiated 27 death investigations from its inception through January 1996. Three of these predate the OIG review of death reports and were initiated at the direction of the Governor or the Director of DCFS. Protocol for death investigations within the OIG generally involve the immediate impounding of the DCFS file and any private agency files to prevent tampering. Then, subpoenas are issued for all relevant external documents, such as school, hospital and police records. After reviewing this initial documentation, the OIG will order the Medical Examiner's Report, relevant court transcripts, and prepare an investigation plan. Once the Medical Examiner's Report is received, the OIG will conduct interviews of parties with information, including the subjects of the investigation. All information is then analyzed to determine whether any discipline is appropriate and what systemic changes within the current institutions might prevent such a tragedy from occurring again. A report, including disciplinary and/or systemic recommendations, is then prepared and sent to the Director of DCFS. After reviewing the report, the Director internally circulates OIG recommendations for comment and submits a response to the OIG.

To date, the OIG has completed twelve death investigations. One of the investigations was closed without a report, because during the pendency of the investigation, the Medical Examiner determined that the child had died of SIDS. Another investigation was closed without a report after a determination that no misconduct was involved. The results of the remaining investigations are included in this report.

In addition to death investigations, the OIG receives over 600 requests for investigation from the general public each year. These investigations range from improper delivery of services to sexual or physical abuse of DCFS wards. The focus of all OIG investigations is to determine whether any DCFS or private agency misconduct was involved. The non-death investigations may also involve serious issues of child safety and welfare and may necessitate immediate attention by the OIG.

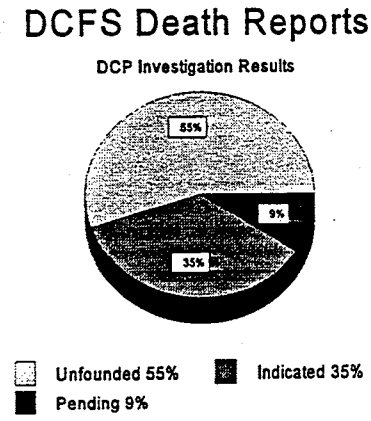
In investigating allegations of abuse and neglect, including those of child deaths, the OIG makes use of expertise outside the Department including the Mental Health Task Force, the University of Illinois Parenting Assessment Team, the Adoption Panel and the Child Death Review Teams. In addition, the OIG relies heavily on law enforcement personnel. When the investigation reveals conduct that rises to the level of criminal misconduct, the OIG refers the investigations to the Illinois State Police.

The Significance of Death Statistics

A death involving prior DCFS or private agency contact may be indicative of any of several factors. A death could signify general societal problems and the outgrowth of problems plaguing areas of poverty, such as drugs or gang violence, when there are no safety nets in place for our children. A death may also signify a need for general, safety or public health information, such as an unusual number of drowning incidents during summer months.

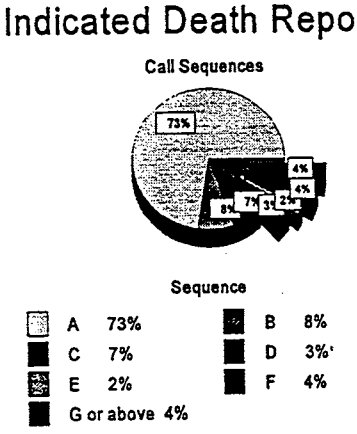
Child deaths may also signify a failure by an individual worker or systemic problems within a private agency or DCFS. Systemic problems may include a lack of training, a lack of supervision or the assignment of inexperienced workers to complex cases. Other deaths, even with prior DCFS involvement, may have been unavoidable, a result of unpredictable factors. The science of predicting violence toward children is imprecise. We are forced to work only with gross indicators of future violence. The OIG becomes concerned when those indicators were present but ignored. In this small percentage of cases, the OIG will conduct further investigations and recommend discipline for the responsible employees and/or systemic change within DCFS or the private agency involved. For instance, in a case in which a child died after being placed in a foster home that was the subject of prior unresolved allegations of abuse and neglect, the OIG recommended discipline and that DCFS institute a system through which workers must check for pending child protection licensing investigations or violations prior to placing a child. In another investigation, however, a child in care died allegedly at the hands of a foster mother with whom DCFS had placed the child. The OIG investigation revealed, however, that there were no previous signs that would have alerted the worker to the possibility of violence in the home. Accordingly, the OIG investigation was closed without recommendations.

Chart 1. The chart below shows annual child death report results by category. Identified are the percentages of Division of Child Protection (DCP) unfounded, pending, and indicated child death reports. OIG investigations are generally limited to indicated reports.



Unfounded= not enough evidence to substantiate that the death resulted from abuse or neglect
Indicated= evidence found to substantiate that the death resulted from abuse or neglect
Pending= DCP investigation is still in progress
Total number of deaths= 619 (This number reflects all reported child deaths since July 1993. The OIG did not begin systematic review of child deaths until January 1995)

Chart 2. The chart below shows the percentage of death cases by Child Abuse and Neglect Hotline sequence letter. The OIG reviews and investigates cases that are B sequence or greater. Letter B represents two accepted calls to the Child Abuse and Neglect Hotline. The OIG has reviewed over 200 cases.



*It is important to note that if an A sequence is *unfounded* and a subsequent call is made, letter A is again assigned to the case. If an A sequence is *indicated*, all subsequent accepted calls are assigned a consecutive letter.

RECOMMENDATIONS

One of the most important tasks of the OIG is to make recommendations following an investigation. Recommendations are sent to the DCFS Director. The Director distributes the recommendations to key personnel for comment. The OIG then monitors the implementation of the recommendation.

Contained below are the OIG recommendations to the Director from completed OIG death investigations. The case issues are identified and the recommendations follow. For confidentiality, names are withheld. The Department's response to the OIG recommendation is placed in italics.

Investigation

Case Issues:

In 1993, a child was returned home to his natural mother who had a history of mental health issues and impulsive behaviors including fire-setting, self-mutilations, and threats of suicide. Six-months after his return home, the child was allegedly hung by his natural mother.The OIG investigation revealed that the DCFS case worker did not document in case files or in court critical information concerning the doubts of mental health professionals of the ability of the natural mother to parent, or a recent fire-setting episode of the natural mother. The caseworker supervisor failed to ensure that the caseworker provideappropriate case management. The Administrative Case Reviewer did not fulfill professional responsibilities by failing to require the case worker to document the mental health history of the mother, thus allowing the child to be returned home.

Recommendations:

-The DCFS caseworker, the caseworker supervisor, and the Administrative Case Reviewer involved in the case should be terminated.

-A standardized data format for use by both the Department of Mental Health and Developmental Disabilities and DCFS should be developed to facilitate communication of relevant information about parenting capabilities and risks in mentally ill parents.

-Parenting assessment teams with expertise in mental illness should be established to assess the potential for harm to children to be placed in a particular home.

- Family Risk Assessments must be completed for **all** cases.
(Current DCFS procedures state that the completion of the form for

unfounded cases is optional.)

-DCFS should establish a system for random review of indicated and unfounded reports to assure workers' understanding and application of risk assessments tools.

-Pursuant to the B.H. Consent Decree, family case files must be impounded in a timely and effective manner to prevent tampering with case files. The OIG will formally adopt a rule to reflect its current impounding practice. **(See Investigative Process)*

Investigation

Case Issues:

In 1993 a two-year-old child was allegedly beaten to death by his mother's paramour. The child's death was the fourth report of abuse and neglect involving the child. The OIG investigation revealed that the DCP investigator assigned to investigate the two reports prior to the child's death was negligent in carrying out those duties. The last report prior to the child's death involved a spiral fracture of the child's arm. Spiral fractures are frequently associated with abuse. The investigator failed to interview the reporter of the abuse allegation, the medical personnel involved in treating the fracture, the DCFS personnel involved with the family, and other persons with information about the family. He unfounded the allegation. The same investigator had indicated the paramour eighteen months earlier for the death of another child. The paramour was under police investigation for murder of that child at the time of the investigation of this child's fractured arm.

Recommendations:

-The investigator should be terminated for failure to fulfill professional duties.

-In order to conduct thorough investigations, investigators should be required to complete standardized risk assessments, contact professional collateral sources including those in law enforcement, and check law-enforcement records for all physical or sexual abuse investigations in which paramours and other non-related adults are present in the home.

-In abuse investigations, the Department should immediately develop a system for securing emergency room records from all hospitals within a reasonable geographic area in order to rule out the possibility of prior injuries.

-Training of all DCP investigators should be updated to include these recommendations.

Investigation

Case Issues:

Following the 1994 death of a five-year-old child whose death was caused by two youths unrelated to the family, OIG became involved when a professional complained that DCFS intended to take protective custody of the child's surviving siblings that would further traumatize the children. The family had an open DCFS case since the five-year-old child's birth. The OIG investigation revealed that the family had multiple problems: drug abuse, homelessness, and inadequate finances. The mother and the children were without their own housing for the entire five years that they were involved with DCFS and stayed in various places. Workers failed to locate the mother and offer her housing assistance. The investigation revealed that limited outreach was provided to the natural mother and the children remaining in her care which placed the children at risk of harm. Caseworkers focused their attention on one child who was placed with a relative. The OIG also examined the Department's response to the child's death. The OIG agreed with the professional that removal of the children did not serve their best interest. The OIG investigation also revealed the lack of an established crisis intervention strategy for traumatic situations involving DCFS involved families.

Recommendations:

-A Division of Child Protection special crisis intervention team should be developed to: initiate appropriate supportive services, assess psychological needs of parents, and work with children who have experienced a traumatic event.

-The Illinois Child Death Review Team strongly recommended a protocol for protecting other children in the home following a fatality.

-The focus of case monitoring should be adjusted to include children at home as well as those in placement.

-To increase communication between the Division of Child Protection and follow-up services, post investigation case meetings should be held and final reports of investigations should contain specific service recommendations in all indicated cases.

-DCFS must develop protocols that ensure the appropriate exploration of permanency options for children in relative foster care. (In this case, the case

workers failed to offer permanency options of delegated relative authority, private guardianship, long-term foster care, and adoption.)

-A protective payee must be utilized when issues of substance abuse are present.

-Services should be built within the context of local community resources such as after school programs or parenting classes.

Investigation

Case Issues:

In 1994, an infant died from cranial cerebral injuries. The infant's father confessed to police that he punched and shook the infant. One month prior to the child's death, the child was admitted to a hospital and diagnosed as having suffered a spiral break to the left femur. A spiral break is frequently associated with abuse. The hospital called the hotline and noted that the injury was caused by possible child neglect. Two days later, the child was returned to his natural father and paternal grandmother. Fourteen days later, while the investigation of the break was pending, another call was made to the DCFS hotline for unsafe environmental conditions. The call generated a B sequence that was immediately unfounded allowing the child to remain in the home with the natural father. The OIG review of the prior investigations revealed that the same DCP investigator, a new employee without adequate supervision, had been assigned to the two prior reports. He failed to interview the reporting doctor and failed to provide an adequate risk assessment of the household.

Recommendations:

-The child protection investigator, a new DCFS worker, should remain on probation.

-The treating hospital should be reviewed by the Cook County Child Death Review Team.

-The Department needs to develop protocol to address responses to spiral fractures.

Investigation

Case Issues:

In 1994, a child was allegedly beaten to death by his mother's paramour. Both the paramour and the child's mother were charged with murder. The death was the eighth DCP investigation involving the family. The OIG investigation revealed that the DCP investigator unfounded the seventh sequence less than 24 hours after the case was assigned, despite being informed by family members that the paramour had frequently beaten the child with belts and dog leashes. The investigator failed to investigate the allegations of family members, failed to interview professionals involved with the family, and failed to review the six prior reports that indicated substantial risk to children in the home.

Recommendations:

-The child protection investigator should be discharged for failing to investigate documented allegations against the child's mother and her paramour.

-Investigator training should focus on the necessity of giving special attention to multiple sequence cases (see Chart 2).

Investigation

Case Issues:

In 1994, a ten-year-old child who was diagnosed as suffering from Oppositional Disorder, Major Depression, and severe Attention Deficit Disorder and Hyperactivity Disorder allegedly strangled himself after having been tied to a radiator by his mother. The autopsy report revealed 19 different scars from old injuries on the child's body, including nine healing injuries and seven fresh injuries. The OIG investigation revealed that in 1991, the child's mother had been indicated for abusing both of her children. The children remained at home. From 1993 to 1994 the mother was indicated on three separate occasions. The first involved allegations that she abused her daughter. DCFS took protective custody of her daughter at that time. Though the allegation was indicated, the investigator determined that protective custody was not necessary and was not taken because the bruises and belt marks were below the waist. Notes from the private agency that monitored the family at home suggested that the investigator advised parents to remove belt buckles in order to not leave marks when they beat their children. The second and third indicated reports involved her son who had scars and bruises on his back, and had been beaten with a broomstick. His mother admitted striking him on both occasions. Protective custody of her son was not taken. Counseling services and parental

stress classes were offered to the mother, but she did not attend. Though homemaker services for the family were part of an ACR service plan, they were terminated by the follow-up worker. The investigation also revealed inappropriate and insensitive actions by the DCFS follow-up worker during home visits.

Recommendations:

-The investigator should be given an assigned desk duty to read and study articles concerning best social work practice and the young child. While on desk duty he should be counseled and furnished professional literature regarding managing aggressive children.

-The investigator and the suburban DCP unit should meet with the private agency director to discuss future practice issues.

-In conjunction with the National Committee for the Prevention of Child Abuse , the Department should develop handouts that discuss the issues of corporeal punishment for families who are under investigation by the Department explicitly for excessive corporeal punishment.

-DCP workers should attend a joint OIG and Cook County Child Death Review Team presentation based on various investigations that demonstrate failures within DCP in properly assessing risk to children.

-The DCFS follow-up worker's supervisor should receive an oral reprimand for failing to resolve a dispute between her worker and the private agency involved in the case.

-The follow-up worker involved with the case should be trained regarding appropriate generational boundaries and appropriate visitation techniques.

-Follow-up workers should visit at least monthly to ensure families are receiving recommended services.

-Copies of homemaker notes should be sent to appropriate DCFS workers on a weekly basis. Prior to any major decision, or in any unusual incident, homemaker notes must be reviewed.

-The Department should create an interagency agreement that mandates multidisciplinary staffings with representatives from DCFS, DMHDD, local school district, and day treatment facilities for open DCFS cases in order to assure the effective and efficient services to emotionally disturbed children and their families.

-The Department should enter into an agreement with DMHDD whereby DMHDD state and community mental health social workers would agree to attend post-discharge staffings for open DCFS family cases following a psychiatric hospitalization.

-A specific needs assessment should be completed regarding type/length and skills when parent training is recommended or ordered for a family with indicated cases.

-The school district and day treatment programs should create a plan with the family regarding care of the child during school vacations.

Investigation

Case Issues:

In 1994, the Department received several complaints regarding the care that children were receiving in group and foster homes of a particular private agency. The major complaints focused on a ward whose arm was broken following a physical restraint by private agency staff and sexual activity between wards at a therapeutic group home. A child had died in a foster care home serviced by the private agency the year before. The OIG investigation revealed that the agency had a prior policy of requiring foster parents and staff to receive approval before calling allegations into the DCFS hotline. The investigation also revealed that the agency clinical director used and approved inappropriate training materials for foster parents and failed to provide an adequate clinical program for treatment and supervision of sexually aggressive youth.

Recommendation:

- The private agency should be required within 30 days to (1) determine which of its children have special needs as a result of having been abused or having a history of abuse; (2) segregate children by gender, developmental stage, and history of aggressiveness; (3) ensure that trained clinical personnel are responsible for developing and implementing individual treatment plans; and (4) ensure that employees working with children are appropriately trained on issues affecting sexually abused and sexually aggressive children.

Investigation

Case Issues:

In 1994 a seven-month-old child died after allegedly being electrocuted by a stun gun possessed by his foster mother. The foster mother had been previously psychiatrically

hospitalized (ten years prior to the incident). The OIG review of the case revealed that the private agency and its caseworkers operated appropriately. The foster parent had shown no prior indications of inflicting harm on any of her natural or foster children. Private agency workers had made weekly visits to the foster home.

Recommendation:

The OIG made no recommendations in this case.

Investigation

Case Issues:

In 1995, a single, 62-year-old foster parent had care of eight children, four of whom were under age two. A child was informally placed in the 62-year-old foster parent's home that was the object of several prior Division of Child Protection (DCP) investigations. The worker was unaware of the large number of children in the home or the prior investigations. Ultimately, the child died while in the foster parent's care. The foster parent was not adequately monitored or serviced. The follow-up caseworker was a member of a team of all new workers without a supervisor. The investigation covered three DCFS divisions: child protection, follow-up, and licensing. DCP failed to notify Licensing of pending investigations. Although a mechanism is in place for DCP to notify Resources and Licensing of pending investigations involving foster homes to ensure that children are no longer placed in such homes, neither the DCP investigator or supervisor utilized the mechanism. A DCFS Resources manager failed to forward a notification from a child protection investigation unit to the Department's computerized placement system to place a hold on the foster home under investigation. The administrator admitted to routinely discarding such notifications since he felt it was not his responsibility to forward this information.

Recommendations:

-The DCP supervisor should be suspended for one day for failure to perform supervisory duties.

-The probation period for the DCFS caseworker involved in the case should be extended.

-The Resources Administrator should receive a suspension for failing to ensure the proper dissemination of critical information.

-The Adoptions worker involved with the case should receive a written reprimand for failing to appropriately investigate a future adoptive home.

- Prior to placing children in foster homes, workers should immediately notify the licensing agency.

-Foster home renewals should include an inquiry into whether the applicant has been the subject of a child abuse and neglect investigation. A hold should be placed on foster homes when an investigation is pending.

-If more than 3 children reside in a foster home, respective workers should hold a staffing every six months. A Crisis Intervention Team should be developed to respond to the needs of a family after the death of a child.

Investigation

Case Issues:

In 1995 a three-year-old child drowned in a neighbor's pool while in foster parent care. A finding of death by neglect was rendered. Illinois suffered from severely high temperatures during the summer of the child's drowning. While DCP indicated the foster parents with neglect, the OIG did not pursue a full investigation into the death since prior to this accident, the family had no history of inadequate care for their foster children. The drowned child had previous incidents of wandering away from the foster parent's supervision which led to the indicated finding of neglect in the drowning. No other children can be placed in the home since it is the subject of a death from neglect.

Recommendation:

-During the same heat spell, accidental drowning of children increased. The OIG recommended that the Department promote increased public service announcements warning parents to take special precautions with their children.

Investigation

Case Issues:

In 1995, a two-year-old child drowned in a toilet while in care at a foster home. A medical examiner ruled the death as accidental. The foster home was caring for six special needs children at the time of the death. Four of the children were under age four; three of the children were under the functional age of two. The foster home had been

cited for various violations and for failing to adhere to caseworker and licensing regulations. A prior home study report suggested that too many young children were in the home and that no additional children should be placed there. The report went unheeded. Prior to this placement, the child had been placed in six temporary placements during a three-and-a-half-month period. A mental health assessment conducted by the private agency involved with the child did not recommend treatment despite the report that the child was developmentally delayed and chanted incessantly for water. The private agency workers assigned to the case were inexperienced and failed to provide the child with necessary services. The private agency's licensing representative never communicated to the children's workers concerns regarding the foster parent's ability to care for so many special needs children. The DCFS monitor assigned to the case had insufficient contact with the private agency worker and failed to adequately monitor the child while placed in the private agency foster home.

Recommendations:

-The private agency contracted to provide foster care services, should establish a staffing protocol for the complete and timely exchange of information between its foster care licensing unit and its foster care placement services prior to placement of any child.

-The private agency licensing unit and its foster care placement services should be reviewed prior to placement of additional children within this agency's foster homes.

-The private agency should institute a curriculum for foster care caseworker training. This curriculum must be reviewed and approved by the OIG.

-All children's mental health assessments completed by the private agency should be reviewed by DCFS Licensing.

-Emergency foster care placements to the private agency should be discontinued until recommendations are completed.

-The number of special needs children in any foster home should be limited to three.

-Children should remain in one placement for the first 90 days where their growth and development can be closely monitored.

Additional Recommendations

The present child investigation system ignores the community context of incidents involving children. Therefore, its ability to respond to allegations associated with impoverished families is inhibited. For example, an "A" sequence allegation involving a lack of immunizations should have a proactive community health response such as the development of public health visiting nurses rather than a DCP investigation. Other allegations based on parent behaviors such as teenage lock outs and disciplining of conduct-disordered youth should be addressed individually. Currently, these DCP investigations are time intensive and detract DCP workers from other serious risk of harm cases. These problems would be remedied more appropriately by a stronger commitment from the Division of Youth and Community Services funded agencies, and from in-home services from community mental health providers. Additionally, DCP should have a Community Risk Manager to review investigations for deflection to available community resources, coordinate a post-investigation staffing among the DCP worker, caseworker and family, and act as a liaison between DCP and deflection agencies.

The probation period for DCP workers should be extended to one year instead of six months to ensure thorough training.

DCP investigators should have cellular phones for safety purposes.

Investigatory responses to serious allegations of risk of harm and death cases require the expertise of the most qualified DCP investigators. Death cases cover a range of circumstances including accidents, homicides, and unknown causes such as SIDS. These cases require intensive and sensitive management skills to protect surviving siblings from the range of family responses to the crises, ongoing police investigations, and even funeral preparations. DCP should install a team that specializes in investigations of child deaths. Additionally, a stratified system whereby only more experienced workers investigate complex, multi-issue cases should be instituted in order to insure the efficacy of investigations and ultimately the health and safety of children and families.

OIG Abuse Prevention Initiatives

Recommendations for investigations

Family Risk Assessments must be completed on all cases, whether they are indicated or unfounded. Such assessments, if objectively used, can aid in the development of intervention strategies. This recommendation requires a change in DCFS procedures, which currently state that the completion of the form in unfounded cases is optional.

Sudden Infant Death Syndrome (SIDS) Cases

Prior to September 1994, the OIG investigated nearly all child death cases regardless of sequence. Many of the OIG investigations involving infants revealed that the child had died from SIDS and were appropriately unfounded by DCP investigators. To address the issue of SIDS, the OIG met with the Illinois Department of Health and Human Services which tracks all SIDS deaths throughout the State. The Illinois Department of Health referred the OIG to Loyola University Chicago and the Chicago Department of Health which are jointly conducting an Infant Mortality Study to discover the environmental issues and other risk factors that might contribute to sudden infant death syndrome (SIDS) . Among the variables that the study is investigating are poverty and substance abuse issues. In Chicago, SIDS deaths are twice the national average while the infant mortality rate is 50 percent higher than the national average.

Because SIDS cases are being monitored and studied by two agencies, the OIG decided to only investigate SIDS cases in which a DCFS employee or private agency failed to appropriately service the child and family. Questions concerning SIDS cases which do not involve employee or agency misconduct are referred by the OIG to The Illinois Department of Health or to the Chicago Department of Health.

A Final Note

This report on Special Investigations of Child Deaths detailed the process of the OIG investigations , the recommendation process, and the case recommendations that were made to ensure that the quality of the lives of children and families involved with DCFS is improved. Ultimately, the OIG seeks to promote practices in the Department to eliminate the need for investigations of child deaths since all children will be adequately protected.

Since its inception, the OIG has offered a number of recommendations for Department-wide change through case investigations, research studies, and program initiatives. The OIG promotes quality services, professionalism, and increases employee and private agency accountability to Illinois families.

APPENDIX II

Child Welfare Agency Licensure Report

Report to the
Director, Illinois Department of Children & Family Services

Child Welfare Agency Licensure and Contracts & Grants

prepared by the
OFFICE OF THE INSPECTOR GENERAL
Denise Kane, Inspector General

March 1996

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(Rev. 5/9/96)

Department of Children and Family Services
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OFFICE OF THE INSPECTOR GENERAL

March 31, 1996

I. INTRODUCTION

The Office of the Inspector General (OIG) has received an increased number of complaints in the past year, involving purchase of service agencies. Completed and pending investigations into these complaints have resulted in issues being raised concerning the role and coordinated function of two Department areas, specifically Child Welfare Agency Licensing and Contracts & Grants. The basis of this report is the OIG's investigative findings, a survey of professional literature, standards developed by similar organizations and institutions, and recommendations made by the BH Panel on Licensing Reform.

Most of the private agencies which have been made part of this report, have been conducting child welfare business in Illinois from approximately 1½ to 8 years. For the most part, these are relatively new and inexperienced organizations.[1]

In general, the OIG concurs with the recommendations made by the BH Panel on Licensing Reform on Child Welfare Agency Licensing Standards and Enforcement. The OIG also agrees with the Panel that the standards of the Council on Accreditation and Medicaid Certification should never substitute for the Department's Licensing Standards.

Child welfare agency standards of Illinois are established in accordance with the Child Care Act of 1969, and serve to 1) protect minors removed from parental care; 2) ensure the provision of proper and beneficial services; and 3) provide a set of expectations by which licensed organizations are expected to responsibly carry out their fiduciary responsibilities. These standards are extended to include the organizational structure, management and operations; obligations to the client; and qualifications of personnel employed by the licensee. This partnership between public and private sectors is intended to provide a safety net of accountability, reciprocity, and quality care to children.

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[1] One nonprofit organization was issued a child welfare agency license without having a facility and prior to business start up.

In the interest of expanding the number of available service providers to meet the growing demand for services, contracts are now indiscriminately issued and licensing standards have been relaxed to the extent that they are now substandard, with nearly non-existent communication between Contracts and Licensing. The implications of relaxed standards, weakened contracts management and enforcement are far reaching. According to public administration researchers, "Public policy becomes cloudy as authority, and who is funding what, become mixed in an agency that delivers services for government and for its own purposes. The "leakage of accountability" in the human service system and the lack of governmental capability or willingness to effectively manage its contracts with service providers is a major problem." (Smith and Lipsky: Nonprofits for Hire. Public Administration Review. January/February 1994, Vol.54, No.1.)

According to the Child Welfare League of America, "No standards should ever be considered final. Standards should serve as a stimulus and a goal for improving existing services." It is through the licensing and contracts systems, that the Department is continuously afforded the opportunity to seek to assure the most effective use of state and federal funds on behalf of the children in its care. DCFS has the authority and responsibility to expect no less than a high caliber of management and leadership, without which efficient and effective service delivery by child welfare agencies cannot be sustained over time. To that end, standards, rules and enforcement should serve to benefit child welfare service providers as well as the children placed in their care.

The OIG's recommendations set forth in this report consist of both specific rule proposals and general abstract concepts on CWA Licensing and Licensing Enforcement, and Contracts & Grants. Although the OIG's findings to date indicate the need for further study, this report is intended to provide the Department with a framework for needed licensing and contracts reform.

II. A. CHILD WELFARE AGENCY (CWA) LICENSING STANDARDS

A "license" as defined by the Department is a document issued by DCFS which authorizes a child care facility to operate in accordance with the applicable standards and the provisions of the Child Care Act and rules promulgated thereunder (DCFS, Adopted Rule Part 383: Licensing Enforcement.)

When reviewing licensing requirements, the BH Panel on Licensing Reform recognized the "delicate balance between relaxing rules to be more inclusive and maintaining regulations that ensure the safety and well-being of children." However, the Department's recent proposed changes to CWA Licensing Standards only serve to further distance the Department from licensed agencies, diminish the Department's shared fiduciary responsibility with licensees, and shift to a lesser degree of accountability by agencies. The OIG contends that the Department's current CWA license application, procedures, and set of licensing standards are deficient to the extent that unqualified or poorly managed agencies are being issued CWA licenses and license

renewals. This has serious implications with regard to agency impact and compliance expectations. For example, child welfare agencies having a long tradition and/or good reputation become tarnished by association, i.e. "all nonprofits are alike." Issuing licenses to poorly managed agencies, serves as a disincentive to work towards compliance and strive for operational excellence.

As reflected in this report, the OIG is particularly concerned with the Department's willingness and ability to hold child welfare agencies responsible for operational excellence in the areas of governance, financial management, executive management, and program/service delivery, and within the framework of a code of ethics. Because standards for child welfare programs and services are not delineated in the Licensing Standards for Child Welfare Agencies, programs and services are not made part of this report. However, the Department is encouraged to examine a major gap in its ability to conduct qualitative evaluations of child welfare programs and services, as well as the need to develop program standards as a basis for assessing the full scope of services.

GOVERNANCE

FINDING

Among the Department's recent proposed changes to licensing standards applicable to the agency's governing body (henceforth referred to as Board of Directors) is the proposal to reduce the required (minimum) number of board members from five to three persons.

A not-for-profit's Board of Directors "is responsible for setting policy to assure the achievement of the organization's mission, for making the major decisions that guide the functioning of the organization, for the fiscal integrity of the agency. This can be effectively done by 1) ensuring that the agency operates within the framework established in the organization's bylaws; 2) having a clearly delineated board committee structure and utilizing operating procedures which enable it to fulfill its obligation; 3) focusing its efforts on the effective performance of key functions in support of the agency's mission, policies and overall goals; and 4) having a board composition which is knowledgeable and sensitive to the needs of the staff, the agency as a whole, and the broader community it serves." (Membership Standards Manual, United Way of Chicago, 1993, p.1.)

It is unreasonable to expect that three people can fulfill the responsibilities of a Board of Directors and provide adequate oversight to all key functions of an organization.

While the Department's Licensing Representatives request that the agency applicant identify its Board committees as part of the license application, there are no standards that address committees of the Board and there is no evidence that Board committee information is used by licensing representatives to assess the organization or compliance.

RECOMMENDATION

The Department should consider the following recommended revisions to the Licensing Standards applicable to the Board of Directors of a child welfare agency:

1. The minimum number of board members should remain at five persons.

2. A) Increase the number of required board meetings from two to a minimum of six (bimonthly) meetings per year for newly licensed child welfare agencies and during the first 4 years of "provisional" licensure.[2] B) Increase the number of required board meetings from two to a minimum of 4 (quarterly) meetings per year for licensed agencies demonstrating strong compliance with licensing standards.

3. The Board of Directors exercises its oversight responsibilities through a standing committee structure which gives attention to program/services, finance/fundraising, human resources/personnel. An executive committee exists to which the Board may delegate certain decision-making responsibility (i.e. convene meetings between regular board meetings to act on matters of emergency).

4. The minutes of board meetings are maintained, organized, kept as a permanent and up-to-date record and include dates of meetings, names of participants, issues covered, committee reports to the Board, and actions taken.[3]

5. The Board of Directors operates in accordance with the agency's bylaws.

FINANCE

FINDING

The Department has no licensing standards to ensure appropriate oversight of fiscal operations by the Board of Directors and fiscal management by the Administrator or designated employee.

To operate responsibly, a private agency "must have an accounting or bookkeeping system which contains certain basic elements, performs certain key functions for the agency and provides the

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[2] In the section on License Application and Renewal Procedures there is a discussion of recommended categories of licensure, i.e. conditional, provisional, probationary.

[3] Council on Accreditation Standard; [committee reports to the Board] inserted by the OIG.

objective and accurate information to fulfill its fiduciary responsibilities to its supporters. It is critical that the Board of Directors receives timely and accurate financial information it needs to carry out its responsibilities. The information needed relates chiefly to financial need, financial resources, financial stability and flexibility, and the programmatic focus of expenditures. The system itself must exhibit effective internal accounting controls, be utilized for systematic financial planning, and respond to internal and external financial reporting needs." (Membership Standards Manual, United Way of Chicago, 1993, p.18.)

The Boards of "developing" child welfare agencies must be actively involved in the planning and control functions of their agencies' budgets. The Board is responsible for conserving and expending the agency's assets for the organization's stated purpose. (Dale, 1978, and Brace, Elkin, Robinson, and Steinberg, 1980.)

RECOMMENDATION

The Department is advised to include and expand on the following suggested standards in the Finance section of the CWA Licensing Standards:

1. Under the direction of the Board's Finance Committee, the agency develops, in a timely manner, an annual operating budget which is used by the Board to monitor its financial operations during the year.

2. At least quarterly and under the direction of the Finance Committee, reports comparing budgeted revenues and expenses with actuals are prepared in a timely manner and submitted to the Board of Directors.

FINDING

The Department's current finance standards for child welfare agencies require "the agency shall maintain a degree of financial solvency that insures adequate care of the children for whom it has assumed responsibility." The Department defines the condition of *financial insolvency* as the agency's "sum of its debts is greater than all of its property, at a fair valuation, exclusive of property transferred, concealed or removed with intent to hinder, delay or defraud its creditors." There is no evidence to suggest that DCFS licensing representatives assess an agency's compliance with this standard during initial application or renewal of licensure procedures. The licensing standards do not provide measures or indicators of financial solvency or predictors of impending financial insolvency for compliance assessment and/or corrective planning purposes.

Investigations into more seriously troubled agencies such as ***Alpha Services, Beta Services, and Gamma Services***, reveal a pattern of financial problems that include late payments to foster

parents, late and unpaid payroll, payroll tax liabilities, and cumulative operating deficits. Reviewing these factors as part of the licensing application and renewal procedures can provide the Department with early warnings of problems and enable timely and appropriate intervention and redress.

RECOMMENDATION

The Department is advised to include and expand on the following suggested standards in the Finance section of the CWA Licensing Standards:

1. When applicable, the agency must demonstrate to DCFS that all (foster parent) board payments are met in accordance with the DCFS contract and annually specified payment schedule.

2. The agency operates in accordance with generally accepted accounting procedures for not-for-profit agencies. The agency has an internal control system designed to safeguard assets, to ensure the accuracy and reliability of financial records and to assure compliance with established policies.[4]

3. Fiscal operations have been structured to avoid persistent debt or excessive cash flow problems.

   a) All agency payrolls are met in accordance with annually specified payment schedules.

   b) No delinquent payroll taxes or other tax liabilities exist.

   c) The agency avoids defaulting on its debts.

   d) Amounts due to the agency are billed on a timely basis and monitored to ensure the prompt collection or disposition.

4. A cumulative operating deficit does not exceed 15% of total operating revenue. Any agency carrying a deficit must develop and implement a deficit reduction plan.

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[4] For a description of the basic elements of an Internal Control System see Membership Standards Manual, United Way of Chicago, 1993.

FINDING

"Fiscal records" is poorly defined in the Department's Licensing Standards as: "current and projected operating budget, and financial records annually audited and certified by public accountants not affiliated with the agency." The insertion of "financial records" to define "fiscal records" is not useful. Department personnel who lack basic technical knowledge of finance and accounting principles will not know what to look for and will probably avoid a review of these records. It is highly unlikely that the Department currently has information to ascertain which licensed child welfare agencies maintain acceptable fiscal record-keeping systems. The OIG suggests that relatively new and developing organizations are at greater risk of failure when their lack of experience (i.e. new staff, limited service track record, poor or underdeveloped financial management systems) is impacted by accelerated contracts and programmatic growth.

RECOMMENDATION

- The Department needs to develop a clear and concise definition of fiscal records, and measures for determining minimal compliance.

FINDING

While investigating ***Delta Services***, the OIG learned that this agency has been operating as a licensed, not-for-profit child welfare agency for the past year, without having secured exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code. Without this tax exemption status, for which Delta Services is eligible, charitable contributions to Delta are not tax deductible and the agency is required to pay federal income tax.

RECOMMENDATION

- All not-for-profit agencies, licensed by and/or contracting with the Department must be exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code.

EXECUTIVE MANAGEMENT

FINDING

The OIG agrees with the BH Panel that there is a need for definition clarification of the position of "Administrator". The Department's current definition of this position is limited to "to carry out the day-to-day management of the agency and the established policies and procedures."

While the BH Panel rightfully points to the need to review the issue of on-site administration of satellite offices of an agency and the difference in responsibilities, the OIG suggests that further delineation of relevant licensing standards for this area will help to clarify the Department's expectations of Administrators as chief executive officers of agencies.

