OFFICE OF THE INSPECTOR GENERAL

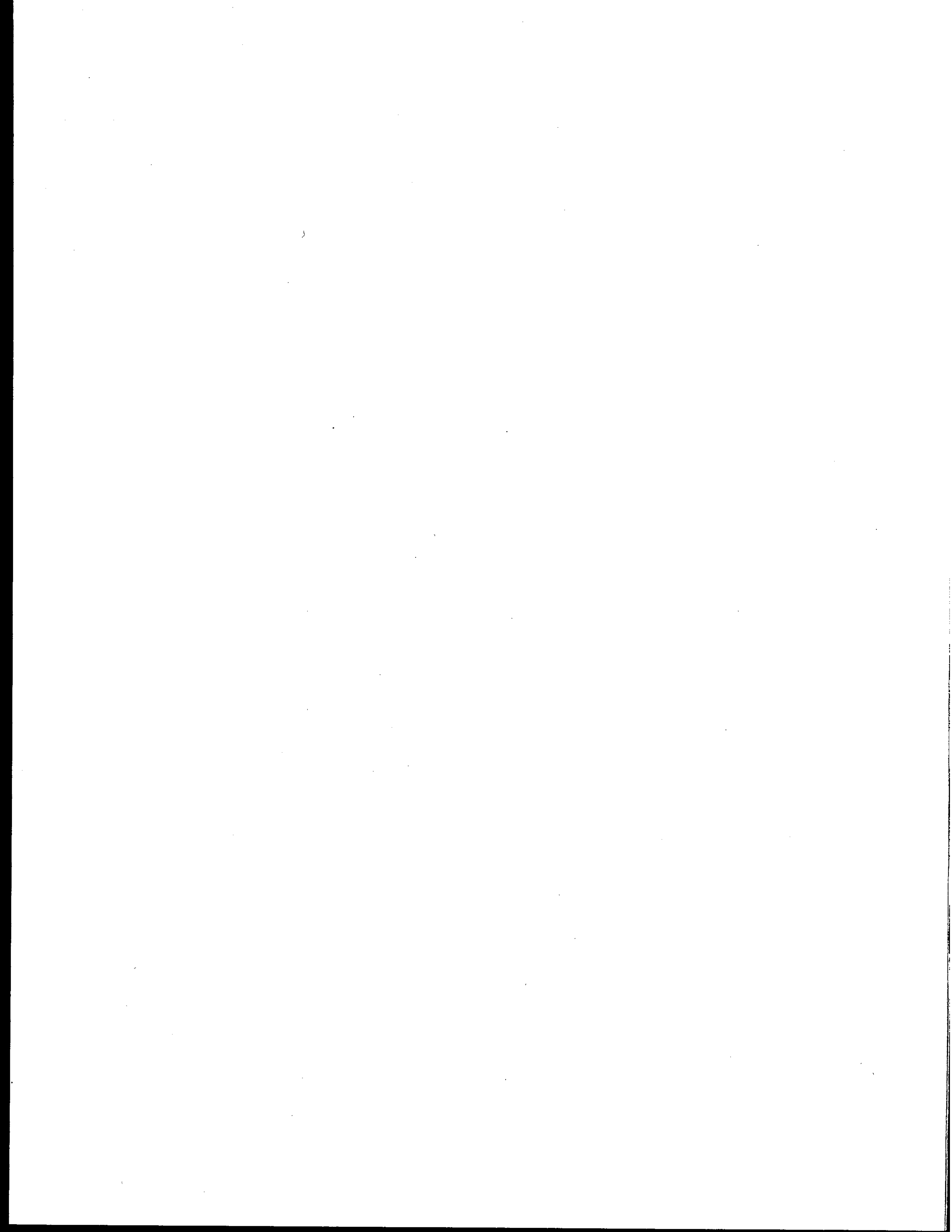
Illinois Department of Children and Family Services

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

Pursuant to 20 ILCS 505/35.5

January 1999

Denise Kane
Inspector General



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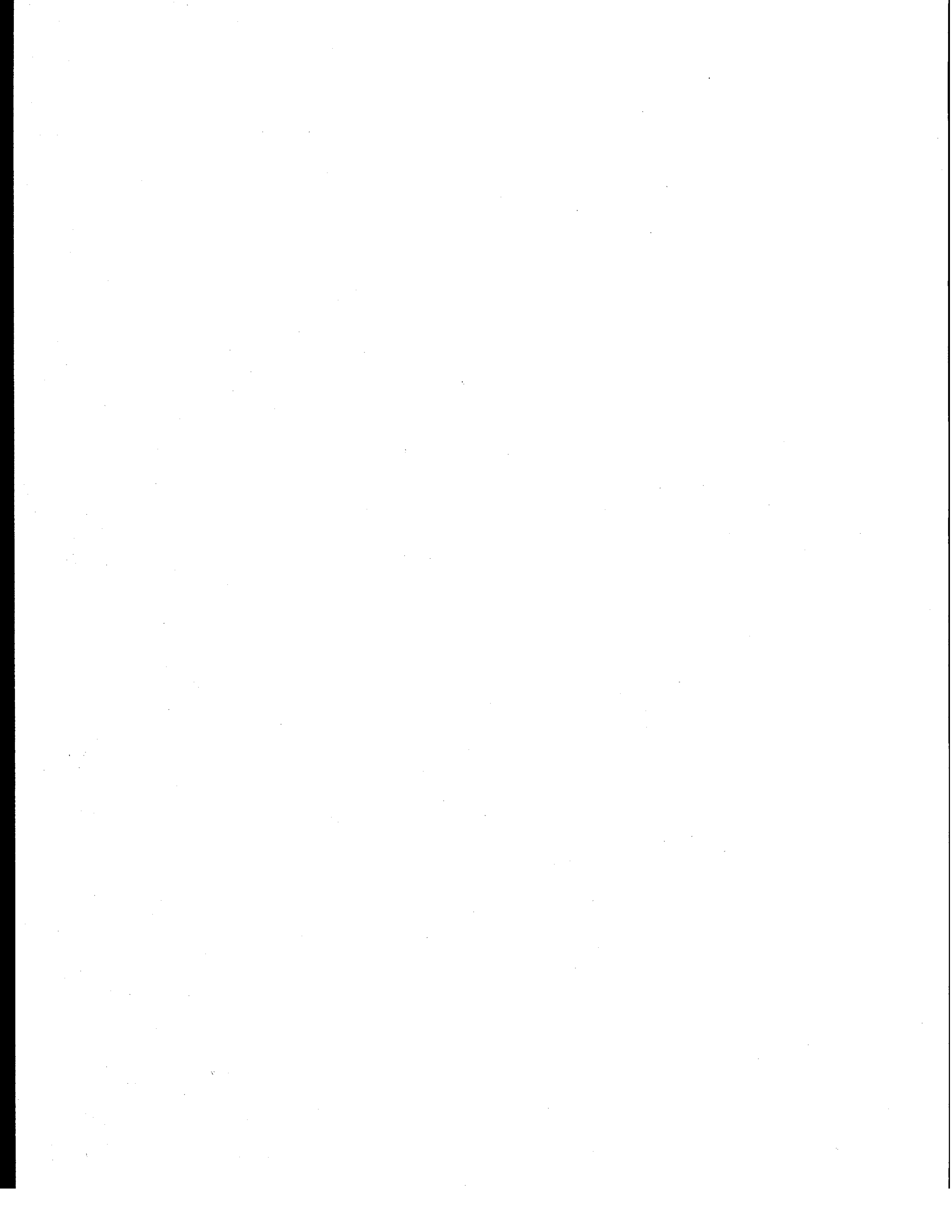


LETTER FROM THE INSPECTOR GENERAL

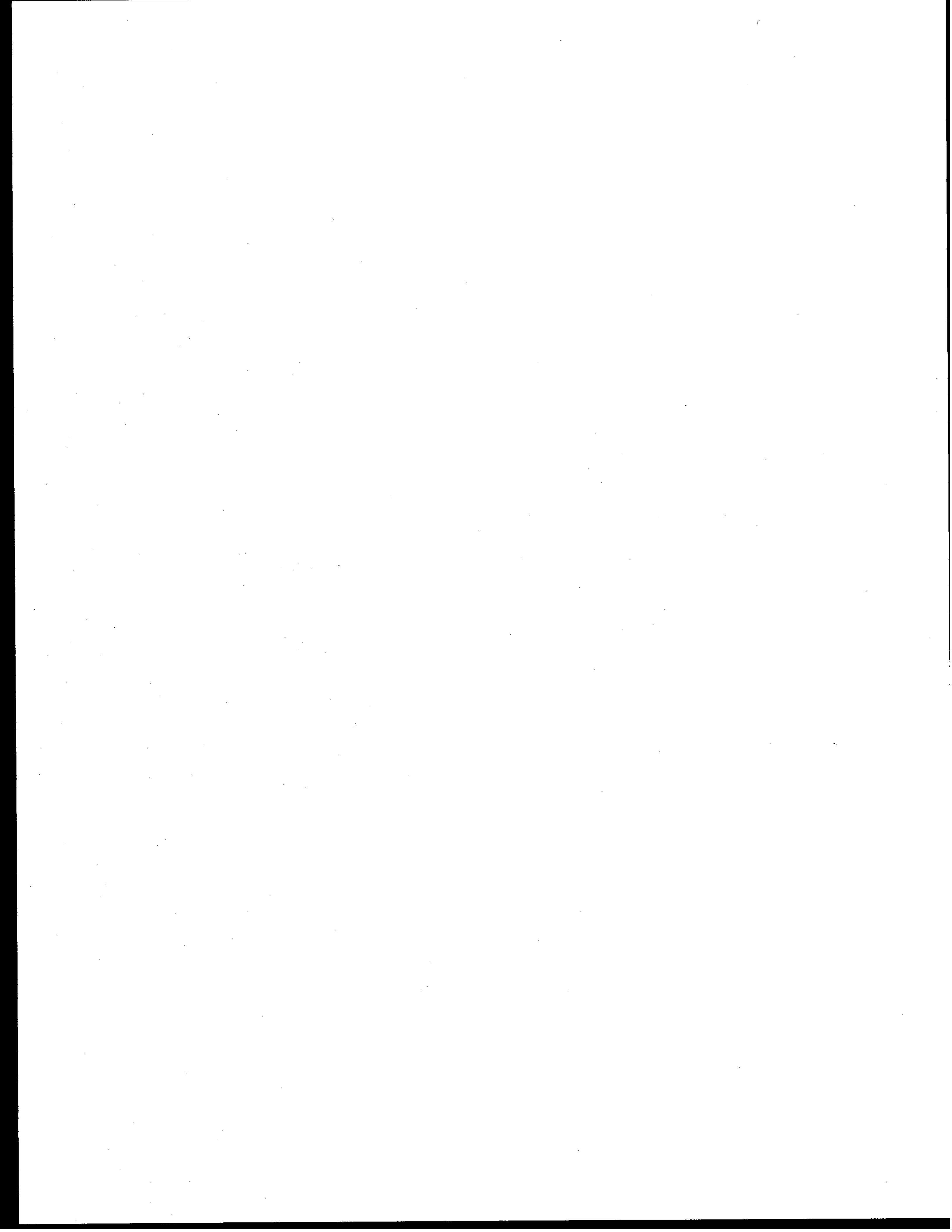
To the Governor and Members of the General Assembly:

I recently revisited the writings of C. S. Lewis and found his discussion of the habits and outlooks of a virtuous person as being particularly relevant to the multi-discipline field of child welfare. To be a just and prudent professional, whether one is a lawyer, legislator, public or private administrator, clinician, or caseworker, requires self-discipline. It also requires a deeper introspection and analysis than are afforded in the limits of pulp language or a strictly market formula. The fiduciary responsibilities that come with the duty to protect children require fortitude and courage in taking prudent and just actions. Lewis tells us prudence is practical common sense, taking the trouble to think out what you are doing and what is likely to come of it. The antithesis of the prudent individual is the intellectual slacker, a foolish person. Justice, he tells us, is more than what goes on in courts of laws. Justice embodies fairness, honesty, give and take, keeping promises and an even-handedness. Our children and our families, as well as the professionals who have the duty to serve them, require an even playing field. Sensationalism and the conceit of self aggrandizing behavior does not justly serve. If we are to live up to our duties to our children and our families we have to humbly recognize where our ignorance or errors contribute to failings or harm. To admit to such should not diminish us but it does require a great deal of fortitude.

It is within this spirit that the Office of the Inspector General produced a training document of critical investigations. The compiled investigations are redacted. For the past several years we have included redacted investigations in our annual report to the Legislature. The purpose of this compilation is to provide prudent professionals a venue for an ethical discussion on individual and systemic problems within the practices of child welfare. We can only better ourselves if we are willing to examine ourselves. There always exists the risk of unscrupulous exploitation of any admission of human or bureaucratic error. However, for knowledge to grow and outcomes to improve we need the honesty and truthfulness that can only occur in good faith. It is with the trust of ethical agencies and individuals who struggle with these issues in a fair and just way that we can have hope for the future of Illinois child welfare. It is only through the discipline of consistent virtuous actions that we obtain integrity.

With Warm Regards,

Denise Kane
Inspector General



The OIG had 987 requests for investigation in FY 98.

Requests for investigation can lead to a full investigation, a partial investigation, technical assistance, referral to other resource, or closure without investigation.

I. OIG INVESTIGATIVE PROCESS

The OIG investigative process begins when the State Central Register notifies the OIG of a child's death or when a member of the general public files a Request for Investigation with the Office. Complaints and death investigations are screened to determine whether the facts suggest possible serious misconduct by a DCFS employee or private agency employee. If a complaint is accepted for full investigation, the OIG will initiate an investigation including a full records review and interviews of relevant witnesses. When the investigation is completed, the OIG prepares a report to the Director of DCFS with recommendations for discipline, systemic changes, or sanctions against private agencies. The OIG then monitors the implementation of the recommendations. When the recommendations focus on a private agency, the OIG may work directly with the agency to ensure implementation of the recommendations.

If a complaint is not appropriate for full investigation by the OIG, the OIG may refer the complaint to law enforcement (if possible criminal acts were committed), the DCFS Ombuds Office, or other state agencies such as the Department of Professional Regulation.

Confidentiality

While conducting investigations, care is taken to conceal the identity of the complainant. All information acquired during an OIG investigation is considered confidential and cannot be released outside of the Department or private agency involved except in compliance with applicable confidentiality statutes. 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 for private agency or Department employees.

Impounding

The OIG is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." 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. When files are impounded, the investigator leaves a receipt for impounded files with the office or agency. Important information may be copied by the worker during the impound in the presence of the investigator. Impounded files are returned as soon as practicable.

File Return Policy

When the Department transferred significant caseloads to private agencies in 1996, the Department did not retain copies of its files before transferring the files to private agencies. As a result, the OIG instituted a policy of making an additional copy of all files impounded in death investigations and returning originals to DCFS Legal to ensure that the Department maintains a central file for certain records.

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. The OIG will assist the law enforcement agency with gathering necessary documents. If the 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 will determine if administrative action is appropriate.

OIG Reports

The OIG's reports are submitted to the Director of DCFS, pursuant to statute. The OIG also reports to the Governor's Office. An 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.

The OIG also uses the reports as teaching/training tools. The reports are redacted to ensure the confidentiality of the families and service providers and then distributed to private agencies, the schools of social work, and DCFS libraries as a resource for child welfare professionals. A packet of redacted OIG reports is available by contacting the OIG at (312) 433-3000.

Monitoring

The OIG monitors implementation of OIG recommendations. Monitoring may take several forms. The OIG may monitor to ensure that Department or private agency staff implement the recommendation or, the OIG may work directly with the Department or private agency in implementing recommendations calling for systemic reform. In addition, the OIG may incubate accepted reform initiatives within the OIG for future integration into the Department. Recommendations made to private agencies are generally monitored directly by the OIG or by the OIG and a representative of the Department's Agency Performance Teams. Results of monitoring significant OIG recommendations are contained in this Annual Report.

Death Review

The OIG investigates all cases in Illinois in which a child has died while a ward of DCFS, the subject of an open investigation or family case, or the subject of a closed abuse and neglect report or case within the last twelve months. The OIG received notification from SCR of 95 child deaths in FY 1998. Death investigations which resulted in major report recommendations are included in the Investigations Section of this Report.

II. RECOMMENDATIONS

In formulating report recommendations, the OIG first determines whether an employee of the Department or private agency engaged in misconduct or poor casework practice. The OIG then assesses the misconduct or bad practice to determine whether to recommend discipline.

Ideally, discipline should be constructive in the sense that it serves to educate an employee on matters related to his/her misconduct. However, it must be more than an educational opportunity. It must also function to hold employees responsible for their conduct. Hence, discipline should have an accountability component as well

as a constructive or didactic one. Without the accountability component, there is little to deter misconduct. Without the didactic component, an employee may conclude that s/he has simply violated an arbitrary rule with no rationale behind it.

Once the decision regarding discipline has been made, the OIG will determine whether the facts suggest a systemic problem or an isolated instance of misconduct or bad practice. If the facts suggest a systemic problem, the OIG may investigate further to determine appropriate recommendations for systemic reform.

The investigations for FY 98 are divided into three major categories: Death Investigations, Private Agency Investigations, and General Investigations.

At the end of the report, reform recommendations are then organized into a format that allows analysis of recommendations according to the function of the child welfare system that the recommendation is designed to strengthen. The OIG is a small office in relation to the Department of Children and Family Services. Rather than address problems in isolation, the OIG views its mandate as strengthening the ability of the Department and private agencies to perform their duties. The recommendations categories are: to promote child safety and protection; to address children's health and educational needs; to promote permanency for children; to develop and promote community resources "of sufficient quality" to meet the needs of children and their families; and to provide general support for child welfare casework.

III. OIG FOSTER PARENT HOTLINE

Foster Parents contact the OIG Foster Parent Hotline by calling: 1 (800) 722-9124

Pursuant to statute, the OIG operates a statewide, toll-free telephone number for foster parent access. Foster parents have called the hotline to request assistance in addressing the following concerns:

- Child Abuse Hotline information; Child support information;
- Foster parent board payments;
- Youth College Fund payments;
- Problems accessing medical cards;
- Complaints regarding DCFS caseworkers and

supervisors ranging from breaches of confidentiality to general incompetence;
- Licensing questions; and
- General questions about DCFS and OIG.

The Foster Parent Hotline received 991 telephone calls in FY 98.

In FY 98, the OIG Foster Parent hotline received 991 calls. Of those, 851 calls were for information and referrals, 65 calls were referred to the SCR hotline, and 75 calls were referred to the OIG for investigation.

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.

INVESTIGATIONS

Death Investigations

Death Investigation 1

ALLEGATIONS

A three-year-old child had been removed from his parents because of physical abuse perpetrated by the father. Four months after he was returned to his mother, the child, who also showed recent signs of physical abuse, was drowned, allegedly, by the mother. The mother was charged with first degree murder.

INVESTIGATION

The OIG investigation found that although the mother had received and consistently participated in services prior to reunification, the private agency failed to put in place a strong reunification plan with services targeted to the special needs of this child, as well as services to support and monitor the mother after the return home. Child welfare professionals failed to recognize the significance of feeding issues and did not use family therapy to help develop a safety plan for the child. In addition, although there were issues of domestic violence and the mother had completed domestic violence services, child welfare professionals did not collaborate with staff to discuss how the mother, who continued to be romantically involved with the father, could effectively control access to the child by the father who had not completed domestic violence services.

RECOMMENDATIONS

(1) The Department should develop a format for a letter to be written by foster parents prior to the child's return home documenting what parents should know about the child.

(2) When a decision is being made regarding reunification, a return home staffing should be held among the caseworker, supervisor, and all persons who have provided services to the family in the last year.

(3) The article, "The Seven Deadly Sins of Childhood: Advising Parents About Difficult Developmental Phases," describing typically difficult developmental stages and the risk of abuse of young children should be used in the training of child welfare staff.

(4) Prior to the return home, the caseworker should meet with the child's teacher or day care provider and advise them to notify the caseworker if the child is absent for two consecutive days and, after return home, caseworkers must check with the child's teacher on at least a monthly basis.

(5) Caseworkers should ensure that therapists working with families have social histories and all psychological evaluations available to them as well as the redacted DCP reports on all indicated sequences.

(6) This report should be redacted and used as a teaching tool among child welfare staff and therapists.

(7) The OIG should convene a meeting with private agency staff and the therapist to discuss the findings and recommendations discussed in this report.

STATUS

(1) The Department is in the process of developing a reunification policy to be issued in Spring, 1999. Included in the policy will be provisions for a form of communication between the foster parent and the parent with details concerning the child prior to return home.
(2) The Department's domestic violence consultant position is currently vacant. The Department plans to fill the position as soon as possible. Once the position is filled, staff will be required to consult with the domestic violence consultant as to the appropriate services that should be incorporated into the service plan in cases where domestic violence is an issue. The Department will track the number of referrals made to the consultant to ensure appropriate use.
(3) The professional journal will be distributed in appropriate training.
(4) The Department will request that a child's teacher or daycare provider contact the case worker if the child is absent for two consecutive days. (The Department will make this request but is unable to require schools to do this.) The Department will require that caseworkers visit with the child's teacher or daycare provider on a monthly basis. The information will be incorporated into the Department's forthcoming reunification policy.
(5) DCFS will issue a Policy Transmittal reminding staff to ensure that therapists have redacted DCP indicated reports for treatment utilization.
(6) A redacted copy of the report will be shared with child welfare staff and therapists.
(7) The OIG met with the private agency and therapist to discuss the report

Death Investigation 2

ALLEGATIONS

The death of a six-month-old boy, the brother of another infant who died while in foster care, highlighted the Department's indifference towards prior OIG recommendations and neglect of duties on the part of DCFS personnel.

INVESTIGATION

On September 2, 1997, a six-month-old boy was found dead in his crib in the emergency foster home in which he had been placed only four days earlier. The DCFS worker who placed him used the FindHome database to locate the home. The FindHome listing did not include any notation of a hold on placements, a pending DCP investigation or the home's history of licensing violations. Previously, five foster children were removed from the home after the DCFS supervisor assigned to one of them reported in court and to the Hotline the home's poor condition and her belief that it was being used to "warehouse" children. About four or five weeks later, four children, including the six-month-old, were placed in the home.

The Department's inability to prevent such an oversight arose from a breakdown of communication and a disregard for both recommended and existing policy. Following the death of the six-month-old's brother as an infant in a foster home in 1995, an OIG investigation disclosed the lack of communication between the Child Protection, Licensing and Operations Divisions of the Department. Specifically, the OIG noted that Child Protection and Licensing failed to notify Operations of pending DCP and Licensing investigations so that workers could avoid placing additional children in questionable foster homes. There were no systems in place requiring workers to routinely check the licensing or abuse/neglect history of homes prior to placing children.

The 1995 OIG investigation found that the lack of interdivisional communication was fostered in part by the failure of certain administrators to accurately assess the range of their responsibilities. During the course of the investigation, one DCFS administrator admitted receiving notices of pending DCP investigations of foster homes but did not believe such information was entered into the FindHome database. He received the notices because of a previously held position (the position he held in 1995). Currently he should not have been receiving the notices. Rather than forward the information to other Department personnel, the administrator threw the notices away. At the time, the OIG recommended the administrator be disciplined for his failure as a manager to ensure that the appropriate person receive the critical information. The manager's direct supervisor strongly disagreed with the discipline recommendation arguing that referral of improperly directed notices was not amongst the manager's "duties". The OIG was eventually notified, however, that the Department had counseled the administrator on his role and the necessity of properly routing information. The OIG also recommended that systems be put in place to ensure workers were informed of pending DCP investigations, licensing investigations or licensing violations in homes prior to placement.

Following the six-month-old's death in 1997, the OIG discovered that the Department had failed to implement any system for consolidating and disseminating this data. It was also learned that the administrator that the OIG had recommended be disciplined, had been promoted to manage the FindHome database and emergency placements. In an interview with the OIG, the administrator stated that he had never been disciplined concerning his prior behavior and denied any knowledge of any criticism of him in the prior OIG Report. A review of his personnel file confirmed the failure to discipline. In his new position, the administrator should now be receiving and acting on the notifications. He never received them or inquired as to why he was not receiving them.

RECOMMENDATION

The investigation of this case revealed an alarming level of unprofessionalism and numerous violations of the *Code of Ethics for Child Welfare Professionals* contained in the *Department Employee Handbook.* Section 7.03a of the *Code* requires that DCFS administrators, "enhance organizational capacity for open communication, creativity, efficiency and dedication." The circumstances surrounding this investigation suggest that this principle has had little impact on some administrators. The lackadaisical attitude demonstrated toward information crucial to the safety of children shows a startling lack of integrity and professional commitment. Furthermore, in violation of section 7.03c of the *Code* which requires administrators, "to establish procedures that promote ethical behavior and hold individuals accountable for their conduct," there is no evidence that the administrator was ever counseled by his supervisor. Rather than exhibiting a commitment to the principles of DCFS, the actions of these administrators suggest little investment in the Department's mission.

STATUS

The Department has made numerous changes as a result of this report. The OIG conducted Ethics Workshops for Department staff on January 16, 1998 and March 27, 1998. All employees received a copy of the Code of Ethics for Child Welfare Professionals and were required to sign a statement certifying it had been given to them.

The Department is implementing the Placement Clearance Process effective December 15, 1998. This Process establishes a central place where DCFS and POS staff can obtain information about unlicensed relatives and licensed foster homes. Information about a foster home's license status and maximum license capacity will be secured through the Placement Clearance Desk.

Responsibility for the Emergency Reception Center (ERC) was transferred from the Division of Child Welfare to the Division of Child Protection to ensure more continuity of services and to better link our emergency response systems together. The majority of children that come to the Emergency Reception Center are placed there by DCP investigators. The Department re-emphasized with ERC staff that foster homes must be checked for pending investigations before placing a child. Also all abuse and neglect reports on foster homes are entered into the Find Home database.

Death Investigation 3

ALLEGATIONS

A four-month-old boy died of natural causes. Because his parents had three other children living in their home and had previously been involved with the Department, an investigation was undertaken to assess potential risks.

INVESTIGATION

The OIG investigation revealed that there were issues of domestic violence and substance abuse which had not been addressed with the family. The four-month-old's mother had been indicated three prior times for various forms of neglect and had admitted to an alcohol addiction. Police and DCFS workers also suspected some level of drug use. A LEADS check conducted by the OIG showed that she had been arrested 21 times with 6 convictions for prostitution and other charges that suggested possible drug use. The boy's father, who sometimes resided with the family, admitted to domestic abuse of the mother. His LEADS check produced 33 arrests and 5 convictions for violent crimes. Although the mother's eight-year-old son, her 17-year-old daughter, the 17-year-old's three-year-old son and the couple's three-year-old daughter were cared for primarily by their maternal grandmother next door, they spent a large amount of time in their parents' home. The 17-year-old had been through juvenile court for possession of cannabis and assault against her mother for attacking her with a table leg.

After the death of the infant, the grandmother became despondent and returned the other children, except for the eight-year-old, to the mother.

RECOMMENDATION

The OIG recommended in April 1998 that the case be referred for child welfare services. Services should include, but not be limited to the following:

(1) Child Endangerment Risk Assessment Protocol
(2) Substance abuse assessment and services for the parents and the mother's daughter
(3) Counseling in problem solving conflict resolution for the mother and daughter
(4) Domestic counseling for the mother and father
(5) Parenting skills classes for the 17-year-old

STATUS

The Department and the OIG agreed to refer this case to a private agency for services. The case was reopened and referred in June 1998.

Death Investigation 4

ALLEGATIONS

A four-year-old boy was beaten to death by his mother 2 and ½ months after being returned home. The mother was charged with first degree murder.

INVESTIGATION

The OIG found that the four-year-old boy's case had been active with the Department since he was born exposed to cocaine in 1992. His mother had an open case with the Department since 1988 and had already lost custody of her two older children. Since becoming involved with the Department, the mother had been in both inpatient and outpatient substance abuse counseling and had involvement with mental health intervention. The mother disappeared for six months with the boy after dropping out of an inpatient drug treatment center. Upon her return, DCFS was granted custody of the child who was placed in a foster home in another town until eventually being returned home. Two and a half months after being returned home, the four-year-old and his two-year-old brother were bathing together. The mother walked into the bathroom and saw the two-year-old touching the four-year-old's penis. The mother allegedly became upset with the boy and according to her, "snapped", beating the boy and then placing him in bed where he was found unresponsive the next morning.

The mother suffered from depression based in part on her own childhood experience of being abused physically by her mentally ill mother and sexually by her brother. She admitted using drugs as a means of relieving her feelings of depression. The mother also had several turbulent relationships with men including the four-year old boy's father, whom she killed during an altercation. No charges were filed against her as the issue of self-defense was raised and the circumstances of the death were unclear. The father of her youngest son had been diagnosed with a serious debilitating and contagious disease. He was living in her home along with the two boys and her abusive brother who had recently been released from prison.

The placement of the four-year-old in a foster home in a different town resulted in a split of casework duties between workers in each town. The Department referred the mother for services while she also involved herself with other agencies independently. This fragmentation of services prevented any one person or agency from forming a clear understanding of the mother's situation. There was no attempt to jointly staff the case with all the parties involved so that all workers and agencies would have common information and be working toward common goals. Instead most of those involved in making decisions about the mother relied on incomplete case histories and her self-reports to them. This fragmentation resulted in the mother receiving inaccurate evaluations, inappropriate or incomplete services and critical decisions being made with insufficient information. The specific child welfare concerns as they related to treatment and the mother's behavior were not identified or addressed. The absence of a collaborative effort on the part of DCFS staff created a lack of adequate support for an unstable mother and allowed the child to be returned to an unsafe environment.

RECOMMENDATIONS

The OIG recommended:
(1) A collaborative service planning staffing occur within three to four weeks of a client's admission to drug treatment.
(2) A discharge/planning staffing occur two weeks prior to discharge from drug treatment to prepare an aftercare plan.
(3) A conference including all collaborating agencies be convened four to six weeks prior to the child's target return home date. The staffing should address the child's developmental, educational and medical needs. A lead worker should be identified to work directly with the parent to arrange necessary services. Additional conferences should be convened before and after the child's return home to cover:

- **enrollment in school, Headstart or day care with parents accompanying them when appropriate**
- **participation in parent/teacher conferences at both the old and new schools**
- **if the child has an Individual Education Plan, engaging the parent as a full partner in the development of an Individual Family Service Plan**
- **enrollment with a primary medical provider and the transfer of medical records**
- **obtaining baseline medical examinations from the new provider**

(4) When a worker becomes aware that a client or significant family member is suffering from a chronic or acute medical condition, the worker should contact the medical provider to determine what supportive services are available.

STATUS

(1) and (2) DCFS, in collaboration with DHS, has worked to develop substance abuse assessment and treatment protocols which address the unique needs of families who are involved with the child welfare system. DCFS and DHS-OASA have finalized a practice handbook entitled, "Guidelines for OASA/DCFS Initiative Programs, 1998". The handbook includes the OIG recommendations.
(3) The Department is developing a reunification policy to be issued by Spring, 1999. Included in the policy will be provisions for a professional staffing to be held prior to return home among the caseworker, supervisor and persons who have provided services to the family in the previous year. The tasks identified by the OIG would be appropriate steps toward a return home that would be included in the service plan.
(4) DCFS staff will be instructed to contact an individual's medical provider, with the consent of the individual, if staff are aware of existing medical conditions which could lead to increased levels of stress.

Death Investigation 5

ALLEGATIONS

In May 1996, the OIG opened an investigation into the case of a 1½ year-old female DCFS ward who died from a massive skull fracture she allegedly received from a fall down a flight of stairs. The OIG received a related complaint about the services provided by the private agency servicing the case. The complaint alleged that the agency was negligent in its duty to protect the girl by failing to identify dangerous environmental conditions, including that the foster care provider's boyfriend was living in the home. The two investigations were condensed into one.

INVESTIGATION

The OIG investigation found that the girl who died was born substance exposed. The girl's mother abandoned the child in the hospital and, over time, neither of the natural parents proved to be consistently willing or able to care for the child. In December 1994 the girl was placed with a paternal aunt. The aunt was serving as a relative caretaker and had applied to become a licensed foster parent.

On March 8, 1996, a hospital employee called DCFS to report that the girl had been brought in by her aunt's boyfriend after allegedly falling down the basement stairs. The employee stated that the girl was suffering from a severe skull fracture, was in respiratory arrest and was not expected to live. She died the following day. The medical examiner found no evidence of previous abuse and concluded that although the injuries could be consistent with a fall down the stairs, the cause of death must be listed as undetermined. Local law enforcement chose not to pursue criminal charges against the boyfriend.

DCFS unfounded the charge of death by abuse against the boyfriend but indicated him for neglect resulting in death, brain damage/skull fracture, subdural hematoma and inadequate supervision. A background check revealed that he had several criminal convictions. The aunt, who was not home at the time of the incident, violated the terms of the relative caregiver placement agreement by failing to notify the private agency of her boyfriend's residence in the home or his use as a babysitter. Her foster parent license application was denied when a background check disclosed a criminal conviction she had failed to disclose on her application. Additionally, the girl had not been brought to her DCFS licensed day care provider for three months.