With respect to the Licensing Standards, the position of Administrator (henceforth referred to as Executive Director) should be clearly communicated as comparable to the highest employed position within an agency. This position is under the general direction of the agency's Board of Directors and the Executive Director is responsible for the effective and efficient implementation of board policy. The Executive Director is vested with and exercises the authority to manage the day-to-day operations of the agency, and to delegate, when appropriate, management responsibilities to designated staff. General responsibilities of the position include: directs all financial operations of the agency; provides overall control and direction of the personnel function of the agency; supervises and directs key staff in the performance of their duties; participates in and supports the activities of the board; determines methods for the assessment and evaluation of agency services and management support areas; and supports the nonprofit agency's fund-raising activities. (Membership Standards Manual, United Way of Chicago, 1993, p.8.)

RECOMMENDATION

The following is suggested wording for newly created standards to address this area of concern:

1. The Executive Director is a full-time employee of the agency.

2. The Executive Director has a written job description which delineates responsibilities and authority, and managerial expectations relative to all segments of agency operations.

3. The Executive Director demonstrates minimal financial competency to direct all financial operations of the agency.[5]

3. All compensation of the Executive Director, including salary, allowances, memberships or other benefits, is reviewed and authorized by the Board of Directors. The size of the agency and its operating budget is given consideration when compensation is reviewed.

4. The Executive Director is evaluated annually by the Board of Directors.

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[5]In proposing this standard, the OIG recognizes that Executive Directors delegate, when appropriate, management responsibilities to designated staff, i.e. a comptroller. However, it is the Executive Director who supervises and directs these key staff in the performance of their duties, and evaluates their performance.

ETHICS

FINDING

Neither the CWA licensing standards nor the Child Care Act address the ethical conduct and practices expected of board members and employees of child welfare agencies, particularly as these relate to relationships within an agency, and relationships with the agency.

The Department recently adopted a Code of Ethics for child welfare professionals and it is anticipated that the Code of Ethics will be made applicable to staff, board members, and owners of child welfare agencies. However, issues and responses of private agencies, including those mentioned below, call for regulation by way of standards or contractual agreement, particularly to address agency representatives who do not recognize unethical conduct or the need take corrective action.

In an investigation conducted by the OIG involving ***Epsilon Services***, a nonprofit agency, the OIG learned that the Executive Director is married to the Chairman of the agency's Board of Directors. Their daughter is the Program Administrator and reports directly to her mother, the Executive Director. The Office of Internal Audits (OIA) has noted similar familial relationships between board members, management, and employees of recently developed child welfare agencies, including ***Zeta Services*** and ***Kappa Services***. Such relationships compromise the integrity of each position and undermine the agency's accountability to its clients and the general public. Family members are unlikely to be able to evaluate and supervise other family members objectively, separating completely their professional relationships from their familial ones. Likewise, an agency's board evaluates the performance of the Executive Director, and sets and approves his/her compensation. The key function of a Board of Directors is to ensure that an agency is upholding its fiduciary obligations. This check and balance cannot occur when members of the board are related to management and employees of the agency.

RECOMMENDATION

The Department needs to develop licensing standards to specifically address conflict of interest:

1. The Board of Directors has adopted a conflict of interest policy minimally requiring that:

    a) no member of the Board of Directors shall derive or appear to derive any personal profit or gain, directly or indirectly, by reason of his or her membership on the Board, or services to the Board. Each Board member:

        - discloses to the Board any personal interest which he or she may have in any current or potential matter before the Board, and

        - refrains from participating in any decision on such matter.

b) members of an employee's immediate family do not serve on the agency's Board of Directors or are employed by the agency. ("Immediate family" is defined as wife, husband, son, daughter, mother, father, sister, brother, in-law, or legal dependent.)

2. Board members do not receive financial compensation for attending board meetings, which includes allowance or reimbursement for out-of-pocket expenses.

FINDING

Although the Child Care Act of 1969 provides for the establishment of standards pertaining to "the character, suitability and qualifications" of the applicant and other persons directly responsible for the care and welfare of children served, the Department's licensing standards on the subject lack clarity and do not have coinciding measures for determining compliance, particularly with respect to the "principles" of an agency applicant. The existing standard basically repeats the statement contained in the Act, "All board members shall be of reputable and responsible character...The governing body of a ...for-profit shall be the owner(s) who shall be of reputable and responsible character".

RECOMMENDATION

- The Department should develop an operational definition and corresponding standards pertaining to "The character, suitability and qualifications of licensing applicants."

FINDING

Qualification standards of agency personnel tend to be either broadly stated or downgraded, and documented certification of qualifications are not required to be made part of licensing records. For example:

> Section 401.13 Child Welfare Workers states: Child welfare workers shall have at least a Bachelor's Degree and shall be under the supervision of a qualified social work supervisor.

Section 401.13 does not and should require that the bachelor's degree be obtained from an accredited school. Of additional concern is that the standard does not require any employment experience related to human services, especially given the fact that the degree is not required to be in the field of human services. A minimal level of competency to deliver child welfare services must be an expectation. A finding in the pending investigation of **Omega Services** is that an inexperienced individual, holding a Bachelors Degree of Science in graphic arts design and formerly employed as a window dresser, was making critical decisions in case management and licensing foster homes.

Section 401.12 Social Work Supervisors b) "If there is no full-time social work supervisor, the administrator shall, in addition, meet the qualifications for social work supervisor."

The above standard does not offer any guidelines as to when it is acceptable or unacceptable for the administrator/executive director to fill the position of social work supervisor. For example, an executive director can serve as social work supervisor on a temporary basis only, i.e. until a position vacancy is filled, or an executive director functioning as a social work supervisor is limited to supervision of three to five child welfare workers at any given time, given the scope of responsibilities of an executive director .

A licensing standard does not exist to limit the number of child welfare workers supervised by a social work supervisor. This concern was addressed by the BH Panel on Licensing Reform.

A licensing standard or procedure does not currently exist to address the validation of foreign degrees.

RECOMMENDATION

It is recommended that personnel related standards be upgraded and more clearly stated:

1. Child Welfare Workers shall have: 1) at least a Bachelor's degree from an accredited school and in a field of human services; or 2) a Bachelor's degree from an accredited school and [work or volunteer] experience in a human services field, and shall be under the supervision of a qualified social work supervisor.

2. Social Work Supervisors shall supervise no more than seven (7) full-time child welfare workers.

3. Any foreign degrees and/or transcripts submitted as proof of education for child welfare worker, professional and supervisor positions, must be interpreted by an accredited agency and must meet the licensing standard.

II. B. FOR-PROFIT CHILD WELFARE AGENCIES

In a recent statewide opinion survey of Illinoisans, funded by the Chicago Community Trust, it was found that "the public holds charities and nonprofit agencies in high regard, and clearly favors programs for at-risk children and families that are run by private nonprofit organizations over programs administered by government agencies."

Nonprofits are also thought to be more trustworthy because the type of people attracted to found nonprofit organizations and work in the sector value nonmarket social outputs and honesty. (Young, Entrepreneurship and the Behavior of Nonprofit Organizations: Elements of a Theory.

1981.) Donors are more likely to volunteer their time and money to a nonprofit organization than to a for-profit because they are assured that their efforts will not be diverted to dividend checks. (Hansmann, The Role of Nonprofit Enterprise. Yale Law Journal.89, 835-901.1980.)[6]

In Competition in Contracted Markets, Richard Steinberg explores the differences and (dis)advantages of nonprofits and for-profit organizations in competitive contracting. He points out that "Nonprofit organizations cannot distribute their financial surplus to those in control of the organization....stockholder interest in maximal dividends leads them to pressure for-profit firms to behave opportunistically when there are informational asymmetries that would leave customers or donors at a disadvantage." Among his many conclusions, Steinberg asserts that "nonprofit organizations deserve some preference in [contract] bidding because they provide benefits to the government [including] reduced opportunistic behavior and reduced transaction costs..."

For-profit agencies are not incorporated for charitable purposes and cannot compete with nonprofits in the philanthropic sector, thus limiting diversity of revenue base in the for-profit agency. Unrestricted or discretionary funds, program start-up funds, special initiative funding, and matching grants are just some of the funding streams exclusively available within the philanthropic community to nonprofit organizations, including child welfare agencies.

DCFS contracts allow for-profit service providers to annually retain up to 9% of revenue as profit so long as the amount of gain is within the allowable administrative expense, which cannot exceed 20% of total direct expenses. Moreover, for-profits are not afforded the tax breaks given to nonprofits, which probably necessitates recovery of tax costs to be built into for-profits' contracts.[7]

Herzlinger notes that nonprofit organizations hold more promise than businesses do, because they are relatively free of the unrelenting need to increase profits, which so often results in a compromised quality of services. But even nonprofits can lose sight of their mission, misuse funds or focus on tangential issues. Herzlinger asserts, "only an informed and proactive board can ensure that an organization will fulfill its function." (Herzlinger, Effective Oversight: A Guide for Nonprofit Directors. Harvard Business Review, July-August 1994.)

Until the 1970's, contracted service providers in the field of child welfare in Illinois were traditionally charitable and not-for-profit organizations. More recently, the Department has engaged in the licensure of for-profit agencies. Even though there is no evidence to suggest that

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[6]Steinberg, Richard. References in Competition in Contracted Markets, 1993. Department of Economics and Philanthropic Studies, Indiana University/Purdue University at Indianapolis.

[7]Nonprofits are eligible for exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code.

for-profits are more efficient and effective child welfare service providers when compared to nonprofits, the Department's licensing standards were adjusted for for-profit agencies which resulted in a lessened degree of accountability.

In accordance with the Illinois Business Corporation Act and DCFS Licensing Standards, the for-profit child welfare agency in Illinois is not required to establish an independent Board of Directors. The owner (or owners) is permitted to fulfill the role and responsibilities of the agency's governing body. Whereas, not-for-profit agencies are required to have a five-member Board of Directors.[8] In the case of ***Lambda Services***, a licensed for-profit child welfare agency, the OIG found that its sole owner served in numerous roles and positions: Board President, Vice President, Secretary, and Treasurer; Executive Director, and Supervisor. Unlike nonprofits, which are directly accountable to their board of directors and to their contributors on whose support they depend, the owner of Lambda Services was accountable to no one. Even though the Illinois Business Corporation Act allows a for-profit corporation's owner to fill any office or position, the OIG is very much concerned with the lack of accountability measures or check and balance systems under these circumstances. Three months into the current fiscal year, Lambda's owner/executive director had not prepared an annual budget nor was a final budget available for the prior year. Therefore, this agency was being fiscally managed outside generally accepted standards of practice.

Another example of the result of lowered expectations was demonstrated by ***Omega Services.*** This for-profit agency is incorporated under the name, Sigma Services and headquartered in Washington, D.C. Omega Services was established in Chicago in 1989 and is one of four affiliates located in the east and midwest. Omega Services is operating in Illinois absent of a local Board of Directors, including the owners. One of the three owners periodically comes into Chicago to meet with staff and provide administrative oversight. The distance between the owners and its child welfare agency in Chicago is troubling. Adding to this concern is the organization's mission statement and other descriptive material about the agency, which do not contain any reference to children or child welfare services or the children of Illinois. Any organization, without a statement of commitment to the people and community it strives to serve, should be suspect.

The Department, inevitably, runs a higher risk when transferring fiduciary responsibility to newly created or underdeveloped agencies, or for-profit agencies, especially when sources and uses of funds and performance are not regularly monitored by DCFS. Where Board requirements and standards on financial management and conflict of interest are lacking, concerns about the utilization of financial assets increases.

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[8]The Department proposes to reduce the requirement to a minimum of three board members.

RECOMMENDATION

1. In general, DCFS should examine whether the Department can place limits on for-profit child welfare agencies through changes in Administrative Rule. One suggestion is that substititute care contracts to for-profit child welfare agencies be limited to residential facilities that include specialized services such as medical and psychiatric.

2. As long as DCFS continues to license and contract with for-profit child welfare agencies, then the Department must develop more stringent standards (consistent with standards developed for nonprofits) for regulating these agencies. For example, for-profit child welfare agencies should be required to establish independent boards of directors in order to qualify for licensure.

III. LICENSING APPLICATION AND RENEWAL PROCEDURES

FINDING

The original license application process is usually the Department's first opportunity to familiarize itself with the agency applicant. It is through this experience that the agency presents its "level of organization development and sophistication, organizational capacity and needs, organizational dynamics and practices." The issuance of a 6-month permit provides additional time in which the agency works to achieve satisfactory (minimal) compliance with the licensing standards to qualify for a license. (An agency can obtain a contract while under permit status.) Each subsequent license renewal event offers DCFS the opportunity to look for improvements and to ensure continued compliance.

For the most part, the Department's CWA Licensing Standards are written in broad, general terms, allowing varied interpretations of the rules and definition of compliance. Through investigations, the OIG found that there are serious differences of interpretation and/or application of rules and procedures across regions, licensing units and even individual licensing representatives.

Theta Services is a case in point in which the Licensing Representative deviated considerably from standards and procedures, and to the extent that a CWA license was issued to a group of individuals who intended to establish a child care facility. This particular Licensing Representative stated to the OIG, "I never issue permits, only licenses. This is more efficient in that an additional site visit is avoided. Theta Services minimally met the standards and that is all that's required." The OIG concluded that the Licensing Representative had not understood the purpose of permits, and was able to apply her own interpretation of rules and procedures. The

OIG found that Theta Services had not achieved minimal compliance with the licensing standards. There was no child care facility, program/services, or personnel in place; in fact, this group was not ready for a permit at the time that the license was issued.

RECOMMENDATION

1. The Department's current CWA Licensing Standards, and application and renewal procedures should be reviewed and revised to more clearly articulate requirements, expectations, and measurements to assess compliance, and to ensure greater uniformity in the interpretation of standards, application of rules, and implementation of procedures.

2. It is recommended that all qualified CWA licensing applicants be issued a 6-month permit prior to licensure.

FINDING

Current reviews of agency applicants for licensure primarily rely on the use of a "document checklist" which does not enable the Department to secure substantive knowledge of the organization, how it operates, and its ability and capability to comply with Department requirements. For example, the manner in which information is currently gathered and "processed" cannot answer the questions: Is the financial management of the agency efficient? Is it well documented? Is it controlled? This is information that should have relevance to decisions made later by Contracts & Grants.

The current licensing review process does not include an examination and integration of collected agency data, and a written analysis or assessment of the agency applicant. (However, the OIG located a licensing representative who prepares a written assessment narrative on agency applicants.) Factual information about an agency coupled with the agency's responses throughout the application/renewal process should provide the reviewer with a strong sense of the organization, including its strengths, developmental needs, and capacity for growth, etc. The kind of information made available during this time include the organization's origin; history; track record in management, systems development, budgeting, planning, and service implementation. Highly informative agency documents include: board meeting minutes, bylaws, mission statement, quarterly financial statements compared to budget, short-term or long-range plan, personnel records, etc.

DCFS Licensing and Contracts staff who were interviewed by the OIG, do not perceive themselves as having the responsibility (and for some, the skills) to conduct qualitative program evaluations or organizational assessments. Program evaluation is generally limited to "utilization reviews" by Contracts & Grants, while Licensing's review of agencies and programs is limited to "compliance with 'weak' licensing standards." When the Department is called upon to evaluate a private agency or its program, there is a tendency for each Department unit to refer the request to the other.

Current licensing rules and procedures have left the Department with superficial impressions of licensed service providers (many of whom have been licensed in the past ten years) and with a false sense of security.

RECOMMENDATIONS

1. The CWA licensing application and renewal process should incorporate an assessment of the organization that includes relevant facts about the organization, identifies its strengths, and areas in need of development.

2. The OIG concurs with BH Panel recommendation that "clear licensing procedures and coinciding forms must be made a priority within the Department."

3. The license renewal process should incorporate established procedures for handling licensees that demonstrate chronic problems with non-compliance with the licensing standards.

4. The license renewal process should incorporate a review of unusual incident reports in the prior year and give consideration to chronic problems.

FINDING

Effective July 1995, child welfare agency license renewals were changed from every two to four years. This policy amendment, which further distances child welfare agencies from being regulated by the Department, is most disturbing in an environment of relaxed rules and weakened enforcement authority. The POS Reinventing Government proposal further suggests that the Department restrict agency licensing/compliance activities to the [initial] application phase only. The OIG believes that further relaxation of requirements placed on child welfare agencies is unadvisable and based on a false assumption that organizations are static or unchangeable entities, and that compliance at any given point in time, ensures compliance at a later date.

RECOMMENDATION

The OIG offers the Department a conceptual framework for child welfare agency licensure which addresses the need for closer monitoring of some agencies, such as newly developed and underdeveloped organizations:

- The Department should explore the concept of a tiered approach to licensure, using license categories (i.e. provisional, probationary, conditional, unconditional) with varying degrees of monitoring and evaluation activities. For example, newly licensed agencies are placed in a 4 to 5 year provisional category, during which time: a) the child welfare

agency and its contract(s) are closely monitored and assessed by the Department; b) the agency is provided technical assistance and linkage with assisting resources for capacity-building purposes; and c) the agency's contracts with the Department are issued and contract amounts may be increased based on relevant information, demonstrated capacity, and deliberate planning.

Licensed agencies in violation of licensing standards and/or contracts are placed on and issued "probationary or conditional licenses" for a maximum of 1 to 2 years. Corrective planning and action, and monitoring occurs during this period. Satisfactory compliance within the specified time period results in reinstatement to regular or unconditional licensure.

Agencies operating in full compliance with standards and contracts demonstrate qualification for a regular or unconditional 4 year license with routine monitoring through contracts and investigations of reported problems or complaints, which may in turn affect the agency's licensure.

FINDING

A review of licensing records of agencies investigated by the OIG, including ***Theta Services, Omega Services,*** and ***Epsilon Services***, revealed that the Department was not in compliance with the Child Care Act of 1969, Section 4.1 Criminal Background Investigations.

RECOMMENDATION

- The Department must enforce the Criminal Background Investigation requirements for all license applicants in accordance with the Child Care Act.

IV. LICENSING ENFORCEMENT

The OIG shares the concern expressed by the BH Panel on Licensing Reform regarding the "general weakness of the Department's licensing enforcement practices to control the proliferation of unlicensed child care facilities in Illinois, to regulate those facilities which have been granted a license, or to ensure that the health, safety, morals or welfare of children placed in child care facilities." The Office of the Inspector General agrees that "the licensing enforcement process is in need of comprehensive restructuring."

The OIG engaged in discussions with (12-15) licensing representatives, many of whom talked about the unlikelihood of successfully revoking a CWA license, even under serious circumstances, i.e. children placed at high risk of harm. According to the Department's Information Systems unit, there are currently a total of 266 licensed child welfare agencies in

Illinois; an additional 22 license applications are pending as of February 1996. Between July 1993 and February 1996, only one child welfare agency license was revoked.[9]

When a license is in the process of being revoked or the Department is refusing to renew a license, the licensee may appeal and continue to operate while their appeal is pending. The OIG was informed that the law prohibits the identification in the system of agencies under appeal.

One licensing administrator recalled that the last appeal by an agency occurred in 1986. The same administrator offered an explanation for the significantly low number of revoked licenses and appeals. "Conditional licenses are issued when the Department indicates its intent to revoke a license. Rather than license revocation, the agency agrees to a conditional license which includes a corrective action plan requiring the agency to comply within a specified time period. If the agency fails to comply, then their license is revoked without an appeal. If the agency complies with the corrective plan, it is allowed to continue operating as a licensed agency." It was the experience of the administrator that some agencies who had conditional license status, phased out their services/contracts or changed the focus of their agency. Some even obtained DCFS contracts for services that do not require licensure.

The OIG could not find any Rule or Procedure for the process described above. Furthermore, a finding by the BH Panel on Licensing Reform was that although the Child Care Act established a category of "conditional license", which can be issued to any child care facility currently licensed, the Department had no written policy on when a conditional license should be issued.

Not all data requested by the OIG was available. For example, the number of licensed child welfare agencies that are for-profit, and the initial date of license issuance for each child welfare agency. Agency and licensing data currently collected by the Department's Licensing units are inconsistently shared with the Information Systems unit. No other central source of information on child welfare agencies, within the context of licensing, could be located.

In 1994, the OIG conducted an investigation of ***Alpha Services***. The OIG found that the agency failed to adhere to terms and conditions of the substitute care contract between DCFS and the agency. The agency failed to make prompt payment to foster parents and failed to comply with rules, policies and procedures as mandated by the Department's Agency & Institution Licensing, Foster Care Licensing, and Contracts & Grants. Although the OIG recommended termination of DCFS contracts based on serious operating problems and violations of Department policies by this agency, the Department directed enormous amounts of resources into this agency. From 1994 until recently, Alpha Services continued to be licensed and received contracts while its problems worsened. The agency is now closed.

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[9]The agency's license was revoked on 12/1/94. The reason for license revocation was not available.

RECOMMENDATION

1. The Department must operationalize enforcement of licensing standards and contract requirements, and develop a strong coordination between the two functions for better control over enforcement of recommendations and critical decision-making, i.e. contract expansion, new contracts development. Effective implementation of this recommendation requires centralization of licensing and contracts systems or strongly coordinated decentralized systems.

2. A centralized data base on private agencies, within legal parameters, is necessary to achieve an effective regulatory role by the Department and for meaningful data utilization.

3. If the Department intends to use conditional license status, it must establish written rules and procedures for the issuance of conditional licenses. When addressing this license status, the Department is advised to give attention to the OIG's suggested categories of licensure.

V. CONTRACTS

FINDING

"A contract is a bargain between two parties, and the test of the contract is whether both sides produce what they agreed to produce."(Smith and Lipsky: Nonprofits for Hire. Public Administration Review. January/February 1994, Vol.54, No.1.)

An investigation of ***Gamma Services*** revealed that Contracts staff do not conduct any type of review of non-substitute care contractees, although contract monitoring by DCFS is stipulated in the contract Clause 9.0. Even at the end of the first contract year, neither non-substitute nor substitute care providers are assessed for performance, service quality, achievement of service objectives, agency management or service delivery capability, appropriateness of expenditures or general contract compliance. Contracts are renewed automatically and increases to contracts are made in the absence of agency accountability or identification of agency or program development needs.

In the program plan (service description) section of Gamma Services' Counseling contract, there is a definition of family therapy as defined by the agency. Cited in the definition is "*...As a result, the extracerebral mind of each family member is altered, and the individual's experience itself changes.*" The OIG questions the integrity of contractual agreements when language like this is approved, but of greater concern is that the evolvement of contracts has placed so much emphasis on the legalistic aspects of the agreement with little regard for the very services which the contract is intended to purchase.

Regarding "unlicensed" agencies, Licensing Enforcement Rule, Section 383.5, Investigation of Complaints Concerning Unlicensed Facilities states: "The Department shall initiate investigations of complaints of unlicensed child care facilities within two business days of its receipt of the complaint." In the case of Gamma Services, the agency's DCFS contract liaison did not conduct an investigation of a complaint he received about this agency. Instead, he instructed the complainant to submit the complaint in writing to a Contracts Administrator and the OIG. According to the executive director of Illinois Partners, the agency was never visited by the contract liaison, and there is no evidence to indicate that contracts staff ever investigated complaints about this agency.

RECOMMENDATION

- The implementation and performance of all first-time contracts should be reviewed by the Department at the end of the first year to assess contract compliance.

FINDING

According to Contracts Administration, the responsibility of contracted agencies as to what they are required to submit to DCFS is "not clear", and agencies are not subjected to any penalty for non-submission of required reports.

The Department proposed discontinuing the requirement that contracted agencies annually submit a Personnel Matrix, identifying all employee positions, salaries, and programs in which they participate. In addition, agencies are required to submit an annual audit to Contracts & Grants only if certain conditions exist. According to the Department's Budget Development unit, currently, agencies are required to submit a budget only in their first contract year, and although all contracted agencies are required to annually submit the Reimbursable Cost Report, not all are submitting these reports.

All of the information contained in key agency documents such as the annual budget, personnel matrix, and cost report, affords the opportunity to test an agency's allocation of revenue and expenditures by program and positions. The Personnel Matrix is particularly helpful when reviewing an agency with multiple child welfare programs. The OIG recognizes that such testing must inherently allow for flexibility and adjustability, recognizing organizational realities such as personnel changes, unanticipated crises in programs, and temporary shifting of staff from program to program. Although DCFS contracts contain a list of "non-allowable costs", there is no evidence to suggest that Contracts staff uniformly engage in a process for determining whether a contracted agency is expending DCFS revenue for non-allowable costs.

RECOMMENDATION

1. The Department needs to restore the original regulatory function and role of Contracts & Grants which are or have been delineated as the Department's responsibilities contained in DCFS contracts--evaluation, monitoring, and ensuring compliance.

2. Reasonable sanctions or penalties must exist to ensure contract compliance. Sanctions can range from temporary closure of intake in an agency to monetary reductions in contracts.

3. The Department needs to develop a formal communication and coordination of information system involving but not exclusive to Agency & Institution Licensing, Foster Home Licensing, Contracts & Grants, Program Administrators, and Agency Performance Monitors.

FINDING

According to contracts staff interviewed by the OIG, most contract negotiators or liaisons have "been around a long time." However, the Department does not currently offer training specifically designed for contract negotiation personnel, and having a lengthy employment history in the Department, does not guarantee that all contract negotiators are skilled to review and analyze agency financial and program reports. In addition, agencies and contracts are not uniformly or consistently reviewed across regions. The contracts process is further complicated by the role of "Springfield". Some contracts and rates, such as group home and institutions, are set and issued from Springfield rather than by region. It is in Springfield where rates are set, and rate appeals are reviewed and outcomes are decided. Springfield has the "final say" with input from the regional contracts staff. Agency documents such as budgets are received by both Springfield and regional contract offices, which suggests there may be duplication of contract activity.

Quarterly review was recently instituted statewide for counseling contracts. However, the frequency of agency/contract reviews continue to vary from region to region.

RECOMMENDATION

1. That Contracts & Grants continues to require of agencies, submission of the Reimbursable Cost Report, annual budget, annual audit, personnel matrix, and random time samples; and that Contracts staff regularly review these documents collectively, and any other relevant agency documents to test allocation of dollars by program and positions, and to ensure the appropriateness of expenditures. It is also recommended that standards be developed to allow such evaluations.

2. Contracts staff should ensure that the salary of the Executive Director is commensurate with the size of the agency and its operating budget. The OIG recommends the establishment and use of salary ranges as guidelines.[10]

FINDING

Overall, the OIG is particularly concerned with the Department's current CWA Licensing and Contract functions within an environment of short-term, rapid growth. Requests for investigations to the OIG are increasingly targeting licensed child welfare agencies that entered the Department's contracts system in the past five years. It was previously suggested in this report that relatively new and developing organizations are at greater risk of failure when their lack of experience (i.e. new staff, limited service track record, poor or underdeveloped financial management systems) is impacted by accelerated contracts and programmatic growth. Even agencies with longevity become vulnerable when establishing new programs. One long standing, stable agency contracted with the Department to establish a Home of Relative (HMR) program. The agency reported to the OIG that their program had grown to 750 children in 1½ years. This agency struggled to control growth to responsibly and effectively address staff issues and increased utilization of the agency's resources. In spite of their efforts, this agency experienced serious staffing issues that created an undesirable instability in the program.

The extraordinary growth of HMR programs in a short time appears to correlate with the current condition of several troublesome agencies, particularly the inexperienced, developing agencies. ***Delta Services,*** which began operating only one year ago, is now responsible for the substitute care of nearly 700 children; ***Zeta Services***, licensed approximately six years ago, is responsible for more than 900 children; and ***Omega Services***, established in Chicago in 1989, is now caring for 1,168 children.

In their study on child welfare contracting in Illinois, Gronbjerg, Chen and Stagner noted that during fiscal year 1989, DCFS purchased services from 2,631 organizations which received 78% of the $244 million that DCFS paid to all service providers that year.[11] The study also found that in fiscal year 1989 only 34 social service agencies jointly accounted for $108 million in DCFS funding which was equivalent to 66% of the funding to social service agencies and 44% of the funding to all service providers. The 34 agencies received at least $1 million each from DCFS in 1989. The findings of the study show that although some factors are more important than others, the amount of DCFS funding providers receive is related mainly to whether they target children,

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[10]The United Way of Chicago periodically publishes the Salary Report: A Survey of Positions in Member Agencies of the United Way of Chicago.

[11]Service providers include individuals.

youth, and their families; whether they are old, established agencies; whether they have expertise with public funding; and how extensively they are involved in coalitions focusing on children and youth.[12]

However, the OIG found that by the end of fiscal year 1994, the number of agencies receiving at least $1 million each from DCFS increased dramatically from 34 in 1989 to 115 in 1994 (78% of total contract funds to agencies).[13] This expansion of agencies represents a 142 percent increase in just five years.

RECOMMENDATION

1. All stand alone Home of Relative (HMR) agencies should be phased out from the Department's licensing and substitute care contracts systems, with the exception of those agencies for whom the Department has evidence of high quality performance.

2. Trends in the issuance of CWA licenses and contracts awarded to child welfare agencies requires further study in order for the Department to most effectively convert to the roles of evaluator, monitor, and enforcer. The awarding of contracts and the current funding levels, need to slow down and level off, especially to developing child welfare agencies and agencies developing new programs. The number of contracts and level of funding to any single agency provider does not reduce or increase the significance of the agency's fiduciary responsibility.

VI. DCFS RESOURCE NEEDS

To perform efficiently, Department personnel need the necessary tools to assess agency compliance; a standards and procedures manual containing user friendly measures that are relatively concrete, objective, and one which comprises measurable pieces of evidence that help staff determine minimal or acceptable level of compliance. Having tools to assess compliance does not negate the fact that staff will be called upon to exercise good judgement as to whether or not an agency is above or below the compliance level.

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[12]Gronbjerg, Chen, Stagner. Child Welfare Contracting: Market Forces and Leverage. Social Service Review, December 1995, pp 590-605.

[13]Source: DCFS Office of Internal Audits

Proper and thorough training of personnel is critical. Licensing representatives and contracts staff must have knowledge of and adequately understand standards and contracts in order to have the ability to explain and apply standards and rules, and implement procedures on a uniform and equitable basis.

To implement a higher standard of enforcement the Department might wish to consider a multi-disciplinary staff to assess agency compliance with both licensing and contract requirements. The Department must have staff who can adequately articulate and evaluate the key functions of an organization: management, finance, program/service delivery, personnel administration. Likewise, contracts personnel must have the ability to assess agency capability, allocation of expenditures, program intent and implementation, and other agency practices such as billing for services.

Licensing and Contracts & Grants personnel must be vested with the authority to enforce Department rules. To ensure appropriate use of authority by staff requires proper qualifications, clearly stated job responsibilities, quality training and supervision, and most importantly, support from the Department's administration.[14] Appropriate use of authority and Department support will require the elimination of the use of "relationships and connectedness, political or otherwise" that enable agencies to secure dangerous or exploitative exceptions to rules or to receive other forms of differential treatment that compromise the quality of care to children.

Technical Assistance Providers

Finally, coordination of information between Licensing, Contracts & Grants, and Program Administration is paramount. The Department could work more effectively with developing agencies and agencies developing new programs if timely and consolidated information was available. With this information in hand, the Department should give consideration to utilizing not-for-profit organizations that are in the business of providing technical assistance and organization development services to agencies. These type of service providers include the United Way of Chicago, Executive Service Corps, CPA's for the Public Interest, and The Support Center.

The OIG does not support the restoration of "mentoring" contracts to child welfare agencies to address capacity-building needs of other service providers. The OIG's report on ***Omicron Services*** details the issues raised by the Department's past contract with this agency for a Mentoring Program.

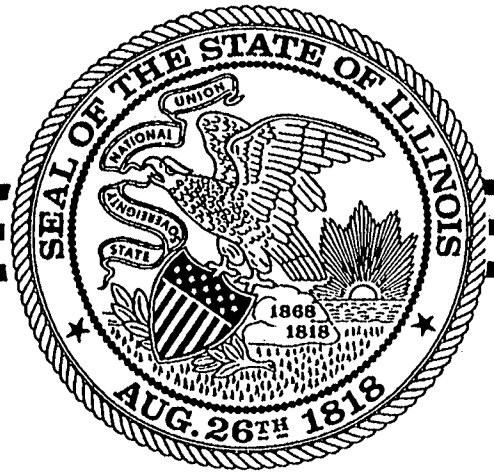
(Rev.5/9/96)

[14]Appropriate use of authority applies to under use as well as overuse of authority.

APPENDIX III

Code of Ethics for Child Welfare Professionals

Code of Ethics



for

Child Welfare Professionals

published by the
Illinois Department of Children and Family Services

DCFS is an equal opportunity employer, and prohibits unlawful discrmination in all of its program/services.

Published by the Authority of the State of Illinois
CFS 1050-67
IL 418-0609
6M Rev. 5/96

STATE OF ILLINOIS

JESS McDONALD
DIRECTOR

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

CODE OF ETHICS FOR CHILD WELFARE PROFESSIONALS

Child welfare professionals are society's representative in its attempts to meet the needs of abused and neglected children and their families. The authority delegated to them to intervene in the lives of families is accompanied by the responsibility to act in a professional manner.

The Code of Ethics for Child Welfare Professionals is the public acknowledgement and acceptance of that responsibility. It sets forth the values and ethical principles which form the foundation of the child welfare field and is intended to guide practice decisions both within the Department of Children and Family Services and within the private agencies with which it contracts. It is also a statement of shared commitments held by professionals working to improve the child welfare field and our promise to our clients and to society that we are worthy of their trust.

Jess McDonald, Director

Denise Kane, Inspector General

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Code of Ethics
for
Child Welfare Professionals

PREAMBLE

Society values each child's natural right to have basic needs for survival and development met and each child's natural right to live with his/her parents. Society also values each parent's natural right to rear his/her child, but through its child welfare laws, defines certain situations in which the parent's rights can be limited so that the child can be protected. Society delegates to the child welfare field and to those who become members of the field the authority to intervene in the lives of families with the goals of ensuring the safety of abused and neglected children, assisting parents in meeting minimum parenting standards, and planning alternative permanent care when parents are incapable of or unwilling to meet those standards.

The child welfare professional is a person who functions in a societally sanctioned decisionmaking capacity for neglected and/or abused children and their families. When individuals accept the role of child welfare professional and the delegated authority inherent in that role, they publicly acknowledge having the professional responsibilities which accompany that authority. Society and agency clients, therefore, have legitimate expectations about the nature of professional intervention as it occurs in one-on-one professional/client interactions, in the management and administration of those providing intervention, and in policy decision-making.

Because of their special knowledge and authority, all professionals are in a position of power in inherently unequal relationships with their clients. The power of child welfare professionals is particularly daunting because of their delegated state authority and the mandated nature of their professional/client relationships. Their clients and society must be able to trust that child welfare professionals are working with their clients' interests in mind with no element of disrespect, punishment, or personal bias. Child welfare professionals must behave in such a manner as to ensure not only that their delegated authority is exercised appropriately but that their clients and society perceive their use of authority as appropriate.

Child welfare professionals' responsibilities to clients are grounded in a fiduciary relationship with its promise of trustworthy intervention in the lives of those less powerful. This type of relationship entails certain responsibilities based on the values of respect for persons, client self-determination, individualized intervention, competence, loyalty, diligence, honesty, promise-keeping, and confidentiality. Child welfare professionals' responsibilities to colleagues, supervisees, foster parents, the court, employees, the child welfare field, and society also find their roots in many of the same values - respect for persons, honesty, promise keeping, and loyalty - as well as in the values of accepting the responsibility for one's actions and their consequences and holding professional behavior to a standard higher than self-interest.

This code of ethics sets forth ethical principles which should be considered by child welfare professionals whenever ethical judgment must be exercised in specific situations and which should become habitual guides to daily conduct. It sets standards of behavior to be adhered to in relationships between professionals and their clients, colleagues, supervisees, foster parents, the court, employees, the child welfare field, and society. Its purpose is to assist in identifying the many and often competing values and responsibilities present in practice issues so that appropriate consideration is given to each value and responsibility in the decision-making process.

It is understood that ethical judgments are made by individuals who bring their personal values, culture, and experiences to the decision-making process. By making public the values and ethical standards shared by child welfare professionals, this code will assist in making ethical decisions more consistent and objective and will reinforce child welfare professionals' accountability to society and to those individuals with whom they have professional relationships.

1. GENERAL RESPONSIBILITIES

1.01 Integrity

Child welfare professionals should carry out their professional responsibilities with integrity, treating those with whom they have professional relationships in a dignified, respectful, honest, and fair manner.

1.02 Propriety

Child welfare professionals should maintain high standards of personal moral conduct when engaged in professional activity. Personal standards and conduct are private matters except when such conduct may compromise professional responsibilities or reduce public confidence in the child welfare field.

1.03 Competence

a. Child welfare professionals should provide services only within the boundaries of their competence based on their education, training, supervised experience, and professional experience.

b. Child welfare professionals should accurately represent their qualifications, educational backgrounds, and professional credentials.

c. Child welfare professionals should be aware of current professional information and take advantage of continuing professional education in order to maintain a high level of competence.

1.04 Avoiding Harm

Child welfare professionals should act in the best interest of those toward whom they have professional responsibilities. It is understood, however, that choices must often be made from among competing values and responsibilities resulting in some values being given priority over others.

a. Child welfare professionals should promote the welfare of those toward whom they have professional responsibilities.

b. Child welfare professionals should avoid harming those toward whom they have professional responsibilities.

c. Child welfare professionals should minimize harm when it is unavoidable.

1.05 Nondiscrimination

a. Child welfare professionals should not engage in and should act to prevent discriminatory behavior on any basis proscribed by law.

b. Where personal or cultural differences could significantly affect child welfare professionals' intervention with a particular individual or groups, child welfare professionals should seek and obtain the supervision and training necessary to ensure that the intervention is unbiased, competent, and culturally appropriate.

1.06 Sexual Harassment

Child welfare professionals should not engage in and should act to prevent sexual harassment.

1.07 Conflict of Interest

1.07(a) Multiple Relationships

Child welfare professionals should take into consideration the potential harm that intimate, social or other nonprofessional contacts and relationships with clients, family members, foster parents, colleagues and supervisees could have on those with whom they have professional relationships and on their professional objective judgment and performance.

1. Child welfare professionals should avoid any conduct that would lead a reasonable person to conclude that the child welfare professional might be biased or motivated by personal interest in the performance of duties.

2. Whenever feasible, child welfare professionals should avoid professional relationships when a preexisting nonprofessional relationship is present.

3. Child welfare professionals should discuss past, existing and potential multiple relationships with their appropriate superiors and resolve them in a manner which avoids harming and/or exploiting affected persons.

4. Child welfare professionals who are also foster parents should disclose and have ongoing discussions regarding these dual roles with their appropriate superior in order to prevent conflicts of interest, abuse of power, or the suggestion of impropriety in carrying out professional activities.

1.07(b) Private Interests

1. Child welfare professionals should not allow their private interests, whether personal, financial, or of any other sort, to conflict or appear to conflict with their professional duties and responsibilities. Any conduct that would lead a reasonable person to conclude that the child welfare professional might be biased or motivated by personal gain or private interest in the performance of duties should be avoided.

2. Child welfare professionals should avoid professional matters where they have a private financial or personal interest. If a situation arises where such a conflict may exist, child welfare professionals should consult with an appropriate superior and take steps to eliminate any potential or real conflict.

1.08 Personal Problems

a. Child welfare professionals should not perform professional activities when they know or should know that personal problems, mental health problems, or substance abuse could impede professional judgment and performance.

b. When such problems could interfere with performance, child welfare professionals should consider obtaining appropriate professional help and determine, along with their appropriate superior, whether they should limit, suspend or terminate their professional duties.

1.09 Documentation of Professional Work

Child welfare professionals should accurately and truthfully document their professional work according to agency policy and/or legal requirements in order to ensure accountability and continuity in the provision of services to clients.

2. RESPONSIBILITIES TO CLIENTS

The client is a child or a family member who is receiving a professional intervention and/or child welfare services from DCFS or through an agency with which DCFS has purchase of service contracts. The first responsibility of the child welfare professional is to the client; however, the specific nature of that responsibility differs depending on whether the client is the child, the parent, or another family member.

A. Responsibilities to the child

The child becomes a client when the child's right to have basic needs met may have been compromised or denied. The child welfare professional acts to ensure that the basic needs of the child are met by the child's parents. If this is not possible, the child welfare professional acts in a timely manner to ensure that the basic needs of the child are met by others.

B. Responsibilities to the parents

The parent becomes a client when the parent's ability to responsibly care for the child has been questioned. Both the parent and the child have the right to live together as a family, and the parent has the right to care for the child, if the parent is able and willing to meet the basic needs of the child. The child welfare professional makes reasonable efforts to help the parent meet the applicable standard of care, and recognizes the changing nature of the responsibilities of the professional to the parent based on the parent's response to intervention.

C. Responsibilities to other family members

Other family members become clients when providing services to them will help meet the basic needs of the child. The child welfare professional acts to provide those services.

2.01 Integrity

Child welfare professionals recognize the vulnerability of their clients and the serious responsibilities associated with intervention in the parent/child relationship. The behavior of child welfare professionals should reflect the emphasis placed by the child welfare field on professional trustworthiness and on the values of respect for persons, client self-determination, individualized intervention, competence, loyalty, diligence, honesty, promise-keeping, and confidentiality.

2.02 Client Self-Determination

The mandated nature of the child welfare professional/client relationship limits the options available to clients, but does not eliminate their right to self-determination. Client self-determination refers to the client's right to make self-determined choices and to freely act upon those choices without undue influence or coercion. It also refers to the client's right to receive information necessary to make a self-determined choice.

a. Child welfare professionals should evaluate the decision-making capacity of all clients and reevaluate it appropriately as circumstances change.

b. Child welfare professionals should ensure that all clients, whatever their age, have the opportunity to make self-determined choices according to their level of understanding and decision-making capacity.

c. Child welfare professionals should ensure that their clients have available to them all of the information necessary to make self-determined decisions.

d. Child welfare professionals should ensure that their clients have the opportunity to make self-determined choices from among the options available to them free from external coercion.

e. Child welfare professionals should ensure that psychological constraints to self-determined decision-making are addressed and, if possible, eliminated or reduced so that self-determination is enhanced.

2.03 Informed Consent

Informed consent emanates from the principle of client self-determination. It promotes decision-making by the client after complete and accurate information regarding the nature of the intervention and the possible consequences of that intervention have been fully discussed by the professional and the client. Child welfare professionals have the responsibility to engage in this process with mandated clients who have not chosen to become clients but who have options to consider and decisions to make within the framework of a mandated intervention.

a. Child welfare professionals should inform clients as soon as feasible and in language that is understandable about the nature of the pro-

fessional relationship, the nature of the professional intervention, the professional's delegated authority and the limits of that authority, which decisions the client can make and which decisions the child welfare professional will make.

b. Child welfare professionals should inform clients of the role of the court, if any, and of their legal and procedural rights.

c. Child welfare professionals should keep clients informed about the case plan throughout the entire intervention.

d. Child welfare professionals should obtain permission for intervention from a legally authorized person when a client is legally incapable of giving informed consent.

e. Child welfare professionals should seek assent for intervention from clients who are not capable of giving an informed consent, giving due consideration to the clients' preferences in pursuing their best interests.

2.04 Confidentiality

a. Child welfare professionals should respect the confidentiality rights of clients and those with whom they work or consult. Confidential information should be used only for professional purposes and shared only with authorized parties.

b. Child welfare professionals have a duty to be familiar with all relevant confidentiality requirements and limitations found in federal and state laws and agency rules that apply to the child welfare field.

c. Child welfare professionals should inform clients of all relevant confidentiality requirements and limitations.

2.05 Sexual Relations with Clients

Child welfare professionals are in inherently unequal relationships with their clients creating the potential for abuse of power. In mandated relationships there is a special potential for harm and exploitation of vulnerable clients by child welfare professionals.

a. Child welfare professionals should not engage in sexual activities with current clients.

b. Child welfare professionals should not accept as clients persons with whom they have previously engaged in sexual activities.

c. Child welfare professionals should not engage in sexual activities with former clients who were adults during the professional intervention

for a period of at least two years after the termination of the professional intervention. Because sexual intimacies with former clients are potentially harmful to the client, child welfare professionals who do engage in sexual intimacies after a two year period following termination of professional intervention are responsible for demonstrating that no exploitation is taking place.

d. Child welfare professionals should not engage in sexual activities with former clients who were minors during the professional intervention for a period of at least two years after the client has reached the age of 21. Because sexual intimacies with former clients are potentially harmful to the client, child welfare professionals who do engage in sexual intimacies after this two year period following the client's reaching the age of 21 are responsible for demonstrating that no exploitation is taking place.

e. Child welfare professionals who are still employed in the field should consult with their superior before initiating with a former client a relationship that has the potential for becoming intimate to help ensure that no exploitation will take place. Child welfare workers who leave the field continue to have the responsibility of considering the potential for exploitation and harm in relationships with former clients.

f. Child welfare professionals should not engage in sexual activity with clients' relatives or with other individuals with whom clients maintain a close personal relationship since such behavior has the potential of being harmful to the client.

2.06 Termination of Services

Child welfare professionals should not abandon their clients. Child welfare professionals should continue appropriate intervention with clients until intervention is no longer required to meet the needs of the child or is no longer appropriate under the applicable statute. At that time, intervention is terminated.

a. Child welfare professionals should promptly notify clients when termination or interruption of services is anticipated.

b. Prior to termination, for whatever reason, except precise order of the court, child welfare professionals should provide appropriate pretermination counseling and take other steps to facilitate transfer of responsibility to another colleague or provider of services if further intervention is required.

c. Child welfare professionals should request the transfer of a case to another professional when compelling reasons prevent successful professional intervention.

3. RESPONSIBILITIES TO COLLEAGUES

Child welfare professionals should act with integrity in their relationships with their colleagues, treating them with respect, honesty, and fairness and accepting their right to hold values and beliefs that differ from their own.

a. Child welfare professionals should cooperate with colleagues in order to serve the best interests of their clients effectively and efficiently.

b. Child welfare professionals should accurately represent the views and qualifications of colleagues, making opinions on such matters known through the appropriate professional channels.

c. Child welfare professionals should extend to colleagues of other agencies the same respect, honesty, fairness, and cooperation that is extended to colleagues in their own agencies.

d. Child welfare professionals should extend to members of other professions the same respect, honesty, fairness, and cooperation that is extended to child welfare professionals.

4. RESPONSIBILITIES TO THE COURT

Child welfare professionals frequently are called upon to appear in court and participate in court proceedings. They have special responsibilities in that setting.

a. Child welfare professionals should treat all parties to the case with respect, honesty, fairness, and cooperation.

b. Child welfare professionals should thoroughly familiarize themselves with the background of the case involved.

c. Child welfare professionals should testify honestly in court. They should apprise the court of all relevant facts in the case, both positive and negative, of which they are aware.

d. Child welfare professionals should advise the court if they come to know of the falsehood of prior testimony given in a child welfare proceeding.

e. Child welfare professionals should take appropriate action against any unethical conduct they observe in court.

5. RESPONSIBILITIES TO FOSTER PARENTS

Foster parents act as a bridge between the client and child welfare agencies. Therefore, child welfare professionals should treat foster parents with respect, fairness, honesty, and cooperation.

a. Child welfare professionals should be familiar with and adhere to the Foster Parent Law which sets forth the rights and responsibilities of foster parents.

b. Child welfare professionals should not engage in sexual activities with foster parents with whom they are presently working.

c. Child welfare professionals should consult with their appropriate superiors when initiating a potentially intimate relationship with a foster parent or if they have had an intimate relationship with a person who will now be working with them as a foster parent. These types of situations should be resolved in a manner which avoids harming and/or exploiting all affected persons.

6. RESPONSIBILITIES IN SUPERVISION

Child welfare supervisors, as members of management, recognize that their primary responsibility is to implement the policies and practices of their agencies so that the best possible services are delivered to clients. Child welfare supervisors also recognize their responsibilities to their supervisees, treating them with respect, fairness, and honesty; offering the professional support necessary to sustain the supervisees' continued motivated work; and providing a work environment which encourages ethical behavior .

6.01 <u>Personal Integrity</u>

a. Child welfare supervisors should not use their position of authority to exploit their supervisees in any way.

b. Child welfare supervisors should not engage in sexual activities with current supervisees.

c. Child welfare supervisors should accept responsibility for their own decisions and the consequences of those decisions. They also have a high level of responsibility for decisions made by their supervisees and should accept appropriate responsibility for those decisions.

6.02 Management Responsibilities

a. Child welfare supervisors should apprise supervisees of current professional information and encourage supervisees to take advantage of continuing professional education in order to maintain a high level of competence.

b. Child welfare supervisors should communicate, explain, and apply legislation, agency policies, and administrative decisions necessary for them and for their supervisees to perform their work competently.

c. Child welfare supervisors should act as advocates for their supervisees by apprising upper management of problems which impede or prevent them from efficiently and effectively performing their duties. They should also suggest appropriate changes in policy and procedure.

d. Child welfare supervisors should provide necessary training and guidance when supervisees' personal or cultural differences could result in biased or discriminatory professional intervention with a particular individual or groups.

e. Child welfare supervisors should consult with supervisees and help with remedial action if they have knowledge of the supervisees' impairment due to personal problems, mental health problems, or substance abuse.

f. Child welfare supervisors should evaluate supervisees fairly and objectively on clearly stated criteria, sharing opinions about the supervisees' performance in an ongoing manner.

g. Child welfare supervisors should take appropriate steps to terminate employment of supervisees who are not competent and are not likely to become competent.

7. RESPONSIBILITIES IN ADMINISTRATION

Child welfare administrators recognize that, although each child welfare professional is responsible for his/her ethical behavior, the agency is responsible for the environment in which ethical judgments are made. Child welfare administrators, therefore, should nurture and model organizational norms that encourage and reward the ethical behavior for which society holds the child welfare field accountable.

7.01 Personal Integrity

a. Child welfare administrators should treat each client, colleague, and employee with respect.

b. Child welfare administrators should maintain truthfulness and honesty and not compromise them for advancement, recognition, or personal gain.

c. Child welfare administrators should take responsibility for their own decisions and behavior.

d. Child welfare administrators should conduct official acts without partisanship.

7.02 Public Welfare

a. Child welfare administrators should exercise their discretionary authority to promote the values of the child welfare field.

b. Child welfare administrators should respond to the public in ways that are complete, truthful, clear, and easy to understand.

c. Child welfare administrators should understand and apply legislation and regulations relevant to their professional role.

d. Child welfare administrators should work to improve and change laws and policies which are counter-productive or obsolete.

e. Child welfare administrators should prevent all forms of mismanagement of public funds by establishing and maintaining strong fiscal and management controls, and by supporting audits and investigative activities.

7.03 Organization

a. Child welfare administrators should enhance organizational capacity for open communication, creativity, efficiency, and dedication.

b. Child welfare administrators should subordinate institutional loyalties to the public good.

c. Child welfare administrators should establish procedures that promote ethical behavior and hold individuals and organizations accountable for their conduct.

d. Child welfare administrators should provide organization members with a working environment which permits frank discussion and criticism of agency operations and with an administrative means for dissent, assurance of due process, and safeguards against reprisal.

e. Child welfare administrators should promote organizational accountability through appropriate controls and procedures.

f. Child welfare administrators should maintain a high level of competence and provide support to upgrade competence throughout the organization.

8. RESPONSIBILITIES IN RESEARCH

Research performed by child welfare professionals should be rigorous and relevant to the delivery of services, the outcomes of interventions, and policy formation in the child welfare field.

a. Child welfare professionals should protect the rights and welfare of research subjects, treating them with respect and dignity and protecting them from harm, danger, unnecessary discomfort, and ethnic and/or social discrimination.

b. Child welfare professionals should obtain informed consent from their prospective subjects, after explaining in language that is understandable to them, the nature of the research; its possible risks, benefits, and consequences; alternative treatments or interventions; confidentiality rights; and the voluntary nature of participation with no penalty for refusing to participate or choosing to withdraw at a later date. Child welfare professionals should answer any questions the prospective subject asks.

c. When the prospective subject is not legally capable of giving informed consent, child welfare professionals should give an appropriate explanation of the research, obtain assent when appropriate, and obtain informed consent from a legally authorized representative.

d. Child welfare professionals should conduct research according to accepted standards of professional competence, federal and state law and regulations, agency policy, and accreditation requirements.

e. Child welfare professionals should obtain the approval of the agency Institutional Review Board and other relevant regulating boards before initiating research and should conduct their research according to approved protocol.

f. Child welfare professionals should report the findings of their research truthfully and completely. They should work to prevent misuse and distortion of their research findings.

9. RESPONSIBILITIES TO THE CHILD WELFARE FIELD

a. Child welfare professionals should perform their duties in a competent, honest, diligent manner to ensure society's continuing trust in the child welfare field.

b. Child welfare professionals should broaden the knowledge base of the child welfare field.

c. Child welfare professionals should critically examine child welfare policies and advocate appropriate change.

d. Child welfare professionals should take appropriate action against unethical conduct by any member of the child welfare field.

10. RESPONSIBILITIES TO SOCIETY

Child welfare professionals should apply the values and specialized knowledge of the child welfare field and should work to increase public awareness of those values in order to promote the general welfare of society.

11. ETHICAL DECISION-MAKING

a. Child welfare professionals have a duty to be familiar with this Code of Ethics and to consider which ethical principles apply in each practice decision.

b. Child welfare professionals should follow applicable ethical principles in each practice decision. If there is a conflict between two or more ethical principles and/or responsibilities in a particular case, child welfare professionals should consult with superiors and colleagues knowledgeable about ethics issues, or with the child welfare ethics board, in choosing a proper course of action.

c. If the demands of an agency with which child welfare professionals are affiliated conflict with this Code of Ethics, child welfare professionals should clarify the nature of the conflict, make known their commitment to the Code, and seek to resolve the conflict in a way that permits fullest adherence to the Code.

d. Child welfare professionals who observe a violation of this Code by a colleague should bring the issue to the attention of the colleague if an informal resolution appears appropriate. If the issue cannot be informally resolved, child welfare professionals should refer it to appropriate superiors and/or to the child welfare ethics board.

APPENDIX IV

Investigative Report (teaching tool)

Department of Children and Family Services
2240 West Ogden Avenue
Chicago, Illinois 60612
(312) 433-3000

Office of the Inspector General

CONFIDENTIAL[1]

This report is being released by the OIG to schools of social work for teaching/training purposes. To ensure the confidentiality of all persons & service providers involved in the case, all identifying information has been changed. All names are fictitious.

Minors:	Julie Jones-Smith (DOB 12/4/91; DOD 6/7/95)
	Linda Brown (DOB 6/24/89)
	Kathy Brown (DOB 9/2/90)
	Billy Smith (DOB 4/7/93)
Subject:	Child Death
Date:	6/30/96

PARENTS

Mother of all children:	Mary Jones-Smith (DOB 11/10/72)
Father of Linda and Kathy:	George Brown (DOB 11/13/69)
Father of Julie and Billy:	John Smith (DOB 12/8/69)

FOSTER PARENTS

Diane and Joseph Jones, maternal step-grandmother and maternal grandfather (Julie)
Elizabeth and Ervin Brown, paternal grandparents (Linda and Kathy)
Joyce Johnson, maternal grandmother (Billy)
Clara Smith (temporary), paternal grandmother (Billy)

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[1] This report is submitted to the Director of DCFS from the Inspector General of DCFS on 6/30/96. All information identifying the complainant must be removed prior to any dissemination beyond the Director's Office. This report and any attachments should be considered confidential. They can only be viewed within DCFS on a "need to know" basis by those persons the Director has deemed appropriate and necessary. Supervisors and other personnel may use this report as a teaching tool to address and implement recommendations. Neither this report nor any information contained therein may be shared with anyone outside of DCFS without the permission of the Inspector General.

SERVICE PROVIDERS

DCFS

POS Monitors/
Workers: Pamela Harris (9/94 - 6/95)
Sally Scott (8/94 - 9/94)
Sheila Warren (7/93 - 8/94)
Anne Bell (7/92 - 9/93)
Peggy Howard (2/92 - 7/92)

POS Monitor Supervisor: Bob Jackson
POS Monitor Acting Supervisor: Ray Phillips
Administrator: Jane Doe
Clinical Consultant: Tim Clark

Private Agency

Caseworkers: Debra Bailey (7/93 - 3/95)
Terry Baker (2/93 - 6/93)
Karen Adams (8/92 - 2/93)

Therapy Agency

Therapists: Laura Foster (9/94 - 6/95)
(She also supervised parent/child visits from 9/93 - 5/94)
Nancy Stevens (11/92 - 9/94)
Supervisor: James Hart

SUMMARY OF COMPLAINT

The OIG received notification that Julie Jones-Smith died June 7, 1995. Julie and her siblings were wards of DCFS. DCFS originally took custody of the children in January 1992 after one-month old Julie sustained a subdural hematoma as a result of being shaken. This initial injury caused brain damage resulting in seizures and delayed speech, motor coordination, and development. Julie, her sisters, Linda and Kathy, and her brother, Billy (removed in August 1993), remained in the physical custody of DCFS until April 1995. The children were returned home on April 12, 1995 under an Order of Protection. Less than two months after the children's return home, Julie died after suffering multiple seizures. The medical examiner ruled Julie's death a homicide caused by cerebral injuries due to blunt head trauma from child abuse.

ANALYSIS

Despite three-and-a-half years of involvement by DCFS, Private Agency and Therapy Agency

and the parents'[2] participation in the services provided, Mary and John still had several unresolved issues in their readiness to be reunified with all their children and to assume full-time responsibility for their care in April 1995. The case records and interviews with those involved in the case do not indicate that these issues were adequately addressed. Among these issues were the following.

1) Counseling

Abuse Counseling: This case illustrates the professional dilemma raised when parents are required to engage in therapy, i.e., who is the best arbiter of change? Throughout the history of this case, Mary and John denied abusing Julie. Mary and John's therapists believed them, operating under the assumption that they did not fit an abusive profile because they did not exhibit the traits of known child abusers. Nancy Stevens and Laura Foster's therapeutic stance consisted of building a relationship and alliance with the parents. The parents' denial was incorporated as part of the therapeutic process. Emphasis was not on the content of the denial, but with the building of a therapeutic alliance. Thus, Ms. Stevens did not challenge Mary and John with the medical evidence that Julie was so severely physically abused at one month that she was left brain damaged or explore the circumstances surrounding Kathy's broken thigh at thirteen months which occurred just three months prior to Julie's injury. Rather, Ms. Stevens continuously interpreted the parents' repeated denial and acts throughout the case as a reaction to them being labeled as abusers. Mary's act of hiding her pregnancy and delivery of Billy was therapeutically interpreted as a cognitive error based on her justifiable fear that DCFS would take custody of Billy. Such a fear was "in accordance with Mary's cognitions about the child welfare system;" John's act of hiding Mary's pregnancy and delivery of Billy was "consistent with his concrete way of viewing the world." Mary's suicide gesture (of which Ms. Stevens was informed by Mary's mother) was explained as the result of cumulative stress. The parents' failure to attend counseling for two months was attributed to the parents' feelings of abandonment or loss due to Ms. Stevens's maternity leave. Likewise, their failure to consistently visit with their children was interpreted in a benign fashion, i.e., they had transportation problems, experienced discomfort and feelings of being judged in the relative foster homes, and were busy caring for Billy (although Billy was born in April 1993, he was not removed from Mary and John's care until August 1993).

Other behaviors of the parents were ignored, excused, or minimized rather than judiciously incorporated into a competing hypothesis by the therapists that one or both of the parents abused two of the children, perhaps during a time of stress. Some examples are the following. There was one known incident of domestic violence between Mary and John. They reported that although early in their dating relationship, John hit Mary, there had been no further such incidents. The act was viewed by both Ms. Stevens and Ms. Foster as a one-time occurrence.

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[2] Throughout this report, whenever the term "parents" or "natural parents" is used, it refers to Mary and John, and not George Brown. George is indicated by name.

When John learned that a relative informed Private Agency that Billy was born, John threatened to "take care of" the person who told Private Agency. This act was viewed by Ms. Stevens as "just making statements" out of anger. John's punching a wall when temporary custody of Billy was declared in court (which led him to be detained by court security) was ignored. The report by Linda and Kathy that Kathy was whooped by Mary during a visit was minimized; Ms. Foster failed to inform the Court that the reported incident involved a belt, that the children also reported being whooped by John, and that Mary had admitted to "threatening" to whoop the children.

Despite these incidents, neither therapist viewed John as having an anger management problem. Mary exhibited throughout the history of this case that she clearly had a problem controlling her anger. She also appeared to become frustrated quite easily. Mary's anger appears to have been induced by stress. Whenever Mary experienced stress leading to anger or frustration, her therapist would provide support and encouragement and calm Mary down. Thus, according to her therapists, Mary had learned anger management skills. Yet, the therapists never tested Mary's ability to manage her anger. As late as March 1995 when unsupervised visits were revoked by the Court, Ms. Foster "calmed Mary during perceived crisis, provided support to Mary in dealing with court's decision to revoke visits; encouraged her to view positive options, and suggested coping mechanisms to deal with dilemma." Thus, Mary's ability to control her anger and frustration during stressful events without the aid of her therapist was questionable.

Because of the nature of the therapeutic relationship, the Department cannot rely on the parents' therapists to remain neutral. Thus, the parents' therapists should not be viewed as the arbiters of change or be allowed to direct the progress of the case. Rather, the caseworker and his/her supervisor must be the arbiters of change, incorporating the parents' progress in therapy into the greater picture presented by the parents. The caseworker must assume responsibility for continually raising the reason for system entry to evaluate the appropriateness of services, conduct risk assessment, and maintain an objective perspective regarding overall progress. In cases of abuse, this responsibility includes acknowledging the severity of injuries inflicted or incurred. In this case, as discussed in "The Return Home Decision" section, both Ms. Stevens and Ms. Foster were instrumental in orchestrating the children's return home.

Child Development Issues Counseling: It does not appear from the case records or the interview conducted by the OIG with Laura Foster that Ms. Foster provided Mary and John with any counseling surrounding child development issues, including normal child development and what they could expect from their children.

Ms. Foster discussed discipline with Mary and John and both agreed to use time-outs as discipline. It does not appear, however, that Ms. Foster explored with Mary and John behavior modification techniques other than the use of time-outs or in what situations discipline was appropriate given the characteristics, needs, behaviors, and developmental

stages of their children.

In this case, Julie and Kathy, in particular, exhibited characteristics and behaviors which put them at risk for abuse. Kathy was aggressive and difficult to control. Julie was medically compromised, was unable to speak, and exhibited negative behavior due to her inability to communicate her needs and wants. She also exhibited unpredictable behavior because of her recent intake of psychotropic medication. Although acknowledging in her interview with the OIG that some children present characteristics and behaviors which make them more vulnerable to abuse, Ms. Foster did not take into consideration these children's vulnerabilities while counseling Mary and John.

Reunification Counseling: From the case records, it appears that the workers and therapists involved with this case assumed that Mary and John desired reunification with all of the children. Yet, Mary and John expressed ambivalence about reunification throughout the history of this case. Ambivalence about reunification has been defined to include "either a pattern of verbal statements that reflect conflicting feelings about parenting, about a particular child, and/or about a child's return home; or a pattern of behaviors that is inconsistent with the parents' stated interest in the child's return." [Peg McCartt Hess & Gail Folaron, "Ambivalences: A Challenge to Permanency for Children, 1991]. Parents' ambivalence about reunification has been found to affect the success of reunification; children of ambivalent parents are more likely to reenter placement. [Hess & Folaron, 1991].

The most obvious verbal indicators of Mary's ambivalence about reunification were the following. In January 1994, Mary informed her therapist, Nancy Stevens, that she planned to surrender her parental rights. According to a case entry by Ms. Stevens, "Mary was clear and adamant about her decision." In August 1994, Linda and Kathy's foster mother, Mrs. Brown, reported to Private Agency caseworker Debra Bailey that Linda and Kathy had stated that Mary told them that Billy and Julie would live with Mary, but that Linda and Kathy would live with their grandparents (The Browns). In September 1994, Mary advised Ms. Bailey, that she was no longer willing to work toward reunification with her children. When Ms. Bailey asked if she wanted to surrender her parental rights, Mary responded that she "just didn't want to do anything."

Parents' inconsistent participation in services and visiting are important behavioral indicators of ambivalence about reunification. [Hess & Folaron, 1991]. The most obvious behavioral indicators of both Mary and John's ambivalence about reunification were their inconsistent visitation with the children (particularly Linda and Kathy) and their inconsistent counseling attendance (including complete withdrawal at times).

Instead of openly, thoroughly, and continually exploring Mary and John's verbal and behavioral indicators of ambivalence, therapists and caseworkers ignored or minimized them. This may have been due, in part, to their own personal values and attitudes. In some instances workers' inattention to the verbal and behavioral indicators of a parent's ambivalence reflect

social and personal values and attitudes. In some cases, the self-esteem of workers appears to become entangled with being able to achieve the goal of reunification and reunification becomes more important to the worker than to the parent. [Hess & Folaron, 1991]. It appears this was the case with Nancy Stevens; when Mary declared her intention to surrender her parental rights, Ms. Stevens contacted Mary's mother and Mary's attorney to discuss Mary's decision. Six days later, Mary changed her mind.

Some parents may express their ambivalence only indirectly through behaviors; many parents are unable to articulate their ambivalence, either because to do so is socially and/or personally unacceptable, or because they are verbally unable due to intellectual limitations, personal immaturity, or restricted vocabulary. Some parents may be reluctant to recognize their own ambivalence. Thus, it is essential that workers be willing and able to access, identify, and assess parents' ambivalence as a dynamic relevant to risk assessment, service planning, and permanency planning. It is imperative that workers openly discuss all permanency options for each child in establishing permanency goals. When all options are not discussed, the worker and family act on the possibly erroneous assumption that parents want to continue to care for each of their children permanently. [Hess & Folaron, 1991].

In this case, "return home" remained the permanency goal for all of the children for the 3-1/2 year duration of the case. At no time did therapists or caseworkers thoroughly explore with the parents their ambivalence toward return home and alternative permanency options available to them with regard to each of the children.

The parents' ambivalence about reunification with Linda and Kathy was more prominent than with Julie and Billy. John was not the biological father of Linda and Kathy and initially did not visit with them at all. Later, both Mary and John visited with Linda and Kathy less often than with Julie and Billy. Mary reportedly had told Linda and Kathy that they would live with their grandparents.

Linda and Kathy were the oldest children and had bonded with their grandparents. They also had a close relationship with their biological father, George Brown. George was a good father who visited regularly with the children and expressed genuine concern for their welfare. George indicated on several occasions that he would like to care for the girls when he became financially capable or have them remain with his parents. The Browns had expressed their interest in providing long-term care for the girls. Therapists and/or caseworkers should have openly discussed and explored with Mary and John this available alternative living arrangement for Linda and Kathy. Mary may have been uncomfortable raising the possibility herself out of fear that she would be viewed as a "bad mother for giving up her children." It was the therapists' and caseworkers' responsibility to raise the issue and if warranted, help Mary understand that it was "ok" to let Linda and Kathy's father and grandparents raise them if she wanted to start fresh with John, Julie, and Billy.

Because it was assumed that reunification with all of the children would be a gain for Mary and John, it appears that there was little exploration of what Mary and John would be giving up in order to care for four young children. Although Ms. Foster appears to have counseled Mary and John regarding how the children would affect their marriage, she does not appear to have explored with them what it would mean personally. For example, did Mary and John truly understand the financial needs/responsibility of full-time care of the children? Was John pressured to take any job, rather than find one with more financial security and career opportunity?

Mary was employed for the majority of her involvement with DCFS and reported that she enjoyed working as a certified nurse's assistant "very much." In May 1994, Mary was accepted into nursing school and planned to become a surgical nurse. Yet, at the time of the children's return home, Mary was not employed and it does not appear that she was in school. Did Mary have to give up her aspirations in order to become a full-time caretaker of her four young children? Did she fully understand the lifestyle change this decision would entail? It does not appear from Therapy Agency's case record that these issues were addressed in therapy with Mary and John.

Extended Family Counseling: Conflict between Mary and John and the extended family foster parents was apparent from the beginning of the case. Case entries reflect that as the case progressed, conflict increased. Private Agency caseworker Debra Bailey, in an interview with the OIG, explained that the natural parents' relationships with the foster parents were "very up and down." There were times when Mary and John would not speak to certain foster parents. Other times, the natural parents and foster parents were "verbally violent" toward each other. The natural parents' alliances with the foster parents kept changing during the case.

Case entries reflect that, on many occasions, Mary and John expressed to their therapists (Ms. Stevens and Ms. Foster) dissatisfaction with the way the foster parents were caring for the children. Although this occurred most often with regard to Julie, it also occurred with regard to the other children. The parents' criticisms were viewed by their therapists as concern for the children instead of dissension between Mary and John and the extended family. Yet, in February 1995, frustrated by the report of the whooping incident, Mary informed her caseworker, Debra Bailey, that she did not want to assist the foster parents with the children's medical care until she got the children returned to her.

Ms. Stevens and Ms. Foster were aware of the continuing conflict between the natural parents and the foster parents. In an interview with the OIG, Ms. Foster stated that she felt Mary's relationships with the extended family created frustration for Mary. Although Ms. Stevens and Ms. Foster facilitated a few discussions between the natural parents and the foster parents to resolve issues surrounding the children's care, these discussions often resulted in hostile, angry confrontations between caseworkers, parents, and foster parents.

In making her decision to recommend return home of the children, Ms. Foster indicated in her interview with the OIG that she took into consideration that the natural parents had the support of the foster parents. While the foster parents expressed their willingness to support the natural parents, Ms. Foster apparently did not consider whether the natural parents would realistically seek the support and assistance of the foster parents with whom they still had unresolved issues.

The conflict among family members in this case was extensive and did create frustration for Mary. Her therapists should have insisted upon and facilitated extended family counseling during the children's foster care placements, and if necessary, following the children's return home.

2) The Return Home Decision

Mary and John's attorneys filed return home motions in January 1995 to be heard on March 29, 1995. The motions were continued until April 12, 1995. Prior to the return home hearing, several significant events took place in this case. On March 6, 1995, knowing that a return home motion was scheduled for March 29, 1995, Private Agency informed DCFS of its decision to withdraw from the case because of the continuing hostility directed at Debra Bailey by foster parents, Mrs. Johnson and Mrs. Jones. Private Agency gave a 14-day notice on March 15, 1995 and was out of the case on March 29, 1995.

Julie and Billy's placements were unstable in March 1995. The Joneses and Mrs. Johnson were anxious to have Julie and Billy returned to the natural parents because they themselves were "too tired" to care for the children and were tired of dealing with the requirements imposed on them by DCFS and Private Agency. The quality of care given Julie by her foster parents was also questionable at this time. Both the Joneses and Mrs. Johnson had indicated that they no longer wanted to care for the children after March 29, 1995. The return home motion was continued until April 12, 1995, however, and the foster parents continued to care for the children until they were returned home on that date.

Unsupervised visits and overnight visits were discontinued by the Court on March 15, 1995 pending resolution by the Court of the GAL's motion to revoke unsupervised visits based on the 2/95 "whooping" incident involving Kathy and Mary. While Ms. Bailey tended to believe that some type of whooping occurred, Ms. Foster reported in a 3/29/95 Progress Report to the Court that it remained unclear whether Kathy was whooped. Instead of focusing on the parents' behavior, Ms. Foster, instead, related that Linda and Kathy reported being whooped in their foster home and that their paternal grandmother told them to report they were whooped by Mary. Ms. Foster failed to inform the Court that the children also reported being whooped by John. She also did not inform the Court that Mary, during an ACR on March 6, 1995, admitted to threatening to whoop the children.

Ms. Foster believed Mary and John when they said they used time-outs as punishment. Of significance is that the whooping incident involved Kathy - the aggressive child who had

consistently shown behavior problems and trouble following rules and directions. Ms. Bailey had earlier expressed concern that "Mary may not be able to handle disciplining Kathy." At the very least, workers should have been concerned about Mary's admission that she threatened to whoop the children. This alone raised the question of whether Mary was truly applying what she had learned about parenting and disciplining the children and further raised the issue of whether Mary would be able to manage her stress and anger while caring for all four children on a full-time basis.