RECOMMENDATIONS

(1) Under the current licensing system, an individual who has been denied a license by one agency can reapply through another agency and become licensed. The OIG recommended that the Department maintain a database to prevent individuals denied a license by one agency from applying through another agency. In addition, this database should allow administrators to place a restriction on individuals applying for licensure. This could be achieved through current licensing records, such as the CACAOS licensing pages or by adding this capability to the Placement Clearance Desk which is currently being developed in response to a prior OIG recommendation.

(2) The OIG recommends that the aunt be restricted from becoming a licensed parent or day care provider.

(3) The OIG recommends that the private agency be advised of the possibility that the girl was not receiving day care services between December 1995 and March 1996. The agency may be owed reimbursement for payments made for services not delivered.

STATUS

(1) The Department is implementing the Placement Clearance Process effective December 15, 1998. The Placement Clearance Desk Process establishes a central place where DCFS and private agency placement staff can obtain information about unlicensed relatives and licensed foster homes. Information about a foster home's license status and maximum license capacity will be secured through the Placement Clearance Desk (PCD). The PCD also has information regarding pending relative or foster home child abuse/neglect investigations, Sexually Aggressive Children and Youth (SACY) protective plans and voluntary and involuntary placement holds.
(2) The aunt's license application was denied in February, 1996. Her home will be placed on hold through the Placement Clearance Process.
(3) DCFS pays daycare providers directly, not through the private agency. Daycare providers submit monthly bills listing children present during the month. No payments were made for daycare services for the girl for the specific time period.

Death Investigation 6

ALLEGATIONS

A child, who was born substance exposed, died after having been accidentally hit in the head with a plastic toy by his brother. At the time of the child's death, the family was part of a DCFS intact family case and the mother, who was caring for seven children, had been indicated for substance abuse.

INVESTIGATION

The OIG investigation revealed concerns as to how the Child Endangerment Risk Assessment Protocol (CERAP) and the Substance Exposed Infant (SEI) Protocol were being used to determine risk and safety to children in cases where the issue of substance abuse is present. The SEI protocol requires that an assessment be made of the children's educational needs. In this case neither the Child Protection Investigator nor the follow up caseworker knew that the two older children had missed over fifty days of school the previous year, indicating that the mother's drug use was probably interfering with her ability to parent these children. Under the SEI protocol, a family is not considered low risk unless a non-drug abusing caregiver is living in the home and available to help the parent. Although the mother had indicated that her brother would help her in the home, he did not live in the home and therefore could not be counted on to provide the around the clock assistance this mother needed.

RECOMMENDATIONS

(1) The Department take demonstrable steps to implement and integrate the SEI protocol, which has been documented for over three years, and use it in conjunction with CERAP in the field.

(2) The worker on this case should receive supervisory hands-on guidance on discussing family planning and locating a clinic in the mother's community that will provide family planning information to her. The worker should document his efforts regarding family planning in the case file.

STATUS

(1) The Department agrees with the recommendation and will work aggressively to achieve full implementation. DCFS referred the SEI protocol to a national panel of experts for review and is currently putting together a small work group to fine tune and implement the SEI protocol.

(2) The worker received guidance regarding family planning issues. The Department will assist the mother in locating a clinic that will provide family planning information to her.

Death Investigation 7

ALLEGATIONS

A fourteen-year-old female DCFS ward hanged herself in April 1998, while a resident at a state mental health facility. The child had become a ward in February, 1997 as a Minor Requiring Authoritative Intervention after she had refused to return home. In 1996, she had been hospitalized at least three times because of suicide attempts. The child had a history of extreme depression. She was the victim of five indicated reports of physical or sexual abuse between 1988 and 1994. The physical abuse was by her mother and step-father, an uncle, and the mother's boyfriend. The sexual abuse consisted of fondling by the mother's boyfriend.

INVESTIGATION

The Inspector General of the Department of Human Services is investigating the mental health center's conduct regarding the ward. The Illinois State Police is investigating the death, as it occurred in a state facility. The OIG investigation examined the Department's handling of the case in terms of the information provided to the facility and its efforts to plan for the future care and services to the ward upon discharge. Complete case records describing her behavior and suicidal desires were furnished to the hospital. The agency provided services to the child, participated in her aftercare planning and had just received approval for residential placement where it was expected she would be placed from the hospital. The investigation found that DCFS provided all pertinent documents and information to the facility to assist in the girl's treatment. DCFS fulfilled all of its obligations to disclose and share information.

RECOMMENDATIONS

No recommendations were made.

Private Agency & Contractor Investigations

Private Agency & Contractor Investigation 1

ALLEGATIONS

Multiple complaints and serious licensing and contract violations culminated in the closure of a group home and foster care agency in October of 1996. Because of the nature and extent of the problems, the OIG initiated an investigation into the circumstances under which the private agency was granted a DCFS license to operate. During an investigation into the licensure of the private agency, a complaint was received from another child welfare agency alleging that the DCFS licensing representative who had handled the licensure of the above group home and foster care agency had solicited a job from a private agency during the post-licensing process. The Department's licensing representative was a subject of this two-fold investigation.

INVESTIGATION

The investigation revealed that the private agency was improperly licensed in 1994. The licensing process carried out at that time had been reduced to a clerical function. The end result was a child welfare agency managed by unqualified people who misrepresented their credentials, financial irregularities and group homes found to be in deplorable condition. The investigation also revealed a gradual relaxation of licensing requirements. From June 1994 to September 1997, Licensing in this division was overseen by an administrator who lacked the required experience, expertise and leadership to ensure that licensing standards were interpreted and enforced in a manner designed to benefit the children entrusted to the Department. During her three year tenure in Licensing, the administrator attended graduate school which was paid for by the Department (SWEP), and resigned from the Department only three months after obtaining a Master's degree. The OIG found that the licensing representative improperly licensed the private agency and failed to perform compliance reviews of the children's records and provision of services.

The second part of the investigation focused on statements allegedly made by the Department's licensing representative. An administrator at a private agency claimed that the licensing representative had told him that their director would no longer qualify as a director under new licensing regulations and suggested herself as a replacement. Although the licensing representative denied making the comment, the OIG found significant indicia of reliability in the administrator's statement of the facts.

RECOMMENDATIONS

(1) Discipline is recommended for the Department's licensing worker and her ethical violations warrant a counseling session.

(2) The DCFS Administration has a duty to address the deficiencies in Agency and Institution Licensing including: a) establishing a Licensing structure, independent of other Department units, b) establishing a qualified, experienced, and capable licensing management team in Cook County and c) directing sufficient resources towards rectifying existing deficiencies and developing the capacity to license qualified individuals and facilities.

(3) The Department should operationalize a formal Request for Qualifications process within Licensing units on a statewide basis.

(4) The Department should audit the records of all licenses processed in the past 3-5 years by this licensing worker to ensure that they have been properly granted.

(5) Supervision of all Licensing staff should require accompanying each worker to agencies at least twice annually. The OIG's previously recommended method of employee supervision and evaluation should be implemented.

(6) Licensing staff should verify background information provided by applicants and their newly hired senior administrators.

(7) The Department should immediately initiate license revocation proceedings on all child welfare agencies whose contracts were canceled because of significant contract and licensing violations.

(8) The Department should take immediate action to recover all funds paid by DCFS for the supervisor's post-graduate education under the SWEP Program.

STATUS

(1) A counseling session was held with the licensing worker on March 25, 1998.
(2) Effective February, 1998, the Office of Licensing was transferred to the Purchase of Service Monitoring Division. At that time, Cook County Agency and Institution Licencing was restructured and strengthened. A Unit Manager was hired effective March 1, 1998. Additional staff were added to Cook Agency and Institution Licensing. Training was provided through the University of Illinois' program for agency executive directors on governance, fiscal and operating practices for maintaining a successful agency. An internal audit regarding work processes and supervisory structures was completed to assist management in strengthening the overall functioning and accountability of the unit.
(3) The Department does not have a formal RFQ process. However all potential applicants for child welfare licenses are initially handled by the Associate Deputy Director of Licensing. The Associate Deputy Director provides a very clear understanding of the qualifications for licensure and provides an analysis of whether the Department has a need for the service the potential applicant is intending to provide. Revised Child Welfare Licensing Standards, issued May 20, 1998, contain a number of new standards an agency must meet to become licensed (these were prior recommendations of the OIG). Governance, fiscal and operating standards that an agency must meet are tested through this process, which essentially serves as an RFQ.
(4) A review protocol was developed and implemented in February, 1998. DCFS has completed the reviews on the majority of the agencies that received licensure in the past three to five years. The remaining reviews will be completed by February, 1999.
(5) The Department agrees with the intent of this recommendation. DCFS supervisors are required to accompany licensing workers on visits at least once a year at a minimum. Licensing supervisors have the discretion to do so more frequently as performance warrants.
(6) The DCFS Office of Licensing has drafted instructions on how to verify background information. This memo was sent to all Regional Licensing Administrators in November, 1998.
(7) The Department agrees with this recommendation.
(8) The Department is attempting to recoup the tuition paid on behalf of this supervisor.

Private Agency & Contractor Investigation 2

ALLEGATIONS

The OIG investigated the services delivered by a private agency to the family of a three-week-old ward, born substance exposed, who died of natural causes. The infant's brother had been a ward since 1994. A review of the family's case record indicated problems with case management and licensing services delivered by the private agency.

INVESTIGATION

The OIG found that the case had multiple caseworkers and periods where the case was unassigned resulting in significant gaps and delays in service. The OIG found that private agency caseworkers failed to enroll the biological mother in substance abuse treatment and failed to monitor prenatal care or request drug screens. A caseworker failed to intervene despite learning that the natural mother was having unsupervised contact with her son in violation of a court order. The agency inappropriately referred the child for counseling and claimed counseling had been completed when no evidence existed that the child needed or received counseling. The agency failed to arrange for hearing and lead level testing and failed to access testing completed by the Public Schools. When difficulties arose regarding his attending school because of bus problems, the agency failed to resolve the situation. After his sister's death, the child was removed from his relative foster placement during the DCP investigation. Throughout the new placement, the child reported incidents of injury and bullying by the foster parent's eleven year old daughter. He was not removed from the home until his aunt made a hotline call after observing bruises on his face and chest. The agency never conducted a licensing investigation and failed to ensure there was a safety plan in place after the first allegation by the child. Throughout the investigation, the agency continued to place children in this home.

RECOMMENDATIONS

(1) DCFS should put a hold on the agency's intake and assist the agency in developing a corrective action plan to address the following: training for all agency staff on DCFS rules, policies and procedures, ensuring case staffings occur following assessments in order to discuss recommendations and to amend service plans, conducting staff turnover analysis for redress and developing policy and procedure to address the need for internal case record reviews and continuity of service provision during case transfers.

(2) DCFS should immediately evaluate the foster parent to determine whether she can appropriately provide foster care. The issues to be assessed are to include but not be limited to her ability to protect foster children in her care, her children's response to foster children in her home and her ability to effectively manage her children's aggressive behaviors.

STATUS

(1) The Department placed a hold on the agency on July 2, 1998. A corrective action plan was developed and compliance is being monitored by the Agency Performance Team.

(2) An evaluation has been completed.

Private Agency & Contractor Investigation 3

ALLEGATIONS

The OIG received multiple complaints about a licensed private foster care agency and its staff. Allegations included late or unpaid foster care board payments, foster homes in violation of licensing standards, misrepresentation of credentials by employees, unqualified employees including family members of the executive director, and significant staff turnover.

INVESTIGATION

The OIG investigation found serious operating problems including: inadequate oversight by a Board of Directors, lack of accountability by the executive director, financial mismanagement due to unqualified personnel and nepotism, failure to complete background checks of employees and positions filled by unqualified staff resulting in poor case management and supervision. It was discovered that in 1976, the executive director had provided false academic credentials to obtain the license to begin operating this child welfare agency.

The investigation revealed that the agency was Medicaid certified in 1994 and was in the process of completing its contract conversion with the assistance of a consulting firm that is contracted by the Department. The consulting firm was hired by the Department to assist the agency in developing billing practices that maximized its ability to "pull-down" federal funds. Neither the Department nor the consulting firm had conducted any substantive review of the services provided to ensure that the services were adequate prior to assisting them with billing. A system that approves the billing capabilities of an agency whose financial practices are seriously deficient is inherently flawed.

The investigation also uncovered the illegal operation of an out of state, non-accredited school which conducted classes in Illinois and granted post-secondary degrees after five months of participation. Classes were held on the premises of the subject agency and eight employees, including the executive director, obtained degrees.

In May 1998, the OIG forwarded a set of guidelines to verify academic credentials and school accreditation status to 281 licensed child welfare agencies in Illinois.

INVESTIGATIVE REFERRAL

A referral was made to the State's Attorney for investigation which resulted in a Final Consent Judgment prohibiting the school from operating in Illinois, ordered tuition refunds to former students under certain conditions, and a Judgment of $2,000 to be paid to the State's Attorney's Office for recovery of investigative costs. A total of 42 students were identified.

RECOMMENDATIONS

(1) All contracts with the private agency be phased out and their cases be transferred to other private agencies with minimal service disruption. All receiving agencies should be provided with complete child and foster home licensing records.
(2) The Department should conduct an audit of the agency's financial records to determine the amount of money owed to the State.
(3) The Department should review the criteria for Medicaid certification to determine both how private agencies with serious financial management deficiencies are certified and to evaluate the appropriateness of the consulting firm's involvement with child welfare agencies with known operating problems attempting to become Medicaid certified.
(4) The Department is advised to routinely assess the financial condition of an agency when relatives of the executive director hold key positions, especially in the area of business and financial management. Appropriate action must be taken when non-profit agencies are found to be run by members of a family to ensure that: a) financial management responsibilities are carried out by a qualified professional, b) financial matters of the agency have not been compromised by relationships and, c) that differential treatment of family members with regard to supervision, salaries and benefits does not exist. Licensed child welfare agencies and institutions should be discouraged from permitting employees to engage in hiring, firing, direct supervision or reviewing job performances of employees who are members of their families.
(5) The OIG developed credential verification guidelines for distribution to the Department and private agencies.
(6) Develop measures to protect the State Central Register from inappropriate requests for CANTS checks by and for private agency workers. (See OIG report #'s 95-495 and 96-532 dated December 23, 1996.

STATUS

(1) The Department's contract with the private agency was terminated in late Spring, 1998.
(2) An audit was commenced during Spring, 1998. DCFS eventually took over all financial management of the agency in its final two months because of extensive irregularities in fiscal management.
(3) DCFS Purchase of Service Agencies are required to demonstrate managerial and fiscal competence. As a result of the OIG's recommendations, agencies requesting Medicaid contract conversions now undergo a DCFS internal review to determine eligibility for conversion. In addition, new procedures were put into place to assist the Department in monitoring the ongoing compliance of all contractual agencies.
(4) Effective July, 1998, DCFS established a Purchase of Service Field Fiscal Unit which is responsible for conducting reviews. Using financial distress indicators or upon referral of irregularities, a field audit is initiated.
(5) The OIG developed credential verification guidelines for distribution to the Department and private agencies. See the OIG's report dated March 16, 1998, File Nos. 96-800 and 97-298 or recommendation regarding verification of credentials of license applicants and newly hired persons in senior management positions. A memo detailing these guidelines was disseminated on November 30, 1998.
(6) The Department assigns an individual identification number to each appropriate POS and DCFS employee that allows them to request CANTS information for use in making child welfare decisions. The Department is in the process of developing a policy to address employee misconduct and violation of confidentiality as a result of systems misuse.

Private Agency & Contractor Investigation 4

ALLEGATIONS

It was alleged that a private agency had acted against a 14-year-old ward's best interests by terminating her placement, ending a nine year foster parent-child relationship.

INVESTIGATION

The OIG found that over the last two years the girl's behavior had become increasingly erratic and belligerent. She began to act out in an increasingly agitated manner, particularly at school. The private agency chose to address these problems with a combination of therapy (even though the girl's previous therapist had terminated treatment as it had reached its maximum benefit) and psychotropic drugs. The foster mother found this program to be ineffective and overly burdensome (transportation and additional appointments) for her as the foster parent. The private agency believed that it had acted properly by removing the girl from the foster home because of the foster mother's reluctance/refusal to comply with agency directives. Because of conflicting stories and documentation which can be interpreted to support either of the two parties, it was not possible to establish whether this removal was justified or the result of growing antagonism between the foster parent and case managers.