For a 30-day period prior to the children's return home, the parents had no overnight or other unsupervised visitation with the children. It does not appear from the case records that Mary and John engaged in any supervised visitation. At the same time, Mary and John were again getting discouraged with the long process of regaining custody of their children and were withdrawing from counseling.

Stressors occurring in the four to six months prior to the children's return home, in addition to the above-stated events, were the following:

1. Both Mary and John's employment situations changed. Mary, who had worked fairly regularly throughout the case's history, was unemployed. John had obtained a new position in November 1994 and appeared to be doing okay.

2. Mary and John were just newly settled in a 2-bedroom apartment after having been evicted from their previous home in June 1994. There were indications that Mary and John thought the apartment might not be large enough for the entire family.

3. True family support systems for Mary and John were questionable. As noted earlier, throughout the history of this case, Mary and John experienced conflict with the relatives taking care of the children.

4. Postponement in the decision to return the children was another stressor for this couple. The original court date of March 29, 1995 had to be continued until April 12, 1995.

5. Getting all the children back at one time. These four children were all under age six and three had lived away from their parents for over three years (other than some overnight visits). The children all required special attention and necessitated appointments, medical care, and transportation to and from day care/school.

Prior to the scheduled March 29, 1995 court hearing, there was no comprehensive case staffing with the DCFS, Therapy Agency, and Private Agency workers to discuss the potential return home of the children. On March 27, 1995, Ms. Foster met with DCFS worker Pamela Harris and then separately with Private Agency worker Debra Bailey to find out whether they intended to recommend the children's return home. While Ms. Harris agreed to recommend

return home, Ms. Bailey stated that her recommendation would be deferred to the DCFS worker.

The case records and interviews with persons involved in this case demonstrate that in making the decision to return the children home, great significance was given to the fact that psychological/psychiatric evaluations conducted in March 1995 on Mary and John did not indicate "any psychiatric illness present in either parent that should prohibit them from functioning in a parenting role." Originally, Dr. Hill, of [Court Psychological Testing Services], was asked to address whether the parents should be allowed to regain custody of the children. This was a question which Dr. Hill was ill-equipped to answer because he did not have all of the available information regarding the parents and children. The request was inappropriate. While Dr. Hill did not address the question, he should have pointed out in the evaluations that he could not make this determination.

The DCFS worker and the Therapy Agency therapists over relied on and misused the psychological/ psychiatric evaluations conducted in this case by viewing them as giving them permission to return the children home. The evaluations, however, only supported that Mary and John did not have any underlying psychiatric illness that would prevent them from parenting their children. Research has shown that only about 10% of child abusers suffer from mental illness or psychopathy. Social factors are thought to account for the other 90%. [Richard J. Gelles, The Book of David, 1996 citing Murray A. Straus, "A Sociological Perspective on the Causes of Family Violence," 1980]. Thus, psychological/psychiatric evaluations are limited. They may disclose whether a parent has an underlying mental disorder or psychiatric illness that would prevent them from parenting their children. They cannot predict, however, whether parents will parent their children nonabusively and, therefore, whether it is safe for children to return home.

A clinical consultation was not initiated prior to the children's return home, despite the availability of Tim Clark, a Licensed Clinical Social Worker and Clinical Consultant in the [Town] office. Although Mr. Clark met with DCFS worker Pamela Harris on April 5, 1995, the meeting was intended to focus on Ms. Harris's well-being. Ms. Harris's comments that the children in one of her cases were about to return home did not initiate a review of the case record or a discussion of the factors precipitating system entry or return home, an after-care plan, profiles and needs of the Jones-Brown-Smith children or remaining risk factors. (See Attachment A, "Clinical Consultation to DCFS," for an analysis of the clinical consultation provided to [Town] office staff.)

Ms. Harris did not receive supervisory approval before deciding to recommend return home of the children. Ms. Harris's supervisor, Bob Jackson, was on extended medical leave. Ray Phillips, the CWS III on Jackson's team, was acting supervisor. When Ms. Harris asked Mr. Phillips for advice regarding the return home hearing, Mr. Phillips advised Ms. Harris not to give a recommendation with regard to returning the children, rather to just present the facts and let the Court make the decision. Mr. Phillips did not offer to review the case and Ms.

Harris did not receive supervisory approval to return the children home.

In March 1995 Reports to the Court, both Ms. Stevens and Ms. Foster recommended return home of the children with a safety plan and supportive services/monitoring in place. Ms. Foster testified at the 4/12/95 return home hearing and recommended that the children return home. Ms. Harris agreed with the Therapy Agency therapists. Private Agency had withdrawn from the case effective March 29, 1995. Debra Bailey, the worker who had the most contact with and information about the family as a whole (parents, foster parents, and children) was subpoenaed to testify at the return home hearing. She was instructed by her supervisors to give only facts and not give a recommendation regarding the children's return home. In an interview with the OIG, Ms. Bailey indicated that if Private Agency had remained on the case, the agency never would have agreed to send the children home in April 1995. Private Agency's withdrawal from the case, so close in time to the return home hearing, was inappropriate. Even so, withdrawing from the case did not relieve Private Agency of its responsibility toward the Jones-Brown-Smith children. If the agency was of the opinion that the children would be at risk if returned to their parents, Ms. Bailey's supervisors should have instructed her to inform the Court of this opinion.

On April 12, 1995, the Court returned the children home under an Order of Protection.

3) Planning for the Children's Return Home

There was insufficient planning for the children's return home on April 12, 1995. The only planning that took place was the preparation of a Safety Plan which was submitted to the Court and made a part of the Court's Order of Protection for the children's return home. The Safety Plan only outlined Mary and John's intentions to plan for the children's schooling, Julie's medical care, and maintenance of the children's relationships with their foster parents. It did not outline concrete steps or plans addressing these areas.

The Safety Plan was conceived in isolation by Mary, John, and Ms. Foster without input from those who knew the most about the children's needs and behaviors (i.e., the children's foster parents and the Private Agency and DCFS workers). As a result, needs and behaviors of the children either were left unaddressed or inadequately addressed.

The following issues and concerns should have been considered and addressed by the natural parents, foster parents, caseworkers, and therapist in a collaborative effort prior to the children's return home.

Julie's Needs and Behaviors: A comprehensive plan for Julie's medical care should have been in place prior to Julie's return home. The Safety Plan only indicated that Mary and John were searching for a pediatrician for Julie, planned to use community resources to provide Julie with sign language services, and wanted to be educated on raising a child with a seizure disorder. Julie was on medication for her seizure disorder and required follow-up medical services. Mary and John should have been educated about caring for Julie prior to her return

home, including what medication Julie was taking, who her doctors were, and what to do if she had a seizure. A Therapy Agency case entry in April 1995, following Julie's return, indicates that Mary had to make repeated efforts to gather complete medical information about Julie from her father and stepmother who seemed uncooperative/forgetful about Julie's pediatrician/medical history. This information should have been provided to the natural parents prior to Julie's return home.

Julie was not able to speak and exhibited some negative behavior due to her inability to communicate her needs and wants. She also was exhibiting inconsistent behavior ranging from hyperactivity to listlessness because of her recent intake of psychotropic medication. There is no indication in the case record that Mary and John were fully educated about Julie's unpredictable behavior and her limitations, including how to manage them.

Knowing that Julie was developmentally disabled and neurologically impaired and had special needs for which Mary and John would need to provide upon Julie's return home, Mary's caseworkers should have required Mary to participate in Julie's special education program and assist in managing her medical care. In January 1995, Mary became upset over the medical care being provided to Julie by her foster parents. At that time, the DCFS and Private Agency caseworkers (Pamela Harris and Debra Bailey) developed a plan with Mary to become more involved in Julie's life and medical care to more readily observe problems. In February 1995, however, Mary informed her caseworker that she did not want to assist with the children's medical care until the children were returned to her.

Julie was referred to Private Agency specialized foster care program for emergency placement in February 1995 due to concerns that her foster parents discontinued her seizure medication. There were no openings available, however, and Julie remained in the care of Mary's step-mother and father. Had Julie earlier been placed in a foster care home specifically for developmentally disabled children (such as that provided by the Chicago Association for Retarded Citizens), Mary could have received special training directly from the foster parent(s).

The Other Children's Needs and Behaviors: Although Ms. Foster reported in the Safety Plan that Linda and Kathy did not have any special needs requiring attention, they did in fact have special needs and/or problems requiring attention. Linda had speech problems, was developmentally delayed in some functional areas for her age, and required ongoing speech therapy. Kathy exhibited behavior problems (e.g., fighting and biting other children) at school and at home, requiring consistent behavioral management. Prior to withdrawing from the case, Ms. Bailey recommended that Kathy become involved in counseling with Linda to address her behavior. Counseling was not arranged, however, prior to the children's return home. In an interview with the OIG, Ms. Foster acknowledged that Linda had "a speech impediment" and that Kathy was "an active, aggressive child who required lots of attention." Then there was the infant, Billy, who had no special needs but obviously required the constant attention and care that any infant requires (Mary's own mother, Mrs. Johnson, at times,

seemed exhausted by the responsibility of caring for Billy).

Although Ms. Foster discussed with Mary and John the three phases of adjustment they could expect when the children returned home (honeymoon, testing, and a leveling off of the children's behavior), no one appeared to consider how the children would be affected by their return home. Linda (age 5), Kathy (age 4), and Julie (age 3) had lived with their grandparents for over three years. No one devised a concrete plan for consistent visitation between the children and their grandparents. Although Mary and John had discussed with Ms. Foster their intention to maintain the children's relationships with their grandparents, their intention was questionable given the existing conflict between Mary and John and the foster parents. A concrete plan for consistent visitation between the children and their grandparents could have alleviated some stress for these children and provided monitoring of the children's care. Such a plan could have been made a part of the Court's Order of Protection upon the children's return home. Family counseling also was not in place upon the children's return home although it had been recommended by Dr. Hill of [Court Psychological Testing Services].

Basic Necessities: Basic necessities were not considered prior to the children's return home. The day following the children's return, Mary informed Ms. Harris that she needed bunk beds, dressers, and additional towels, sheets, and chairs. She also inquired about Norman funding, SSI, and transportation for the children to and from school. Case entries by Ms. Foster also indicate that Mary had insufficient clothing for the children and was working to transfer WIC services for the children.

A more proactive approach by workers involved in the case in making transportation arrangements for the girls to school; scheduling appointments for Julie's medical care; and obtaining clothing, furniture, and other needs in advance of the children's return, might have alleviated some of the parents' stress upon the children's return.

Respite Care: No one ensured that Mary and John would have respite care upon the children's return home. It is not known whether this was due to oversight or whether the use of relatives was presumed. Again, based on the existing conflict between Mary and John and their extended family, it is questionable whether Mary and John would have reached out to their family for assistance and support.

If family counseling or mediation had been utilized prior to the children's return, a respite care plan could have been devised among the extended family. Advance arrangements could also have been made with the foster parents to provide assistance whenever Mary or John would not be available to handle the children's transportation, medical appointments, and school meeting needs, especially in the beginning. No planning or mediation was facilitated, however, between Mary and John and the foster parents.

Gradual and Incremental Transition Back to Parents' Home: No one considered returning the children home gradually and incrementally. Rather, all four children (ages 5, 4, 3, and 2)

were sent home at once to two young parents who had not cared for the children on a full-time basis for several years. Ms. Foster stated in an interview with the OIG that she never considered recommending that the children be returned home incrementally as she thought the parents could handle all four children. This leaves open the question of whether Ms. Foster considered the characteristics, needs, and behaviors of the children when planning for their return home. Kathy and Julie were the two children at highest risk to return home. Both had already suffered injuries and both exhibited characteristics and behaviors which made them more vulnerable to abuse.

Although Mary and John had informed Ms. Foster that they would share the responsibility of caring for the children, their history showed that Mary had the majority of responsibility for dealing with the couple's problems and concerns about the children. Mary often expressed anger that John was not supportive enough. Regardless, John was working full-time and Mary was left with the overwhelming task of the daily care of four children under 6 years of age who each had special needs and behaviors. In addition, she was trying to obtain necessities and set up services for the children. Returning the children gradually and incrementally would have eased the adjustment to having full-time caretaking responsibility for the children. It would have given Mary and John an opportunity to learn and begin to manage the characteristics, needs, and behaviors of one or more of the children prior to assuming care of all of the children.

4) Monitoring After the Children's Return Home

There was grossly insufficient monitoring of the Jones-Brown-Smith family following the children's return home. At the time of Julie's death on June 7, 1995, DCFS had not complied with the tasks ordered by the Court on April 12, 1995. DCFS has not referred Kathy for counseling and had not arranged for school assessments for Linda and Kathy. Most importantly, DCFS had not arranged for any support services for the family. This family was without a primary caseworker when the children returned home, despite DCFS having been informed as early as March 6, 1995 that Private Agency was withdrawing from the case (and having received a written 14-day notice on March 15, 1995) and Therapy Agency's stated intention to accept and service the case. On May 10, 1995, Ms. Harris and Ms. Foster discussed that Therapy Agency had verbally agreed to accept the case for monitoring and that Ms. Harris was awaiting caseworker assignment. According to both Ms. Harris and Ms. Foster, Ms. Foster indicated that she was in the home weekly and would monitor the family until a caseworker was assigned. At the time of Julie's death on June 7, 1995, a primary caseworker still had not been assigned to this family and an objective monitor still was not in place.

A "Court Order Compliance Efforts" Report by DCFS to the Court indicates that homemaker services were offered to Mary and she declined them. Yet, Mary should not have been given a choice in the matter. Homemaker services should have been in place prior to the children's return home, regardless of whether Mary wanted them. A homemaker could have assisted Mary in caring for the children, obtaining needed services, and making and meeting

appointments, thus decreasing Mary's stress level. Most importantly, a homemaker could have provided objective monitoring of Mary and John's care of the children.

Ms. Harris, knowing that the family did not have a primary caseworker or a homemaker, made only one visit to the Jones-Brown-Smith family. During her unannounced visit on May 9, 1995, Ms. Harris did not ask to see Julie who was reportedly asleep in her bedroom. With the exception of this visit by Ms. Harris, the only monitoring this family received was that provided by Ms. Foster. Ms. Foster was an inappropriate monitor for this family. Her role had already been defined as providing support to the parents and advocating for them. Ms. Foster was invested in Mary and John's success and her ability to remain objective should have been seriously questioned by Ms. Harris.

Ms. Foster provided in-home counseling to Mary and John four times from the time the children returned home on April 12, 1995 until May 17, 1995 when Mary reported that Julie fell off her bike. Ms. Foster noted that the children appeared healthy and happy during these visits. Following Mary's report on May 17, 1995 that Julie fell off her bike, Ms. Foster had phone contact with Mary on May 18, 21, and 22, 1995. She made home visits on May 19 and 25, 1995.

During Ms. Foster's home visit on May 19, 1995, Mary stated that when Julie awoke that morning, the right side of her face was swollen. She reported that she took Julie to [Hospital1] emergency room and that Julie was released as she appeared fine. Mary was instructed by [Hospital1] to take Julie to [Hospital2] if she began to vomit, developed a fever, or began acting strangely. Mary showed Julie's discharge papers to Ms. Foster. Ms. Foster observed that Julie's face was swollen and discolored and that she appeared groggy. During a phone conversation on May 22, 1995, Mary reported to Ms. Foster that she took Julie to [Hospital2] emergency room requesting that she be admitted because she had a fever and diarrhea for two days. A CAT scan was completed and Mary was told to take Julie home and bring her back if she displayed abnormal behavior or vomited. During her visit on May 25, 1995, Ms. Foster noted that Julie's swelling was still present, but appeared to have decreased. Again, Mary showed Ms. Foster Julie's discharge papers.

Ms. Foster properly maintained frequent communication with Mary for the week following Julie's reported fall and saw the discharge papers for Julie's medical treatment. Yet, on May 19, 1995, Foster observed that Julie was groggy - a sign of a concussion. Julie's grogginess, in combination with her being a neurologically compromised child, should have prompted Foster to accompany Mary in taking Julie to [Hospital2], or minimally, to contact the doctor who reportedly saw Julie to advise him of Julie's condition. Ms. Foster reported in her interview with the OIG, however, that grogginess was not one of the signs for which the doctor said to watch.

Following her visit on May 25, 1995, there was no further contact between Ms. Foster and Mary until Mary paged Ms. Foster on June 5, 1995 to report that Julie began having seizures

and was rushed to the hospital. From June 5 to June 8, 1995, Ms. Foster provided in-person and telephone support to Mary.

Following Mary's report to Ms. Harris on May 19, 1995 that Julie had woken with a swollen face, Ms. Harris went on vacation leave. Mary's report did not prompt Ms. Harris to ensure that a home visit or follow-up with either Mary or Ms. Foster was made. Ms. Harris learned from her supervisor on June 8, 1995 that Julie had died on June 7, 1995. At that time, Ms. Harris spoke with Ms. Foster and learned of Julie's reported fall off her bike on May 17, 1995 and the sequence of events since Mary reported Julie's swollen face to DCFS.

RECOMMENDATIONS

Return Home Protocol

Deciding whether to return children home is as important a decision as deciding whether to terminate parental rights. Both decisions are identified by the Department as two of the most critical decisions affecting children and their families. (P.305.30) The decision to return a child home requires discussion with the caseworker's supervisor and supervisory approval. (P. 305.30) It does not, however, require a review of the case record by the supervisor or an independent clinical consultation. Yet, the Department has established Legal Screening Committees to evaluate whether cases are appropriate for involuntary termination of parental rights. (P.305.110) The Legal Screening Committee includes members who were not previously involved in the case. The caseworker must provide the members of the Committee with documentation supporting the decision to terminate parental rights. The primary functions of the Legal Screening Committee are to "determine if the case is appropriate for involuntary termination and to determine if there is sufficient documentation to proceed toward involuntary termination." (P.305.110). Such a review process does not exist with regard to the decision to return a child home.

Various cases involving child deaths investigated by the OIG provide support for the creation of a thorough review process prior to deciding to return children home. The ---- ---- child death investigation (report forthcoming) provides a particularly tragic example of a child who never would have been returned home when he was had a thorough review process been in place and utilized prior to returning him home.

DCFS should design a Return Home protocol which must be followed before DCFS or a private agency can decide to return children home. The Return Home protocol should be implemented within the next **18 months** (The protocol will take time to develop, Rules and Procedures will have to be revised, and DCFS and private agency staff will need to be educated and trained with regard to the protocol).

The OIG recommends that the protocol include, but not be limited to, the following. Prior to a return home hearing (or prior to making the decision to return children home in cases where

DCFS has the discretion to return children home), an experienced social worker, not previously involved in the case, must conduct an independent review of the case record. The case record should include a recently completed Child Endangerment Risk Assessment Protocol Safety Determination Form (CFS 1441) which currently is required to be completed immediately prior to returning a child home (P. 305, Appendix K).

A case staffing must then be held, including the experienced social worker, the primary caseworker and his/her supervisor, all persons providing services to the family, and whenever possible, those persons' supervisors. The focus of the staffing should be whether those involved with the family believe that it is in the best interest of the children to return home at that point in time and whether the return can be safely accomplished. This inquiry should include, but not be limited to, the following:

(1) has the problem which brought the children into the system been sufficiently addressed and resolved?; how has it been sufficiently addressed and resolved?;

(2) have the parents adequately completed the tasks required of them in their service plan?; were the tasks relevant to the family's problems and risk/safety concerns?

(3) what are the characteristics, needs, and behaviors of the children returning home?; have the parents been educated about these characteristics, needs, and behaviors?; have they demonstrated that they will be able to manage them;?

(4) what special services will the children need when they are returned home (e.g., counseling, visitation with foster parents or family members, special schooling or medical care, etc.)?; are the parents aware of the special services their children will need when they are returned home?; have they been given an opportunity to demonstrate (and demonstrated) behavior consistent with providing/participating in the special services while the children were in care (e.g., attending the children's medical appointments, participating in family counseling, involving themselves with the children's special education program, etc.)?;

(5) do the parents have their own support system?; will they realistically use this support system, especially in times of crisis?; who does the support system consist of?; are those persons aware of their role to provide a safety net for this family?;

(6) in what manner will the children be returned home?, i.e., in cases involving multiple children with special characteristics, needs, and/or behaviors, consideration should be given to returning the children home gradually and incrementally; where siblings have been placed together, they should return home together. DCFS currently operates as an all or nothing system; either all of the children are returned home or none of the children are returned home. Making the decision to return children home, however, does not necessarily mean that all of the children must return home at the same time.

Returning children home gradually and incrementally, could help to ease the adjustment period and relieve some stress for the children and parents involved. DCFS workers need to be educated to consider this possibility; judges may also need to be educated to accept such a plan.

(7) what basic necessities does the family need before the children return home?; does the family need assistance in obtaining these necessities?; who will assist the family in obtaining them?;

(8) what support services must be in place before the children are returned home, i.e., what safety measures should be provided to mitigate the possibility of future harm to the children (e.g., homemaker services, visiting nurse, scheduled/unscheduled visits by a monitoring worker, counseling, day-care, respite care, etc.)?; who will provide the services?; what information must the service providers be given to effectively provide services?; how frequently will the services be provided?;

(9) is the family aware of community resources which are appropriate for and available to them?

Where agreement is reached to recommend return home or where return home is likely to be ordered by the Court, a concrete and comprehensive Return Home Plan should then be devised addressing the issues identified during the staffing. The primary caseworker should devise the plan with the parents and whenever possible, the children's foster parents, extended family, or the persons identified by the parents as their support system. Whenever the foster parents are not included in the actual planning session, their input regarding the children's characteristics, needs, and behaviors must be sought prior to the planning session. Clear role expectations must be established for all adult parties concerned (including service providers). The caseworker's supervisor must approve the plan, ensuring that all issues raised during the staffing are addressed in the plan.

Such a Return Home Protocol will serve multiple purposes. First, the use of an experienced social worker not previously involved in the case will provide a measure of objectivity (and additional expertise) in deciding whether return home is appropriate. Second, the staffing will enhance team decision-making and decrease the effect of individual bias. Third, the protocol will identify issues which must be addressed prior to children returning home and services which must be in place prior to children returning home. Fourth, the protocol will better prepare those involved in the case for the return home hearing in cases where the Court is responsible for making the decision to return children home. In those cases, while the Court has the ultimate authority to decide whether to return children to their parents, the workers involved in the case possess the most comprehensive information about the children and their families. They are in the best position to determine whether return home at a particular point in time is in the children's best interest and whether it can be accomplished safely. DCFS and the private agencies with which it contracts have an obligation to the children they serve to

address these issues with the Court. Children cannot afford to have their workers "leave the return home decision up to the Court." The protocol will better prepare workers to objectively present the evidence to the court and provide support for their recommendations.

The Return Home Plan should be submitted to the Court and a request should be made that it be incorporated as part of the Court's Order of Protection for returning the children home. Because the provision of support services and monitoring of the family is critical following the children's return home, the Department must ensure that these services are ready to be provided on the day the children are returned home. Therefore, the Return Home Plan should include a realistic date for the physical return home of the children based on when support services will be in place. DCFS should request that it be allowed to synchronize the physical return home of the children with the provision of support services.

In cases where the Court returns children home against the advice of the workers involved in the case, DCFS must attempt to provide the greatest measure of safety possible to the children in their home. This involves requesting that the Court delay the physical return home of the children until support services can be obtained and in place upon the children's return home.

Within the next three months, all DCFS and private agency supervisors should be instructed through an information transmittal that a Return Home Protocol is being developed and that in the meantime, the supervisor's approval for return home decisions must include a signed statement that the supervisor has reviewed the case record and ensured that an after-care plan is in place for the children's return home.

Specialized Foster Care

The protocol being developed for entry into specialized foster care for the POS Redesign should include an exception to the "one family, one caseworker" goal in cases where it becomes apparent that a child needs specialized foster care and the agency servicing the case does not have the capability to meet the child's special needs (because it does not have a specialized foster care program or because there are no openings available). Provision must be made for the referral of the child to a program external to the agency.

Education and Training

Three issues identified in this case and other cases which the OIG has investigated should be addressed by DCFS. The first involves educating DCFS and private agency staff about the limitations of and appropriate and inappropriate uses of psychological/psychiatric evaluations. The second involves dispelling the myth that consideration cannot be given to prior injuries suffered by children which resulted in unfounded DCP investigations. While an investigation may have been unfounded, the fact remains that an injury occurred. Multiple injuries to children in the same family is cause for concern. It is the injuries themselves which must be considered in assessing risk, not the unfounded reports. The OIG recommends that current staff be educated on these issues through the use of an information transmittal and that future staff be educated by revising training to address these issues.

The third issue involves child development training. Child welfare staff continually fail to take into consideration children's special needs, characteristics, behaviors, and developmental stages in planning for their care. The attached article, "Seven Deadly Sins of Childhood: Advising Parents about Difficult Developmental Phases" addresses seven of the most difficult developmental phases that children go through that may trigger an abusive response. The article discusses the phases and gives practical alternatives to a violent response. This article, or an adaptation of the article, should be used in all future training of child welfare staff. The article should be distributed to all current staff, including private agencies.

INVESTIGATION

PERSONS INTERVIEWED: Pamela Harris, Bob Jackson, Ray Phillips, Jane Doe, Tim Clark, Debra Bailey, Laura Foster, Nancy Stevens, James Hart, Detective, [Town] Police Department, [Hospital] Department of Psychiatry.

DOCUMENTS REVIEWED: DCFS case record, DCP investigative files, Private Agency case record, Therapy Agency case record, Cook County Juvenile Court record, various medical records, school records, police reports, and the autopsy report for Julie Jones-Smith.

NARRATIVE

(For a detailed account of the history of this family, please see the "Chronology of Case" attached to this report.)

Family Composition

Mary Jones (DOB 11/10/72) had two daughters with George Brown (DOB 11/13/69). Linda Brown was born on 6/24/89 and Kathy Brown was born on 9/2/90. Mary later became involved with John Smith (DOB 12/08/69) in November or December 1990. They began living together in June 1991. Their first child, Julie Jones-Smith, was born on 12/4/91. Their second child, a son, Billy Smith, was born on 4/7/93. Mary and John were married on 7/2/94.

DCP Involvement

The Jones-Brown-Smith family first came to the attention of DCFS in October 1991. A

hotline report was made when thirteen-month-old Kathy Brown was admitted to [Hospital] with a break to her upper right thigh. [Hospital] Emergency Room records show that Mary stated that Kathy and her two-year-old sister Linda were jumping on the bed, that Kathy began to cry, and Mary found her between the wall and the bed. Mary told hospital personnel that she thought Kathy got her leg caught between the bed and the headboard and fell. A DCP investigation was conducted, the allegations were unfounded, and the investigative file was not available for review.

A second DCP investigation was initiated after a hotline call from [Hospital] on January 9, 1992. The reporter stated that one-month old Julie Jones was diagnosed with a subdural hematoma with accompanying brain damage. Doctors at [Hospital] determined that the child's injury was the result of trauma. Child abuse was suspected because Mary had no explanation for the child's injury. (CANTS 1, SCR 000000-A) This A sequence investigation was indicated on January 29, 1992 for 03 (subdural hematoma) to Julie. No skull or bone fractures were noted; shaken baby syndrome was indicated. Mary and John stated that they were the only caretakers for Julie and that they did not know how Julie could have received her injuries.[3] The case was also indicated for 22 (substantial risk of physical injury) to two-year old Linda and one-year old Kathy due to the serious nature of Julie's injuries and the parents' lack of an explanation as to how Julie was injured. The A Sequence DCP investigative file referred to the earlier DCP investigation involving Kathy's broken thigh.

Placement of the Children

DCFS was granted temporary custody of Linda, Kathy, and Julie on January 31, 1992. Linda and Kathy Brown were placed in the home of their paternal grandparents, Elizabeth and Ervin Brown, on January 31, 1992. Julie remained hospitalized for almost three months as a result of her injury. During that time she required cerebral taps to drain excess fluid that accumulated around her brain and she showed developmental delays such as the inability to lift her head, grab at objects, and follow objects with her eyes (Julie was then four months old). On April 1, 1992, Julie was released from the hospital and placed in the home of Mary's step-mother and father, Diane and Joseph Jones. It is unclear from the case record whether hospital personnel or anyone from DCFS discussed with the Joneses that Julie would have special needs. Temporary custody was taken of Billy four months after his birth for substantial risk of harm based on the injury to Julie. He was placed in the home of Mary's mother, Joyce Johnson, on August 23, 1993. Billy spent two months in the home of John's mother, Clara Smith, after Mrs. Johnson had surgery in December 1993. After her recovery,

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[3] The police conducted an investigation into Julie's injury. Both parents agreed to and submitted to polygraph examinations. Deception was indicated on both, however, both parents denied any knowledge of how the child sustained her injury. The parents denied shaking, dropping, or hitting Julie and also denied that she had fallen. The police investigation was suspended for lack of evidence. (A sequence investigative notes)

Mrs. Johnson resumed caring for Billy. These home of relative foster care placements were maintained for all of the children until the children were returned to Mary and John in April 1995.

Case Monitoring/Follow-up Services

During this case's three-and-half year history with DCFS, there were multiple workers assigned to the Jones-Brown-Smith family, including five DCFS workers, three Private Agency workers, and two Therapy Agency therapists. DCFS provided direct services to the family until August 1992 when the case was transferred to Private Agency. DCFS continued to provide POS monitoring of the case. Therapy Agency provided therapy to Mary and John from November 1992 until Julie's death in June 1995.

A goal of return home was selected and maintained for this family throughout the family's involvement with DCFS. Service plans were established for this family in March 1992, August 1992, February 1993, December 1993, February 1994, August 1994, and March 1995. Only one ACR was held (March 1995), although a desk review was conducted in February 1994.

1) The Parents

a) Mary and John

The service plans contained the following tasks for Mary and John: parenting classes, counseling, visitation with the children, maintenance of housing, maintenance of income/employment, monthly contact with the POS worker, and psychological and psychiatric evaluations. Mary and John's progress in completing the service plan tasks set forth for them is summarized below with emphasis on major events and the status of the service plan tasks at the time of the children's return home. For a detailed examination of the parents' progress in completing service plan tasks, please see the "Chronology of Case" attached to this report.

Parenting classes: Both Mary and John participated in a parenting class at Therapy Agency. Mary attended 8/8 sessions and 4/4 home visit sessions. John attended 7/8 sessions and 3/4 home visit sessions. They received completion certificates on November 18, 1992. Their instructor informed Mary and John's therapist, Nancy Stevens, that she was pleased with Mary and John's participation and that both Mary and John improved their skills greatly.

Counseling: Mary and John began weekly counseling with Therapy Agency in November 1992 to address the physical abuse of Julie. They continued with counseling until Julie's death in June 1995.

Nancy Stevens, M.A., L.S.W. and Laura Foster, M.S.W. counseled Mary and John on abuse counseling, stress and anger management, discipline, and family reunification. Both individual and joint sessions were held with Mary and John. Joint sessions included addressing Mary and John's relationship. Ms. Stevens indicated in reports that Mary and John willingly engaged in counseling and a trust relationship seemed to develop. Throughout the history of this case,

however, Mary and John denied abusing Julie. From the beginning, Ms. Stevens appeared to believe them. The parents gave these different accounts of how Julie may have sustained her subdural hematoma: Julie had problems ever since birth, she was premature and had Group B Strep which can lead to seizures; perhaps someone did something to Julie while she was at a New Year's Eve party in 1991 while Julie was napping in a back bedroom for an hour and a half; Julie got sick and started having seizures and they took her to the hospital; there was a long delay in receiving care at the hospital; a toy popcorn popper was thrown on Julie's head by her sisters; Kathy rolled over Julie in bed; and Julie's ingestion of water diluted with her formula.

Medical experts had determined that Julie was physically abused. She was so severely abused that she was left brain damaged. Mary and John admitted being the only persons who cared for Julie. The Court, after hearing medical testimony, entered a physical abuse finding on Julie on September 23, 1992. Instead of challenging the parents with the medical evidence that Julie was physically abused, Ms. Stevens, instead, accepted the explanations given by Mary and John as possibilities for Julie's injury. For example, Ms. Stevens expressed in an interview with the OIG that Mary and John thought the delay in receiving care at the hospital was significant. She requested Julie's medical records to verify the delay and advised Mary and John to work on this possibility with Mary's attorney.

In a 4/19/93 Progress Report to the Court, Ms. Stevens reported that both Mary and John remained at a loss to explain how Julie was injured and, "although we may never know for sure, this may be one case where the parent is not at fault." In an 8/4/93 Progress Report to the Court, Ms. Stevens reported that Mary and John consistently denied injuring Julie, and "we may never know if they are in clinical denial of the perpetrated abuse or if they deny wrongdoing and someone else injured the child."

On August 5, 1993, the Court requested a written report from Ms. Stevens outlining the issues Ms. Stevens was addressing with Mary and John regarding child abuse and shaken baby syndrome. In her "Abuse Counseling Statement," Ms. Stevens explained that in a case where an accused parent denies responsibility, assessment and treatment includes a discussion about the circumstances of the injury with responses compared to known perpetrators for similarity and difference and consistency; collection of family history and relationship history; family capacity to form a therapeutic relationship and their functioning in the relationship; outside psychological evaluations or psychiatric diagnosis for mental disorder; parenting and life skills training; and intervention.

In a 1/4/94 Progress Report to the Court, Ms. Stevens indicated that she had spoken with Mary and John jointly and individually on at least five occasions about Julie's injury, that their responses were not consistent with those found in research on known perpetrators, and that she saw genuine confusion and indignation as well as a searching for possible answers. She further stated that Mary and John's personal and family histories and their ability to form a working therapeutic relationship did not follow known offender patterns, as they were nonmanipulative

and admitted frustrations and mistakes. Later, Ms. Stevens indicated that outside psychological and psychiatric evaluations supported her impressions.

In her therapy with Mary and John, Ms. Stevens never took into account Kathy's broken thigh which occurred only three months prior to Julie's subdural hematoma. Although the DCP investigation was unfounded, the fact remained that another of Mary's children (at age 13 months) was injured while in the care of Mary and John. The March 1993 social investigations of Mary and John referred to this incident as a cause for concern: "Kathy suffered a broken hip which was never explained. Mother is in denial about this incident as well . . . Mother's failure to acknowledge the children's physical abuse in spite of overwhelming evidence is a continued area for concern."

The children's GAL expressed as early as January 1993 that unless Mary and John admitted injuring Julie, the Public Guardian's Office would not allow the children to return home. Ms. Stevens informed the GAL that this was not something she could demand from Mary and John if they continued to deny any knowledge of how Julie was injured in the first place. According to an 8/23/93 case entry by Ms. Stevens, the Judge also made clear his feelings that unless there was an admission of guilt, progress by the parents would not be recognized. Subsequent GALs on the case maintained this position.[4]

In March 1994, the GAL called Private Agency caseworker Debra Bailey to report that she consulted with Michael Miller of [Agency] who recommended that she maintain her position that the children were in danger because one parent abused Julie and the other failed to protect her and the parents' counselor was not moving forward because she had removed the option that one of the parents abused Julie. It does appear that Ms. Stevens gave up the competing hypothesis that one of Julie's parents abused her. After January 1994, Ms. Stevens no longer addressed the issue of denial and who abused Julie. She moved on to issues of discipline, anger management, and coping with everyday stresses, including meeting the tasks set forth by DCFS.

Mary and John hid very successfully from Ms. Stevens (up to her 8th month) Mary's pregnancy with Billy despite in-person counseling sessions. During an individual session with John in February 1993, Ms. Stevens asked John about birth control as she did not think it would be a good idea for him and Mary to get pregnant. John stated that he and Mary were "using something" (at that time Mary was 7 months pregnant).

In March 1993 Linda and Kathy's foster mother informed the Private Agency worker, Terry Baker, that Mary was expecting a baby any day. When Baker confronted Mary, Mary denied that she was pregnant. After Ms. Stevens was informed by Baker that Billy was born on April 9,

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[4] The case was later transferred to a different calendar with a new GAL and judge. The children were returned over the objection of the Public Guardian's Office.

1993, Mary told Ms. Stevens that she had wanted to tell her about the pregnancy, but that she was afraid DCFS would take the baby. She also stated that she wanted to show Ms. Stevens that she could be a good mother. Ms. Stevens informed Mary that she would not advocate that DCFS take the baby. John expressed anger to Ms. Stevens and stated that he would "take care of" the person who told Private Agency about Billy. Ms. Stevens advised John that any violent or retaliatory act would not be in his best interest in terms of regaining custody.

In a 4/19/93 Progress Report to the Court, Ms. Stevens stated that although Mary demonstrated an error in judgment by not advising her workers about her pregnancy, Mary's fear reaction and reasoning were "in accordance with Mary's cognitions about the child welfare system." John could not understand why the secrecy surrounding Billy's birth should affect the family's case. According to Ms. Stevens's report, this was "consistent with his concrete way of viewing the world."

On the initiative of the children's GAL, in August 1993, four months after Billy's birth, temporary custody was taken of Billy. While DCFS and Private Agency agreed with that action, Ms. Stevens noted that she testified that Billy had been living safely with his parents for four months and that Mary and John had made progress. According to a case entry by Ms. Stevens, when temporary custody of Billy was declared in court, John punched a wall and was detained by court security for disorderly conduct.

In November 1993, Mary made a suicide gesture/attempt by ingesting a prescribed medication. She did not reach out for Ms. Stevens prior to taking this action. Later, she explained that after visiting Billy she became extremely sad and "couldn't take it anymore;" she had nothing to live for if she was not going to get her children back. Mary was hospitalized and treated for the suicide gesture. She was seen by a psychiatrist who indicated that an in-patient hospitalization was not necessary. Mary agreed with Ms. Stevens to tell Private Agency about her suicide gesture because she did not want it "to be like it was with Billy" and have people think she was hiding it. Mary and Ms. Stevens later met with the Private Agency worker, Debra Bailey, and informed her about the attempt. Ms. Stevens informed Ms. Bailey that she and Mary would address Mary's depression in counseling. During sessions with Mary, Ms. Stevens monitored Mary's depression and assessed her for suicidal ideation. Mary did not appear suicidal for the remainder of the case.

In January 1994, Mary informed Ms. Stevens that she planned to surrender her parental rights. Ms. Stevens provided her with information on the ramifications of her decision. According to a case entry by Ms. Stevens, Mary was "clear and adamant" about her decision. With Mary's permission, Ms. Stevens contacted Mary's attorney and Mary's mother to discuss Mary's decision. Six days later, Mary changed her mind, stating that in talking with John, she realized that she could keep going toward reunification.

On September 15, 1994, Ms. Stevens informed Ms. Bailey that Mary and John had not

participated in counseling since July 13, 1994. Private Agency's Ms. Bailey had not had contact with Mary and John since August 31, 1994. On September 21, 1994, Ms. Bailey directed a letter to Mary and John advising them that she was aware that they were not attending counseling and that visitation with the children was inconsistent. She reminded them that they must complete their service plan tasks. On September 26, 1994, Mary telephoned Ms. Bailey to report that she was no longer willing to work toward reunification with her children. When Ms. Bailey asked if she wanted to surrender her parental rights, Mary responded that she "just didn't want to do anything."

When Ms. Stevens confronted Mary on August 10, 1994 about their missed sessions, Mary expressed that she was sick of all the appointments and was under a lot of stress. At that time, Ms. Stevens was preparing for maternity leave. Therapy Agency's Laura Foster, who had previously been assigned to the case to supervise parent/child visits, took over as Mary and John's therapist. Ms. Foster was instructed by Ms. Stevens to focus on return home issues as Ms. Stevens had already addressed the abuse issue. Ms. Foster directed a letter to Mary and John on September 19, 1994 advising them that if they did not contact her by October 5, 1994, Therapy Agency would terminate services. At their first meeting on September 28, 1994, Mary denied to Ms. Foster that her inconsistency in counseling had anything to do with Ms. Stevens's leaving. Rather, she stated that she was tired of counseling as she had been attending for over a year.

While Mary and John continued with counseling in October and November 1994, Mary reported during a home visit with Ms. Bailey on November 17, 1994, that she was not getting anything out of counseling and that she could discuss her issues with her mother or friends. Ms. Foster advised the Court in a 1/4/95 Progress Report that she had been unsuccessful in making appointments with Mary and John since the last court date on December 1, 1994. She noted that Mary and John had been "involved in counseling for an extended period of time and intensive assertive outreach is no longer clinically appropriate." She stated that unless Mary and John were willing to develop and participate in a treatment plan, counseling would no longer be effective. Counseling with Mary and John did, in fact, continue until Julie's death. Ms. Foster provided grief and support services to Mary following Julie's death until June 14, 1995 when the Court removed Therapy Agency from the case.

Visitation: Initially, visitation was occurring at the children's foster homes under the supervision of the foster parents. Mary was to have weekly contact with Linda, Kathy, and Julie. John was initially only required to visit with his biological child, Julie. Visitation by Mary and John was described by Therapy Agency and Private Agency as inconsistent and sporadic through July 1993, particularly with regard to Linda and Kathy. In a 7/23/93 letter to Mary's attorney and an 8/4/93 report to the Court, Ms. Stevens outlined factors contributing to Mary and John's failure to consistently visit with the children. These factors included transportation problems, discomfort and feelings of being judged in the foster homes, and the care of baby Billy born in April 1993 (Billy was not removed from Mary and John's care until August 23, 1993). Private Agency case entries also indicate busy work schedules and trouble dealing with the relative foster parents as factors.

During a visit with Ms. Bailey on July 26, 1993, Mary requested off-site visitation with the children. On August 5, 1993, the Court entered an order that Mary and John's visitation occur outside the foster parent homes two times per month supervised by Private Agency and two times per month supervised by Therapy Agency. The family's caseworker, Debra Bailey, supervised the visits for Private Agency and Laura Foster supervised the visits for Therapy Agency. Ms. Stevens also supervised some visits to keep abreast of Mary and John's progress. The visits took place in various places including agency visitation rooms, McDonald's and the children's maternal grandmother's home. Overall, interactions between the parents and children were described as positive and appropriate. In October 1993, supervised visits began occurring in Mary and John's home. In a 1/4/94 Visitation Report to the Court, Ms. Foster noted that she was impressed with Mary and John's parenting skills and that the children were bonded and attached to Mary and John.

On May 19, 1994, the Court granted Mary and John unsupervised day visits. Case entries indicate that DCFS, Private Agency, and Therapy Agency were in agreement with that action. While Mary and John had unsupervised day visits, they visited with Billy nearly every day, visited Julie several times per week, and visited Linda and Kathy once per week.

On December 1, 1994, the Court granted Mary and John unsupervised overnight visitation one week-end evening per week. Case entries indicate that DCFS, Private Agency, and Therapy Agency were in agreement that the family progress toward unsupervised overnight visitation. The Court granted Mary and John unsupervised overnight visitation to include two week-end evenings per week on January 5, 1995. Private Agency and DCFS appeared to agree that the visits be extended. Ms. Foster, on the other hand, did not give a recommendation because Mary and John had not participated in counseling since December 1, 1994.

It appears that all of the children were participating in overnight visits. The children's foster parents reported that they appeared to be going well, however, on a February 2, 1995 visit to the Brown foster home, Ms. Bailey learned that Kathy was "whooped" during a visit; Linda reported that Kathy got in trouble and was whooped by Mary. No marks were observed on Kathy and Mrs. Brown stated she was unaware of any whoopings.

Ms. Bailey reported the whooping incident to DCFS worker Pamela Harris on February 2, 1995, stating that Linda and Kathy were very unclear, gave conflicting accounts, and changed their statements. In a 2/2/95 Unusual Incident Reporting form, Ms. Bailey noted concern regarding Mary's behavior "when she becomes angry or has to discipline and concern that Mary may not be able to handle disciplining Kathy." Ms. Bailey directed a letter to Mary on February 3, 1995 advising her that Kathy reported being whooped, that DCFS was notified of the incident, and that no physical punishment may be used as discipline.

Ms. Bailey and Ms. Foster each interviewed Linda and Kathy twice with regard to the incident. On February 15, 1995, Ms. Foster discussed with Mary and John the reported whooping and the outcome of her interview with Linda and Kathy. Ms. Foster requested that Mary and John

describe the punishment used by them. Mary and John stated that they do not whoop the children; they use time-outs to discipline them. Upset and frustrated by the report and Ms. Bailey's 2/3/95 letter, Mary called Ms. Bailey on February 24, 1995 to report that she did not want any involvement working with and helping the foster parents with medical appointments until she got the children returned to her.

In a 3/29/95 Progress Report to the Court, Ms. Foster reported that it remained unclear whether the children were actually whooped. "The interview did however disclose information that the children were being whooped on their feet in the home of their paternal grandparents." The children also stated "that they were told by their grandma to report that they were whooped during the weekend visitation." Ms. Bailey spoke with Mrs. Brown on March 10, 1995 regarding discipline. Mrs. Brown reported that she does not whoop the girls but uses techniques such as leaving Kathy alone if she acts out. Mrs. Brown continued to support the return home of the children.

On March 6, 1995, Ms. Bailey rated both Mary and John unsatisfactory with regard to the 8/31/94 visiting plan, stating, "Kathy reported that Mary whipped her and this does not follow the guidelines of a minimum parenting standard of DCFS to use no corporal punishment." According to a case entry by DCFS's Pamela Harris, the whooping incident was addressed at the 3/6/95 ACR. At that time, Mary stated that she did threaten to whoop the children, but that she used time-outs requiring the children to sit on the side of the tub or on the bed.

Ms. Bailey reported the whooping incident to the children's GAL. On March 15, 1995, the GAL made a motion to revoke Mary and John's unsupervised visits with the children. The Court entered an order suspending all unsupervised visitation between Mary and John and the children until March 29, 1995 when the case was scheduled to be heard on a Return Home Motion. It does not appear that Mary and John engaged in supervised visitation with the children from the time unsupervised visits were revoked on March 15, 1995 to the time of the children's return home on April 12, 1995.

Housing: Mary changed residences five times from the time the children were removed (1/92) to the time they were returned home (4/95); John changed residences four times during this period. When Linda, Kathy, and Julie were removed from Mary and John, the family was living in an apartment. In July 1992, Mary and John began living with John's mother, Clara Smith. In September 1992, Mary reported to Private Agency's Karen Adams that she moved to her own mother's home because of conflict with John's family. John continued to live with his mother. In May 1993, Mary and John moved to a rent-to-own home in [Town]. On June 2, 1994, Nancy Stevens went to the home and found new tenants living there. Mary and John were evicted from the home in late May/early June 1994. When contacted by Ms. Stevens, John reported that he and Mary intended to tell Ms. Stevens at their next appointment which they thought was at Ms. Stevens's office. On June 3, 1994, Ms. Stevens spoke with Mary who was initially defensive about Ms. Stevens's inquiries regarding their move. Ms. Stevens noted that, "Mary eventually agreed that DCFS/POS needed to be informed." On June 9, 1994, Mary informed Ms. Bailey

that she and John were evicted and living in a motel until they found a new home. Mary reported that they had an oral agreement to make repairs and withhold rent and they obtained a lawyer with regard to the eviction. Ms. Bailey later verified this information with the attorney retained by Mary. In November 1994, Mary and John moved into a two-bedroom apartment in [Town]. Both Ms. Bailey and Ms. Foster found the apartment to be clean and appropriate for children. Mary and John were still living in this home at the time of the children's return home in April 1995.

Employment: It is unknown whether Mary and John were employed at the time of the children's removal in January 1992. The first reference to employment in the case records is a 6/3/92 Social Assessment which stated that Mary was in school to become a certified nurse's assistant and John was unemployed. Mary reported part-time employment as a certified nurse's assistant for several different agencies from July 1992 to May 1994. Employment verification for Mary was obtained by Private Agency in January 1993 and March 1994. While attempting to verify employment for Mary in September 1994, Ms. Bailey learned that Mary was unemployed. While she was working, Mary reported that she enjoyed her position as a certified nurse's assistant "very much." In May 1994, Therapy Agency reported to the Court that Mary was recently accepted into nursing school at [School] and planned to become a surgical nurse. No further information regarding school for Mary was recorded, therefore, it is unknown whether she actually enrolled in school. Mary was unemployed at the time of the children's return home in April 1995. It is unclear whether she intended to resume work or attend school or whether she intended to stay home as a "full-time" mother. It does not appear that Mary's therapist explored this issue with Mary.

John spent a significant amount of time from June 1992 to April 1995 either unemployed or in temporary employment. It appears that John was unemployed from June 1992 until approximately March 1993 when he reported employment with [Temporary Services]. In July 1993, John reported that he was unemployed. From September 1993 to May 1994, John reported employment as a porter mechanic at [Car Dealership], however, employment verification for John obtained by Private Agency in May 1994 was for employment with [Temporary Services]. The case records do not contain employment information with regard to John for the period June 1994 to October 1994. In November 1994, Private Agency received an employment verification letter from [Car Dealership2] which stated that John was employed there since November 21, 1994 as a lot supervisor at $7/hour. Mary reported in March 1995 that John was still employed at [Car Dealership2] and earned approximately $1200/month. Thus, it appears that John was employed at the time of the children's return home in April 1995.

Monthly Contact with POS Worker: Beginning with the 2/18/93 Client Service Plan, a requirement was added that Mary maintain monthly contact with the caseworker. From the beginning, Mary had trouble interacting with the Private Agency and DCFS caseworkers. Various case entries refer to Mary's displays of anger, hostility, and defensiveness toward the workers due to her frustration with the "system" and her belief that the workers were not helping her get her children back. Mary discussed with therapist Nancy Stevens how she felt "out of

control" with her workers and felt persecuted and criticized by them. At a desk review held on February 25, 1994, Mary expressed that she was not agreeable to the task of monthly contact with the Private Agency worker. Ms. Bailey noted in a case entry that Mary openly expressed anger toward her and the DCFS worker and that Mary continued to resist and resent them. Therapist Laura Foster also noted in a case entry that Mary's reluctance to respond to Bailey was discussed at the desk review.

Psychological/Psychiatric Evaluations: Mary and John were cooperative with referrals for psychological testing. Mary underwent a social investigation in March 1993 by [Psychological Testing Agency], a psychological evaluation in June 1993 by [Psychological Testing Agency], and two psychiatric evaluations, one in April 1994 by Psychiatrist Daniel Gray, M.D. and one in March 1995 by Psychiatrist John Hill, M.D. of [Court Psychological Testing Services]. John underwent a social investigation in March 1993 by [Psychological Testing Agency], a psychological evaluation in June 1993 by [Psychological Testing Agency], and a psychiatric evaluation in March 1995 by Psychiatrist John Hill, M.D. of [Court Psychological Testing Services].

The March 1993 social investigations state that Mary and John "are both in denial related to the accusation of physical abuse. This couple impressed as unstable and appears to lack the maturity of responsible adults." The social investigation refers to Kathy's broken hip and states that Mary "is in denial about this incident as well . . . Mother's failure to acknowledge the children's physical abuse in spite of overwhelming evidence is a continued area for concern." Mary's psychological evaluation in June 1993 indicated that she was mildly depressed and struggling with feelings of having been emotionally abandoned and criticized. [Psychological Testing Agency] recommended the following for both Mary and John: weekly individual psychotherapy; continued therapy to deal with denial regarding children's abuse; parenting skills training; and assistance with independent living skills.

Mary underwent a psychiatric evaluation in April 1994 by Psychiatrist Daniel Gray, M.D. Dr. Gray was asked to examine Mary to "determine [her] level of stability" prior to her court hearing in May 1994 for unsupervised visits. Dr. Gray discussed Julie's shaken baby syndrome with Mary. Mary denied any abuse, stating that Julie was born prematurely and developed seizures at one month. She also stated it was a hard delivery. Dr. Gray found that Mary related well; had good eye contact, appropriate affect, intact memory, and good judgment and insight; and exhibited no evidence of thought disorder or obsessive thinking. Mary was given the Zung Depression Rating Scale and scored in the range of moderate depression. Dr. Gray's diagnosis was dysthymic disorder with anxiety. He concluded that Mary seemed sincere and presented herself in a stable, consistent manner and that in his opinion, she could be trusted with taking care of her children.

Mary and John were evaluated by Psychiatrist John Hill, M.D. of [Court Psychological Testing Services] in March 1995 for two purposes: (1) addressing whether the parents should be allowed to regain custody of the children and (2) recommending any psychological, psychiatric and/or

social work services should reunification take place. Dr. Hill reviewed various documents regarding the family, including the [Psychological Testing Agency] evaluations and the psychiatric evaluation by Dr. Gray. He also spoke with therapist Laura Foster and the GAL on the case. Mary and John provided information during the evaluations consistent with the case record. During her individual evaluation, Mary stated that she had no idea what happened to Julie to cause her injury. She denied shaking the child and stated that her understanding of how Julie was injured is that water accumulated on her brain. During his individual evaluation, John stated that he felt the Shaken Baby Syndrome diagnosis was an excuse for the doctor not to consider that Julie's injury may have been the result of something other than abuse. Both Mary and John denied disciplining the children in a rough manner.

Dr. Hill concluded that neither Mary nor John appeared to be symptomatic of a major mental illness. He did find, however, that Mary had a dysthymic disorder characterized by a low level continued depressed mood that had not reached the level of incapacitating her functioning. Mary did not appear to require psychiatric medication or hospitalization. Dr. Hill thought, however, that she might benefit from individual therapy of a supportive nature which might develop into insight-oriented therapy.

Based on his clinical examination of both parents, his review of the documents provided to him, and his conversations with Laura Foster and the GAL, Dr. Hill concluded that in his "opinion to a reasonable degree of medical certainty that there is not any psychiatric illness present in either parent that should prohibit them from functioning in a parenting role." Dr. Hill did not directly address the issue of whether the parents should be allowed to regain custody of the children. Rather, he made recommendations should reunification occur. These recommendations included the continuation of psychological support for the family which might include family therapy, couple's counseling and/or parenting skills training as well as continued supervision by a social worker for regularly scheduled visits and drop-in visits. He also recommended continued couple's counseling for a minimum period of one year to establish a solid parenting bond and solidify the parental roles.

b) George Brown

In servicing this case, it was assumed that all of the children would be returned home to Mary and John. Thus, little consideration was given to Linda and Kathy's biological father, George Brown, as a potential long-term caretaker of the girls. Although Mrs. Brown (George's mother and the girls' foster mother) informed Private Agency caseworker Karen Adams in August and November 1992 that George wanted to care for his daughters, Ms. Adams did not make an effort to contact George. George was not contacted until July 1993 when Debra Bailey was transferred the case. Even then, his role in the case was limited to supervised visitation with his daughters.

Throughout the case, George visited with Linda and Kathy under the supervision of his parents. By all accounts, he was a good, concerned father. On several occasions, George indicated that he wanted to care for his children, but that he did not think he was financially capable. On another

occasion, George telephoned Ms. Bailey to report that he wanted his parents to continue caring for the girls because Mary could not care for them properly and he could not afford to support them.

As the case progressed toward return home of Linda and Kathy to Mary and John, George indicated his intention to secure visitation rights. In the March 1995 Service Plan, Ms. Bailey included a task for George that he obtain legal advice regarding visitation with the girls if they returned home to Mary.

2) The Children - Julie, Linda, Kathy, and Billy

a) Development, Behaviors, and Needs

Julie: Julie was developmentally delayed as a result of her initial injury. In September 1992, a staffing was held at [School for Special Education]. At that time, Julie (age 9 months) scored below her chronological age on receptive and expressive language skills (2 and 3 months), and on cognition (5 months), adaptive (7 months), and personal/social (4 months) skills. Her gross motor skills were age appropriate. A plan was developed for in-home training with [School for Special Education]. In-home training began in October 1992.

In August 1993, Julie began center-based instruction five days per week at [School for Special Education]. In September 1993, Julie (age 21 months) scored below her chronological age on expressive language skills (11 months), and on cognition (13 months), self-help/adaptive (13 months), social/emotional (16 months), and fine motor (15-16 months) skills.

Throughout the history of this case, Julie did not speak. A 10/93 case entry by Private Agency's Debra Bailey indicates that Julie had "only been able to say 'ma' and screech." Julie would indicate a need or want through action, for example, pointing to her high chair when she wanted to eat. In June 1994, Ms. Bailey noted that Julie needed speech therapy because she was three-and-a-half years old and "unable to speak a single word." A 7/94 Progress Report to DCFS by Ms. Bailey indicates that [School for Special Education] was attempting to develop speech skills with Julie.

May and July 1993 case entries indicate that Julie was able to walk, tended to cry without reason, and placed every item into her mouth. In May 1994, Julie still had a noticeable oral fixation; on at least three occasions (1/94, 2/94, and 5/94) she required medical attention because of constant sucking on her fingers.

A 5/94 case entry indicates that Julie was still being toilet-trained; she was able to indicate the need to use the toilet, but still had one accident/day. At that time, Julie was able to feed herself and drink from a glass by herself. On August 4, 1994, Mrs. Jones reported that Julie was nearly toilet-trained.

In December 1994, Ms. Bailey stated in a Progress Report to the Court that Julie had made some progress in school, but that she was still delayed in speech, motor coordination, and other basic tasks. She noted that Julie was to be transferred to an early learning program in January 1995. [School for Special Education]'s 12/94 transition note and discharge summary indicated that Julie needed to develop speech and language skills and that she exhibited some negative behavior due to her inability to communicate her needs and wants.

In January and February 1995, Julie underwent neurological testing at [Hospital]. It was discovered that she suffered from seizure disorder. She was placed on Tegretol and Phenobarbizine. In March 1995 doctors were still trying to regulate the dosage as Julie was suffering side affects ranging from hyperactivity to listlessness. She also experienced physical imbalance.

In a 3/29/95 Progress Report to the Court, Ms. Bailey reported that Julie was still unable to speak and therefore had trouble communicating. She further reported that Julie was transferred to the [School] Early Childhood Program but that due to her recent intake of psychotropic medication, her behavior might require her to be placed in a more restrictive setting. She noted that Julie was being evaluated for an appropriate school to meet her needs.

Linda: Early in the case (7/92), it was noticed that Linda had difficulty speaking. Linda's speech continued to be problematic throughout the history of this case. Linda was evaluated at [School] and the Child Development and Disability Clinic in December 1992. Linda, at age 30 months, was found mildly developmentally delayed in cognitive and language skills, scoring at 20-22 months for expressive language and 22-24 months for receptive language. It was recommended that Linda be placed in a special education program with a small pupil/teacher ratio and that she undergo speech therapy.

It is unclear whether Linda ever received speech therapy prior to October 1994. In March 1994, Ms. Bailey noted during a home visit that she "talked with Linda with a complete lack of understanding," that Linda was very quiet when speaking. Mrs. Brown said that she would make a follow-up appointment with Linda's speech therapist, however, previous case entries do not reflect that Linda was receiving speech therapy. In June 1994, Ms. Bailey offered Mrs. Brown referrals for Linda's speech therapy. A 10/94 Progress Report to the Court indicates that Linda's speech was evaluated and that she was in weekly speech therapy at her school.

Linda never received special education services. Rather, she was placed in [Nursery School/Day Care Center] in March 1993. In November 1993, Ms. Bailey noted that Linda showed difficulty speaking and delays with motor functions such as writing. She showed consistent difficulty with her homework, such as tracing and printing.

Linda remained at [Nursery School/Day Care Center] throughout her involvement with DCFS, attending kindergarten there in the 94-95 school year. In a 3/29/95 Progress Report to the Court,

Ms. Bailey stated that Linda received individual attention for her slow learning at school and that her teachers had expressed concern for Linda's inability to grasp the knowledge in the classroom. In a 3/10/95 case entry, Ms. Bailey indicated that Linda was to start [a different] school on June 11, 1995. In a 3/29/95 termination/transfer summary, Ms. Bailey noted that Linda continued to sound muffled and was difficult to understand.

Kathy: Kathy's behavior was problematic throughout the history of this case. Kathy was placed in [Nursery School/Day Care Center] in March 1993. A 10/93 case entry indicates that Kathy was having behavior problems at school. Her foster mother reported to Ms. Bailey that Kathy frequently had to sit in a corner at school because she fought with and bit the other children. Behavior problems at home were noted in November 1993; during a sibling visit over Thanksgiving at her maternal grandmother's home, Kathy threw cereal and punched her sisters. In December 1993, Ms. Bailey observed Kathy misbehaving and noted, "Kathy was near to impossible to control." It was reported that Kathy was aggressive and bossy and refused to share and follow directions. On December 20, 1993 Ms. Bailey referred Kathy for counseling at Private Agency to address her behavior problems.

Kathy began counseling with Private Agency in January 1994. Some sessions included Linda and Mrs. Brown. In February 1994, Kathy's teacher reported to Ms. Bailey that Kathy's behavior had improved since Christmas. Mrs. Brown also reported improvement in Kathy's aggressiveness and behavior. Kathy's behavior remained stable and her counseling was terminated in June 1994. During a home visit in October 1994, Mrs. Brown reported to Ms. Bailey that Kathy was behaving herself in school, but that she had some concern about Kathy's hyperactivity. Ms. Bailey observed Kathy and noted that she was jumping around and could not stand still.

Case entries indicate that Kathy was an emotional, attaching child who had difficulty being on her own. Kathy was extremely attached to Mary. Often, she would throw temper tantrums when it was time to leave a visit, screaming, "I stay Mary's house." She tended to become upset and aggressive when Mary failed to show up for visits. Case entries also indicate that Kathy was bossy with Linda and tended to become upset if she did not get what she wanted.

Behavior problems were noted again in February 1995. Ms. Bailey noted that Kathy was outspoken and aggressive in her behavior, that Kathy fought with her sister, had trouble following rules in her foster home, and got in trouble in school because she did not listen to her teacher.

In a 3/29/95 termination/transfer summary, Ms. Bailey recommended that Kathy become involved in group counseling with Linda and be effectively disciplined so that she understands the consequences of her behavior. In a 3/29/95 Progress Report to the Court, Ms. Bailey reported that Kathy was hyperactive and had trouble behaving herself in the home. She also

reported that Kathy's teachers had reported that Kathy fights with the other kids and will not follow directions and that her behavior had interfered with her own and other children's ability to learn. In a 3/10/95 case entry, Ms. Bailey noted that Kathy was "completely out of control" and in danger of being kicked out of school.

Billy: Throughout the history of this case, Billy was developmentally on target. He did not appear to have any special needs. March and April 1994 case entries indicate that Billy was walking steadily, could eat with two fingers, and was close to speaking. In October 1994, Billy was saying a few words. In February 1995, Mrs. Johnson reported that Billy was almost toilet-trained.

b) Placement Stability

The Joneses (Julie): There was conflict about Julie's placement in the Joneses' (Mary's father and step-mother's) home from the beginning of her placement there in April 1992. A 4/14/92 case entry reflects that John had not seen Julie since her discharge from the hospital because of disagreements between him and Mrs. Jones. It is unclear from the case record whether the DCFS follow-up worker arranged for Julie's placement with her maternal grandfather and step-grandmother or whether it had previously been arranged by DCP. Mary wanted Julie placed with her own mother, Mrs. Johnson. It is unclear whether this was ever considered prior to Julie's placement in the Jones's home. On June 3, 1992 Mary requested that Julie be moved to her mother's home. The caseworker did not document whether she ever addressed this request.

Case entries throughout the case records reflect that Mary was not particularly close to her father or her step-mother before or during the placement of Julie. Mary expressed feelings of being emotionally abandoned by her father as a child. Visitation with Julie in the Jones home was often inconsistent because of the conflictual relationship between Mary and John and the Joneses.

Throughout the case's history, Mary was critical of the care provided to Julie by Mr. and Mrs. Jones and expressed concern about Julie's well-being in their home. There was merit to Mary's concerns. From the case record, it appears that the Joneses provided adequate care for Julie through 1993. Beginning in 1994, however, problems began to arise, most noticeably with regard to the Joneses submitting documentation of medical care for Julie. In February, April, and June of 1994, Ms. Bailey directed letters to the Joneses requesting documentation of Julie's medical care. She also requested the documentation during her visits to the Joneses' home. The Joneses eventually complied with Ms. Bailey's requests for documentation of Julie's medical care.

In February 1994, therapist Nancy Stevens met with Mary and John and Mr. & Mrs. Jones to discuss the Joneses' care of Julie. Mary and John were upset because Julie had a severe ear infection and it was Mary and John and Mrs. Smith who took Julie to the hospital for treatment. In May 1994, Mary again expressed concern about Julie's treatment in the foster home, informing

Ms. Bailey that Mrs. Jones continually refused to take Julie to the doctor and insisted that Mary and Mrs. Johnson take her. Ms. Bailey noted that many of Mary's concerns were valid; that Julie might be neglected by Mrs. Jones and needed "more attention than FP may be willing to give." In June 1994, [School for Special Education] spoke with Ms. Bailey and reported that the school was questioning whether to continue Julie's case because of the lack of medical information in her file. In a 7/11/94 Progress Report to DCFS, Ms. Bailey noted concern that the Joneses were not working with Julie's school to accomplish similar goals because of their perception that the school had not helped Julie.

As early as January 1993 the Joneses expressed that they felt Julie should be returned to Mary and John. Beginning in July 1994, the relationship between Ms. Bailey and the Joneses became strained. On a home visit conducted in July 1994, Mrs. Jones refused to speak with Ms. Bailey. In August 1994 Mrs. Jones contacted Ms. Bailey to report that she could not give Julie the attention she needed as she was also caring for two other children (the Joneses were a licensed foster home). Ms. Bailey's impression at the time was that Mrs. Jones was being pressured by Mary. In September 1994 Mrs. Jones again reported to Ms. Bailey that she could no longer care for Julie because she could not give her what she needed. Mrs. Jones gave a 14-day (verbal) notice for Julie's removal. Ms. Bailey noted that she hoped to move Julie, perhaps to Joyce Johnson's home, by October 5, 1994. Apparently Mrs. Jones changed her mind because Julie was never removed.

In a 12/1/94 Progress Report to the Court, Ms. Bailey stated that Julie's foster parents had been able to "provide her with the proper and additional care" she needed. Yet, on December 22, 1994, Ms. Bailey gave Mrs. Jones a 14-day notice because of medical neglect in failing to keep appointments for Julie. Mrs. Jones later denied medical neglect and threatened to file a lawsuit if Julie was harmed by removal. Julie was not removed. On January 5, 1995, Ms. Bailey completed a UIR stating that at her last home visit, Mrs. Jones reported that Mary discovered that Julie had "walking" pneumonia and took Julie to [Hospital] and obtained a prescription. Mary was upset that Mrs. Jones did not notice that Julie was ill. At that time, the DCFS and Private Agency workers developed a plan for Mary to become more involved in Julie's life to more readily observe problems. On January 12, 1995, Ms. Bailey directed a letter to the Joneses that DCFS and Private Agency had decided to maintain Julie in their placement and expected them to continue with their foster parent duties. In February 1995, upset over Kathy's report of being whooped, Mary informed Ms. Bailey that she did not want any involvement working with the foster parents, including seeing to Julie's medical needs, until the children were returned to her.

In January and February 1995, Julie underwent neurological testing at [Hospital]. Dr. Ward found that Julie had seizure disorder and placed her on medication. Apparently, the Joneses stopped giving Julie her antiseizure medication because of what they perceived as erratic behavior on Julie's part while taking the new medication. On February 14, 1995, Ms. Bailey reported to Ms. Harris that Dr. Ward informed her that Julie was severely brain damaged as

evidenced by the CAT scan and EEG and that he believed Julie "was definitely physically abused." Dr. Ward stated that he felt "very uncomfortable with the child being with anyone in the family" because Julie had been taken off her medication. On February 15, 1995, Ms. Bailey referred Julie to Private Agency's specialized foster care program for emergency placement due to concerns that her foster parents discontinued her seizure medication. Ms. Bailey learned that there were no openings available and Julie remained in the Joneses' home. In a 3/29/95 Progress Report to the Court, Ms. Bailey stated that Julie's placement was unstable and indicated that the Joneses preferred that Julie live elsewhere after March 29, 1995 because they were tired. She indicated that Private Agency was monitoring the home closely through weekly phone calls and at least once monthly home visits.

Despite concerns about the care being provided to Julie by the Joneses, Mary's many requests that she be removed, and the Joneses' own requests that she be moved (regardless of whether they were sincere), Julie remained in the Joneses' home until she was returned to Mary and John in April 1995.

The Browns (Linda and Kathy): Julie's siblings, Linda and Kathy, were placed with their paternal grandparents, the Browns. The relationship between Mary and John and the Browns was also strained, primarily because the Browns were Mary's ex-boyfriend's parents. Both Mary and John expressed feelings of discomfort in the Browns' home. Case entries reflect that Mrs. Brown often reported that Mary would not speak with her while visiting or picking up the girls.

Although the Browns also occasionally had difficulty submitting documentation of medical care for Linda and Kathy, case entries reflect that all of the caseworkers involved with the Jones-Brown-Smith family agreed that the Browns took excellent care of Linda and Kathy. The Browns expressed interest in providing long-term care for Linda and Kathy, including adoption. Although on several occasions, Mrs. Brown expressed concern about Mary resuming full-time care-taking responsibility of the children, she supported each step in the reunification process and continually expressed her willingness to return the girls when Mary was ready. The Browns were concerned about being able to continue their relationship with Linda and Kathy once the girls were returned to Mary, and they discussed this with DCFS caseworker, Pamela Harris, in December 1994. Ms. Harris informed them that Mary did not have to let them see the children once they were returned to her and advised the Browns to join Mary and John in counseling to devise a plan for continued contact with the girls. Mrs. Brown later reported to Ms. Bailey that George would secure visitation rights with the girls if the children were returned to Mary. On two occasions (12/94 and 3/95) Ms. Foster indicated in reports to the Court that Mary and John had discussed the importance of maintaining the children's relationships with their foster parents and planned to determine a visitation schedule.

Mrs. Johnson (Billy): When Billy came into care in August 1993, he was placed with Mary's mother, Joyce Johnson. Early on, Mrs. Johnson had contact with the caseworkers; she and Mary

were both upset that the children were not placed with her. In July 1992, Mrs. Johnson requested visitation with Linda, Kathy, and Julie. The Court granted Mrs. Johnson unsupervised visitation with the children on April 19, 1993. She hosted sibling visits and supervised some parent/child visits. In a 6/7/93 Transfer Summary, the DCFS worker, Anne Bell, noted that Mary, Mary's mother, and Mary's therapist, Nancy Stevens, had formed an alliance which she indicated had interfered with servicing the case.

During December 1993 and January 1994, Billy was placed with his paternal grandmother, Clara Smith, while Mrs. Johnson recovered from surgery. From March 1994 to approximately September 1994, Therapy Agency provided homemaker services to Mrs. Johnson to assist her in caring for Billy. Therapy Agency again provided homemaker services to Mrs. Johnson in February 1995.

Of all the relative foster parents, Mary's relationship was best with her own mother. Mary described her relationship with her mother as "close and generally supportive," stating that although they argued, she never doubted her mother's love for her. Mary's therapist, Nancy Stevens, noted similarities in Mary and Mrs. Johnson's behaviors. A 3/10/93 case entry indicates that Ms. Stevens began to recognize patterns of behavior in Mary and her mother where they are either "very shut down and tuned out or highly emotional." She discussed with Mary and Mrs. Johnson how this could be a disservice to them. In March 1993, Ms. Stevens witnessed an argument between Mary and her mother. When arriving for an appointment on March 23, 1993, Mary and Mrs. Johnson were having a "very loud yelling argument." Mary was in tears and Mrs. Johnson was telling her she was stupid for thinking her brother would come through for her to co-sign a house loan for Mary. Therapy frequently focused on Mary's relationship with her mother. In April 1993 Mary stated that she realized that her mother was the most shallow, verbally abusive person to her when she was younger. Mary began to understand how her mother affected her; she would get angry and totally shut down until she felt overwhelmed and then verbally explode. Mary expressed that she could never verbally abuse her kids the way her mother did. According to Ms. Stevens, Mary was reflective, not self-pitying.

It appears from the case record that Mrs. Johnson was generally supportive of Mary. Like Mary, Mrs. Johnson was upset by the slow progress of the case. In mid-1994 a conflictual relationship developed between Private Agency's Debra Bailey and Mrs. Johnson. In April 1994, Mrs. Johnson expressed her hope that Billy would return home in May 1994 as she thought the case had gone on too long. Another case entry in July 1994 indicates that Mrs. Johnson was upset that the case was not progressing.