RECOMMENDATIONS

(1) The OIG recommends that when foster parents' job performance is in doubt, steps taken by the social service agency to correct these difficulties should be carefully documented and copies of this documentation sent to the foster parent. For repetitive problems of minor to moderate severity, a process of progressive discipline should be adopted (i.e., verbal warning, written warning, formal disciplinary action, termination) with provision for external appeal. This particular case might have benefitted from external assistance and early intervention provided by the Department's Placement Stabilization Services.

(2) Treatment of emotional, behavioral and cognitive disorders is an art rather than a science in which most existing interventions yield modest benefits and all have varying effects across individuals. Case managers must constantly monitor treatment outcomes and, after a reasonable trial period in which existing interventions are demonstrated to be ineffective, explore alternative treatments. Concern for outcome should be present even when clients are receiving generally accepted treatments from fully accredited service providers. The OIG also recommends that the Department assemble a new committee to provide external review and consultation for foster care children with severe behavior management problems.

(3) The private agency's policy and staff training materials should be reviewed to see that they clearly describe the supportive role case managers should assume relative to foster parents. The central function of foster parents in child welfare systems (e.g., surrogate parents providing 24-hour care in their own homes) should be emphasized. This material should be circulated to all agency case managers and included in the curricula for regular in-service training.

STATUS

(1) The Department agrees that a better process to evaluate and give feedback to foster parents on their care of children is needed. The Director has requested the OIG, in conjunction with the Department, raise this issue at a Statewide Foster Parent Advisory Meeting. The Department will then bring together a group of foster parents, providers and Department staff to develop the process.

(2) The Department should develop a clinically sound mechanism to measure treatment outcomes. A behavioral health committee is being formed by the Office of Health Policy and the Clinical Services Division to develop a well organized service response to the behavioral health needs of DCFS children. A primary task of this committee will be to develop an evaluation tool as well as a process for monitoring behavioral health services. The committee will include the DCFS Medical Director, a psychiatrist, a chief psychologist and social work, behavioral and client advocate representatives.

(3) Clinical/Training will share this report with the private agency and will review the agency's policy and service staff training curricula. The agency will be provided needed professional assistance, materials and support.

Private Agency & Contractor Investigation 5

ALLEGATIONS

The OIG investigated a complaint that a foster parent was unsuitable to continue to care for wards because she had an indicated report for physical abuse against her son. The private agency that licensed the foster parent refused to remove the foster children when requested, stating that the foster parent had completed a corrective action plan.

INVESTIGATION

The OIG found that the foster parent was initially licensed by Agency A in 1988. In 1996 she had an indicated report of physical abuse for biting her adopted son. While the foster parent did receive services to address her son's special needs, Agency A based their claim that she could continue to be a foster parent on a flawed assessment that failed to address the fact that the services the foster mother received did not address the issue of the abuse of her son. The foster parent then transferred her license to Agency B. The OIG found that Agency B failed to complete a home study or gather significant information. Agency B failed to complete requested licensing investigations of the home. The indicated finding of abuse for the intentional biting of a child did not bar the mother from being licensed as a foster parent. The children placed with the foster parent were removed at the request of the Public Guardian, who objected to the placement of any current and future clients in the foster parent's home. Agency B decided to place adolescents in the home. While Agency B indicated she needed training on teenagers, she never received training. Two teenage boys with significant behavior problems were placed in the home.

RECOMMENDATIONS

(1) A foster parent license should be revoked or denied based on an indicated finding of Priority II allegations that involve intentional abuse such as biting, scalding, or choking a child.

(2) The private agency should transition out the older minors placed with the foster parent.

(3) The foster parent's license should not be renewed. The private agency should make appropriate referrals or offer services to the foster parent such as vocational and/or employment training and job placement services.

(4) The private agency should review all foster home licensing records to ensure they are complete.

(5) The proposed Placement Clearance Desk should be notified of all pending DCFS and Licensing investigations of foster homes and place a hold on the placement of children pending the outcome of the investigations. The agency conducting the investigation should submit a copy of the report to the Placement Clearance Desk before a hold can be removed.

(6) The OIG will convene a meeting with the private agency to discuss the findings and recommendations contained in the report.

STATUS

(1) DCFS Rule and Procedure will be amended to reflect that indicated findings of the Priority II abuse allegations of biting, scalding or choking a child warrants denial or revocation of a foster parent license.

(2) DCFS has removed all of the children from the home except for a 19-year-old male who refuses to leave. The private agency is working on transitioning him to independence.

(3) The foster mother's license will be maintained until the 19-year-old has left the home at which point the license will not be renewed. The foster mother's name will be referred to the Placement Clearance Process as ineligible for additional placements.

(4) The private agency completed a review of all foster home license records to ensure that the OIG recommendations were addressed.

(5) The Department disagrees with this recommendation. The Placement Clearance Process requires a hold on placements in homes which are under investigation for child abuse or neglect. Licensing investigations can be for minor infractions as well as serious ones. The Placement Clearance Process allows the authorized agent to place holds on foster homes under licensing investigations for health and safety issues. However the Regional Administrator is not required to place that hold if the home is being investigated for a minor infraction.

(6) The OIG met with the private agency to discuss the report and recommendations.

Private Agency & Contractor Investigation 6

ALLEGATIONS

The OIG received multiple complaints alleging that a child welfare agency failed to make reasonable efforts to service children in its care, and that a newly hired case worker was directed by the agency's executive director to testify falsely in court that specific children had been seen and serviced by the case worker. The complaint also alleged misuse of agency funds and non-payment to foster parents.

INVESTIGATION

The investigation revealed that during the agency's licensing by DCFS in November 1994, the executive director misrepresented her credentials. The investigation found serious operating problems including: inadequate oversight by a Board of Directors, no evidence of a functional accounting system or internal controls, incomplete personnel records and background checks of employees, incomplete foster home records and grossly inadequate services to children. The investigation also revealed that the executive director violated Department policy when she issued a foster home license to an employee. The employee's foster home record was incomplete and his application contained false information. The same employee's personnel file contained false academic documents. The OIG investigation revealed two other licensed foster parents had indicated abuse and neglect reports. DCFS terminated its contract with the agency just prior to completion of this investigation.

INVESTIGATIVE REFERRALS

The names of three agency employees were referred to the Illinois Attorney General for criminal investigation.

RECOMMENDATIONS

(1)The Department should immediately initiate revocation proceedings on the foster home licenses of the agency's employee and the two foster parents with indicated abuse and neglect reports.

(2) The OIG is available to Department personnel to discuss outstanding issues found in children's case records.

(3) The Department's Agency and Institution Licensing personnel should verify the academic and employment history of an agency's senior administrators. Verification of executive directors' credentials should occur anytime there is a change in that position.

(4) The Department should consider establishing a central depository of names of child welfare professionals who conducted themselves inappropriately for special review prior to their re-employment in child welfare.

STATUS

(1) Two children remain in the foster home of the agency employee and their license remains in effect until April 15, 2001. After a DCFS decision to remove the children, the foster home appealed and an administrative decision dated May 4, 1998, granted the appeal to have the children remain in their home. The second foster home remains licensed but no children are currently placed in the home. The third foster home is not licensed and has no children placed in the home. These foster homes will be referred to the Placement Clearance Process effective December 15, 1998, for a hold on future placements.

(2) The Department canceled the agency's contract in March, 1998, and the cases were transferred to other agencies.

(3) The DCFS Office of Licensing has disseminated instructions on how to verify background information based on the OIG report. These instructions will be sent to all Regional Licensing Administrators on November 30, 1998.

(4) Agency Performance maintains a list of individuals who have been identified as having false or insufficient credentials. This information is available to potential employers. DCFS has instructed agencies to check prior employment histories with former employers before extending job offers. DCFS is developing a process for licensure/certification of child welfare staff.

Private Agency & Contractor Investigation 7

ALLEGATIONS

The OIG investigated an allegation from the Court that a private agency caseworker had inadequately serviced a family.

INVESTIGATION

The OIG found that this case was transferred from an agency that the Department had closed. The case records from the closed agency were in disarray. At the time of case assignment, each receiving agency was given only the children's names, current placement and next court date. DCFS Legal, which maintains a file on all families involved with the Court, was not utilized to reconstruct the case files. The OIG found that the caseworker from the receiving agency did an acceptable job given the limited information she had.

RECOMMENDATIONS

(1) Prior to the first court hearing subsequent to a case transfer because of an agency closure, the judge should be informed by DCFS Legal of the following: a) the amount of time the case has been with the newly assigned agency and caseworker, b) the condition of the case record at the time of transfer and c) what the new caseworker has completed since receiving the case.

(2) DCFS Legal should assist in ensuring that when cases are transferred from closing agencies, the receiving agency has access to DCFS Legal's documents regarding the case at the time of transfer.

(3) DCFS Legal should maintain copies of the following documents on all cases; service plans, social histories, service reports, progress reports, diligent searches, evaluations, assessments, and court orders.

STATUS

(1) The OIG's recommendation cannot be applied statewide since the Office of Legal Services does not regularly staff courtrooms or appear through counsel in the vast majority of cases in counties other than Cook County. This recommendation would cause the Department to create special procedures for presentation of evidence in Cook County only.

Currently, judges in juvenile court routinely receive information regarding case assignment. Prior to each court date, information regarding caseworkers and agencies assigned to cases is given to the Court Facilitator who brings this information to the courtroom. The Department regularly advises the court of the current caseworker and POS agency through testimony by a worker, or information provided on inquiry from the Court Facilitator. The OIG's recommendation would create an affirmative duty on the part of Department legal staff to provide information regarding the assignment, condition of files and status of work in all juvenile court cases when the case is transferred from a closed agency, whether or not there is a problem with the case transferred. There is no such affirmative duty in the Juvenile Court Act.

DCFS Legal staff do not receive nor review case records. Legal staff cannot be required to do so since this would place the attorneys in the position of performing the actual work for a client instead of representing them. Such activities would blur the distinction between attorney and client, cause legal work to be discoverable and become witnesses in cases. Agency Performance teams review case records on transfer from closed agencies and are asked to provide relevant testimony if necessary in particular juvenile court proceedings. For these reasons, DCFS attorneys should not become independent fact-finders with administrative responsibilities.

(2) Information in DCFS Legal files is shared with private agency staff upon request.

(3) The purpose of the legal file is to provide information necessary for the legal staff to represent the Department in juvenile court. DCFS Legal files are not intended to duplicate the case record, as defined in DCFS Rule and Procedure, or even the case record maintained by the clerk of the court as DCFS Legal has access to the full case record and court file when necessary. Items in the OIG's recommendation may be submitted in the course of a court proceeding and may be retained in the legal file, but only as necessary and needed in a particular case. Thus, while the legal file can be helpful, it is not a comprehensive case file that meets the requirement of the Department's file policy.

OIG NOTE: This response represents a fundamental philosophical disagreement between the OIG and the Department. The Department's response contends that informing the court of relevant facts concerning case transfer problems would create an "affirmative duty" that does not otherwise exist in the Juvenile Court Act. In fact, the Juvenile Court Act imposes a duty on the Department, as Guardian, to act in the best interests of the minor. In addition, the Department has certain duties based on the public's investment of trust in the agency. To fulfill its duties, the Department must have comprehensive historical information about children and their families to make informed decisions and to allow the court to make informed decisions. The Department cannot avoid these duties by contracting with private agencies. The duties encompass the responsibility to share information that a fact finder would need to evaluate information provided by the Department or private agencies. If the information cannot be provided by DCFS attorneys, the OIG agrees that the information could be conveyed by courtroom liaisons instead.

The OIG is also concerned about the portion of the response that suggests that DCFS Legal staff could not review case records. While the OIG was not suggesting that DCFS Legal should make the ultimate clinical decision in a case, it is disturbing that the Department's attorneys do not view it as part of their responsibilities to be sufficiently familiar with a case to raise legitimate concerns based on a knowledge of the record. The OIG knows of no other practice of law in which knowledge of one's clients' work would be considered to "blur the distinction between attorney and client."

Private Agency & Contractor Investigation 8

ALLEGATIONS

In Fiscal Year 1997, the OIG received a copy of a report on a private agency from the Office of Internal Audits (OIA). The report disclosed significant financial mismanagement of DCFS funds by the private agency and suggested possible fraud of up to $1,000,000. The OIG learned that the private agency was one of the few newly developing child welfare agencies that had received accreditation from the Council on Accreditation (COA). Accreditation will have increased importance under the new licensing standards and performance contracting. The OIG undertook an investigation into COA's standards to determine how the private agency under investigation by the Department received accreditation.

INVESTIGATION

The OIG investigation found that in order to receive accreditation, a private agency must disclose whether it has faced, "allegations or findings of professional misconduct, financial malfeasance, failure to comply with laws and regulations governing equal opportunity and personnel administration, or investigations by auditing, regulatory or monitoring bodies which have identified problems at the agency." COA also requires private agencies to submit a questionnaire to their major funding sources which are returned directly to COA. At the time it submitted its accreditation application, the private agency was aware of the OIA's investigation into their financial practices.

The OIG was informed that the criminal investigation of the private agency was "on hold" because the Department was pursuing settlement discussions. Settlement discussions included recouping funds owed out of future monies to be paid by DCFS.

INVESTIGATIVE REFERRALS

The OIG referred the audit to both the IRS and the Attorney General for further investigation. COA agreed to conduct its own investigation to determine whether COA accreditation was secured fraudulently.

RECOMMENDATIONS

(1) The Director institute an agreement with COA that in the future, all child welfare agencies seeking accreditation submit their questionnaires directly to the Office of the Director of DCFS for the Director's signature and approval.

(2) The Department advocate with COA that they investigate the circumstances surrounding the private agency's alleged failure to disclose. If it is determined that this action amounts to fraud by omission, accreditation should be revoked. In addition, if it is determined that accreditation was procured without full disclosure, the Department should ensure that the private agency's current accreditation will not entitle them to any enhanced consideration under either licensing or contracting standards.

(3) The Department should actively pursue criminal prosecution of responsible parties at the same time as pursuing a civil settlement. The Department must ensure that all monies accepted by the Department in settlement of any civil claims come from personal holding of culpable parties or private fundraising and not from contract monies currently coming from the Department.

(4) The Department should terminate its current contracts with the private agency in light of the results of the investigations and the issues of trust that may be raised by their failure to properly disclose relevant information to the accreditation agency.

STATUS

(1) Questionnaires received from COA on behalf of child welfare agencies seeking accreditation are submitted to the Director's Office for signature and approval. **(OIG NOTE: This process will require further OIG monitoring. Several months after the process was in place, the Department was unable to produce copies of letters. The Department responded by transferring responsibility to a different deputy.)**

(2) The COA initiated a formal investigation of the private agency to determine whether the agency is qualified to remain accredited or if the accreditation was obtained through the private agency's failure to disclose relevant information.

(3) The Department formally requested the Financial Crimes Task Force to review the private agency audit to determine if any criminal wrongdoing exists. The Department agrees that any monies accepted by the Department in settlement of any civil claims should come from personal holdings of culpable parties or private fundraising and not from contract monies currently coming from the Department.

(4) The Department has placed the agency on hold and is working with the agency on downsizing their operations. Further action against the agency will be considered when the final results of the Financial Crimes Task Force and the COA investigations are complete.

Private Agency & Contractor Investigation 9

ALLEGATIONS

A complainant alleged that a DCFS employee had improperly failed to get necessary records from a private agency during a DCP investigation. The complainant also alleged that various private agencies with Department contracts had concealed abuse by failing to call the hotline even though they had a reasonable suspicion that a child was being abused or neglected. During the DCP investigation, a private agency had been named private guardian of the minor and the Department had acquiesced to private guardianship. The mother was indicated for risk of harm. The private guardian agency had placed the minor in a secure foster home and was offering services to the family directed towards return home. The complainant later alleged that the DCFS employee had irresponsibly agreed to delete a requirement for a parenting assessment from a court order, in which the private agency had agreed to certain services that would be provided prior to any return home. DCFS was not a party to the private guardianship/custody case and had not screened the case into abuse/neglect court.

INVESTIGATION

The OIG investigation revealed that various agencies had failed to turn over documents because they believed the documents to be protected by the Mental Health Confidentiality Code. OIG intervened to ensure that documents were accessed and reviewed by the Department.

OIG reviewed the transcript of the proceedings during which the Department representative was alleged to have agreed to delete a requirement of the parenting assessment. The transcript did not support the complainant's allegation.

INVESTIGATIVE REFERRAL

OIG referred the questions of whether ANCRA had been violated and whether the private agency handbook was misleading in terms of compliance with ANCRA to the State's Attorney's Office.

RECOMMENDATIONS

(1) The Department should promulgate rules prohibiting private agencies from pre-screening reports of abuse or neglect.

(2) In the event that a private agency is charged with failing to call the hotline, the Department should intervene and seek the removal of the private agency as private guardian.

(3) The Department should meet with the private agency to clarify questions regarding pre-screening abuse and neglect reports.

STATUS

(1) Department Rule 300, Reports of Child Abuse and Neglect, Interference with Reporting Prohibited, specifically states that mandated reporters who report instances of child abuse or neglect in their capacity as members of the staff of an agency may also notify the person in charge of the agency. However the person in charge may not exercise any control, restraint, modification or other change in the report or forwarding of such report to the Department. Any person who knowingly and willfully violates any provision in this section shall be guilty of a Class A misdemeanor.

(2) The Department was informed that on January 16, 1998, the OIG spoke with the State's Attorney's Office. The State's Attorney's Office had requested additional information from the complainant. Pending the receipt of that information, the States Attorneys Office would not be proceeding further with criminal charges against the private agency. Guardianship intervention by the Department is not necessary.

(3) The Department met with the agency to discuss these issues.

Private Agency & Contractor Investigation 10

ALLEGATIONS

The workers at a private agency failed to recognize evidence of or respond to allegations of physical and sexual abuse in a foster home, leaving several children at risk. The OIG received a letter from the Office of the Public Guardian protesting the renewal of the foster home's license.

INVESTIGATION

A private agency placed three brothers who had been removed from their mother's care in a foster home. At the time the three boys were placed, the foster mother lived with her mother, her maternal grandparents, her two adopted children and one other foster child. Sometime during the year prior to the boys' arrival, three other foster children had been removed from the home. One girl reported being sexually molested by the grandfather and another reported being hit with a spatula as a regular form of discipline, but both cases were unfounded. At various times, all four foster children were assessed for sexually aggressive displays and behavior consistent with abuse. Although the evaluation did not substantiate physical or sexual abuse, one hospital evaluator stated that the foster mother seemed unable to adequately care for the children and added that all of the children were apparently involved in or exposed to high levels of sexual activity.

The private agency worker for two of the foster children expressed her "strong concerns" regarding the placement of children in the home in a memo that was sent to an agency supervisor and copied to two others as well as the worker for the three brothers. However, the boys remained in the home for four months until a court ruling removed all foster children from the home for assessment.

RECOMMENDATIONS

(1) This report should be shared with the Director and Board of Directors of the private agency. The agency should use the facts of the case for discussion with management to ensure that workers are trained to identify safety issues and act on information in psychological reports that point to problems managing foster children. Based on the negative information in the psychological reports and the repeated claims of abuse, the foster home's license currently up for renewal, should not be renewed.

(2) This report should be reviewed to ensure that licensing administrators understand that when the Department has information suggesting that a private agency foster home should not be relicensed, the Department should intercede to ensure that the private agency performs its responsibilities.

STATUS

(1) This report will be shared with the Director and Board of Directors at the agency's meeting in December, 1998. The foster mother's license was surrendered effective October 16, 1997, per written request from the foster mother. She will be prohibited from being re-licensed.

(2) A memo was sent to Agency and Institution licencing supervisors and staff advising them that the Department has the right and responsibility to ensure that licenses are not issued or reissued to unsafe foster homes. It is the responsibility of the licensing staff to ensure that private agencies carry out their responsibilities for supervising foster homes appropriately.

Private Agency & Contractor Investigation 11

ALLEGATIONS

A private agency misrepresented its leadership in order to obtain licensing under false pretenses.

INVESTIGATION

A private agency was incorporated as an agency specializing in international adoptions. It was a for-profit agency licensed by DCFS. The man who formed the agency and applied for licensing by DCFS was an attorney who had been disbarred for embezzling money from an estate he represented. He was convicted of felony charges for the theft. Just before DCFS issued a license to the private agency, licensing learned of his criminal record and disbarment. DCFS allowed the agency to name a figurehead as director of the agency while the prior director continued to act as director in all other ways. The agency accepted money from families interested in international adoptions, but no children ever became available. After complaints were received from families, the Legal Department of DCFS filed charges for revocation of the private agency's license. OIG assisted Legal in obtaining documentation and interviewing the families.

RECOMMENDATIONS

The moral character of the director of an agency applying for licensing should be considered by licensing representatives. This case could serve as a training tool as an example of when the moral character of a license applicant should be put to serious question

STATUS

The report will be used as a training tool for licensing staff. The agency's license was revoked.

General Investigations

General Investigation 1

ALLEGATIONS

A three-month-old boy was admitted to a hospital with a broken tibia. The hospital staff deemed the boy to have been a victim of abuse and determined that leaving the child in the home presented an extremely high risk situation because of: the severity of the injury which was unexplained by the infant's history, the infant's very young age, the mother's refusal to believe the baby had been abused despite having been present in the home at the time the abuse occurred, the mother's long-standing relationship with the child's father (the alleged perpetrator) and the fact that the father tested positive for drugs. Because the child protective investigator assigned to the case disagreed with hospital personnel and exhibited oppositional behavior, the hospital staff contacted DCFS management. At that time, hospital staff were told that the infant's case would be screened into court, thereby leading hospital staff to believe that DCFS would seek temporary custody and that the infant would be removed from his parents. However the child protective investigator, who did not believe that abuse had occurred, advocated in court for the infant to remain at home under an order of protection. After the case was screened into court, the infant was returned to his mother under an order of protection and his father was granted supervised visits. These visits were to be supervised by the infant's mother.

Thirty-five days after the infant was first brought to the hospital, he was readmitted. This time the infant arrived comatose. Further examination revealed a large depressed skull fracture, subdural hematoma, retinal hemorrhages, and a one-week old rib fracture. Accordingly, the OIG opened an investigation.

INVESTIGATION

The OIG investigation uncovered a combination of poor judgement and a breakdown of the supervisory system that resulted in a child being put in an extremely high risk situation. The investigator who handled the initial case discounted the hospital doctor's finding of abuse because the investigator believed the doctor to be a racist. The investigator allowed this bias to cloud her own judgement in the face of corroborating evidence gathered by both DCFS and independent doctors. The investigator's supervisors, confused by their own beliefs about the doctor and uncertainty about the procedure for screening cases into court, allowed the investigator to proceed unchecked towards her personal goal of returning the infant home while ignoring numerous signs pointing to the parents' inability to care for the child. The investigator asked for and received permission to screen the case into Intensive Family Preservation Services rather than taking custody of the child which was an inappropriate solution for this family given the number of high risk factors involved including the tender age of the infant and the fact that no services could ensure that the abuser would not return at night.

RECOMMENDATIONS

(1) The Department should determine the extent to which DCFS workers harbor an adverse perception of the hospital staff and a meeting should be convened with hospital administrators to address this perception.

(2) The child protective investigator should be disciplined for her lack of professionalism and failure to conduct a full investigation. Her judgement is impaired by her own irreconcilable biases that place vulnerable infants at risk of harm.

(3) The Administrator of Intensive Family Preservation Services should be removed. As administrator, she failed to develop genuine screening guidelines that would have prevented IFPS from accepting a high risk case involving substance abuse when there was no way of monitoring whether an abusive, drug-addicted father would have access to an infant that he had already allegedly abused.

(4) The manager of IFPS should be disciplined for his failure to engage assertively in the management of a problem case when he was given due notice by outside professional colleagues of the existing dangers.

(5) Other workers and supervisors should be counseled for failing to identify risk factors and not intervening to ensure that the risks to the infant's safety were objectively assessed. These individuals should be counseled for not following the infant's case after assuring the hospital staff that the case would be properly handled and for failing to closely monitor the case in light of the worker's behavior and biased position coupled with the risk of harm to the infant.

STATUS

(1) The Department met with the doctor and hospital staff on July 30, 1998.

(2) The child protective investigator was discharged from the Department effective August 20, 1998.

(3) The Department has completed a complete review of the IFPS program. The recommendations from that review are currently under DCFS consideration. The Department has restructured the management of the IFPS program. Effective September 26, 1998, all referrals to IFPS must be approved by both the Child Protection Supervisor and the Child Protection Manager.

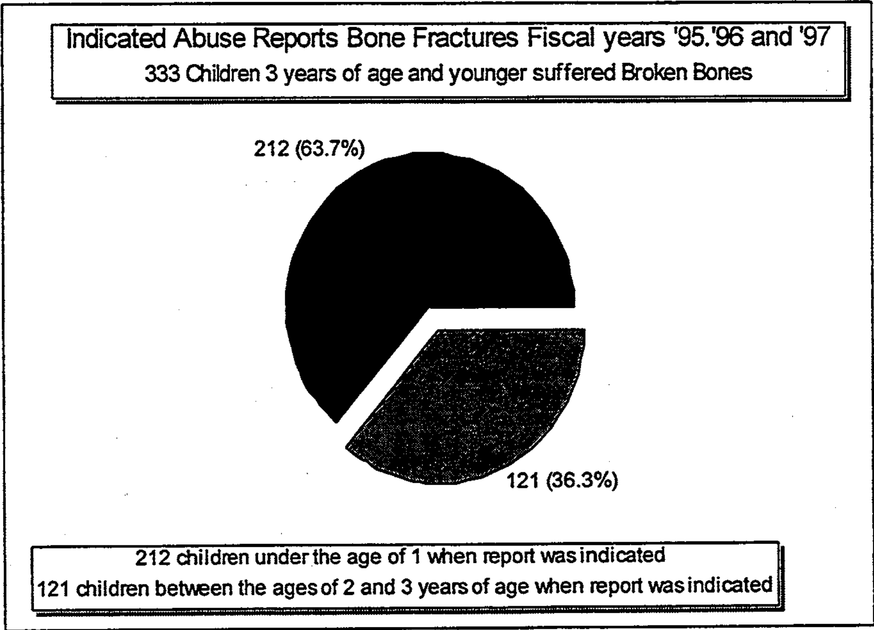
(4) See previous response.

(5) Other DCFS workers were counseled in June, 1998.

SUPPLEMENTAL FACT SHEET FOR GENERAL INVESTIGATION # 1

According to the State Central Register 333 children 3 years of age and younger were indicated victims of broken bones during the fiscal years '95, '96 and '97. Over 200 (63%) of the victims were under one year of age when the report was indicated. Of those, 173 (82%) were indicated on a "A " sequence and 39 (18%) on a 'B" sequence or above.

Overall, the number of indicated reports on children 3 years and younger for the "A" sequence totaled 255 (77%). The "B" through "S" sequence reports accounted for 78 (24%) of the total indicated reports for bone fractures.



Sequence Indicated Reports	Children under 1 year of age	Children over 1year of age and up to 3 years of age	Total number of childrenr 3 years of age and younger
A	173	82	255
B	20	19	39
C	6	8	14
D	4	3	7
E	3	1	4
F	3	2	5
G	0	2	2
H	1	2	3
K	2	0	2
N	0	1	1
S	0	1	1
Total.	212	121	333

Because of the possibility of false positives in the data the number of abusive families who present a clear risk to their infants and young children is uncertain. For example, some of the CANTS/Hospital reports may reflect lack of testing for differential diagnosis (e.g., toddler fractures). Others may be facility reports.

The child welfare profession has learned from clinical research and experience that there is an increased risk of future maltreatment if prior acts of violence have occurred and that children younger then 3 years of age are at particular risk. If the qualitative and quantative data show that mitigating circumstances exist in a percent of the cases, then that information can be used for critical pathway decision-making in determining the appropriateness for using family preservation services in cases of abuse to children under three. Given the high frequency of broken bones with vulnerable children under 1 year of age there are legitimate questions regarding the child welfare response in Illinois. For example:

- What is the incidence of subsequent harm/physical injury to the child or siblings after an indicated report of a broken bone? (Please refer to OIG Death reports.)
- What information, including type of prior indicated reports, would inform child welfare regarding the risk of future abuse?

General Investigation 2

ALLEGATIONS

The fatal stabbings of two foster parents, committed by their 16-year-old grandson, a DCFS ward, presented circumstances suggesting the possibility of employee misconduct and systemic problems.

INVESTIGATION

The Department placed a 16-year-old ward with his grandparents in March 1995 following two-and-a-half years of out-of-state residential placements. A private agency provided the foster care management and counseling services to the adolescent boy and his foster parents. After approximately three months in this relative foster care placement, the adolescent's behavior became increasingly aggressive and non-compliant as evidenced by school truancy, discharging a gun into the mattress in his bedroom, possession and display of several knives and his refusal to take his psychotropic medication. In response to this deterioration, the Department caseworker referred the adolescent to a Placement Stabilization program to attempt to stabilize the youth in his foster care placement with his grandparents. After three weeks of providing placement stabilization services to the youth and his relative foster parents, however, the placement stabilization worker determined that the placement could not be stabilized and referred the youth to the Department's Screening, Assessment, and Support Services (SASS) program for possible hospitalization. After two failed attempts in nine days after the initial referral, a SASS evaluation determined that the youth was not appropriate for hospitalization and recommended deflection services, despite a recommendation from the adolescent's treating psychiatrist that the adolescent may require hospitalization if he continues to fail to take his medication. An intensive one month wraparound plan was devised to provide services to the adolescent and his grandparents. The service provider who contracted with the Department to provide the wraparound services was the same individual who conducted the SASS evaluations. Approximately two weeks after the SASS evaluation, the youth fatally stabbed both his grandparents.

The OIG investigation also revealed that the Department caseworker took no action in response to learning that the adolescent had been in possession of and discharged a firearm in his home. The Department's Rules and Procedures fail to address this issue. The Department failed to understand the inherent conflict of interest that effected the case judgements.

RECOMMENDATIONS

In an *Interim Report* (dated 2/20/96), the OIG recommended that the Department draft and implement a protocol for addressing the issue of wards who are in possession of firearms and other weapons.

In the Final Report, the OIG recommended:

(1) The Department should establish formal clinical protocols to assist decision-makers in the process of identifying children who are good candidates for return to the community. The availability of a placement for the child should only be one component of that protocol.

(2) When clinically required, day treatment programs, respite and emergency hospital beds should be generally expected components of any wraparound plan for a minor returning in-state from a residential program. The Department needs to address the absence of these resources, in particular with regards to LANs (Local Area Networks).

(3) PSSW (Placement Stabilization Services to Wards) guidelines should be revised to provide that placement stabilization is not necessary when a team of professionals has determined that there is a safety risk in the current placement. The guidelines should address allocating resources or designating broader network areas for minors with these needs.

(4) The SASS (Screening, Assessment and Support Services) Program Plan must be revised to include important elements of SASS Protocol and SASS Best Practice. The revised Program Plan should include built-in safeguards to reduce clinical biases and specific procedures for referrals with inherent conflicts of interest such as round table discussions on common biases in diagnostic reasoning. The Department should consider differential diagnoses and strategies for deliberating about Type I and II errors. In addition, the Department should require that 90 day deflection services only be furnished by the SASS agency and not a new entity, as per the contract language.

(5) SASS system needs to provide genuine substantive monitoring of compliance with the Program Plan. Currently, only one consulting agency reviews performance of SASS contracts, and its review does not include quality assurance of clinical determinations or services or compliance with required components of the Program Plan, such as supervision, procuring necessary second opinions and timeliness of assessments.

(6) The Department should develop a protocol delineating clear duties and responsibilities of all those involved in the Local Area Networks (LANs). The protocol should include guidelines charging the Department caseworker with the responsibility of ensuring that the delineated duties and responsibilities are met.

(7) The Department should promulgate a zero tolerance for weapons procedures and enlist the LANs network to locally support juvenile law enforcement's investigators and community-based initiatives to set a zero tolerance standard for weapons.

(8) The Department should cease to contract with the SASS evaluator for future services based on her performance in this case. Any current contractual work should be closely monitored for clinical decision-making, clinical biases, conflicts of interest and compliance with contractual requirements.

STATUS In response to the *Interim Report* dated February 1996, the Department drafted a weapons protocol in November 1998.