In October 1994 Mrs. Johnson informed Ms. Bailey that she thought Julie should be in a different placement and offered to care for her. Ms. Bailey noted that Mrs. Johnson was hostile while discussing Julie's placement. The subject of Julie's placement arose again in November 1994. In a case entry, Ms. Bailey indicated that Mrs. Johnson became angry discussing Julie's placement and screamed obscenities at Ms. Bailey. Ms. Bailey noted being offended and slightly scared with some concern regarding how Mrs. Johnson controlled her anger around Billy. She

further noted, "this family appears to have anger management problems." By December 1994, Mrs. Johnson resisted speaking with Ms. Bailey during home visits. On one occasion, in January 1995, Mrs. Johnson reported that she had nothing to say to Ms. Bailey and refused to talk with her. At that time, Ms. Bailey noted her belief that Mrs. Johnson was not going to cooperate with her and was hostile toward her.

On March 24, 1995, Mrs. Johnson reported to Ms. Bailey that she would recommend that Billy return home on March 29, 1995 and that she no longer wanted to care for him. Ms. Bailey explained to Mrs. Johnson that she needed to write a 14-day notice. Ms. Bailey noted in a case entry that Mrs. Johnson appeared tired of dealing with the situation with DCFS.

3) Private Agency Withdrawal from the Case

As just discussed, in the months just prior to the return home of the children, the relationship between Debra Bailey and the Joneses and Mrs. Johnson became strained. The foster parents directed their hostility about the case at Ms. Bailey, often using foul and aggressive language. At times, the foster parents refused to speak to Ms. Bailey. On several occasions, Ms. Bailey noted her belief that the Joneses and Mrs. Johnson were no longer going to cooperate with her.
At an ACR held on March 6, 1995, Ms. Bailey and her supervisor reported that Private Agency would be giving a 14-day notice because they no longer felt that they could service the case. Laura Foster reported that Therapy Agency would be interested in servicing the case and on March 7, 1995 DCFS's Pamela Harris left a message for Therapy Agency's intake worker for referral of the Jones-Brown-Smith case to Therapy Agency. On March 15, 1995, Private Agency directed a written 14-day notice to Ms. Harris in which Ms. Bailey stated that despite efforts to develop a cooperative relationship with the foster parents, Joyce Johnson and Diane Jones, there continued to be hostility directed toward her which interfered with her servicing of the case. Private Agency withdrew from the case as of March 29, 1995. Ms. Bailey completed termination/transfer summaries for the children and a final progress report to the Court in which she recommended that the children remain in their respective placements "until or if the Department would be in agreement of returning the minors to their natural parents."

4) The Return Home Decision

In January 1995, Mary and John's attorneys filed motions to be heard on March 29, 1995 for return home of the children. On March 8, 1995, the GAL filed an emergency motion to be heard on March 15, 1995 to suspend Mary and John's unsupervised visitation with the children based on the reported whooping incident involving Kathy. On March 15, 1995, the Court entered an order suspending all unsupervised visitation between Mary and John and the children until March 29, 1995 or further order of the Court. The GAL's motion was continued until March 29, 1995 to be heard with the parents' motions for return home.

On March 27, 1995, Ms. Foster met with DCFS worker Pamela Harris to discuss return home of the children. According to a case entry by Ms. Foster, Ms. Harris agreed to recommend return home of the children on March 29, 1995. Ms. Foster also met with Debra Bailey. According to

a case entry by Ms. Foster, Ms. Bailey stated that her recommendation for return home would be deferred to the DCFS worker. On March 27, 1995 Nancy Stevens directed a letter to the Court in which she recommended that the children be returned home with a safety plan in place and on-going monitoring for a period of time. In a 3/29/95 Progress Report to the Court, Ms. Foster recommended that the children be returned home with a safety plan in place and the provision of supportive services. Ms. Foster also submitted a Safety Plan to the Court which was developed by Mary and John and herself. The Safety Plan outlined Mary and John's intentions to plan for the children's schooling, Julie's medical care, and maintenance of the children's relationships with their foster parents.

On March 29, 1995, the GAL's motion to suspend visitation and the parents' motions for return home were continued until April 12, 1995.

On April 5, 1995, Pamela Harris met with Tim Clark[5] for approximately 15 minutes in the cafeteria to discuss three of her cases, one of which was the Jones-Brown-Smith case. Ms. Harris's supervisor, Bob Jackson, was on extended medical leave. Jane Doe, Administrator for the [Town] Area Office, asked Mr. Clark to meet with Ms. Harris as she appeared to be stressed out. According to both Ms. Doe and Mr. Clark, the purpose and focus of Mr. Clark's contact with Ms. Harris was to ensure that she was okay. According to Mr. Clark, the content of Ms. Harris's comments with regard to the Jones case was that there was a whooping incident, SCR would not accept a report of the incident, the children were fine and about to be returned home, and reports were glowingly in favor of the parents. Based on the information presented to him, Mr. Clark said that Ms. Harris's approach to the case looked "okay." It was not clear to Mr. Clark whether Ms. Harris was seeking permission for the children's return home or whether the decision already had supervisory approval.

Ray Phillips, the CWS III on Bob Jackson's team, was acting supervisor during Jackson's absence. According to Mr. Phillips, he had one communication with Ms. Harris regarding the Jones-Brown-Smith case. Ms. Harris asked Mr. Phillips for his advice with regard to the return home hearing. Mr. Phillips advised Ms. Harris not to give a recommendation with regard to returning the children, rather to just present the facts and let the Court make the decision.

On April 11, 1995 Pamela Harris completed the form "When DCFS Intends to Return Child to Home of Parents." In answering the question, "[w]hat was the date and specific, original reason for removal," Ms. Harris wrote, "1-31-92" and "physical abuse, subdural hematoma which may have been shaken baby." She checked "yes" in response to the question, "[h]ave the reasons for removal changed?" Where the form said, "[s]pecifically, list any remaining risks to the child

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[5] Tim Clark is a Licensed Clinical Social Worker who was acting as a clinical consultant in the [Town] Field Office pursuant to a contract with [Training Institute]. Mr. Clark is a family therapist and a doctoral student at [School]. He has both supervisory and formal teaching experience.

(i.e., abuse, neglect)," Ms. Harris wrote "none." Where the form asked what other agencies' recommendations were regarding the return of the children, Ms. Harris recorded that Private Agency made no recommendation regarding return, that Therapy Agency recommended return home, and that [Court Psychological Testing Services] recommended return home. With regard to what services would begin to the family/children when returned home, Ms. Harris checked "counseling" and "worker contact." Although the form requested the "frequency" and "effective date" of the services, Ms. Harris left these areas blank. Only Ms. Harris signed the form; the signature lines for supervisor, area administrator, and regional designee were left blank.

On April 12, 1995, the Court granted the return home of all of the children to Mary and John and entered a 2-25 Order of Protection including provisions that Mary and John provide all care necessary to the children; cooperate with reasonable requests of DCFS; not use corporal punishment; notify DCFS within 24 hours of any injury to child which would require professional medical treatment; ensure the children attend school daily; provide adequate supervision (by natural parents or relatives); continue with counseling; and follow Therapy Agency's Safety Plan tendered to the Court. The Order of Protection also included provisions that DCFS assess what support services (including homemaker services) would assist the parents and provide the services immediately; refer Kathy for counseling; arrange for a school assessment for Linda and Kathy; and monitor the parents' counseling. The Court set a review date of October 12, 1995.

5) Planning for the Children's Return Home

Planning for the children's return home consisted of the development of a Safety Plan by Mary and John and Laura Foster in March 1995. The Safety Plan was submitted to the Court and made a part of the Court's Order of Protection for the children's return home. The Safety Plan, written by Ms. Foster, identified Mary and John's intentions with regard to the children's schooling, Julie's medical care, and maintenance of the children's relationships with their foster parents.

According to the Safety Plan, Mary and John intended to keep Linda enrolled in [Nursery School/Day Care Center] as they believed that the school was productive for her and that they had looked into an appropriate school for Linda to enter first grade next year. Ms. Foster stated, "[a]t the present time Linda does not present with any special needs and no other services are needed at present." Mary and John intended to maintain Kathy at [Nursery School/Day Care Center] also and were looking into bus service for Kathy to continue to attend [Nursery School/Day Care Center] the following year. Ms. Foster stated, "Kathy currently presents no special needs that need attention at this time." With regard to Julie, Ms. Foster stated that Mary and John had been consistently concerned about Julie's medical care and had begun to search for a pediatrician for Julie. She stated that Mary and John planned to use community resources to provide Julie with sign language services and that they wanted to be educated with regard to raising a child with a seizure disorder. Ms. Foster noted that Julie was currently in need of educational services and that Mary and John were seeking an appropriate educational placement for her. Ms. Foster indicated that Billy had no special needs warranting immediate services.

Ms. Foster stated that Mary and John had discussed the importance of maintaining the children's relationships with their foster parents and that they planned to determine a visiting schedule. She further indicated that Mary and John had discussed the primary responsibilities each would assume upon the children's return home.

6) Monitoring Following Return Home

There was minimal monitoring of the Jones-Brown-Smith family following the children's return home on April 12, 1995. The Court ordered DCFS on April 12, 1995 to complete the following tasks: (1) assess what support services (including homemaker services) would assist the parents and provide the services immediately; (2) refer Kathy for counseling; (3) arrange for a school assessment for Linda and Kathy; and (4) monitor the parents' counseling. The Court set a review date of October 12, 1995. An examination of the DCFS case record showed that none of these tasks were complied with prior to Julie's death on June 7, 1995. A "Court Order Compliance Efforts" Report to the Court, however, indicates that homemaker services were offered to Mary and she declined them and that DCFS had continued to monitor the parents' counseling.

Private Agency had withdrawn from the case prior to the return home. Although Therapy Agency had indicated it's intention to take over the case, it had not yet done so prior to the children's return home. In Therapy Agency's "Sequence of Events since Return Home" submitted to the Court after Julie's death, Ms. Foster indicated that on May 10, 1995 she and Ms. Harris discussed the progress of Therapy Agency accepting the after-care monitoring contract for the family, that [the intake worker] of Therapy Agency had verbally agreed to accept the case, and that Ms. Harris was waiting for a caseworker assignment from Therapy Agency. According to Ms. Harris's "POS Monitor's Report" submitted to the Court after Julie's death, Ms. Foster indicated that she would monitor the family until a worker was assigned. Ms. Foster confirmed in an interview with the OIG that she told Ms. Harris that she was in the home weekly and would advise Ms. Harris if she noted any concerns. A Therapy Agency worker was never assigned to the family.

According to case entries by Ms. Foster and her Sequence of Events since Return Home report, Ms. Foster provided counseling to Mary and John in their home on April 13 and 19, 1995 and on May 3, 10, 19, and 25, 1995. Ms. Foster noted that the children appeared healthy and happy. According to Ms. Harris's POS Monitor's Report, Ms. Harris met with Mary at the DCFS office on April 13, 1995 to discuss issues of Norman funding, SSI, and the minors' educations, and advised her on how to obtain the necessary services. At that time, Mary indicated that she needed bunk beds, dressers, and additional towels, sheets, and chairs. According to the report, Ms. Harris had some phone contact with Mary during April 1995, primarily regarding issues of Norman funding and transportation for the children to and from school.

Ms. Harris made one (unannounced) visit to the Jones-Brown-Smith home from the time the children were returned home on April 12, 1995 to the time of Julie's death on June 7, 1995. The visit occurred on May 9, 1995. According to a case entry by Ms. Harris and her report to the Court, Ms. Harris observed that the living room was clean and well-furnished and that there was

food in the kitchen. She did not observe the children's bedrooms. Ms. Harris saw all of the children except Julie who was reported to be asleep in her room. Ms. Harris noted that no problems were reported and that the children appeared healthy and happy.

On May 17, 1995, Mary telephoned Ms. Foster to report that Julie fell of her bike. Mary explained that while Julie was sitting on her bike, Linda bumped into Julie with her bike because she could not stop. According to Mary, Julie did not cry, appeared puzzled, and had two scratches on her head. Ms. Foster advised Mary to notify DCFS.

On May 19, 1995, Mary telephoned Ms. Harris to inform her that Julie had woken with a swollen face. According to Ms. Harris's POS Monitor's Report, Ms. Harris asked Mary if Julie had sustained any injuries or whether anyone had hit her. Mary responded that she did not know of any reason Julie's face was swollen. Mary advised Ms. Harris that she would be taking Julie to the hospital and Ms. Harris advised Mary to contact her if anything was wrong. Ms. Harris went on vacation leave and there was no follow-up by DCFS.

Following Mary's report that Julie fell off her bike, Ms. Foster had phone contact with Mary on May 18, 21, and 22, 1995. She made home visits on May 19 and 25, 1995. On May 19, 1995, Mary stated that when Julie awoke that morning, the right side of her face was swollen. She reported that she took Julie to [Hospital1] emergency room and that Julie was released as she appeared fine. The doctor at [Hospital1] told Mary to take Julie to [Hospital2] if she began to vomit, developed a fever, or began acting strangely. Mary showed Julie's discharge papers to Ms. Foster. During her visit, Ms. Foster observed that Julie's face was swollen and discolored and that she appeared groggy. On May 22, 1995, Mary reported to Ms. Foster that she took Julie to [Hospital2] emergency room requesting that she be admitted because she had a fever and diarrhea for two days. She was told to take Julie home and bring her back if she displayed abnormal behavior or vomited. Again, Mary showed Julie's discharge papers to Ms. Foster. During her visit on May 25, 1995, Ms. Foster noted that Julie's swelling was still present, but appeared to have decreased.

There was no further contact between Ms. Foster and Mary until June 5, 1995, when Mary paged Ms. Foster to report that Julie began having seizures and was rushed to the hospital. From June 5 to June 8, 1995, Ms. Foster provided in-person and telephone support to Mary.

On June 8, 1995, Ms. Harris learned from her supervisor that Julie had died on June 7, 1995. At that time, Ms. Harris spoke with Ms. Foster and learned of Julie's reported fall off her bike on May 17, 1995 and the sequence of events since Mary reported Julie's swollen face to DCFS.

Denise Kane
Inspector General

ATTACHMENT A

Clinical Consultation to DCFS

Julie Jones's case was monitored by the DCFS [Town] Area Office. In 1994, the [Training Institute] contracted with the Department to provide clinical consultation to staff at the [Town] office. The Clinical Consultant was Tim Clark, LCSW, a subcontractor of the [Training Institute]. Mr. Clark is a family therapist and a doctoral student at the [School]. He has both supervisory and formal teaching experience. Consultation services began in July 1994. Mr. Clark was at the [Town] office approximately 20 hours per week.

In August 1995, interviews were conducted by the OIG with Mr. Clark and Ms. Jane Doe, [Town] Office Administrator, to discuss the clinical consultation provided to [Town] Office staff by Mr. Clark. A (revised 1/12/95) document titled, *Clinical Consulting Initiative Position Paper* (attached) outlined the responsibilities of a Clinical Consultant. According to Mr. Clark, this position paper, which he helped develop in January 1995, was the only known written description of a clinical consultant's responsibilities. Ms. Doe reported that the position paper existed prior to July, 1994 and was only used for the purposes of contract development and consultant selection. Ms. Doe stated the document was never referred to after consultation began.

According to the position paper, the overarching responsibility of the clinical consultant was to provide one-on-one clinical assistance to [Town] Office core supervisors. The document specified various areas in which assistance would be offered by the consultant to both supervisors and caseworkers. The position paper stated, "[w]hile not abandoning their involvement with other Supervisors, the Clinical Consultants will concentrate on *Termination of Parental Rights and Return Home Cases.*

Ms. Doe reported that the arrangement for clinical consultation was never put in writing nor did she independently, or jointly with the clinical consultant, develop a written description and plan for clinical consultation or delineate the role and expectations of the consultant. Rather, she said it was understood that the clinical consultant would meet with her supervisors, engage in general discussion of cases/issues, and review cases referred by workers, supervisors or administrator. Although Ms. Doe admitted her *staff do not know what clinical supervision is and are afraid of it,* she made no effort to formally introduce, explain and communicate the value of clinical consultation services to staff. In addition, an assessment of staff was never conducted by the [Training Institute] or Mr. Clark to identify strengths and barriers, and to develop a strategy for creating an environment conducive to appropriate and optimal use of clinical consultation. As the administrator of the [Town] office for three years, Ms. Doe possessed some history of the office and knowledge of her staff and she, therefore, might have contributed to a useful "needs assessment" and helped integrate clinical consultation into the workplace.

The end result is that clinical consultation services as delivered by Mr. Clark significantly deviated from the position paper. Consultation services were offered on an informal basis, that is, *the consultant was available to staff, and staff use of clinical consultation was optional.* A

structured case consultation process did not exist; there were no regularly scheduled meetings or formal case staffings, and there had been no effort to identify impending *Termination of Parental Rights* and *Return Home cases* (as contained in the position paper) for purposes of review and assessment, planning and decision-making, clinical assistance, or supervisory direction.

According to Mr. Clark, approximately 25% of [Town] Area staff had *no contact* with him, while Ms. Doe was under the impression that all her staff utilized the consultant, albeit to varying degrees. Staff were permitted to inappropriately utilize Mr. Clark's time to assist with direct casework activities, such as finding placements, making telephone calls for caseworkers, or to fill in for a supervisor. Mr. Clark willingly participated in these activities because he determined that he could not perform his job unless the workers came to view him as a helpful presence in the office. As part of this process of relationship building with staff, Mr. Clark also engaged in mundane activities, such as helping to move office furniture. It is the OIG's opinion that, contrary to the consultative approach taken, it is through the clinical consultation experience that staff develop confidence and trust in the consultant, as well as in themselves and their judgement.

Initially, Mr. Clark was not assigned an office or other appropriate work area and he consulted with staff in the cafeteria. Although Mr. Clark and Ms. Doe both reported that they were comfortable with this arrangement, the lack of private space available to a clinical consultant diminishes the importance of clinical consultation, not to mention the lack of privacy, the din of cafeterias, and the confidential nature of cases.

When consultation occurred, it was usually without preparation (e.g., a review of the record) and it generally involved responses to crises and discussion of selected or segmented case issues as presented by the caseworker. This occurred in the Jones case. Although Mr. Clark understood that he had the authority to bring about full case staffings, since July of 1994, not a single case was given the benefit of a comprehensive case staffing.

Mr. Clark reported that his input was routinely given verbally. Occasionally, his comments and recommendations were made in writing. He did not practice making case entries in records to document his involvement and input on cases. Although Mr. Clark recorded who he met with and the name of the case, he did not maintain notes on the content of his consultation.

Ms. Doe's explanation for the manner in which the clinical consultant was used, was that *staff do not have the time required for case staffings.* Yet, decreasing and minimizing crisis-driven supervision and the crisis response mode to case management is precisely what the clinical consultant was there to help address. As a teaching tool, clinical consultation can facilitate up-front planning, enhance the worker's case knowledge and understanding, develop informed and more sound critical decision-making processes, and gain greater control over cases.

Based on the OIG's interview with Mr. Clark, it was concluded that his consultative approach was non-directive and lacked focus. He had no written contract or agreement defining his official job responsibilities. Both he and Ms. Doe failed to give proper definition to his role,

identify and prioritize cases for consultation, establish a structure and process by which supervisors and caseworkers were expected to engage in case staffings, convey the importance of case review and planning, and incrementally identify strengths, weaknesses, or other issues among supervisors and caseworkers. Mr. Clark's ill-defined role undermined his ability to fulfill his fiduciary responsibility to help improve and strengthen the collective knowledge and skills of supervisors and caseworkers to more effectively monitor and manage cases.

It would appear that Ms. Doe and Mr. Clark lost sight of the original intent and purpose of clinical consultation. Early on, the focus shifted from children's cases to the well-being of staff. Specific to the Jones case, Mr. Clark was asked by Ms. Doe to fill in for an absent supervisor and look over Pamela Harris's work because Ms. Harris was "frazzled." Ms. Harris's supervisor, Bob Jackson, was on extended medical leave and Ms. Doe was concerned about Ms. Harris and whether her cases were being handled properly. According to both Ms. Doe and Mr. Clark, the purpose and focus of Mr. Clark's contact with Ms. Harris was to ensure that she was "okay."

On April 5, 1995, Mr. Clark and Ms. Harris met for approximately 15 minutes in the cafeteria to discuss three of her cases, one of which was Jones. The content of Ms. Harris's comments was that there was a "whooping" incident, SCR would not accept a report of the incident, the children were fine and about to be returned home, and reports were glowingly in favor of the parents. Based on this information, Mr. Clark said that Ms. Harris's approach to the case looked "okay" and that he accepted her word and the competency of the private agency. There was no discussion of the factors precipitating system entry or return home, an aftercare plan, profiles and needs of the Jones/Brown children, or risk factors in the case. Furthermore, Ms. Harris's comment that "the children are about to go home" did not initiate a review of the record. In addition, it was not clear to Mr. Clark if Ms. Harris was seeking permission to go forward with the case, that is, return home, or whether this case had received supervisory approval. *Although all return home decisions require supervisory approval (P.305.30), none was obtained in the Jones case.*

The manner in which consultation services were offered at the [Town] Office calls into question the quality of administrative leadership and the existence of systemic barriers to effective implementation and utilization of consultation services by staff. Supervisors and caseworkers were not prepared for the introduction of a clinical consultant to their work environment nor were they guided and encouraged to practice optimal utilization of clinical consultation services. A crisis-driven system, supported by administration, impedes the implementation and use of comprehensive case reviews, front-end planning activity, and strong case management.

In January or February of 1995, an internal case by case review was initiated by Jane Doe for the purpose of determining court status, gaps in service, what resources were provided to the case, and to make recommendations to supervisors. Also under consideration was whether some cases should be transferred to private agencies. Approximately 80 percent of the cases had been reviewed as of August 14, 1995. Ms. Doe informed the OIG that the review was not documented; no data was collected to ascertain patterns of service issues or common problems

regarding cases and service delivery; cases were not categorized by return home, termination of parental rights, disruption/at-risk children/placements, or by any other reference point; cases were not reviewed to determine the need for case planning or case staffings. Ms. Doe did not take this opportunity to begin structuring a case consultation process or to begin positioning cases and staff for much needed direction (which precipitated the assignment of a clinical consultant to the [Town] Office).

CLINICAL CONSULTING INITIATIVE
POSITION PAPER

It will be the responsibility of the the Clinical Consultant to offer one-on-one clinical assistance to specifically identified Area Office Core Supervisors. While not abandoning their involvement with other Supervisors, the Clinical Consultants will concentrate on *Termination of Parental Rights and Return Home Cases.*

Clinical Consultants will assist in:

- Role modeling for caseworkers by assisting in the Comprehensive Assessment Process.
- Accompanying caseworkers on selected home visits.
- Identify cases that should be directed toward Termination of Parental Rights.
- Identifying cases that should be directed toward Return Home.
- Strengthening the 30 day Service Planning Process.
- Improving the caseworker Court delivery/preparation process.
- Strengthening the Case Consultation Process.

Clinical Consultant Coordinator will assist Core Supervisors in:

- Preparation of staff meetings.
- Strengthening the decision making process.
- Improving/evaluating the Service Planning Process.
- Assisting in identifying clinical/support resources.
- Identifying "Wrap Around Services."
- Straightening the Comprehensive Assessment Process.
- Identifying Preventative methods for 'Disruption'/'At-Risk' Children/Placements.
- Assisting caseworkers with time management issues.

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APPENDIX V

LEADS Protocol

LEADS PROTOCOL

WHEN TO USE LEADS

LEADS should be used in both investigations and follow-up work in the following circumstances:

- **when the facts suggest violence**
- **when the facts suggest drug abuse**
- **when the worker fears a violent reaction to a DCFS visit**
- **when the facts suggest sexual abuse**

WHAT LEADS CAN DO

A LEADS check can give you the following information regarding names checked:

- open (unresolved) arrests
- closed (not resulting in conviction) arrests
- convictions
- existing orders of protections
- existing warrants issued
- current address
- drivers license information

WHAT LEADS CANNOT DO

LEADS is not a substitute for an FBI fingerprint check. LEADS cannot give information relative to any aliases used by the subject.

LEADS can never be used for pre-licensing or pre-employment checks.

LEADS is not a substitute for CANTS checks on all adults living the household.

LEADS accessed through the State Central Register will only give **Illinois** criminal history. If you have reason to suspect that the subject has a criminal record outside of Illinois, you must contact the Office of the Inspector General, Bureau of Investigations (312-433-3040) to request an out-of-state check. You will need to have the SCR or DCFS number, along with the social security, birthdate and name and address of the subject.

PROCEDURE

To initiate a LEADS check, workers should call 1- 800 - 25- ABUSE and request a LEADS check. Once transferred to the LEADS operator, the worker must be prepared with the full name of the person and as much additional identifying information as is available (such as date of birth, social security number and address) along with the SCR Number or open DCFS file number.

USE OF LEADS

LEADS is an indispensable tool in the risk assessment decision-making process. It is also helpful to the caseworker in assessing risk to the worker in conducting an investigation. Criminal background information will often be useful as a starting point for an investigation to pinpoint areas of concern that require further information.

In assessing the importance of LEADS information, the following guidelines should be used:

- Criminal history information should be considered in relation to the ability to care for the child.

- Arrests are not convictions. Closed arrests are relevant only to show a possible pattern of activity or to identify issues that require further investigation. Arrests may also be relevant to assessing conflict resolution abilities and stability of the home environment.

- There is no clearer predictor of future violence than past violence. Thus, workers should pay particular attention to criminal history involving interpersonal violence.

- Gang-related activity may present a danger to children but workers should be sensitive to the fact that African-American adolescents and young adults are disproportionately charged with mob action.

- The age of the conviction should always be considered.

- If LEADS data appears relevant, you should retrieve underlying documents, such as police reports, to learn relevant details.

- Consult the attached LEADS Assessment Guidelines to assess LEADS data.

WARNING

LEADS is an important tool for DCFS. It must not be abused. Use of LEADS is strictly limited to information relevant to a pending DCP or OIG investigation or open DCFS casefile by the responsible DCFS or OIG personnel. Any attempt to use LEADS for any other purpose may subject the requesting party to discharge and or prosecution.

CONFIDENTIALITY

All arrest information learned through LEADS, as well as the actual LEADS printout, must be kept strictly confidential within DCFS and the OIG and must not be disseminated for any purpose except as authorized by a supervisor. Conviction information may be shared as necessary, along with police reports, which are public information.

REPORTING

The Department will notify the entering agency whenever it performs a LEADS check on an individual which shows an outstanding warrant. The OIG will notify the entering agency on all OIG initiated LEADS checks. (DCP or SCR) will notify the entering agency on all operations initiated LEADS checks.

LEADS Assessment Guidelines

The following chart from the Family Assessment Worksheet Factors may be helpful in assessing criminal background information.

NO/LOW RISK	INTERMEDIATE	HIGH RISK
No evidence of any past or current caretaker criminal activities; previous history of criminal activity by the caretaker poses no current risk to the child; or previous record of arrests for nonviolent crimes that did not involve the child; caretaker is on probation and is meeting all requirements of probation	Caretaker is suspected of current participation in felonious criminal activity; previous record of violent crimes perpetrated against nonrelated adult victims; habitual criminal activity that currently interferes with caretaker's ability to provide minimal child care; habitual criminal activity and/or gang related activity presents a clear danger but child has never been actually harmed	Caretaker has a confirmed arrest record including use of force or violence against children; previous history of violent crimes perpetrated against an immediate family member; habitual criminal activity that severely impairs the caretaker's current ability to provide minimal child care or supervision; habitual criminal activity and/or gang related activity repeatedly exposes child to immediate danger from high risk environment

APPENDIX VI*

Sexual Abuse Report

* Recommendations are omitted from the redacted version of this report (pages 16 - 19).

Child Sexual Abuse Allegations

in the context of

Child Custody/Visitation Disputes

A Review of the Literature and Recommendations

October 24, 1995

1. Incidence of Sexual Abuse Allegations in Custody Disputes

There is a widespread belief that sexual abuse allegations in child custody disputes are common; accounts of an "epidemic" of such reports have appeared frequently in the popular media, fueled by attention to celebrated cases such as the Mia Farrow/Woody Allen divorce and the Morgan/Foretich case, in which allegations in a custody dispute aroused public sentiment (Myers 1990). It is important, however, to examine these claims and to determine the actual extent of the problem.

Certainly, the incidence of divorce is rising. It is currently estimated that half of all marriages end in divorce; 60 % of them include minor children and of these, 10-15% involve a custody dispute (Charlow 1987). In addition, the relitigation rate in divorces that include children is 10 times greater than those without children (Charlow 1987). At the same time, sexual abuse reports have risen dramatically in the past two decades (Besharov 1988). It is to be expected, then, that sexual abuse allegations in custody disputes are on the rise as well.

Early reports, based on anecdotal case histories in small clinical samples, indicated that 35-45% of child custody disputes involved sexual abuse allegations (Green 1986; Benedek and Schetky 1985). More recently, there have been a few larger studies (Thoennes and Tjaden 1990; McIntosh and Prinz 1993), but comparison between them is difficult because they use varying definitions of context, (all divorce cases, only contested custody cases, inclusion of visitation disputes), different definitions of sexual abuse, and approach the problem from contrasting directions (sexual abuse cases that involve custody disputes vs. custody disputes that involve alleged sexual abuse). An early large scale study in Oakland, California (Duryee 1993) sampled contested custody cases during two 3 month periods. It was found that the 1986 sample contained 524 cases, of which 6% included sexual abuse allegations; the 1987 sample had 861 cases with sexual abuse allegations in 5%. The largest study (Thoennes and Tjaden 1990) sampled 9,000 custody and visitation disputes in 8 different areas around the country and found that sexual abuse allegations varied with location, ranging from 1% to 8%. The authors, using estimates of the numbers of children involved in these reports, concluded that custody/visitation disputes generate approximately six times more sexual abuse allegations than the general population. Although these studies do not confirm the extremely high incidence rates and dramatic rise reported in the early (Guyer and Ash 1986) or small scale studies, they establish that child sexual abuse allegations are over-represented in custody disputes and occur in a significant number of cases.

2. Reasons Sexual Abuse Allegations May Coincide With Divorce/Custody Disputes

In a thoughtful paper, Faller (1991) reviews and categorizes the dynamics that may lead to sexual abuse allegations during or following marriage dissolution. She points out that these cases generally fall into one of four groups: 1) divorce precipitated by the discovery of abuse: approximately half of the women who discover that their husbands have sexually abused their children file for divorce, 2) long-standing sexual abuse that is only revealed during the marital

breakup and the departure of the abuser from the home, when the mother or the abused child may feel sufficient safety to reveal the abuse, 3) abuse precipitated by separation and the loss of structural constraints, which may leave a potential abuser more stressed, lonely, vulnerable, - or vengeful, and 4) false or erroneous allegations arising from misperceptions, heightened vigilance, or outright fabrication. It has also been pointed out that divorce often increases the exposure of the child to additional caretaking adults, so the risk of extrafamilial abuse or abuse by a stepparent may be increased (Thoennes and Pearson 1986).

In the majority of cases, it is the mother who makes the allegation against the father; in a much smaller proportion, the father alleges abuse by a stepfather or, in a few cases, the mother is the alleged perpetrator (Thoennes and Tjaden 1990; Faller and DeVoe 1995). Occasionally, initial allegations by one parent are countered by similar allegations by the other parent. The majority of the allegations involve sexual molestation, rather than actual intercourse (Thoennes and Pearson 1986). These divorce cases differ significantly from most cases of intrafamilial sexual abuse in intact families, in which non-abusing members – often including the mother of the abused child – are reluctant to believe that the father is a perpetrator and typically do not make the initial report or only report when given strong outside support (Faller 1991; Sirles and Lofberg 1990).

In a scenario typical of many of the more troublesome cases (Haynes 1994), a preschool aged child returns to the mother's home from a visit with the father complaining of some vague discomfort. Either spontaneously or on questioning by the mother, the child makes a statement that could be suggestive of sexual abuse, such as "daddy touched my pee-pee". The mother then takes the child to a pediatrician for examination; often, the child is taken to a child therapist for a sexual abuse evaluation as well. These professionals, as mandated reporters, will generally make a report to the DCFS hotline if they feel any ambiguity about the probability of abuse. Once a report is made, there will usually be court action to suspend visitation with the father while the allegations are investigated. If the investigation does not find sufficient substantiation for the charge, the mother, who is frequently still convinced that molestation occurred, may take the child for further sexual abuse evaluations or question the child more extensively, seeking more substantial evidence that can support her efforts to protect the child. She often refuses to resume visitations and the father may seek court action to force compliance. More allegations may be made and the parental conflict will continue to escalate. By this time, the child has generally been examined and interviewed by many adults and has directly experienced the emotional impact of these allegations, over and above the possible abuse experience itself. If no abuse is substantiated or if there is a strong difference of opinion between various evaluators, the situation may drag on for an extended period. If some resolution is eventually reached, it is frequently an all-or-nothing solution; some courts will side with the accusing parent, others convinced the accusing parent has emotionally abused the child by "coaching" the child to make false allegations, will place the child with the alleged perpetrator. In either case, deprivation occurs because the child is placed in the sole custody of one parent and allowed only very limited contact with the other parent. In addition, because children internalize parental imagos as they develop their own identity, the extreme polarization of such resolutions – which characterize one parent as all good and the other as all bad – can be emotionally damaging for the child.

3. Incidence of Erroneous Allegations

When sexual abuse allegations arise in custody disputes, the charges may seem intuitively suspicious (Myers 1990), despite the many legitimate reasons for these claims. Divorcing spouses may be desperate to retain full custody of their children and marital litigation is sometimes carried out in an atmosphere is "unadulterated venom" (Nizer 1968). Obviously, allegations of sexual abuse offer a tactical advantage in the determination of parental fitness, so they are frequently seen in this context as manipulative and vengeful. This view, captured by the old adage "hell hath no fury like a woman scorned", has been fostered by numerous media articles that report a "wave of false allegations" in custody disputes as well as books in the popular press by "falsely accused" fathers (Tong 1992; Ferguson 1988).

Child abuse investigators have long been aware that some reports of child abuse in the general population are fabricated by vengeful neighbors, family members, or manipulative teenagers (Yuille et al. 1993; Everson and Boat 1989). A few false sexual abuse reports have been attributed to Munchausen By Proxy Syndrome (Barker and Howell 1994; Meadow 1993), Delusional Disorder (Rogers 1992), or other emotional disturbances in the parent (Goodwin et al. 1979) or child (Mikkelson et al. 1992; Yates and Musty 1988). It has been estimated that 4-10% of all sexual abuse reports are knowingly false (Besharov 1988). One study found 5-7% "fictitious" allegations in their general sample (Jones and McGraw 1987). Other researchers have noted that in some cases, allegations may be true but the wrong individual is named as the perpetrator (Loveless 1989; Faller 1990).

There have only been a few, relatively limited, research studies of the outcome of sexual abuse reports in custody disputes (Thoennes and Tjaden 1990; McGraw and Smith 1992). These studies indicate that about 40-45% are "founded" or "substantiated", which is the same proportion as the general population (Besharov 1988). Of the "unfounded" allegations, a majority provide insufficient evidence to substantiate abuse but only a small number have been determined to be erroneous or "fictitious". There are few studies focussed specifically on erroneous reports in cases that involve custody disputes. Clinical studies, which generally lack scientific rigor, indicate that "fictitious" reports account for approximately 20% of these allegations (Faller 1990; Jones and Seig 1988; Faller and DeVoe 1995). One study, however, used a non-biased sample and a standard validation process designed by the Kempe Center in Denver: these researchers re-examined cases that involved custody disputes evaluated by the Boulder County (Colorado) Sexual Abuse Team and determined that 17% were "fictitious" (McGraw and Smith 1992). These studies suggest, then, that in custody disputes, erroneous reports may be as much as 2.5 - 3 times higher than in the general population.