In response to the recommendations made in the final report:
(1) The Department is in the process of developing a protocol to structure the decision making and case planning for youth returning to the community from residential care.
(2) The PSSW Program Plan was revised to reflect that placement stabilization is not necessary when a team of professionals determine that there is a safety risk in placement.
(3) The SASS Program Plan has been revised to include the recommendations of the OIG as well as components of the SASS Best Practice documents. The use of the decision support tools developed by Dr. John Lyons is also required by the Program Plan and supported by regular training sessions provided by Northwestern University. The Program Plan now specifically requires that any situation involving a disagreement between SASS and a physician will result in following the physician's recommendation (i.e. Physician Override Provision). In addition, the Program Plan includes provisions for emergency situations allowing for a child to be taken directly to an emergency room in response to serious high risk situations.
(4) The SASS Program Plan requires providers respond to referrals within four hours. In addition, SASS providers are instructed to request that children in need of emergency room treatment be transported directly to hospital emergency rooms. The Department agrees to clarify that it is the caseworker's ultimate responsibility to ensure that a child who is need of hospitalization is taken to the hospital emergency room. DCFS is amending Rules and Procedures to reflect this.
(5) The Department is in the process of contracting with Dr. John Lyons, Northwestern University, for FY99 to provide monitoring of the SASS Program Plan.
(6) The Department provides ongoing training on the SASS Program Plan. Downstate, the training occurs through biannual regional SASS meetings. In Cook County these meetings are held on a monthly basis.
(7) The Department is in the process of contracting with Northwestern University for FY99 to provide SASS program monitoring. All deficiencies resulting from the review of the private agency will be handled with corrective action plans, including personnel issues.
(8) The Department developed and issued Wraparound Contracting Guidelines that provide clear and concise duties and responsibilities for Local Area Networks. These guidelines became effective April 13, 1998.
(9) In November 1998, the Department developed draft policy to provide DCFS and POS staff with a standardized response and reporting procedure relating to the DCFS wards who are suspected to be or are in possession of a firearm or firearm ammunition. The OIG concurred with the draft.
(10) The Department's counseling contracts with the SASS evaluator have been terminated.

General Investigation 3

ALLEGATIONS

The OIG became involved in this case after reading a status review of a joint program of DCFS and a hospital providing medical care for substance exposed infants. The review included information that three families were receiving intact services through the program when the teen mothers, themselves wards of the Department, had given birth to babies who tested positive for PCP, but were allowed to retain custody of the children.

INVESTIGATION

The OIG investigation revealed that twin sisters had been placed into a private agency's independent living program, despite mounting evidence that they were using drugs and were not attending school or working. They both became pregnant soon after their placement, and were subsequently transferred into that same agency's Pregnant and Parenting Teen Program. Both twins gave birth to infants exposed to PCP within one month of each other. While they participated in these programs, evidence of their drug use mounted but was not addressed by the private agency.

The Department also failed to monitor the twins, although there was ample evidence that the Department was aware of the twins' drug use and the fact that it was not being addressed. No DCFS monitor of the case was appointed until after the twins both gave birth to infants exposed to PCP. Once a monitor was appointed, she repeatedly failed to address concerns about the twins' drug use and, in fact, did not even meet them until six months after receiving the case. After the birth of her substance-exposed infant, one of the twins was transferred into the program, which subsequently dropped her because of her failure to participate. The program did not adequately monitor her case. The DCFS Teen Parent Coordinator did not adequately monitor this case or implement proactive remedies even though she was receiving monthly reports showing the poor school attendance of the teens.

The OIG investigation also revealed that the private agency's Pregnant and Parenting Teen Program was seriously mismanaged. When the Program Manager was told that there was a surplus of funds, she made a decision to pay each client $200 per month in clothing vouchers. She organized many trips for the teens, which were supposed to have an educational purpose. However, the Program Manager authorized trips such as a visit to an out of state mall which was fully paid for by the private agency. During this time, most of the teens were not participating in rehabilitative services. The program collected over $8,000 a month for the care of the two mothers, yet failed to provide appropriate services to their teens. For example, the private agency had told DCFS that it needed higher per diem rates because it would provide such things as a part-time nurse/midwife, pre and post natal equipment, increased training for staff and increased random drug tests. Two years after it had negotiated this higher per diem, the private agency still had not put in place any of these services. Over 70% of the teens were not attending school.

Additionally, the problem of the mothers' drug use had not been addressed by the child protection investigators sent to investigate allegations of risk of harm to the infants because of the twins' drug use. Approximately eight months after the babies were born when evidence of the drug use could no longer be ignored, workers at the Pregnant and Parenting Teen Program made a call to the State Central Register concerning the twins and their drug use around their babies. One DCP worker indicated one twin. The other DCP worker did not indicate the other twin, despite investigating an identical report. This worker focused her investigation on issues such as the cleanliness of the apartment, and ignored all the information she collected concerning an uncontrolled drug habit. Parenthetically, this DCP worker called herself "Doctor," despite the fact that her only doctorate was in the philosophy of counseling and was earned in ten months of time through a correspondence course at a non-accredited school.

RECOMMENDATIONS

The OIG recommended that:
(1) an in-depth analysis be conducted on a random sample of program files;
(2) Supervisors of the Pregnant and Parenting Teen Program receive training on substance exposed infant protocol;
(3) the Department employ a standard psychosocial assessment tool to develop relevant intervention plans when clinical concerns arise over a class member's capacity to parent;
(4) the report be shared with the agencies awarded the Network for Parenting Project;
(5) the Department conduct an audit of the private agency;
(6) the private agency's Pregnant and Parenting Teen Program be closely monitored;
(7) the Caucus for Adolescent Health continue to certify pregnant and parenting teen programs;
(8) the DCP worker cease referring to herself as "Doctor," and, in its next personnel handbook, the Department forbid employees from referencing unaccredited educational titles in the workplace or community;
(9) the DCP worker be disciplined; and
(10) the Department monitor be disciplined.

In an addendum to the report, the OIG made additional recommendations that:
(1) the private agency's independent living program be retooled;
(2) the private agency's independent living program see that each of its employees receives substance abuse training and that the worker assigned to this case receive counseling concerning her reaction to the twins' drug use;
(3) the private agency's Pregnant and Parenting Teen Program take appropriate action concerning the poor management of its program, and consider such issues as whether the Manager of the Program should be removed or should receive some kind of discipline; and
(4) the position of the Teen Parent Coordinator be abolished.

STATUS

(1) The Clinical Division has engaged Dr. John Lyons of Northwestern University Hospital to review the SEI protocol and its first piloted model, Healthy FIT, for the purpose of developing an external evaluation of the Healthy FIT Program at Mt. Sinai Hospital. An evaluation tool is being reviewed and information is being entered into a database system. Dr. Lyons projects that the analysis of Healthy FIT will be complete by April, 1999. A Year Two Healthy FIT Status Report will profile 200 clients and selected interventions for a smaller group of intact family cases. The Clinical Services Division will complete the report by December, 1999.

(2) The Clinical Services Division is developing an SEI Training Plan in cooperation with the Office of Health Policy and a state-wide DCFS/SEI Training and Implementation Committee. The training program is being developed in collaboration with the OIG. The training methodology is a five module, interactive video, skill-building curriculum in Field Services Offices and local team meetings. The Clinical Services Division will work with the Pregnant and Parenting Teen Programs statewide to ensure that this training curriculum is available for them and tailored to their needs. The training should be available by Spring, 1999.

(3) The Department met with management of the private agency in September and shared with them a copy of this report and the psychosocial assessment. The private agency has agreed to utilize the protocol.

(4) The report will be shared and used as a teaching tool.

(5) The Department will conduct an internal audit.

(6) The Department has shared the concerns with the agency charged with monitoring the private agency. Further, the Caucus of Adolescent Health recommended to DCFS that the private agency receive provisional certification status. On October 26, 1998, DCFS notified the private agency that deficiencies must be corrected within 90 days of the date of the letter or the contract will be discontinued.

(7) The Caucus will be retained as the certifying body.

(8) The DCP worker has resigned from the Department effective November 7, 1998. The Department's Employee Handbook and the Code of Ethics for Child Welfare Professionals contain language prohibiting employees from misrepresenting their professional credentials.

(9) As stated above, the DCP worker resigned from the Department effective November 7, 1998.

(10) The Department is in the process of administering the appropriate disciplinary action.

Addendum

(1) and (2) The Department will work with the private agency to retool their independent living program including expanding substance abuse training.

(3) The Pregnant Teen Program manager is no longer employed by the private agency.

(4) The position of Teen Parent Coordinator is required under the Hill-Erickson consent decree. Given the recent reforms in the teen parent system through the development of a Teen Parent Service Network under the monitoring agency, DCFS believes that it is necessary for the Coordinator to assist in the implementation of the new program. The Coordinator's job duties have been revised to reflect this and the need for an ongoing coordinator will be evaluated at the end of the fiscal year.

General Investigation 4

ALLEGATIONS

The Department had taken custody of a seven-month-old baby with a fractured leg, but two months had gone by and the mother had not yet been contacted by a DCFS worker. The parent had been indicated for abuse by the Child Protection Investigator even though later reports by doctors concluded this was not a case of abuse.

INVESTIGATION

The OIG investigation revealed that the case had not been assigned to a worker. Although the OIG was unable to determine how this breakdown occurred, it did ensure that a caseworker was assigned to the case and that services were provided to the parent. The Child Protection Investigator's determination that the child's fracture had been caused by abuse was based in part on statements from physicians at the treating hospital who said it was unlikely that the baby could have sustained such a fracture from a fall from the bed as the mother claimed. Before the investigation was closed, other doctors submitted reports indicating that the fracture had not been caused by abuse. These reports, however, were not made available to the investigator because the parents were unfamiliar with DCFS procedures and they had no caseworker with whom they could have shared the information.

RECOMMENDATION

Although the investigator's decision was correct based on the information he had at the time, the OIG concluded that the second opinions of the doctors should have been considered and recommended that the Department conduct an administrative review of the case to determine if the indicated finding of abuse against the mother should be expunged.

STATUS

The Department conducted an administrative review of the case and has determined that the "indicated" report should be expunged. Although the investigator indicated the report based upon the information available at the time, the additional medical opinions support an "unfounded" status. The report has been expunged and a revised notification letter has been sent.

General Investigation 5

ALLEGATIONS

The OIG received an anonymous complaint alleging that a DCFS licensed foster parent fraudulently received day care payments from the Department using several aliases. The complaint further alleged that the foster parent falsified her foster parent licensing application and that her husband is a cocaine addict with a history of domestic violence.

INVESTIGATION

The investigation revealed sufficient evidence to show that the foster parent committed fraud by allowing her sister to receive payments under the guise of being a day care provider. It appeared that the fraudulent day care provider would endorse the checks and keep a portion of the money while the foster parent received the remainder. In addition, daycare was provided from eight in the morning until six at night even though both children were school aged.

There was evidence that the foster parent failed to comply with licensing regulations and standards as required by DCFS. The foster parent had accepted multiple children into her home knowing that she was licensed for only one.

There was also evidence that two DCFS caseworkers failed to check with licensing or the foster parent to ensure that licensing provisions were not being violated.

INVESTIGATIVE REFERRAL

The fraud issue of the investigation was referred to the State's Attorney's Office. The case is pending.

RECOMMENDATIONS

(1) The Department should run all school age children receiving full or part-time child care money to determine if there is over payment. The list obtained should also be reviewed to see if any particular caseworkers' names appear consistently, suggesting patterns of behavior.
(2) The Department should notify the Placement Clearance Desk to place a permanent hold on the foster parent's home.
(3) The two DCFS placing caseworkers should be disciplined for failure to check the foster parent's license before placing children.

STATUS

(1) A child is considered receiving full-time day care if the child receives day care services for more than five hours per day. It is possible that some school age children receiving before and after school care are in care more than five hours per day. The Department is completing a data run on all school age children between the ages of five and eleven. The data will be analyzed for possible overpayment issues and to determine possible fraud by caseworkers.
(2) The Department initiated revocation proceedings on the foster care license. The Placement Clearance Process will be effective December 15, 1998. The foster home will be placed on hold.
(3) The Department is in the process of administering the appropriate disciplinary actions against the employees.

General Investigation 6

ALLEGATIONS

A five-year-old boy died in September 1997 of Myocarditis, a natural cause of death. The boy was the subject of a prior indicated report when he was 3½ years-old for having contracted a sexually transmitted disease from an "unknown" perpetrator.

INVESTIGATION

In reviewing the prior indicated report, the OIG discovered that the report was based on the boy having blisters on his penis which tested positive for Type I herpes (oral herpes). The OIG consulted with medical personnel who speculated that the boy may not have been the victim of sexual abuse, but rather may have self-transmitted the herpes from his mouth to his genitals.

Further review by the OIG revealed that the boy denied ever being touched by anyone or giving or receiving oral sex. Access to the boy had been limited and his parents could not think of anyone who may have sexually abused him. The boy's father, his babysitter's children and the other children at his day care center were cleared of having herpes. The boy had a history of masturbation, which is not uncommon for a 3½ year-old. A medical examination of the boy revealed no evidence of sexual abuse. The doctor's impression was that although the lesions on the boy's penis could be consistent with herpes, they did not represent a classic case. A viral culture was positive for oral, but not genital, herpes.

Medical literature reviewed by the OIG on sexually transmitted diseases differentiates herpes simplex virus (HSV) 1 from HSV 2. HSV 1, or oral herpes, is a viral infection which normally occurs on or about the lips and mouth (e.g., cold sores or fever blisters). HSV 1 is highly contagious and easily passed from one person to another by direct contact with skin and saliva. HSV 2, or genital herpes, is also a viral infection which is spread primarily through direct contact between genital fluids. Both HSV 1 and HSV 2 can appear on or in the mouth and genitals. Young children who have mouth sores and/or an infection of the gum tissue as a result of HSV 1 may autoinoculate (self-infect) themselves in the genital area. A thorough assessment and history-taking by a physician must be done to determine if children and adolescents who present HSV 1 genital lesions have concomitant oral HSV 1 or a history of mouth sores in the previous two weeks. In general, HSV 1 infections in children are probably primarily nonsexually transmitted (although sexual transmissions of HSV 1 can occur).

The OIG concluded that although neither the doctor nor the DCP investigator investigated whether the boy had a history of cold sores in the weeks prior to his genital lesions, the boy's history of masturbation, his denial of sexual abuse, and the lack of any supporting evidence of sexual abuse suggested that the boy autoinoculated HSV 1 from his mouth to his genitals.

RECOMMENDATIONS

(1) The indicated report of a sexually transmitted disease being given to the boy by an unknown perpetrator be expunged and that his parents be notified in person that in all likelihood the boy was not a sexually abused child. Rather, the boy probably autoinoculated the HSV 1.

(2) Redacted copies of the OIG report of the case be shared with DCP administrators to be used as a training tool with sexual abuse investigation supervisors and investigators to make them aware of the possibility of autoinoculation in young children and the need to rule it out before making a finding of sexual abuse.

STATUS

(1) There is no conclusive evidence to support or refute the OIG's analysis of this case. Maintaining an indicated report on an unknown perpetrator could prove to be valuable information if a future incident with another child occurred. The Department disagrees with expunging the indicated report. Although it is possible that the child autoinoculated himself, the Department feels that such contact would be unwelcome and intrusive in light of his death.

(2) In all cases involving herpes, a distinction must be made between HSV 1 and HSV 2 and staff should consult with medical personnel about the possibility of autoinoculation. A redacted copy of this report has been forwarded to Child Protection managers with the directive that the information be shared with supervisors and line staff.

General Investigation 7

ALLEGATIONS

In February 1998, a woman, her three children and her 17-year-old boyfriend were found murdered. On February 14, 1998, the 16-year-old half brother of the boyfriend was charged with the five murders.

INVESTIGATION

The OIG learned that the mother of the 16 and 17-year-olds had two prior contacts with the Department in November, 1997 and January, 1998. The murdered woman was also a subject of one of those investigations. She had an open case with the Department after having been indicated for inadequate shelter. Both investigations contained materials showing a pattern of behavior by the 16 year-old that indicated he was a child out of control. He was indicated on the second report in January for attempting to choke his younger brother. The Investigator noted that he "appears to like to solve problems with violence."

RECOMMENDATION

With the number of indications there were showing the 16-year-old was out of control, he should have been reported to the Juvenile Court for consideration for a delinquency petition. The investigator should have explored with the local police the troubles the boy was having with the law and why placing him under house arrest had been considered. The anger displayed by the choking incident should not have been ignored just because the indicated party refused services. Another avenue, such as Juvenile Court, should have been explored. In Juvenile Court there are consequences for a minor refusing services.

STATUS

The Department will inform and/or screen with local States Attorneys indicated child abuse and neglect cases involving juvenile perpetrators with known or alleged juvenile delinquency petitions. An Information Transmittal will be issued by February, 1999, to all Child Protection Managers with the mandate to train all Child Protection Supervisors on this process.

General Investigation 8

ALLEGATIONS

The current rule requiring a juvenile court finding of abuse or neglect before a child is eligible for adoption subsidies places an unreasonable burden on current and prospective adoptive parents and is contradictory to acting in children's best interests. The OIG was asked to examine the Department's existing policy after two foster families expressed their belief that the absence of subsidies would prevent them from adopting their foster children.

INVESTIGATION

The rule, enacted in March 1996, requires a judicial finding for adoption assistance. In these two cases, involving one boy with a cleft palate defect and another born substance exposed, the parents voluntarily surrendered custody of the children to the state. Since no court actions ever needed to be initiated, no judicial findings exist, making the boys ineligible for adoption subsidy funds.