In most studies, "fictitious" or erroneous reports include misperceptions, confused interpretations of non-sexual events, and deliberate falsifications (Mantell 1988). Several authors, noting that outright fabrications are relatively rare (Faller 1991; MacFarlane et al. 1986), and conscious of the strained communication and acrimony characteristic of many custody disputes, have suggested that the increase in "fictitious" reports reflects a disproportionate increase in parental misperceptions and misinterpretations of behavior (Myers 1990; Ackerman 1995). The accuracy of this speculation requires further evaluation; if it is correct it provides further justification for the exercise of particular care and caution in the investigation of sexual abuse allegations in custody disputes.

4. Sexual Abuse Evaluations

There is little solid research on reliable signs of sexual abuse in children that could serve to quantify investigative work. Various protocols, based on clinical experience (Yuille et al. 1993; Faller 1993; Gardner 1995; Hoorwitz 1992) have evolved in the child welfare literature, but no method can provide absolute certainty. Many of the common behavioral indicators of sexual abuse can be found in response to other stressors, such as physical abuse, emotional stress, or other trauma (Berliner and Conte 1993). In fact, the literature reflects a long-standing debate over the validity of these indicators and calls for an intensified research effort. In an effort to quantify these signs, Faller (Faller 1988) examined 3 widely accepted indicators of valid child sexual abuse: 1) the child's ability to provide idiosyncratic details of the context of the abuse; 2) child statements or behaviors that demonstrate sexual knowledge beyond that expected for the child's developmental age; and 3) evidence of an affective response by the child in recounting the abuse experience. Her study searched for evidence of these signs in 103 cases of child sexual abuse in which the perpetrator made an admission of guilt [60.2% full admission, 22.3% partial admission, 17.5% indirect admission]. She found evidence of all three signs in 68% of the cases, 15.5% had two signs, 10.7% one sign, and 6% no sign. These results, however, were weaker when age and gender were taken into consideration; boys and younger children were less likely to validate these indicators as signs of abuse. Other research has questioned some of these indicators, particularly child sexual knowledge, because research on normal child sexual development is just beginning (Friedrich et al. 1991). Furthermore, modern children are frequently exposed to sexually explicit information in the popular media (Lamb 1994). One study (Gordon et al. 1990) showed no difference in sexual knowledge between abused and nonabused children in two groups of 2-7 year olds matched for SES. In the last few years, there have been concerted efforts to develop formalized practice protocols for child sexual abuse evaluation. These protocols represent the best in clinical knowledge and are gradually becoming more uniform and consistent in application, but they have yet to be tested and validated by extensive empirical research (Conte et al. 1991; Horner and Guyer 1991a; Hall 1989). At this point, even the experts in child sexual abuse evaluation recognize that "the unanswered questions cover a much larger area than the points of consensus" among them (Lamb 1994).

Even after a thorough evaluation has been carried out, legal determination of sexual abuse often founders in an adversarial system designed to discover the truth through weighing counterposed evidentiary facts. Incidents of child sexual abuse only include physical evidence in about 15% of cases (Jones and McGraw 1987) and even this evidence is difficult to construe because it generally does not implicate a specific perpetrator. There are rarely adult witnesses to the crime and the testimony of a child victim or child witness raises issues of suggestibility and reliability of child testimony, particularly if the child is young. Frequently, the significant time delay between the initial report and testimony at trial compromises confidence in reliability.

Given the dearth of evidence, much weight is generally given to expert testimony. Qualifications of experts may vary considerably (Hall 1989; Herman 1988), however, because there is no standard uniform training or certification in child sexual abuse evaluation. Testimony is based largely on clinical impressions, so the opinions of various experts may often differ considerably (Berliner and Conte 1993). In some cases, the child's therapist may be called as an expert witness, which may compromise the neutrality of the testimony (Borgida

et al. 1989). Although in the past, experts were legally constrained from offering an opinion on the "ultimate question" (that is, whether or not the abuse had actually taken place) recent changes in the Federal Rules of Evidence – which have been adopted in Illinois through case law – now allow this. Often, there is pressure exerted on the experts by the legal system to provide an opinion on the ultimate question in sexual abuse cases (Thoennes and Pearson 1986), but APSAC guidelines (Stahl 1994) recommend considerable caution; technical manuals for psychologists warn the practitioner about the limitations of their knowledge and recommend against this practice (Hall 1989; Ackerman 1995; Melton and Limber 1989). In an interesting study (Horner et al. 1993), a small group of clinical experts on child sexual abuse were given identical case data on a child custody case that involved child sexual abuse allegations; their responses to the ultimate question ranged across the entire spectrum of possibilities.

Although it is sometimes possible to prove that sexual abuse occurred or to obtain an admission of guilt from the perpetrator, in unsubstantiated cases it can almost never be entirely ruled out (Horner et al. 1992). Societal norms (Konker 1992) favor false positive decisions over false negative decisions (Elterman and Erhenberg 1991; Horner and Guyer 1991b; Loewy 1993). That is, the danger of leaving a possibly abused child unprotected is generally viewed as much more intolerable than the harm incurred in wrongly punishing an accused perpetrator (Levy 1989).

5. Sexual Abuse Evaluations in the Context of Custody/Visitation Disputes

The biases and complexities inherent in child sexual abuse evaluations are only exacerbated when custody or visitation disputes are involved. Although it is appealing to imagine that the sexual abuse allegations could be considered quite separately from the parental dispute, it is actually impossible to avoid the intrusion of interpersonal parental issues into child protection considerations and juvenile court proceedings – or to consider the marital dispute apart from the impact of the sexual abuse allegations. Furthermore, if the allegations are unsubstantiated, suspicion often lingers on and has an insidious effect on deliberations; one parent may be seen as a potential abuser, the other may be suspected of concocting false charges. This has led one legal expert to compare sexual abuse allegations in a custody dispute to the act of throwing a skunk into the courtroom: "it may be possible to get rid of the skunk, but getting rid of the smell is almost impossible" (Loveless 1989).

This compounding of custody issues with child protection makes evaluation even more complicated. As J.E.B. Myers (1990) notes, "decision making in custody and visitation litigation is always difficult, but when allegations of sexual abuse arise the task assumes Herculean proportions". Custody is usually considered private litigation – disputes *inter partes* – carried out in domestic relations court and determined solely by the best interest of the child. When sexual abuse allegations are made, however, child protection becomes a major issue and if initial investigation warrants substantiation, the juvenile court and, in some cases the criminal court, will become involved as well. This entanglement of three court systems, which often operate in isolation from one another, can create lengthy delays in decision-making. Furthermore, because each court has its own procedures, spheres of authority, fact finding styles, and dispositional powers, judicial action may be uneven and fragmented. Standards of proof range across these systems from "a preponderance of the evidence" or "clear and convincing evidence" in various civil matters to "beyond a reasonable doubt" in criminal

court, and evidentiary rules also may vary (Myers 1990). When the standard of proof is less than "beyond a reasonable doubt" and the only evidence presented is the statement of a child, the accused parent bears a substantial risk of fact finding error (Levy 1989). Furthermore, exceptions to the hearsay rule – such as the state of mind exception, the excited utterance exception, and exceptions specific to child sexual abuse cases – are often admitted when sexual abuse allegations are made; in many cases, a significant proportion of the evidence is hearsay. In addition, special mechanisms instituted to protect child witnesses from further trauma, such as screens or videotaped evidence, may compromise the right of the accused parent to cross-examine witnesses. (Myers 1990). Thus, sexual abuse allegations tend to distort custody disputes, not only by derailing consideration of parental fitness, but also by pressing legal safeguards to the limit – some would say beyond the limit (Levy 1989) – of acceptability.

Similarly, sexual abuse evaluations are even more difficult when they are complicated by custody issues and divorce dynamics. The evaluation process itself may be compromised by the emotionally charged nature of the allegations (Gordon et al. 1990; Derdeyn et al. 1994). One study (McGraw and Smith 1992) noted that CPS investigators often approached these situations tenuously, dreading the polarization that was created by opposing factions of evaluators, psychologists and attorneys. The investigators in their study commented that they did not always scrutinize such cases as closely as they would in non-custody allegations and that they tended toward bias, prejudging such allegations as false. They also reported that they were intimidated by the legal proceedings, allowing their speculations about how the case would be handled in court to usurp their adherence to a clinical process of validation. In some cases, the investigators felt that their own personal experiences with divorce or custody battles impeded their skills in assessment and evaluation. Another study (Conte et al. 1991) surveyed child sexual abuse professionals and found that 90% of them believe custody issues could distort evaluation; 13% had experienced this first hand. The evaluative process can also be undermined when charges and countercharges lead to repeated interviews with the child (MacFarlane et al. 1986) because the evaluation relies on initial, uncontaminated information.

In both custody disputes and sexual abuse allegations, determinations tend to rely heavily on expert testimony. In divorce courts, where the determining factor is the child's best interest, there is an awareness that allowing each parent to bring in separate evaluations of parental fitness can readily degenerate into an unproductive battle of the experts. In many States, custody disputes are first mandated to mediation and, if this fails, a neutral evaluator – who is usually a psychologist or other mental health professional with extensive experience in custody evaluations – is appointed by the court. Some States have statutory specifications for the determination of best interest which can guide the evaluative process. But even when careful guidelines are followed, such as the protocols developed by the APA and by the Association of Family and Conciliation Courts (Stahl 1994), there is still the potential for a bitter court battle because there is only a limited body of research to guide decision making in custody (Johnston et al. 1989; Weithorn and Grisso 1987); this leaves the recommendations and qualifications of the neutral expert open to challenge in court. For dispositional issues heard in juvenile court, dependence on expert testimony may be heightened and, lacking the statutory structure of a best interests determination, even more vulnerable to challenge (Gallet 1989). Even though some progress has been made in defining sound evaluation procedures in child sexual abuse (Lamb 1994), this field is still in its infancy (Konker 1992) and much more research remains to be done. Experts may offer testimony on the credibility of witnesses, the

capability of witnesses, or the probability the abuse occurred. There has been considerable disagreement, reflected in case law and the writings of legal experts, about the admissibility of various kinds of testimony (Levy 1989). Since sexual abuse evaluation lacks any scientifically validated indicator tests, courts have differed on whether evidence from evaluative interviews meets the "Frye" test (Romer 1990) – that is, whether the methods used to obtain the evidence are generally accepted as reliable within the relevant scientific community (Morris 1989). Some have argued that any evidence that assists the trier of fact should be admissible (Federal Rules 702, 703) (Ceci and Bruck 1993), while others have pointed to the ambiguity inherent in much psychological evidence, particularly that derived from the use of anatomically correct dolls, as so unscientific as to be misleading – by lending an "aura of infallibility" to unproven methods – and therefore inadmissible (Federal Rule 403) (Levy 1989; Hall 1989). Furthermore, in almost all sexual abuse allegations in custody disputes, triers of fact can be confronted with contradictory testimony because experts can be found to support both sides (Ackerman 1995). Thus, the confounding of custody issues by child sexual abuse allegations pushes court processes to the cutting edge of the interdependence of law and psychology and, in so doing, arouses the tensions and uncertainties this generates (Weithorn 1987; Hoorwitz 1992).

There was a burst of clinical work in the 1985-92 period focussed on the issue of sexual abuse allegations in custody disputes. Although all these reports acknowledge the special difficulties inherent in evaluation of these cases, they diverge sharply in their evaluative protocols and in their assessment of the prevalence of "fictitious" allegations (Green 1986; Benedek and Schetky 1985; Elterman and Erhenberg 1991; Faller 1990; Cooke and Cooke 1991; Wakefield and Underwager 1988). One group of clinicians gained the majority of their experience with improbable or unsubstantiated cases, either because they frequently served as expert witnesses for accused parents, acted as court appointed evaluators for poorly substantiated cases, or were involved in some of the notorious investigations of group sexual abuse allegations in day care settings that were based on questionably obtained evidence. This group tends to see fictitious allegations as the norm, arising from vengeful motivation on the part of many accusing parents. They feel many children are "coached" or "brainwashed" by the accusing parent to make fictitious allegations. They ascribe this process, sometimes referred to as "Parental Alienation Syndrome" (Gardner 1992a), to a concerted effort by the accusing parent to discredit the other parent and remove them entirely from the life of the child. Frequently, the accusing parent is seen as "hysterical" or "paranoid" (Gardner 1994; Green 1986); the child, fearing the loss of this preferred parent, goes along with this parent's distortions, out of confused loyalty (Elterman and Erhenberg 1991). These clinicians have developed special criteria for distinguishing "false" allegations from "true" cases (Gardner 1992b; Schetky and Green 1988). For example, they assess the timing of the allegation in relation to requested changes in custody or visitation; note whether there is a "rote" quality to the child's verbalization of the event(s); judge whether the child uses sexual language more sophisticated than that usual for a child of the given age; observe whether the child appears comfortable in the presence of the accused parent; and watch for signs that the child anxiously scans the face of the nonaccusing parent for approval during a rendition of the event(s) – as well as a host of other indicators that they claim are indications of "coaching" and distinguish "false" allegations from "true" ones. Gardner (1989) has developed extensive lists of these indicators for each parent and child involved in an allegation, believing that a case that presents a substantial number of these indicators, as interpreted by the clinician, can generate sufficient

evidence to prove or disprove the allegation. These indicator lists have not been validated by any standard evaluative measure. The opposing group of clinicians, on the other hand, views false allegations as exceedingly rare (Faller 1991; MacFarlane et al. 1986). These clinicians are generally child sexual abuse experts who have pioneered the development of careful evaluative techniques and have long advocated the importance of taking sexual abuse allegations seriously. Their clinical samples, taken from cases referred to sexual abuse evaluation centers, have generally been previously screened to exclude false or dubious cases (Faller 1990). Typically, these clinicians refute the unitary meaning attached to the indicators by the first group and show that any behavior may have a variety of meanings, including a meaning exactly opposite the one given by the first group (Corwin et al. 1987; Berliner and Conte 1993). For example, they demonstrate many valid reasons that sexual abuse allegations may coincide in time with custody proceedings; point to "rote" or affectless recitation as common in repeated retelling or dissociative processes; attribute the awareness of some sexually sophisticated information to the current access of children to sexually explicit media; and consider it quite appropriate for children to turn to parents for approval and support in anxiety-provoking situations, such as an evaluation for sexual abuse. These clinicians point to the lack of experimental validation for the interpretations assigned to these signs by the first group and express concern that they may be used by poorly trained professionals as a base for recommendations in legal action (Hanson 1988). They have been particularly critical of the practice, espoused by the first group, of directly assessing the relationship between the child and the accused parent (Derdeyn et al. 1994; Gardner 1992b) because they feel this may further traumatize the child, undermine the child's trust in the evaluator (Faller et al. 1991), and provides little useful information. While the first group argues that it is better to proceed with unvalidated protocols than to flounder in ambiguity (Gardner 1995), the second group stresses proceeding with greater caution in these cases while increasing efforts to study these issues in more scientifically validatable ways (Faller 1990; Corwin et al. 1987).

This strong division in the clinical literature probably reflects both the effects of selection bias and the unusually high pressure for a definitive true/false determination of sexual abuse allegations involving child custody. Interestingly, it parallels the polarization presented by the marital dispute as well as the separation between the courts. For example, interviewing the child with each parent is standard in custody determinations but is seen as meaningless or detrimental in sexual abuse evaluations when one parent is an accused perpetrator. Such dichotomies tend to reinforce extreme positions and obscure the commonalities between them. There are, however, at least some areas of consensus between these groups of clinicians. Both groups recognize the complexity of the evaluative process in these cases and agree that they require a different approach from allegations arising in intact families. There is also agreement that the interpersonal dynamics in these cases make misperceptions more likely (MacFarlane et al. 1986; Schetky and Green 1988). It is also widely accepted that the allegations in custody dispute cases involve younger children. One study (Faller 1990) found the mean age at evaluation for a sample of children sexually abused by a non-custodial father was 5.4 years, while it was 8.7 years for biological fathers in intact families and 9.9 years for stepfathers. Another study (Paradise et al. 1988) indicated that children in disputed custody cases were on the average younger (5.4 years) than in other biological parent cases (7.8 years).

6. Child Suggestibility

Much of the controversy over evaluation of sexual abuse allegations in custody disputes is related to views on child suggestibility. All clinicians are aware that the dynamics of custody disputes can have an emotional influence on children, particularly young children, but assertions that children make false claims because they are "brainwashed" or "coached" must be evaluated carefully. In the past few years, research efforts have addressed children's ability to distinguish truth from falsehood, the reliability of children's memories, and the vulnerability of children to suggestive influence (Goodman and Bottoms 1993). Much research has also examined the use of anatomically correct dolls in sexual abuse evaluations and whether they foster, hinder, or confuse the process (Boat and Everson 1993). It has been hoped that these investigations would provide evaluative clarity, particularly in situations that might involve leading or suggestion by child therapists or other adults who might question the child and would also provide information about the credibility of child witnesses.

These studies have shown that earlier formulations, such as "children never lie about sexual abuse" and "young children can not distinguish fact from fantasy" are considerably oversimplified (Johnson and Howell 1993). But these efforts have failed to definitively establish the boundary conditions for children's suggestibility, even with the relatively sophisticated methodologies and realistic conditions employed by these studies. In a careful and thorough review of this literature, Ceci and Bruck (1993) contrast research evidence that children are particularly vulnerable to suggestion with opposing research evidence of children's ability to resist suggestions and to give accurate testimony. They cite 5 representative studies in support of each position, illustrating the features of these studies that make comparison of results difficult, such as mixed results within studies and variabilities in methodology that "demonstrate interpretive problems on both sides of the debate". In an effort to disambiguate these suggestibility findings, they cite other research studies on related cognitive, social, and biological factors. They note, for example, that 83% of developmental studies demonstrate that preschoolers are the most suggestible group. Although their synthesis of results from these various fields of inquiry can only be considered plausible conjectures at this point, they conclude that there is now overwhelming research support for the view that "there are significant age differences in suggestibility, with pre-school children being disproportionately more vulnerable than either school-aged children or adults." This review also examines the impact of social factors on suggestibility and the frequency with which children make errors of commission. A number of studies show that leading or misleading questions can influence children to make false claims about central events, even events that could be suggestive of sexual abuse (Lepore and Sesco 1994). For example, in an anatomically correct doll study, 3-5 year olds gave inaccurate answers to the question "did he touch your private parts" 32% and 24% of the time, respectively (Goodman and Aman 1990). Repeated questioning about central events also reliably affected the suggestibility of young children; in one study, 42% altered their response with repeated questioning (Cassel and Bjorklund 1992). Another major conclusion of Ceci and Bruck's review is that social factors also affect truthfulness. Studies have established that children have been shown to lie consistently when the motivational structure favors lying – to avoid of punishment, protect a loved person, or avoid embarrassment (Ceci and Bruck 1993). For example, when fifty 3 and 5 year olds observed their mother accidently breaking a Barbie doll and hiding the pieces, only one told a neutral interviewer what had happened. In fact. even when asked specific and even leading questions, none of the 5 year olds revealed the

secret (Bottoms et al. 1990).

These conclusions, however, simply illustrate the potential for suggestibility or lying, particularly by younger children, under certain circumstances. An awareness of suggestibility should not undermine the reality of traumatic events (Bolker 1995). Ceci and Bruck (1993) recognize that despite the capacity for suggestion, "children – even pre-schoolers – are capable of recalling much that is forensically relevant". It is certainly clear from these studies that considerable care must be taken in evaluating and interviewing child victims and witnesses to avoid possible contamination of their testimony, especially young children (Klajner-Diamond et al. 1987). But even though this research helps inform the evaluative process in child sexual abuse allegations, it only bears tangentially on the issues specific to the context of a child custody dispute and the dynamics of divorce.

When divorce involves young children, loss, separation, and oedipal issues may be intensified for the child (Thoennes and Pearson 1986; Faller 1991). In this "oedipal phase", children become more conscious of physical and sex role differences between the sexes and may become preoccupied with these concerns, asking many questions, increasing masturbatory activity, or behaving in a coy or petulant manner with the parent of the opposite sex (MacFarlane et al. 1986; Friedrich et al. 1991). Thus, some children will sexualize non-sexual activity or behave seductively, particularly in response to the stress of loss (Jenny and Roesler 1993). Furthermore, children whose parents have divorced and taken new partners are more aware of sexual expression between adults than children in intact families (Thoennes and Pearson 1986). Parental availability may diminish – in some cases because mothers who were at home are forced to work, but also because the powerful impact of the marital separation may cause the parent to withdraw emotionally, eroding parental functioning (Ackerman 1995). Some parents, particularly following a bitter breakup, may have little difficulty imagining that their former spouse is capable of anything, including sexual abuse (Faller 1990). For a few parents, the acrimony of the custody dispute may actually serve as a mechanism for retaining the tie to their former spouse (Wallerstein and Blakeslee 1989), particularly when the marital relationship was characterized by high levels of hostility over dependency issues.

Although these dynamics can enhance the vulnerability of a child to sexual abuse at the time of a divorce or custody dispute, they can also contribute a powerful component to suggestibility. Brown (1995) has pointed out that outside of Ceci's work, research on suggestibility that considers the impact of both cognitive and social factors has been largely limited to forensic settings. Brown reviews the literature on "interrogatory suggestibility" and distinguishes the interpersonal pressure brought to bear in interrogatory suggestion from simple post event misinformation or personal vulnerability to hypnotizeability. Citing Gudjohnsson's studies of the impact of interrogatory suggestibility on confession rates in forensic settings (Gudjohnsson 1992), he lists the major elements of interrogatory suggestibility:

- a questioning procedure within a closed social interaction
- interrogation within the context of interpersonal trust
- questions focused primarily on past experiences, events, or recollections
- questioning within a context of considerable uncertainty about what actually happened
- an interviewer who has high expectations that the interview should provide definite answers and often has clearly biases hypotheses about what happened

- the interview takes place in the context of high stress
- the interrogatory style uses systematic leading and sometimes intentionally misleading questions
- there is strong positive or negative emotional feedback, like praise or blame for the answers given.

Care must be taken in extrapolating research results to actual situations. It is important to note, however, that all the elements of interrogatory suggestion may be present when, in the context of an acrimonious custody dispute, a child is questioned by an anxious parent who has observed child behaviors or verbalizations, such as bedwetting, masturbation, nightmares, or reluctance at visitations with the ex-spouse, that may suggest the possibility of abuse to the parent. Rather than "coaching", a malicious implantation of "false" beliefs, or outright lying, the child is more likely to be subject to interrogatory suggestion. Particularly when the questioning is repeated and includes suggestive or leading questions, the child and the interrogating parent may develop misinformed conceptions that construe relatively innocuous actions as sexual behavior or, more rarely, to imagine actions that did not occur (Faller 1991; MacFarlane et al. 1986). Interrogatory suggestion, as opposed to a bizarre "folie-a-deux", offers a reasonable explanation for this phenomenon, particularly because it is supported by current research. It is tempting to ascribe the excess erroneous claims of child sexual abuse in custody disputes to misperceptions of this kind. This interpretation is appealing both because it provides a sensible rationale for these misperceptions and because it avoids the polarization implicit in labeling the accusing parent "hysterical", "paranoid", or "malicious". It also normalizes the intense convictions of the accusing parent in pursuing protection for the child. At the same time, it emphasizes the difficulties inherent in evaluation of a child who already may have been subject to leading questions and misleading information in a powerful social context – even before the allegations were reported. Brown (1995) has associated interrogatory suggestion with iatrogenically produced pseudomemories of childhood trauma in adult therapy. His warning in those cases must also be heeded in this situation: the evaluator must recognize the associated risk of harm to the child of premature conclusions, proceeding with great care and a willingness to tolerate ambiguity (Cornell 1995).

7. Balancing Child Protection with Parental Rights

When child sexual abuse allegations arise there is an overriding concern with child protection. Although lip service has been given to the importance of maintaining the relationship between the child and the accused parent when allegations are brought during a custody dispute, many accused parents are barred from contact with their children for extended periods. Traditionally, court interference in the postdivorce parent-child relationship has only been limited for grave cause (Levy 1989). It is well established that children suffer when denied contact with either parent (Ruman and Lamm 1985); for example, lack of contact with the father has been linked to cognitive and learning deficits in boys (Johnston et al. 1989; Wallerstein and Blakeslee 1989). Lack of contact with a parent can also increase the trauma of the divorce because children often blame themselves for the separation and become even more fearful of losing the remaining parent (Gordon 1985). If the accused parent is cleared, the

months or years covered by the proceedings may disrupt the relationship so severely that it is irreparably damaged (Ackerman 1995; Elterman and Erhenberg 1991; Charlow 1987). If the charges are suspicious but unsubstantiated, there is currently no mechanism to rehabilitate the parent-child relationship with sufficient safeguards to support child protection. Even when the charges are substantiated, it is "rarely in the child's best interest to totally sever contact with the abusive parent" (Faller 1990). As Faller points out, unless the abusive parent is extremely dangerous or contact is highly traumatic for the child, the relationship should be preserved because: 1) there may be many other aspects of the relationship that are positive; 2) continued contact will help the child work through feelings about the sexual abuse as well as the divorce; and 3) access will encourage a realistic view of the parent. When visitation is arranged, however, it is often carried out under very strained conditions that may serve to perpetuate parental conflict and miscommunication. This is unfortunate because, as Wallerstein's extensive research with divorced families has shown, it is sustained parental conflict, rather than limitations on the amount and time of parental contact, that creates the most severe problems for the child (Wallerstein and Blakeslee 1989).

8. Current State of Affairs: The Need for a New Agenda

Although serious concern has been raised about these cases for many years, custody disputes complicated by child sexual abuse allegations have continued to create problems within the systems designed to resolve them. Typically, they consume an inordinate amount of time and energy and, through a kind of ripple effect, involve numerous professionals and governmental agencies, as parents pursue their concerns through the courts. Charges may generate counter charges; accusing parents may withhold visitation and accused parents may then seek contempt citations. A child may disclose to a succession of professionals, so even unsubstantiated allegations may be followed by further allegations; without any mechanism to force closure, the process may extend for many years. Some parents, fearing they will not find the justice they seek, may even disappear into the "underground railroad" (Fahn 1991)).

The system for resolution of these cases is also cumbersome, labor intensive, and costly. In one representative Illinois case, Mullins v. Mullins (1986), the initial trial required 13 days of hearings and produced 1000 pages of testimony. The decision was then appealed, creating even more work for the courts and the professionals involved in the case.

Our current system for handling sexual abuse allegations in child custody disputes has been termed "woefully inadequate" (Wallerstein and Blakeslee 1989). Unfortunately, systems designed for child protection are distorted by custody dynamics and courts established to resolve marital disputes are confounded when sexual abuse allegations arise (Dobrish 1989). Although almost half of these cases involve substantiated abuse, the remainder fall into a grey area with various degrees of suspicion or probability because it is generally impossible to prove unquestionably that abuse did not occur. There is no mechanism within the current court system to tolerate the ambiguity intrinsic to these situations. Some courts, probably in response to the frustration of handling repeated unsubstantiated allegations, have moved to award full custody to the accused parent (Mullins v. Mullins). A number of states have legislated a punitive fine against parents who bring repeated "fictitious" allegations (Loewy 1993), seeing these parents as malicious and abusive in their own right. In fact, Faller and DeVoe (1995) have recently noted the punitiveness frequently directed at accusing parents. In

their sample. 13.6% of accusing parents received sanctions ranging in severity from jailing to prohibition from making further hotline reports. This alarmingly high proportion of sanctioned cases is even more troubling because they tended to be cases in which abuse was deemed "likely" rather than those with apparently false accusations.

In all of this, it is the child who suffers the most harm. Systems designed to protect the child and determine the child's best interest only compound the damage that has already been done. The fragmented and adversarial nature of the response only sustains – and may even intensify – the parental dispute. At the same time, a narrow preoccupation with true/false determinations precludes exploration of the dynamic issues that underlie these situations. It is essential that a new mechanism be developed for child sexual abuse allegations in the context of custody disputes that can hold harm to the child to the absolute minimum, work to reduce parental dysfunction and conflict, and resolve issues of child protection fairly, carefully, and as quickly as possible (Gallet 1989).

Conclusion

These recommendations represent a radical change. The complexities associated with sexual abuse allegations that arise in the context of disputed custody have been recognized for many years but they have remained a thorny and intractable problem. A single case can involve a large number of professionals, many days of court testimony, and an immense amount of paperwork. Legislators, governmental agencies, and community activists may be drawn into the action. This occurs because the current system can not function effectively in both realms - child protection and marital disputes -simultaneously; instead, progress on both fronts is impeded. Children who are subject to sexual abuse or sexual abuse allegations in the midst of a custody dispute are already experiencing serious family dysfunction (Bresee et al. 1986). It is a tragedy that the systems designed to help them are dysfunctional as well. Surely the time has come to confront the underlying causes of this dysfunction, even though firmly established institutional structures and cherished assumptions may be challenged. The construction of a system that can respond effectively and fairly will require a real collaborative effort, system-wide commitment, and the courage to build new structures in the face of considerable ambiguity - but the children in these difficult situations deserve no less.

Joan M. Palmer, LCSW, BCD
October 24, 1995

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APPENDIX VII

Investigative Report (teaching tool)

Department of Children and Family Services
2240 West Ogden Avenue
Chicago, Illinois 60612
(312) 433-3000

Office of the Inspector General

This report is being released by the OIG for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, all identifying information has been changed. All names are fictitious.

FILE NO.: 960,020
MINOR: John Reeves
DATE: 5/15/96

SUMMARY OF COMPLAINT

The Office of the Inspector General investigated the death of John Reeves (DOB 9/12/95) which occurred on 12/11/95. The medical examiner's autopsy report concluded that the minor died of starvation due to parental neglect. At the time, John's mother, K. Reeves, had an open intact family case with DCFS, which was being serviced by Alpha Family Care.

SUMMARY OF INVESTIGATION

The OIG interviewed the following individuals: J Red (Alpha Family Care intact family caseworker); L Brown (Alpha Family Care intact family caseworker); R Green (Alpha Family Care intact family supervisor); G. Danner (former Alpha Family Care intact family supervisor); B Strong (Alpha Family Care Division Director); T Walter (DCFS monitor); K White (DCFS monitor); Barbara Loy (DCFS supervisor); W Ray (DCP investigator); D Shaw (DCP investigator); C Klein (Loyola SIDS research project); Dr. J Jones (medical examiner); Lauren Reeves (sister of John Reeves); R Stewart (Executive Director, Beta Center); W James (Unit Supervisor, Beta Center); J Laker (counselor, Beta Center); and R Ross (DASA).

The OIG reviewed the following documents: Alpha Family Care's case file; R Green's supervisory notes and correspondence; employment records for Colleen Star, J Red and R Green; Alpha Family Care's contract with DCFS; DCFS monitor file; DCP file; Beta Center treatment records for K. Reeves; medical examiner's autopsy report; medical records for K. Reeves, and minors Aisha and John; school records for minor Lauren; Cross Family Center drug drop records; General Hospital abuse/neglect evaluation records for minors Lauren, Adam, Beth, Nina, Aisha, and nephew Kevin Smith; and the DCFS memo to Alpha Family Care regarding service delivery and case audit.

BACKGROUND

John Reeves (DOB 9/12/95) was the youngest of six children born to K. Reeves (age 32). The other children in the family at the time of John's death were Lauren Reeves (age 17), Adam Reeves (age 13), Beth Reeves (age 8), Nina Blackmon (age 4), and Aisha Reeves (age 3). Lauren's son, Kevin Smith (age 2), resided with his mother in the Reeves household. Lauren is currently pregnant and expecting her second child in June 1996.

John Reeves' death was the fifth report of abuse/neglect involving this family. The Reeves family first came to the attention of DCFS on 6/3/93. This A sequence case alleging environmental neglect (house was filthy, piles of clothes and food on floor) was unfounded. The B sequence does not appear on the SCR report, so it is believed that this report was unfounded as well and the allegations are not known.

A numbering error was made on the D sequence, which was not noticed until after the C sequence was assigned. The indicated D sequence report was made on 3/6/94, when Aisha Reeves was born exposed to cocaine and syphilis. Aisha weighed 5 lbs. 2ozs. at birth which placed her in the small birth weight category. According to the DCP investigation completed by G Wright, K. Reeves denied having a drug problem. She explained that she had been offered something to smoke and was unaware that it contained cocaine. The General Hospital social worker, A Lopson, had expressed concerns about releasing the baby due to the mother's lack of cooperation. Ms. Reeves had refused treatment for her syphilis and had not met with the hospital social worker as requested. Aisha had received treatment for her exposure to syphilis immediately after birth. On 3/16/94 the DCP investigator observed Ms. Reeves and her older children in their home. She described the home condition as fair and stated that the children were appropriately dressed and displayed no outward signs of abuse or neglect. In addition, the investigator noted the presence of clothing for the infant. With regards to the syphilis, the DCP investigation indicates that Ms. Reeves received treatment. However, there is no medical report in the DCFS file to confirm this information (a review of the General Hospital medical record has failed to confirm that Ms. Reeves did receive treatment). The DCP report states that Ms. Reeves was given information on drug rehabilitation, after which the DCP investigator, Ms. Wright, concluded that the case should be indicated and then closed, as no services were needed. However, services were needed as evident by Ms. Reeves' serial pregnancies, contraction of a sexually transmitted disease, and denial of drug use, all of which support the possibility that Ms. Reeves' life was out of control due to drug abuse.

On 8/26/94 another hotline report was made alleging environmental neglect. Present in the home at the time of the report were K. Reeves and her children, Lauren, Adam, Beth, Nina and Aisha. This report was assigned a C sequence due to the numbering error. The DCP investigation was initially conducted by D Quinn. She observed dirty dishes in the sink., clothing all over the floor, and rotten food in the refrigerator. The investigator did observe sufficient food in the house for the children, as well as formula and WIC coupons for the baby. Ms. Quinn reported that the children appeared healthy and no outward signs of abuse or neglect were observed. Ms. Reeves reported that her gas was turned off and the family was using electric burners for cooking. Ms. Reeves reported to the investigator that the home would be cleaned immediately.

On 9/19/94, the case was reassigned to C Kelsh to complete the DCP investigation. On 9/30/94 Ms. Kelsh visited the Reeves home. She reported that the house was dirty with trash strewn in the mother's room. Ms. Kelsh noted that the children were dirty and that Nina was not appropriately dressed. Although housekeeping standards were poor, the investigator observed adequate amounts of food in the home. On 11/1/94, Ms. Kelsh indicated the case for environmental neglect and inadequate clothing for Nina. In her report, Ms. Kelsh stated that "the mother seems overwhelmed by the small living environment and so many people." In light of the conditions observed in the home, Ms. Kelsh concluded that Ms. Reeves was in need of DCFS services. She stated that, in particular, Ms. Reeves was in need of homemaker services and parental stress classes. The investigator also recommended a drug assessment/evaluation. Ms. Kelsh's assessment of this situation is to be commended as she recognized and accurately identified the precipitating problem and service needs.

Alpha Family Care Involvement with the Reeves Case

Alpha Family Care's contract with DCFS states that "Intact Family Services are full-case-responsibility casework services" requiring a "minimum of two face-to-face contacts per month" with each family. According to the contract, casework responsibilities are specified as follows:

> The worker's responsibilities include a direct counseling role; a parenting training role with individual parents; an advocacy role with other governmental, medical and community systems; a risk monitoring/management role; and the responsibility to manage and coordinate supportive services. A normal constellation of supportive services includes therapy as needed, teaching homemaker service when needed, formal parenting training classes, protective day care when needed, and access and linkage to substance abuse treatment services (p. 6).

With regards to drug treatment, the contract states:

> Intact Family Service providers shall establish a referral mechanism with one or more of these [DASA] programs and formalize it in a letter to be attached to the contract. Providers hereby notified that, in every such referral, it is critical to advise the DASA-funded provider in writing that the person being referred is a DCFS client.

Colleen Star's Casework.

The Reeves family was referred to Alpha Family Care for intact family services on 11/16/94. On 11-21-94, Alpha Family Care caseworker Colleen Star was assigned to provide services to the Reeves family. Ms. Star received a bachelor in social work in 1994 from Valparaiso University in Indiana. Her position at Alpha Family Care was her first social service job after graduating.