The boy with the cleft palate defect will require successive facial surgeries as he grows up. His foster father's health insurance through his employer will not cover the cost of the operations and the couple recently had triplets, further extending their resources. The other boy was placed with a single woman who works for a non-profit organization. The foster mother already has an adopted son who is eligible for subsidies and was under the impression that this child would also receive assistance. It was not until the adoption worker began completing the subsidy forms that she realized the boy was not covered under the terms of the new rule. Even though both families wish to adopt these boys, they fear they will have to ask for the transfer of the children because they will be unable to afford their medical needs.

RECOMMENDATION

The OIG recommended the Department use its emergency rulemaking authority to alter adoption assistance rules and develop a means to serve the needs of these two boys and others like them who are in need of a permanent home. The Department spends significant resources to recruit adoptive parents and match them with waiting children. In these cases competent parents have stepped forward, met licensing standards and demonstrated their devotion to the children placed with them. The Department must support these placements with a change in the adoption subsidy rule which allows for assistance in the absence of a judicial finding on a case by case basis when the child has been placed and monitored by DCFS and meets the current definition of special needs. The individualized review of cases could exclude private adoptions.

STATUS

The Department issued Policy Guide 98.5, Adoption Assistance One-Time Only Eligibility, effective July 1, 1998. The purpose of the Policy Guide is to provide instructions for the approval and issuance of state funded adoption assistance for children who cannot be adopted without adoption assistance and who became the legal responsibility of the Department through voluntary surrenders or consents to adoption by a specialized person when there has been no adjudication or probable cause finding of abuse, neglect or dependency.

General Investigation 9

ALLEGATIONS

The OIG received a complaint in November of 1995 from a complainant who alleged that in December of 1992 they had called the hotline to report that a woman had physically abused her son and that an administrator had interfered with the hotline report because the administrator had a personal involvement with the accused woman. The complainant further alleged that the administrator prevented a private agency from receiving service contracts from his Field Office because the agency was directed by the former spouse of the woman with whom the administrator was involved.

INVESTIGATION

The alleged abuse was investigated by a Child Protection Investigator in a separate office from the administrator. The report was unfounded because of insufficient evidence. There was no evidence to support allegations that the administrator attempted to improperly influence the finding.

Even though the DCFS administrator had the authority to recommend that the private agency's services not be utilized, the OIG found no evidence to show the administrator's relationship with the mother influenced his decisions to recommend that his Field Office not enter into a service contract with the private agency. The agency had never entered into a contract with that Field Office and decisions not to use them as a service provider were made prior to the administrator's assignment to his position in that Field Office.

Department rules do not prohibit administrators from maintaining a non-professional relationship with any citizen. However, the Code of Ethics which was implemented in May of 1996, suggests that, "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."

RECOMMENDATION

The supervisor should be retrained in the Code of Ethics at core training.

STATUS

The supervisor was discharged from the Department effective July 17, 1998 for conduct unrelated to the OIG investigation.

General Investigation 10

ALLEGATIONS

A Cook County Assistant State's Attorney learned that the biological mother of a 2-year-old was arrested for buying heroin from an undercover police officer on May 9, 1997. The mother had left her child in a car for fifteen to twenty minutes while attempting to buy the heroin. After reviewing the case and determining that the Hotline had never been called, the Assistant State's Attorney called the Hotline in July of 1997. DCP initiated an investigation of the allegation of inadequate supervision. The OIG was contacted after the DCP investigator informed the ASA that the case would be unfounded because the incident had occurred 2 months prior and the mother was in a substance abuse treatment program.

INVESTIGATION

The OIG investigation revealed that, although the DCP investigation was not completed, the DCP investigator was going to unfound the allegations against the mother based on the following: (1) two months had elapsed between the time of the incident and when the hotline was called, (2) the mother was currently enrolled in a substance abuse treatment program, and (3) the mother appeared to have adequate support and resources. The investigation also revealed that the DCP investigator had made his initial determination to unfound based solely on the mother's self-report of her substance abuse treatment and her promise not to let any similar incidents happen again, prior to verifying her participation or progress in the methadone treatment program. There is also no indication that the DCP investigator conducted a LEADS check on the mother despite the fact that the hotline allegation arose from an incident in which she was arrested for attempting to buy heroin. After consulting with a Department substance abuse expert, the OIG requested an administrative review of the decision to unfound. The allegation of inadequate supervision was ultimately indicated.

RECOMMENDATIONS

(1) The Adult Substance Abuse Screen over relies on information gathered from a client's self-report. The validity, reliability and usefulness of this tool would be increased by requiring workers to verify certain information. The OIG recommended the Adult Substance Abuse Screen be revised so as to require CANTS and LEADS checks to confirm information reported by the client.
(2) The OIG recommended Training for Child Protective Investigators (CPIs) and Rules and Procedures regarding substance abuse include the directive that a client's current participation or willingness to participate in a substance abuse treatment program are not grounds for unfounding an abuse or neglect allegation.

STATUS

(1) The Department agrees that the Substance Abuse Screen is not comprehensive enough to assist staff in decision making around substance use/abuse issues. Because of this, the Department has made a number of efforts to not only improve the screening tool but also to develop a formal approach to assessment. First, the Interventions Program is being established in December, 1998, at Cook County Juvenile Court. This program will serve as a single point of entry for all cases coming into the Department in which substance abuse is identified as an issue. This service will ensure consistency in the assessment process from the point of entry into the Department. Additionally, Interventions is developing a Substance Abuse Screening Tool that will be more comprehensive and reliable.

CANTS checks are already completed on all subjects of reports, including those household members added after initiation of the investigation. These checks document all previous "indicated" allegations including "drug exposed infant".

Department staff have been instructed to indicate who provided the responses to questions on the Substance Abuse Screen. Staff will also question other adult household members , if available, if there is reason to suspect the subject is not being truthful. The Department will issue an Information Transmittal clarifying those instructions.

The Department is in the process of implementing the LEADS protocol. This protocol will expand and clarify the use of LEADS.

(2) CPI training addresses the issue of making findings based upon evidence surrounding the incident, not the subsequent actions of the alleged perpetrator. Child Protection will work with Clinical staff to strengthen the training curriculum in this area. A Policy Interpretation is being developed to remind staff of this requirement.

General Investigation 11

ALLEGATIONS

In January 1997, the OIG received a complaint from the Public Guardian's Office requesting that the OIG investigate a DCP investigator after he was indicated for an allegation of physical abuse against his daughter. According to the DCP report, the investigator beat his daughter for a week, at one point hitting her in the face with a closed fist causing swelling to her jaw. The complaint further alleged that at the time the girl was conceived in 1979, her mother was a 16-year-old DCFS ward living in a group home where this DCP investigator was a caseworker.

INVESTIGATION

The OIG reviewed a social assessment prepared in December 1988 when the girl and her step-sister were removed from their mother, who was raising them alone, after indicated reports of abuse and neglect. In the report, the girl identified the DCP investigator as her father and the mother explained that she became pregnant by the investigator after becoming involved with him while living at a group home when she was 16 and he was a 29-year-old caseworker. In an interview with OIG, the investigator readily admitted his involvement with the mother at the home beginning in 1978. The investigator's application to the Department covers the years 1978-79 but omits any mention of the group home.

The social assessment indicates that for the nine years the mother had custody of the girl, she was a poly-drug user with a long history of prostitution. The investigator acknowledged to the interviewer that, "[The mother and her daughters] sometimes stayed in abandoned automobiles and were generally in tenement buildings whenever he saw them, but that the family rarely stayed in one location for very long." The investigator never reported allegations of neglect or harm or sought to gain legal custody of his daughter.

RECOMMENDATION

The Department should consider the advisability of the investigator's continued employment with the Department after a review of the DCP file given; 1) his history of sexual abuse against a DCFS ward when he was a staff person at her group home, 2) his propensity for violence as demonstrated by the indicated report which involved punching his daughter in the face with a closed fist hard enough to induce swelling, and 3) his inability/unwillingness to assess risk based on his failure to call the hotline or attempt to gain custody of his daughter despite his knowledge of her mother's transient lifestyle and drug addiction.

STATUS

The investigator was discharged from the Department effective August 28, 1998.

General Investigation 12

ALLEGATIONS

The OIG received a complaint alleging that DCFS mishandled the licensing of a foster home resulting in unnecessary and extended delays that threatened to remove a 12-year-old girl from the home of an unlicensed non-relative where she had lived for 7 years.

INVESTIGATION

The investigation revealed that even though the girl was not living with her family at the time of previous DCFS involvement in 1994, her case was wrongfully swept into the legal system when her siblings were found neglected by their mother. The girl's father had guardianship of her and when he was incarcerated, he appropriately left the girl with a female friend who had cared for the child for most of her life. The furor surrounding the high profile incident, which did not involve the girl, resulted in the transfer of guardianship from the father to DCFS rather than to the woman. Over a three year period, the Department's case worker missed opportunities to achieve permanency for the girl through guardianship or adoption by the woman. The Department's foster home licensing staff failed to expedite the licensing process even though they were aware the girl was in a pre-adoptive home. In order for an adult to adopt a child, a foster home license is required. The investigation revealed that the woman's licensing process centered on foster care rather than adoption related issues.

While the foster home licensing process gathers information regarding the adult's preference by type of children, it fails to collect information necessary to assess a foster parent's skills, experience, knowledge or willingness to learn new skills for the purpose of achieving a good placement match. Without family assessments, preference checklists provide one-sided and subjective criteria for the selection of foster home placements.

RECOMMENDATIONS

(1) Policy and procedures should be developed to effectively distinguish foster home licensure from licensure for the sole purpose of adoption.

(2) Foster home licensing personnel should be trained to perform substantive assessments of prospective foster and pre-adoptive families.

(3) The investigative report should be shared with the Department's staff responsible for a special project targeting incarcerated parents. Project staff should work with Permanency Services to afford incarcerated parents the opportunity to consider permanency options for their children.

(4) The Department's foster home licensing worker should be counseled regarding timely licensure of pre-adoptive families, assessments, and proper fingerprinting procedures.

(5) The Department's case worker should be reprimanded for failing to expedite foster home licensure of the woman or advocating permanency for the girl. The caseworker should be counseled on issues in the report pertaining to her performance.

STATUS

(1) DCFS implemented an Adopt Only Training Curriculum for families who are only seeking a foster parent license for the purpose of adoption. The Department has implemented an Adopt Only Licensing Process.

(2) DCFS has created a Family Development Specialist Training. This training is a three week comprehensive curriculum to provide staff with the knowledge and skills needed to license foster homes. DCFS is also revising the Adoption/Guardianship Core Training to better prepare adoption workers to do comprehensive assessments of families who wish to adopt.

(3) The report was shared with Department staff working with Dwight Correctional Center, the intake center for all women entering the Illinois Correctional system, to inform incarcerated women of DCFS policy regarding permanency for their children in our system. Department of Corrections Staff have been provided information and training directly related to the new permanency laws and their impact on women in the correctional system. Program enhancements include developing a process to identify parents and children involved in both DCFS and DOC systems, policy revisions to address the provision of services to meet the special needs of DCFS wards with incarcerated parents and identification of services available to the incarcerated parent when reunification is a viable and appropriate plan for the family.

(4) The Department agrees that discipline would have been appropriate closer to the time of the incident,, however, because of the time lapse disciplinary action would not be appropriate at this time. The Department will have the supervisor discuss these issues with the foster home licensing worker.

(5) The Department agrees that discipline would have been appropriate closer to the time of the incident, however, because of the time lapse disciplinary action would not be appropriate at this time. The Department will have the supervisor discuss these issues with the case worker.

General Investigation 13

ALLEGATIONS

The OIG received a complaint, alleging DCFS had entered into an agreement with a 17-year-old girl to care for three of her siblings, ages eleven, eight, and six. The complaint further alleged that poor jüdgement was used in placing such a great amount of responsibility on a 17-year-old.

INVESTIGATION

The Office of Inspector General found that the agreement entered into by the Department and the 17-year-old stipulated:

1. The girl was not to allow her mother or father to leave with any of the children.
2. If the parents tried to take the children, she was to notify the police and DCFS.
3. If another 15-year-old brother of hers who was incarcerated by the Department of Corrections was released, she would not allow him to reside with her.
4. If she became aware of the location of yet another 14-year-old brother of hers, whom the Department was trying to locate, she was to contact DCFS. She was also not allowed to take care of him.

The OIG found that the agreement entered into by the Department and the girl had been sanctioned by the State's Attorney's Office. Even though the Department believed the girl was capable of caring for the children, it was too great a responsibility to place on a 17-year-old. It was unreasonable to believe that a 17-year-old who wanted to keep her family together, would turn a sibling away from her home under any circumstances. The 17-year-old was eventually indicated for violating the care agreement and putting the children at risk for allowing her brother to stay with her after he was released from jail. It was also unreasonable to believe that she would be able to prevent her parents from removing or intervening with the care of the children. Furthermore the plan was inadequate because it did not provide for a homemaker to be placed to assist in caring for the children or create a contingency plan to ensure the children's safety and well being.

RECOMMENDATION

Even though a safety protection plan was in place and the girl agreed to the conditions, because of her age and circumstances, she was unintentionally set up to fail. The Department put the girl in a situation that made her go against her goal, "to keep her family together." DCFS is currently involved in court proceedings with the 17-year-old (She is not the subject of the petitions. The natural parents are the subjects of the petitions). The girl is attempting to regain custody of her siblings. The Department should reverse the indicated finding against the 17-year-old.

STATUS

The Department conducted an administrative review of this case and has determined that the "indicated" finding should be overturned. The report has been "unfounded" and a revised notification letter has been sent.

General Investigation 14

ALLEGATIONS

A six-year-old boy, a ward of the Department, had a history of numerous failed placements because of severe behavioral problems. The boy became acquainted with a potential foster home that all parties involved believed would be an ideal placement for the boy. However, the Department was unable to license the foster home because the potential foster father had a felony conviction which was a legal bar to licensing.

INVESTIGATION

Numerous appeals were made to the OIG to help resolve the situation in such a way that the boy and this family could be together. It was learned that the foster father's felony conviction was for drug trafficking twenty-seven years ago. The situation was discussed with the caseworker, the local Assistant State's Attorney, the guardian ad litem for the boy and the Director's office.

RECOMMENDATION

The OIG recommended that the family be given private guardianship until parental rights are terminated at which time the guardian ad litem could be appointed as "guardian with right to consent to adoption." The adoption could then be conducted privately which would not require licensing. A home study would have to be completed, but the adoption court could waive the felony conviction.

STATUS

The couple's application for licensure was denied due to a prior criminal conviction which is an absolute bar to licensure. The criminal conviction occurred 27 years ago and the husband has had no criminal involvement since that time. In agreement with all parties, private guardianship was given to the wife through probate court. A child welfare referral was completed and an intact family case was opened for monitoring.

General Investigation 15

ALLEGATIONS

This case came to the attention of the OIG because of allegations that a follow-up team worker and his supervisor improperly took custody of a six year-old boy despite the unfounding of charges by the DCP.

INVESTIGATION

The OIG investigation found that in January 1996 a hotline report was made by hospital emergency room staff after treating the boy for a large burn on the back of his right hand and noticing a large fresh bruise on his thigh and older marks on his cheek and forehead. The physician suspected abuse because although splashing was given as the explanation for the injury, he determined that the hand would have to have been held under water for some time to cause the burn. The subsequent DCP investigation revealed that in December 1995, the boy had been in an automobile accident in which he suffered a broken collarbone, contusions and possible nerve damage which would explain the old injuries and how the boy could have had his hand in hot water for a long time without feeling the pain. The charge of abuse was unfounded but the case was left open and referred to follow-up to evaluate the boy for possible mental and physical disabilities stemming from the accident. In February 1996 those tests were completed.

In April 1996, the boy's mother began receiving letters from a follow-up team member requesting to meet with and examine the boy. The mother refused to allow either the worker or his supervisor to have any contact with her son stating that she was through dealing with the state. The worker and his supervisor then screened the case into court based on the old bruises and the scalding incident. The worker and his supervisor did not thoroughly review the case to find out that the charge against the mother had been unfounded. Instead they proceeded into court without notifying the mother of the hearing and secured an order of temporary custody of the boy, removing him from his home and placing him with his maternal grandmother.

Both the worker and his supervisor acted with complete disregard for the boy's best interest. They failed to read the entire file and when confronted with the error by the mother, demanded that she show them proof. Their actions in removing the boy from his home were unconscionable and retaliatory. Both abused the power entrusted to them by the State.