Ms. Star completed a service plan on 12/16/94, which was not signed by a supervisor until 3/2/95. Ms. Star specified four service needs, three of which had been already identified by the DCP investigator. The recommended services were: drug evaluation and treatment for K. Reeves, parent skills training, homemaker services, and a 0-3 program for Aisha. Ms. Star also completed a social history on 12/16/94 which documented the need for services in these four areas. The social history also noted that the home was in terrible condition (dirty dishes in the sink.; food on the counters, table and floors; piles of clothes and garbage in every room; dilapidated furniture; roaches all over the walls and floors), and that the children were often dirty and only partially dressed. Ms. Star wrote that K. Reeves was "easily overwhelmed," and "needs a great deal of support and aid in following through on tasks and services." She also documented that Ms. Reeves' drug usage had increased since the death of her mother approximately four years earlier.

Colleen Star provided services to the Reeves family from 11/21/94 until 5/11/95. During this period she did fulfill her requirement to visit the family at least two times per month. However, there was little progress made on the four service needs listed in the service plan. Between 12/94 and 2/95, Colleen Star scheduled three drug drops for K. Reeves. However, Ms. Reeves was notified of possible dates for each drop, which made the drug drops planned rather than random. Ms. Reeves rescheduled her first drop, missed her second, and completed a drop on 2/1/95, when Ms. Star provided transportation to the appointment. This drop was positive for cocaine, and prior to providing the urine sample, K. Reeves told Colleen Star that it would be positive. The record indicates that Ms. Reeves told the worker that she wanted to enter drug treatment. Ms. Star responded to this request by providing Ms. Reeves with a list of drug treatment programs and instructing her to call and initiate services. Ms. Star's response in this situation appears to be the standard operating procedure, as Mr. Red told the OIG in an interview that he had also provided Ms. Reeves with a list of drug treatment programs. Ms. Star chose this approach even though this was a client whom she acknowledged needed support in obtaining services. Moreover, Ms. Star was aware that Ms. Reeves had no phone, which would have made any attempts to initiate a self-referral to drug treatment difficult, if not impossible. Ms. Star provided K. Reeves with additional referral sheets on later dates, but the record does not indicate that she recognized the vital need for a proactive approach to engage her client in substance abuse treatment. According to G. Danner, Ms. Star's supervisor at Alpha Family Care, Ms. Star needed to develop a knowledge of substance abuse issues. This was noted in Ms. Star's 9/6/94 performance evaluation, and it was agreed that she would attend the next available DCFS training on substance abuse. There is no documentation that Ms. Star ever enrolled in or attended this training.

K. Reeves was referred to Alpha Family Care's parenting program on 12/1/94. Although transportation was provided, Ms. Reeves was dropped from the program in late January 1995 for

missing two classes. Ms. Reeves began parenting classes with Alpha Family Care again on 3/14/95. She attended only two out of eight sessions and was dropped from the parenting program a second time. After Ms. Reeves' second failure to complete this task, Colleen Star did not explore why Ms. Reeves was not complying with the service plan, and there was no discussion of court intervention due to her inaction.

As noted above, Ms. Star made a recommendation for 0-3 services for Aisha. There is not documentation in the record which specifies Ms. Star's rationale for recommending the service, such as specific developmental delays or effects from drug exposure. However, a later evaluation completed by the General Hospital Under the Rainbow Program determined that this service was warranted. Ms. Star referred Aisha to the University of Illinois Early Childhood Research and Intervention Program. The case file indicates that Ms. Star scheduled three intake appointments in February, March and April 1995 for Aisha, but Ms. Reeves did not follow through. Ms. Star's record does not reflect any assistance in arranging transportation to completed the assessment, even though Ms. Reeves had a pattern of not complying with referrals.

Lastly, Ms. Star recommended homemaker services for Ms. Reeves. The DCP report, which Ms. Star had in her files, emphasized the importance of this service to "teach mom how to clean, keep a clean home and how to organize a daily work as well as a schedule for the kids." However, the record does not show whether this service is ever discussed with Ms. Reeves and Ms. Star never provided homemaker services while she was responsible for the case.

It appears that Ms. Star told Ms. Reeves that she needed to make progress on the aforementioned services, but Ms. Star did not establish any consequences for noncompliance. When Ms. Star left Alpha Family Care on 5/11/95, K. Reeves was approximately five months pregnant with John. This information does not appear in Ms. Star's case notes, so it is possible that she was not aware of Ms. Reeves' pregnancy.

J Red's Casework

The Reeves case was transferred to J Red on 5/12/95 when Ms. Star left Alpha Family Care. Mr. Red holds a bachelor of arts degree in independent studies from Chicago State University and is currently pursuing a masters of science in education, school guidance and counseling also at Chicago State University. Prior to joining CFC in April 1995, Mr. Red was employed at Newlife as a Family Counselor for 3 ½ years and prior to that was an Income Maintenance Specialist with the Department of Public Aid for 1 ½ years. Mr. Red completed DCFS Core Training during his employment with Newlife in June 1993, and completed the Risk Assessment Program while at CFC. In an interview with the OIG, Mr. Red reported that during the time he had the Reeves case his caseload consisted of 16-17 cases, which was larger than other workers'. Mr. Red indicated that the reason for this was to allow other workers to complete DCFS Core Training.

Between 5/95 and 12/95, Mr. Red had, at the most, four in-person contacts with Ms. Reeves and, in addition, up to seven in-person contacts with some of the Reeves children (the case record contains

contradictory records of home visits). There were an additional sixteen unscheduled attempted home visit during this period, nine of which took place between 3:00 p.m. and 5:00 p.m. at the end of the work day. The record notes that from 10/4/95 until John's death on 12/11/95, Mr. Red had no in-person contact with Ms. Reeves.

The DCFS Intact Family Program contract with Alpha Family Care requires "discussions and completion of (a) service plan every six months." According to the record, Mr. Red did not complete a review of the initial service plan, which had been developed by Ms. Star on 12/16/94, in May 1995 as required. Mr. Red completed this review on 1/11/96, seven months late and one month after John's death.

During the time he was assigned to the case, J Red never implemented the four services identified in Colleen Star's transfer summary. Ms. Reeves did not attend any further parenting classes and Aisha did not enter a 0-3 program. During his interview with the OIG, Mr. Red's explanation for why he did not make a 0-3 program referral was that he "didn't get around to it." However, he acknowledged that Aisha was extremely short and overweight and that this service was important. After John's death all of the Reeves children received evaluations at General Hospital's Under the Rainbow program. Aisha's medical evaluation, which was performed when she was 21 months old, determined that she was below the fifth percentile in height and in the 50th percentile in weight. Her bone age was that of a nine month old infant. A speech and language evaluation determined that she was at risk for delay in language development, and was diagnosed with Expressive Language Disorder. In addition, Denver II Developmental Assessment determined that Aisha had Developmental Coordination Disorder.

During this period, Aisha's sibling, Nina, would have also been eligible for a 0-3 program, but neither caseworker pursued early intervention services for her. Her Under the Rainbow evaluation determined that she was in the fifth percentile in both height and weight. She was diagnosed with having an Adjustment Disorder with Anxiety and minimal Receptive Language Disorder. General Hospital recommended that she be evaluated for Attention Deficit/Hyperactivity Disorder in three months if her over activity continued. It was also recommended that Nina's height and weight be monitored every three months in order to rule out risk for Failure to Thrive.

J Red stated that parenting classes and homemaker services were irrelevant until the drug abuse was addressed. Although this was an appropriate prioritization of services, he acknowledged that he did not actively assist Ms. Reeves in obtaining drug treatment. In an interview with the OIG, Mr. Red stated that "drug addicts know how to get into drug treatment." Mr. Red discussed drug treatment with K. Reeves, but, like his predecessor, he only provided referral listings to the client. During a home visit on 6/14/95, Mr. Red did suggest that Ms. Reeves identify a relative to care for the children so that she could enter treatment. However, he did not actively arrange a care plan for the children and according to the record he never again discussed this intervention with Ms. Reeves. In his recording of the 6/14/95 home visit, Mr. Red wrote that "the worker does not consider that the kids being at immediate risk but the conditions had to change as soon as possible before their [sic] would be a risky situation." Although Mr. Red documented his concerns of potential risk to

the children, his next face to face contact with Ms. Reeves occurred four months later on 10/4/95 approximately 3 ½ weeks after John's birth.

According to records obtained from General Hospital by the OIG, K. Reeves attempted to get drug treatment on her own in May 1995. On 5/8/95, Ms. Reeves went to General Hospital Birthing Center. At the time of her appointment, she was 20 ½ weeks pregnant, and she admitted to recently using cocaine. Ms. Reeves was concerned that her unborn child's activity had diminished and feared that her drug use was harming the child. The birthing center referred her to the General Hospital Fresh Start Program, and Ms. Reeves went for an intake appointment that same day. However, she did not attend any subsequent appointments with this program.

On 8/24/95, K. Reeves, who was 8 ½ months pregnant with John, went to General Hospital Birthing Center due to pre-labor pains. General Hospital, after determining that she was not in labor but had cocaine in her system, referred her to Beta Center. Her admission to Beta Center that same day occurred approximately eight months after Alpha Family Care identified the need for her to undergo a drug assessment. Ms. Reeves delivered a drug-free baby fourteen days later due to the intervention of General Hospital and Beta Center.

Because of his infrequent home visits, Mr. Red was not aware that Ms. Reeves had entered drug treatment. When he visited the home on 9/5/95 expecting to see Ms. Reeves, he was informed by Lauren that Ms. Reeves was in an in-patient program. The case file does not indicate that Mr. Red investigated the care plan for Ms. Reeves' four other children while she was in treatment. During his interview with the OIG, Mr. Red stated that he attempted to contact K. Reeves at Beta Center to find out what kind of treatment she was receiving, but that Beta Center staff would not allow him to speak with his client. Beta Center records do not indicate that Mr. Red ever attempted to contact K. Reeves nor inquire about her progress during her 2 weeks of treatment. Mr. Red stated that he never spoke to or visited Ms. Reeves while she was in treatment, nor did he inquire about the continuation of drug treatment services for K. Reeves after the birth of her child.

During his interview with the OIG, Mr. Red stated that he was not aware of Ms. Reeves' pregnancy until early August 1995, when he was told by Lauren Reeves. Mr. Red acknowledged that this conversation was not documented in the case file. Although Ms. Reeves delivered John on 9/12/95, Mr. Red did not learn of John's birth until 10/4/95, when he visited the home intending to check on Lauren (he stated that he assumed that K. Reeves was still in drug treatment). This brief visit was Mr. Red's only contact with John before his death. K. Reeves was home with John, and Mr. Red's notes from that visit state that the baby looked small but in good health. During his interview, J Red stated that he was not "trained enough" to know that John might have been sick. He stated that the other children did not appear malnourished and assumed that Ms. Reeves was drug-free. He did not determine whether or not Ms. Reeves had successfully completed drug treatment at Beta Center nor whether she was receiving any aftercare services. Mr. Red acknowledged that he did not ensure that John was receiving proper nutrition or medical care. During an interview with OIG, Mr. Red stated that on 10/4/95 he thought the home looked one hundred percent better than before and that Living standards were acceptable. However, he also acknowledged that the condition of the home was

previously deplorable bringing into question if a one hundred percent improvement could result in acceptable living standards. Mr. Red's last description of the condition of the Reeves' home was inconsistent with the findings of the DCP investigator W Ray, who reported to the OIG that during his investigation of John's death on 12/14/96, the home was in terrible condition (he reported that he had never seen so many dirty clothes during his 11 years with DCFS), and that the home appeared to have been that way for some time.

There were six weeks between Mr. Red's discovery that John was born and his next home visit. On 11/21/95, he dropped off a Thanksgiving food basket, but was in a hurry and did not enter the home nor carefully observe the children. This was Mr. Red's last contact with the Reeves family prior to John's death.

During the seven months that J Red provided services to the Reeves family, he never screened the case into court for removal of the children, despite Ms. Reeves' failure to comply with service requirements. When asked in an interview with the OIG why he never screened the case, Mr. Red replied, "The name of the program is Intact Family." He explained that the goal is to keep the family intact whenever possible, unless the children are at risk, and that parents are given time to make progress. Mr. Red told the OIG that he has never screened a case into court and that he only knows of only one Alpha Family Care worker who had attempted to screen a case. He again explained that the goal of Intact Family Services is to keep families intact, suggesting that Intact Family Service workers do not screen cases in due to the nature of the Intact Family program. The Intact Family Service contract with CFC supports Mr. Red's interpretation since a stated service goal is "to maintain 86% of families intact throughout the service period," and a process goal is "concluding service to at least 50% of families within 12 months, with a recommendation of case closure to the Department." The contract also stipulates that the "average length of service will at all times remain at or below 12 months."

Although none of the needed services had been completed and the 12/16/94 service plan had not been reviewed, J Red recommended case closure in September 1995 since the case was approaching the contract goal of an average of 12 months of service. According to Mr. Red's supervisor, R Green, Mr. Red never produced the necessary documentation which would have enabled Mr. Green to evaluated Mr. Red's recommendation for closure.

Supervision Problems Within Alpha Family Care

G. Danner supervised the Intact Family Service Program at CFC from 1989 until 3/1/95. B Strong was hired as the Austin division director for AFC in February 1995. During the one month that Ms. Danner's and Ms. Strong's employment with AFC overlapped, Ms. Danner attempted to familiarize the new division director with the workings of the Intact Family Program. Ms. Danner's position was filled by Glen Edwards, who remained at AFC for a brief period of time. R Green was hired to replace Mr. Edwards on 6/19/95 as the coordinator of the Intact Family Services Program. Mr. Red was supervised by R Green during the six months prior to John's death. Mr. Green holds a masters degree in public administration from Roosevelt University. According to his employment records, Mr. Green had six years of supervisory experience in his previous job at DePaul Center.

In his last position at DePaul Center, Mr. Green was the assistant director. In that position he was responsible for program development as well as supervision of program coordinators providing services to developmentally disabled adults placed in residential facilities. Prior to his employment at AFC, Mr. Green had no experience in the field of child welfare.

According to the job summary provided by AFC, Mr Green was "responsible for the overall coordination and direction of the Intact Family Services Program under the supervision of the Austin Division Director through: clinical/administrative supervision of the child welfare specialists, homemaker and administrative assistant; and management and maintenance of all aspects of program operations." Mr. Green's responsibilities outlined in the job description included the following:

> Manage and maintain all aspects of IFS Program according to agency and DCFS contracts, policies and procedure. Provide administrative/clinical supervision to CWS workers regarding client progress and risk factors through: weekly supervision sessions; daily supervision regarding new case information; review of all case documents and reports; periodically attending home visits to observe and train workers; and approving /assisting in critical decisions about cases.

Upon his arrival at AFC, Mr. Green's staff consisted of seven new and predominantly inexperienced workers. Four of the workers entered DCFS Core Training shortly after his arrival. J Red had begun work at AFC the month prior and had already completed DCFS Core Training through his previous employment at Center For New Horizons. Similarly, another new employee, L Brown, had also previously completed Core Training at Newlife. Both he and Mr. Red assumed casework responsibilities immediately upon their being hired.

Mr. Green, who was responsible for clinical supervision, received little in-house training at the beginning of his tenure at AFC. In an interview with the OIG, Mr. Green stated that his training by AFC was "little bordering to none." As of this date, Mr. Green has never participated in Core Training even though he has no past experience in child welfare. According to Mr. Green, AFC administrators decided it was not feasible for him to leave the unit to attend Core Training during his first few months with the agency. As of this date, Mr. Green has still not attended Core Training; AFC Division Director B Strong stated to the OIG that this is because Mr. Green possesses sufficient supervisory experience and his participation in Core Training "will not make or break" this worker. Mr. Green reported to the OIG that he completed a DCFS management training course during the summer of 1995. However, this training did not address case management or clinical issues. Instead, Mr. Green relied on his own reading and the assistance of DCFS supervisor Barbara Loy to familiarize himself with child welfare. It is significant to note that Mr. Green sought assistance outside of his agency to familiarize himself with the workings of his own program. Mr. Green acknowledged that his limited understanding of child welfare has directly impacted on his ability to supervise in an effective manner. He noted that he has prepared training materials and procedures for the workers in his unit based on his own limited knowledge.

Shortly after arriving at Alpha Family Care, Mr. Green arranged for the DCFS monitors to work directly with him, instead of meeting individually with intact family workers. His rationale was to

free up the workers to complete Core Training and meet with their clients. However, this produced a communication gap and the DCFS monitors were not fully apprised of case activity.

When Mr. Green began his position with AFC, he was told by the program director that Mr. Red had a lot of experience in child welfare and would function as the senior worker in the unit. Mr. Green reported that in September 1995, Mr. Red requested permission to close all his cases, stating that the time period for servicing these cases was up. However, Mr. Red never produced the paperwork required to close these cases. Mr. Green indicated that, overall, Mr. Red had a nonchalant attitude towards his casework responsibilities, an attitude which continued even after John's death.

According to Mr. Green, problems with Mr. Red's work performance have been identified in his other cases. After John's death, Barbara Loy, supervisor of the DCFS unit responsible for monitoring AFC, met with DCFS administrators Jack Targonski and Adelle Prass on 12-20-95 during which it was decided that Ms. Loy would review all of J Red's cases. Ms. Loy completed her review by the end of January and determined that out of the 49 children in Mr. Red's caseload, 41 were not being adequately monitored. Problems identified by Ms. Loy in her review included missing risk assessments, no evaluated service plans, no client contact for months on end, no referrals for drug treatment, and no documentation of services. For example, her review identified a case that involved twins that were diagnosed as borderline failure to thrive in which no service provision had been documented in the case record. Ms. Loy also identified a case which was opened with AFC on 7/6/94 in which the mother has a mental illness diagnosis with a drug problem and is caring for her 16 month old child. There had been no case entries since 8-2-94, no visits, no risk assessment, no modifications to reflect that client might have refused services and no information on the status of the child nor was the 497 current. Mr. Red recommended that this case be closed in 8/95 under the impression that it was ready for closure. The case had been opened under Intact Family Services for the allotted 12 months.

Despite these glaring problems with Mr. Red's casework, Mr. Green reported that he was not supported by upper AFC management in his attempts to demand the timely completion of work by Mr. Red and other workers. After her review of Mr. Red's caseload, Ms. Loy met with the division director of AFC, Ms. Strong, regarding his casework as well as problems identified in another AFC worker's caseload. Alpha Family Care's response to the deficiencies identified on the Reeves case, as well as problems on numerous other cases, was to transfer Mr. Red to their foster care program. However, prior to his transfer, Mr. Red chose to resign, a decision that Ms. Strong described to the OIG as "regrettable" since she believes Mr. Red did nothing "negligent".

Based on Ms. Loy's findings, which were reported to Mr. Tempet and Ms. Pratt, AFC's intake was closed on 2/1/96. Ms. Loy then returned to AFC to review another worker's cases due to reports that he had failed Core Training and had to take the Risk Assessment exam twice before passing. Mr. Green had recommended that this worker be terminated. However, the program director, Ms. Strong did not support this recommendation. A review of this worker's cases reaffirmed that intake at AFC should remain closed. To date, AFC's intake is closed.

DCFS Monitoring Unit

During the time the Reeves case was being serviced as an intact family case by Alpha Family Care, the DCFS monitors had sporadic contact with the POS agency workers and supervisor. Bev Crane was the first DCFS monitor assigned to the Reeves family. She received the case on 11/15/94, but the DCFS file does not contain any record of her involvement. T Walter was assigned to the Reeves case on 3/29/95. However, her case notes do not begin until 6/23/95. Her first case note is alarming in that it states that the children were at environmental risk, that no food was in the home per the POS worker, and that a homemaker referral was needed. Her next case note, not written until 11/8/95, indicates that the DCFS monitor was awaiting case closure at the end of the month if the POS caseworker determined that the home environment was appropriate, the presenting issues were resolved and the children were not at risk. This note also indicated that the POS worker had reported that the baby was doing well.

According to R Green, T Walter and K Donaldson, there was reduced contact between the Alpha Family Care workers and the DCFS monitors between June and December 1995. At Mr. Green's request, the DCFS monitors communicated with him directly, rather than meet with AFC caseworkers on individual cases as many of the workers were in Core Training and needed time to visit their clients. According to Barbara Loy, DCFS monitor supervisor, AFC had been indolent about sending over necessary paperwork to the point that often her workers had little work to complete. So, between June and December with no paperwork to process and only Mr. Green to communicate with, the DCFS workers often had nothing to do.

In her interview with the OIG, T Walter reported that during this time she was concerned that AFC's intact family cases were not receiving enough coverage. When asked about Mr. Red's performance during this period, Ms. Walter stated that Mr. Red had claimed to be overwhelmed by his caseload. However, to her knowledge, there was never any discussion within DCFS that the Department should reduce or remove Alpha Family Care's intact family cases while these new workers completed training. In addition, Ms. Walter stated that it was understood that caseworkers would call the DCFS monitors as needed to discuss problem case situations. Mr. Red, who was the unit's most senior caseworker, did not discuss the Reeves case with the DCFS monitor during this time.

DCFS supervisor Barbara Loy told the OIG that, overall, Alpha Family Care's intact family services program has been extremely problematic in terms of meeting DCFS documentation requirements. Ms. Loy reported that she has made repeated requests for paperwork, even since John Reeves' death, but has been frustrated in her attempts.

Beta Center Involvement

Ms. Reeves was referred by General Hospital to Beta Center Maternal Addiction Center (MAC) for detoxification on 8/24/95. An initial assessment at Beta Center by Frances Lorenze on 8/24/95 indicated that Ms. Reeves reported using drugs since she was 27 years old and that she presently uses crack cocaine 3-4 times a week. Ms. Reeves was "not neatly groomed" and identified her children as a strength.

Ms. Reeves signed a release of information form on 8/28/95 authorizing contact between Beta Center and DCFS, however, there were no documented attempts by Beta Center staff or Mr. Red to contact each other. The form indicated that Ms. Reeves had identified Mr. Red as her DCFS worker. When the OIG interviewed the staff from Beta Center, the staff discussed the difficulty they have in identifying and contacting DCFS workers. If DCFS workers do not contact Beta Center after learning that their clients were admitted, Beta Center currently does not have the resources to track down DCFS workers when clients do not provide accurate worker names and phone numbers. It is especially difficult, if not impossible, when clients do not realize that their DCFS worker is a private agency worker, as evident in the Reeves case . In response to this problem, Beta Center is currently revising their intake forms to distinguish between DCFS and private agency workers in hopes of improving communication with DCFS and therefore service to clients.

Ms. Reeves was discharged from the detoxification unit and transferred to MAC-B on 8/28/95. On 9/2/95, Ms. Reeves' primary counselor, paraprofessional J Laker, indicated in her session notes that Mr. Reeves' drug usage started after the death of her mother, that she needs treatment after delivery, and that a visit with her children had been scheduled to observe their interaction on 9/10/95. During a 9/6/95 session with Ms. Laker, Ms. Reeves made a phone call and arranged for treatment after the delivery of her baby. A visit between Ms. Reeves and four of her children took place on 9/10/95. Case notes by Ms. Laker on 9/11/95 regarding the 9/10/95 visit, do not indicate which four children were present, however, Aisha was specifically referred to in the case notes. Ms. Laker's notes also indicate that based on her observations of the interactions between Ms. Reeves and her children, Ms. Reeves needs to work on her parenting and communication skills so her children begin to trust her again, and follow up on the nutritional and medical need of the family, especially the youngest (referring to Aisha).

Alpha Family Care found out by chance that the mother was receiving treatment at Beta Center and failed to monitor her progress. Alpha Family Care was unaware that the mother did not return to Beta Center after John's birth. Beta Center's MAC-B unit does not have the funding needed to provide outreach to clients who leave before successfully completing their treatment programs. Alpha Family Care as the service provider had the responsibility to reengage this mother into treatment and failed to do so.

DCP Investigation After John's Death

On 12/12/95, a hotline report was made after John Reeves was found dead on 12/11/95. The report noted that Ms. Reeves found John unresponsive at approximately 5:00 a.m. on 12/11/96 and was brought to General Hospital where he was pronounced dead upon arrival. The report also noted that John was very thin and appeared to have not been fed; Ms. Reeves could not show Chicago police officers any baby food in the home, other than one bottle which contained old formula. At birth John weighed 5 lbs. 6 oz., but weighed only 5 lbs. 10 oz. when he was brought to the hospital 3 months later at the time of his death. The hotline report noted that the home was filthy, with piles of clothing, old food, and dirty diapers everywhere.

As noted earlier, W Ray completed the DCP investigation. In his investigation, Mr. Ray stated that the home was filthy; clothes were piled high, old food was left out in the kitchen, windows were knocked out, and four mattresses and box springs were black with filth and urine. In addition, he did not observe a crib, baby food, or any other evidence that a newborn lived in the home. In his Family Assessment Factor Worksheet, Mr. Ray described the condition of the home as "deplorable." He noted that K Reeves had an extensive substance abuse problem which compromised her parenting abilities. In addition, he observed that the children "appear to have adjusted to the circumstances of their lives," and that they do not seem to expect more; they appear content with the order of things.

C Klein, a researcher from the Loyola University SIDS Research Project, visited the Reeves' home on 12/12/95 as part of a protocol to investigate all deaths of infant wards. Mr. Klein observed the home prior to the DCP investigator's visit. Mr. Klein told the OIG that the home was in bad condition. He noted the following about the home: The outside stairway leading to the apartment had dangerous holes (Mr. Klein feared that he would fall through the stairs, but this is never noted in any of the Alpha Family Care case notes); the temperature inside the home at 10:00 a.m. was 40 degrees; the couch where John had been laying when he died was filthy; and food and dirty dishes were laying around. Mr. Klein interviewed K Reeves, who claimed that she had last fed John at 1:30 a.m. on 12/11/95. However, she was not able to provide Mr. Klein with any information about John's feeding schedule (she reported that she fed him whenever he was hungry).

This report was indicated for the following allegations: abuse (substantial risk of physical injury), and neglect (death and environmental neglect). K Reeves is currently awaiting trial for murder. Protective custody was taken on 12/12/95 and the children were immediately placed in a five-day inpatient evaluation at General Hospital's Under the Rainbow Program. After the evaluation was completed, Alpha Family Care placed the children in foster homes. Lauren and her young son, Kevin Smith, were initially placed with her father, Oscar Randle. This placement disrupted soon after. Lauren, Kevin and Beth are currently in relative foster homes, Lauren and Kevin are with maternal uncle, Roy Williams and Beth is with her father, Don Honan. Adam and Nina are placed with Ann Garvel and Aisha is with Joyce Santos.

Alpha Family Care currently has a contract with DCFS to service approximately 70 intact families,

of which over half involve substance abuse. The DCFS pays Alpha Family Care approximately $4500-5000 annually per family in the Intact Family Service Program. The mishandling of this case resulted in enormous costs for this family as well as for the State of Illinois, and highlights the need to develop case management programs within DASA agencies that are more capable of providing services to substance abusing parents and their children.

ANALYSIS

Alpha Family Care's intact family services unit was ill equipped at every level to carry out the core functions of the program. The turnover of three supervisors in three months contributed to the unit's instability. Moreover, the current supervisor, R Green, lacked the child welfare background necessary to effectively supervise and monitor the workers in his unit. The entire unit of seven caseworkers had less than one year's experience in intact family services. This, combined with the inexperience of the supervisor, has made it difficult for that unit to perform at an acceptable level. In addition, it appears that the division director, B Strong, did not stay actively involved with the Intact Family Services Program throughout the unit's transitional period, nor provide adequate training to the new supervisor, even though she had ultimate responsibility for the program's performance.

Both AFC intact family caseworkers assigned to the Reeves case lacked sufficient clinical knowledge of substance abuse issues needed to provide adequate services to K Reeves. Ms. Reeves' repeated failure to seek and complete drug treatment should have alerted each worker that this client did not have the capacity to address this problem on her own. In addition, neither worker established clear consequences for Ms. Reeves' noncompliance with services.

Colleen Star's position at AFC was her first job out of college. Her supervisor, G Danner, appropriately identified her knowledge deficiencies, and had begun to address them prior to both Ms. Danner and Ms. Star leaving the agency. However, J Red was considered by the division director, Ms. Strong, to be a senior caseworker, capable of handling the most problematic cases and the largest caseload while the new members of the unit came up to speed in their new positions. The OIG's investigation revealed that Mr. Red was clearly overwhelmed and unskilled, despite his previous experience in child welfare. In addition, Mr. Red's limitations were not identified for some time due to Mr. Green's lack of knowledge of child welfare practice. Mr. Red wanted to close the Reeves case and never considered screening the case into court, demonstrating a lack of clinical knowledge about substance abuse and risk assessments. Although Mr. Red's supervisor eventually identified his performance deficiencies, these problems were not addressed prior to John's death.

The DCFS unit did not adequately monitor AFC's intact family unit during its transitional period. Per R Green's request, DCFS monitors T Walter and K White relied on the AFC caseworkers to bring problem cases to their attention, rather than address problems identified through regular contact. In agreeing to scale back their involvement with the AFC unit while the new workers completed training, they compromised the Department's ability to ensure quality service provision.

The DCFS monitoring unit contributed to the poor service delivery to the Reeves family. However it should be noted that the unit's supervisor, Barbara Loy, acted quickly to identify and attempted to remedy problems within Alpha Family Care's intact family unit after John Reeves' death.

PROPOSED REDESIGN FOR INTACT FAMILY SERVICES

According to Besharov (1994) drug addiction must be seen as a chronic, relapsing disorder which cannot be addressed by traditional child welfare programs. Because most substance abusing parents experience a series of relapses before achieving permanent abstinence, child welfare practice with these families must be radically reoriented to respond to relapses and ensure the safety of children in the home. Most importantly, it must be remembered that there is no "quick fix" to substance abuse.

Currently, all families referred for Intact Family Services are assigned to a DCFS contracting agency based on availability, not on an agencies' ability to address the precipitating problem. Cases in which the primary reason for the DCFS Involvement has been a substance abusing parent, have lacked the collaboration necessary to coordinate the services needed to effectively service both the substance abuser and their family. This lack of collaboration and coordination has resulted in the fragmentation of services and children lingering in the child welfare system. It is no surprise then, that substance abuse cases remain open longer in the public child welfare system, no matter how they were treated. (Schuerman, Rzepnicki, and Littell, 1994) This lack of expertise and fragmentation in the Reeves case resulted in a child's death, a mother's indictment for murder, and four other children who may require state intervention for some time.

According to the DCFS/DASA Initiative Evaluation Planning Meeting, DCFS receives approximately 25,000 new intact family cases per year of which approximately 80% are in Cook County. Of these 25,000 families, it is estimated that half of the mothers would be considered in need of drug treatment. The Reeves case demonstrates the complexities involved in providing services to families headed by drug abusing parents. The challenge to caseworkers is to provide safeguards for children, adequate support to parents seeking drug treatment, and to establish appropriate consequences for noncompliance. According to Richard P. Barth, the largest group of children entering the child welfare system are those who have substance abusing parents. (Besharov, 1994) A 15 state survey on placement prevention indicated that for substance exposed infants the average length of service was 4.17 months, whereas the resolution of drug treatment takes one to two years. Because most of these children will remain at home, child welfare must protect these children by providing longer-term intact family services and by providing new alternatives. Instead of brief in-home services which result in 1) reentry of the child into the child welfare system; 2) threats to the child's development; and 3) subsequent children born exposed prenatally to drugs, Barth recommends extended services that include the following: perinatal aftercare, extended case management, developmental follow-up, intensive family preservation services, shared family care arrangements that combine characteristics of in-home services and out-of-home care, and informal family support services.

A more effective and efficient model must be developed to address substance abuse. This new model should address substance abuse as the core presenting problem within the family, which must be addressed immediately upon opening the family's case. This new model, which will be termed the Intact Family/Recovery (IFR) model for the purpose of this report, will combine a child welfare practice approach with a substance abuse treatment approach. In housing the case management unit within a substance abuse treatment program, rather than in a traditional intact family services program, the need for substance abuse treatment will be brought to the forefront of service provision efforts. In addition, this approach builds upon existing drug treatment programs rather than duplicating similar services within child welfare agencies.

The OIG proposes that the Department conduct clinical trials with a selected group of substance abuse treatment programs to provide intact family services to families brought into the system on a drug exposed infant report. These agencies include those identified in the OIG's Best Practice project: Bensenville LifeLink, Catholic Charities, and Lutheran Social Services of Illinois. Outside of the Best Practice project, OIG would like to explore the possibility of developing the IFR model with HRDI, Association House and Womens Treatment Center. If these clinical trials are successful, then an RFP can be developed for replication throughout Cook County and the State.

The DCP investigator will refer the family to the IFR program immediately after a substance exposed infant has been brought to the attention of DCFS. Within one week, the DCP investigator and the IFR team (an MSW Level casework supervisor and a paraprofessional outreach worker) will meet with the parent and her extended family in the home. At this staffing, a pre-screening packet will be presented to the mother, which will clearly outline her responsibilities to complete drug treatment as well as the consequences of noncompliance (i.e. filing of petition at juvenile court). In addition, the agency will select an appropriate protective payee for the parent's AFDC check (if applicable) in order to ensure that family income is not used to purchase drugs.

The parent will be required to immediately enter drug treatment after a care plan is developed for her children. Extended family involvement is critical to the development of the care plan, the rehabilitation efforts of the substance abuse program, and the development of a strategy for relapse. In addition to the extended family, the child care plan may include on site day care provided by the treatment facility. On site day care, as one of its benefits, would afford workers with an opportunity to observe their clients' interactions with their children. In addition, 0-3 services could eventually be built into the treatment facilities' day care programs.

As drug treatment progresses, the outreach worker will work closely with the mother through intensive contact with the family, based on the practice model developed by Project Safe. In attempt to address the aforementioned growing need, DCFS and DASA collaborated in 1986 and began the Project Safe program which offers intensive outpatient, substance abuse treatment and aftercare for women reported to DCFS for abuse or neglect. Unique to Project Safe is the use of outreach workers who assist referred women in making contact and formal entry into treatment. Outreach workers maintain almost daily contact with each client, serving in whatever capacity is necessary to encourage recovery and meet practical needs. In Besharov's (1994) work on substance abuse and

child welfare, he notes that case aides are well suited to provide families with intensive, frequent contact necessary to engage them in services. All of the agencies identified by OIG to develop the IFR model currently administer the Project Safe program.

The outreach worker could be individuals who are in recovery themselves (although aides would be required to have been clean for a specified period of time); as such, the outreach worker will be sensitive to the substance abusing parent's challenges, as well as convey to the parent the realistic consequences of continued drug use. Outreach workers would accompany the parent as she initiates drug treatment and would continue to provide intensive support during the early stages of treatment to increase the parent's commitment to services. Providing transportation is a crucial component to help assure the parent's attendance. In addition, outreach workers will provide homemaker services specifically designed to target the chaos within the home which results from the parent's substance abuse (including the establishment of a daily routine and development of a household budget).

The outreach worker's daily contact with the parent will be monitored by an MSW level casework supervisor, and regular staffings which include the casework team and the treatment counselors will be held to ensure a coordination of service delivery. A parent's noncompliance will be identified early on, so that the team can confront the parent and file the pre-screened petition, if necessary.

Because substance abuse treatment is a lengthy process, the IFR program must involve a longer service provision period than the 12 to 15 months currently allotted for intact family service. Recovery is a lifelong process, and services must not be terminated prematurely, before the family has truly stabilized. Although the intensity of casework may diminish after the mother has successfully completed certain treatment components, the outreach worker may maintain contact with the family for up to 24 months.

GENERAL RECOMMENDATIONS

- DCFS should implement the Intact Family/Recovery Program in FY 1997. The Department should redirect funds currently allocated for generic intact family service programs to those child welfare providers who also have substance abuse treatment programs, specifically the Project Safe program. Alpha Family Care does not have the capabilities to deliver these specific services. Alpha Family Care may have the ability to assist DCFS with intact family cases that have mental health, medical or housing issues as these services are currently offered through this agency.

- DCFS should review Alpha Family Care's intact family cases to determine which cases have substance abuse as the primary presenting problem. Those cases should be immediately transitioned to an agency which is capable of delivering substance abuse treatment.

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