RECOMMENDATIONS

In July of 1997, the OIG recommended:
(1) The follow-up worker should be disciplined for failure to review the file, failure to assess and offer appropriate services and providing false information to the court.
(2) The supervisor should be penalized for failing to supervise, abusing her power and approving the illegal removal of the boy from his home.
(3) These findings should be shared with the State's Attorney's Office.

STATUS

(1) Appropriate disciplinary action is being taken with the worker.
(2) Appropriate disciplinary action is being taken with the supervisor.
(3) The information contained in the OIG report was shared with the State's Attorney's Office.

General Investigation 16

ALLEGATIONS

A child was sexually abused by the same perpetrator on three different occasions, yet it was not until the third occurrence of abuse that the case was screened into court and custody was taken.

INVESTIGATION

The OIG learned that after the first incident of abuse against the child, the case was investigated, the perpetrator indicated and the case closed. After the second incident, the case was investigated, indicated against the mother (for substantial risk of injury) and against the perpetrator (for sexual penetration), and opened as an intact family case. After the third incident, the Department took custody of the child. A failure to elicit information regarding issues of domestic violence, depression, substance abuse, history of sexual abuse contributed to an inaccurate assessment of the mother's ability to protect her child. At the time the first incident was investigated, it was not Department policy to screen such cases into court. Although the case was referred for intact family services after the second incident, the intact family worker, who is no longer with DCFS, was not aware that the child had been sexually abused previously and did not understand the impact of the mother's issues as they related to her ability to protect her child.

RECOMMENDATIONS

(1) The Department put in place guidelines developed by a Department administrator for screening sex abuse cases into court. Because the report from the mother's therapist provided little information about the multiple issues faced by the mother, workers would have a difficult time determining whether the mother would be able to protect her daughter in the future.

(2) Caseworkers should specify what issues must be addressed in therapy when referring a client for services.

(3) Given the concerns raised by the OIG report regarding the DCP worker's investigation and documentation in this case (documenting in-person contacts with the mother and her children when in fact no in-person interviews were done) as well as concerns recorded in her evaluations, this report should be shared with the worker's current supervisor to ensure that proper supervision regarding these deficiencies is provided in her current position.

STATUS

(1) A policy guide will be developed and implemented by February, 1999. It is expected that a few minor changes will be made to the draft due to varying court procedures between Cook County and Downstate.

(2) The Department's current Consent for Release of Information allows for specific information to be requested from the provider. The Department is developing a Policy Interpretation to clarify the need for specifying what issues must be addressed in therapy when referring a client for treatment.

(3) The DCP worker transferred to ERC and no longer provides direct service to clients.

General Investigation 17

ALLEGATIONS

A DCFS employee maintained a personal relationship with the natural mother of two boys, former wards of the Department, who had been adopted. The natural mother wanted to keep up on the progress of her children, however the adoptive parents were not interested in an open adoption. Services to the boys and the adoptive home were provided by a private agency.

INVESTIGATION

The OIG investigation found that the DCFS employee attempted to take advantage of his position in the Department in order to obtain the information the mother desired from the private agency. The employee also had a phoney business card made up, giving himself a title that did not exist. The OIG investigation found that the agency refused to divulge any information about the adopted brothers to the worker.

RECOMMENDATIONS

(1) The DCFS worker be disciplined for using agency supplies and time for personal gain and that he be cautioned not to use the business cards he made up with the non-existent job title.
(2) The private agency be advised that if the worker persisted in calling their agency for information about the children, it could consider bringing harassment charges against him through the police department.
(3) The adoptive family be advised that if the worker or natural mother contacted them they could contact their local police.

STATUS

(1) The DCFS worker was discharged from the Department May 30, 1998. The worker has appealed the discharge. The appeal is pending.
(2) The Agency Performance Team Liaison informed the private agency of their options.
(3) The Agency Performance Team Liaison contacted the private agency. The agency will inform the foster parents of their options.

General Investigation 18

ALLEGATIONS

The OIG received a complaint from a client alleging that during a telephone conversation with a DCFS caseworker, the client asked to speak with the caseworker's supervisor. When the caseworker moved the telephone receiver away from his ear, the client heard the caseworker say, "I'm tired of this shithead nigger."

INVESTIGATION

The investigation revealed that there was substantial evidence to show that the caseworker used vulgar language directed towards a client in the workplace. The caseworker denied calling the client a "nigger". However, by his own admission, he placed his hand over the telephone receiver, and in the presence of fellow DCFS employees said, "I can't deal with this fuckhead anymore, where's [the supervisor]?"

RECOMMENDATIONS

(1)The client's case should be reassigned to another DCFS caseworker.
(2)The caseworker should be counseled at all of his evaluation sessions regarding employee conduct until such time as his supervisors determine that counseling is no longer needed.
(3)The counseling sessions should be documented and made part of his personnel file in accordance with the union contract.

STATUS

(1) The client's case was reassigned to another caseworker.
(2) The caseworker was counseled regarding his inappropriate use of language. The caseworker transferred to licensing and an exit evaluation reflects further counseling. A formal letter of apology was sent to the client by the caseworker.
(3) The counseling sessions were documented and remain in the caseworker's file.

General Investigation 19

ALLEGATIONS

In January, 1998, an unidentified man came into a DCFS office with a packet of material his daughter had received from a woman in a local shopping mall. The packet contained some confidential material and transcripts suggesting a possible breach of confidentiality.

INVESTIGATION

The information contained in the packet pertained to a specific case involving a boy who was removed from his parents' home after a warrant was issued for their failure to appear in court. After his removal from their care, his parents engaged in a campaign to secure the boy's return to the family. The parents have campaigned in various ways for support from the community, including circulating petitions for signatures, and have been very public about their version of events. A review of the case file and the specific packet of materials received at the shopping mall made it clear that the information was distributed by the parents.

RECOMMENDATION

There is no indication that the Department or its personnel have done anything to breach the confidentiality of this case. There is no evidence of inappropriate behavior on the part of any DCFS personnel. No recommendations were made.

General Investigation 20

ALLEGATIONS

A woman filed a complaint with the OIG alleging that a DCP investigation of her was unnecessarily delayed causing her financial difficulties and personal distress.

INVESTIGATION

In September 1994, the Department received a hotline report stating that the woman had repeatedly slapped her son at a county fair. In October 1994, the woman was indicated for "risk of harm" to her son based on the incident. Soon after, the woman notified the Department that she wished to appeal the finding. The evidence showed a single slap to her son's face that left an imprint. The expungement proceeding did not commence until September 1996, two years after the incident occurred. At the time the proceeding began, the Department was aware of a court case that determined if a fair hearing was not held within 299 days of a challenge, indicated findings must be expunged. The Department proceeded with its action against the woman who, over the two years, had hired first an advocate and then a lawyer at a cost of $4,000. The Department finally acknowledged that too much time had passed to pursue the case and expunged the indicated finding.

RECOMMENDATION

The Department should not underestimate the potential damage to the public trust when integrity of the process is compromised. When the Department is slow to admit an error that it was aware of at the outset of a hearing and has forced a member of the public to undergo personal hardship, public perception of the agency's mission can become understandably distorted. The harm to the public is multiplied by the Department's failure to assess requests for appeal when they are initially received. If resources do not allow for timely hearings in all cases, the Department needs to ensure that the potential risks to children are minimized. The Department needs to assess future risks and make difficult decisions that may mean not pursuing appeals of less serious abuses in order to free up resources to ensure the Department can provide timely hearings in more serious cases. It seems likely that with such a process in place, this case might not have been pursued.

STATUS

The Department is concerned that all citizens receive a prompt, fair administrative hearing when they have been found to have abused or neglected a child. In furtherance of the goal of providing prompt hearings, many changes have occurred in the Administrative Hearings Unit in the past year. The Department has hired five new Administrative Law Judges to hear appeals and one support staff member. The Department will also be hiring three additional support staff. The Department has hired temporary help until the additional support staff are hired and trained.

The Department has reviewed Rule 336, Appeals of Child Abuse and Neglect Investigation Findings, and is proposing substantive changes to the Rule to streamline the appeal process. A number of improvements have been made to assist in streamlining and expediting the process including obtaining additional personal computers for support staff, analyzing workflow on a step-by-step basis to more evenly distribute duties and developing a database capable of tracking service appeals at each stage and generating management reports.

The State Central Register Appeals Unit has also made several improvements that will help facilitate first level review appeals in a more timely manner. These improvements include hiring additional staff, prioritizing cases for review and faster response time on redacting and forwarding cases to child protection managers.

These combined improvements will allow for better management control of Department resources resulting in more timely hearings in all cases.

General Investigation 21

ALLEGATIONS

The OIG received a complaint alleging a DCFS caseworker had inappropriately changed the foster home placement of a girl based on race. The complaint further alleged there might be employee conflict of interest, and a possible violation of Federal Law.

INVESTIGATION

The OIG found that there was no evidence to show that the placement of the girl was racially motivated. However, there was substantial evidence to show that another caseworker conducted herself unprofessionally and was disruptive by saying, "that baby belongs in a black home", in a way that could be heard by co-workers. Although this gives the appearance of racial motivation, the OIG found that this DCFS worker was not assigned to the case, nor did she have any involvement in the decision to move the girl.

There is also evidence to show that the primary DCFS caseworker created a conflict of interest by attempting to circumvent the necessary process for child placement with a foster parent. The caseworker tried to place the child in a co-worker's foster home that was licensed by a private agency. When a foster home is licensed by a private agency, the private agency is the entity with the ability to place a child with that foster parent.

RECOMMENDATIONS

(1) The primary DCFS caseworker should be disciplined for attempting to circumvent the proper procedure in the placement of children.

(2) The DCFS worker who made the inappropriate remarks should be required to attend Inter-ethnic Placement Act training.

STATUS

(1) The primary DCFS caseworker was counseled by her supervisor immediately following the incident and the counseling session was documented.

(2) Additional IEPA training is being scheduled for the second worker's region and she will be required to attend.

General Investigation 22

ALLEGATIONS

The OIG received three separate complaints regarding the handling of a DCP investigation into possible sexual abuse of a 5-year-old child. The complaints alleged that the investigator had revealed the identity of a reporter and had conducted a biased investigation.

INVESTIGATION

The OIG investigation revealed that the allegations of sexual abuse had arisen in the context of an intensely acrimonious custody battle. Identical allegations had been investigated and unfounded six months earlier. This investigation resulted in an indicated finding for risk of harm against the father for "badgering" his son to disclose information relevant to the previously unfounded abuse charges. The OIG determined that although statements made during the course of the investigation could be criticized, the statements should not be judged outside the context of the investigation and custody battle, both of which were complex and difficult.

RECOMMENDATION

The OIG prepared a full report and recommended that the report be shared with DCP supervisory and management personnel to use as a supervisory tool with the investigator.

STATUS

The indicated report against the father was expunged January 23, 1998. This report was shared with a DCP administrator and supervisor. The report was also shared with the field teacher who met with the investigator to discuss the issues contained in the report. The investigator remains under close supervision.

General Investigation 23

ALLEGATIONS

The OIG received a complaint alleging that DCFS did not provide a mother with assistance in arranging transportation for visitation with her children during 1993 and 1994. The complaint also alleged that a DCFS supervisor maintained a personal relationship with the relative caretaker for two of the children, and that he intervened in the case even though he was no longer the casework supervisor. The complaint further alleged that the supervisor delayed the return home of the children to their mother because of his relationship with their relative caretaker.

INVESTIGATION

The OIG found no evidence to show that the supervisor's friendship with the relative caretaker prompted him to intervene in the case, nor was there evidence to show that the supervisor delayed the return home of the children.

Although there was no evidence to show that the supervisor maintained an intimate relationship with the relative caretaker, there was evidence to show that he maintained a friendship with her that created the appearance of a conflict of interest. The supervisor should have taken appropriate action to avoid the perception of a conflict of interest.

RECOMMENDATION

The supervisor should be required to attend ethics training. He should also be counseled by his immediate supervisor in regards to conflict of interest as dictated by DCFS in the State of Illinois Employee Handbook.

STATUS

The supervisor was discharged from the Department effective July 17, 1998 for conduct unrelated to the OIG investigation.

General Investigation 24

ALLEGATIONS

In April 1996, the OIG received a complaint alleging that a DCFS supervisor instructed a caseworker to continue working on a case despite a Court order removing the worker from the case.

INVESTIGATION

The OIG investigation revealed that the supervisor disagreed with the court order and instructed the caseworker that she would not officially be taken off the case. The supervisor placed undue significance in DCFS Legal's appeal of the court order contesting removal of the caseworker. The supervisor did not appreciate the importance of complying with a court order regardless of her own feelings about its wisdom. The supervisor was aware of her caseworker's activities in this case.

RECOMMENDATIONS

(1) The supervisor should be disciplined for failing to comply with a court order.

(2) DCFS Legal should track all court orders affecting the Department and ensure that supervisors understand the potential for contempt findings and the need for compliance regardless of pending appeals.

STATUS

(1) The supervisor was counseled on July 10, 1998.

(2) DCFS Office of Legal Services (OLS) has a mechanism to flag non-routine orders that direct the Department to take or refrain from taking certain actions and ensures that staff are properly advised of the legal strategy with respect to these orders. OLS does not track every routine order entered by every court in the 102 counties of the state. DCFS simply lacks the resources to do that and it would not be a good use of resources to attempt to track every order. Operations staff appear in court and work closely with our regional counsel to identify problem orders.

OLS also ensures that supervisors understand the potential for contempt findings. Emphasis is placed on the role of the Juvenile Court in our legal training and the consequences of violating court orders. OLS also advises staff in individual cases and recommends courses of action in accordance with court orders and legal strategy.

OLS does advise staff of their recommendations regarding compliance with court orders pending appeals or motions to reconsider court orders. In this particular case, counsel for the Department specifically advised of the necessity of having another worker handle the case until the court ruled on the motion to reconsider the removal order.

General Investigation 25

ALLEGATIONS

Several OIG investigations revealed instances of parents being indicated for abuse or neglect either because of dependency issues or extenuating circumstances. In some instances the parents were never given an initial opportunity to care for their children.

INVESTIGATION

A child was born to a mother with a chronic seizure disorder that could not be controlled by medication. The mother suffered several seizures each week, which left her disoriented and caused memory lapses. Protective custody was taken before the child was discharged from the hospital after her birth. The mother was indicated for inadequate supervision and risk of injury. The mother questioned how she could be charged with abuse when she had not yet had the opportunity to care for her child. Another child was born with a severe genetic disorder known as Fraser Syndrome which resulted in multiple congenital defects and required a great deal of constant care and monitoring. The mother wanted to care for her son, but there was concern as to her ability to adequately care for her child. The mother was indicated for risk of injury, because she was not able to provide adequate care while the child was still in the hospital. The child subsequently died while in DCFS custody.

RECOMMENDATIONS

(1) DCFS rules and procedures should be amended. There must be some limit placed on the application of "risk of harm" to restrict its use to those situations it was originally intended to handle. The definition should require some overt act on the part of the parent before substantial risk of harm can be found. A new category labeled "dependency" needs to be added to the list of possible allegations. The rules also need to be amended to clarify that DCP workers can investigate an allegation of dependency and to allow a worker to indicate a caretaker for dependency. An amendment is needed to allow a DCP worker to take a child into protective custody when dependency is alleged.

(2) DCFS should consider contracting with a private agency that would establish a specialized DCP unit which would handle dependency cases. Cases referred from this unit would solely involve allegations of dependency. The DCP unit would be responsible for investigation in order to determine proper caregivers and for providing child welfare services to families that have been reported to the State Central Register as dependency cases.

(3) DCP workers need to undergo training in order to understand rules changes and their implementation. Workers at the State Central Register need training to recognize dependency matters and to learn to refer these cases to the specialized DCP Unit.

STATUS

(1) The correct allegation is "substantial risk of physical injury" not "risk of harm." The definition does require some overt act on the part of the parent to indicate the allegation. The Department provides training to hotline staff to clarify the intent of all allegations.

The Department disagrees with adding an allegation of "dependency." Dependency is defined in the Juvenile Court Act (JCA), not ANCRA. The JCA only gives only gives law enforcement the authority to take protective custody. Amending ANCRA to include a "dependency" allegation would define dependency as abuse and neglect and therefore chastise those parents who, through extenuating circumstances, are not able to care for their children.

Currently, hotline calls alleging dependency are routed for child welfare services. Additional training will be provided to hotline staff on how to correctly identify and route dependency allegations. If a child protection investigation determines a report is not abuse or neglect but dependency, the investigator contacts law enforcement to take protective custody and refers for child welfare services.

(2) The Department does not agree with this recommendation. The Department believes that the current system adequately handles reports of dependency. The Department will provide additional training in these areas.

(3) As indicated above, the Department does not believe it is necessary to establish a specialized unit at a private agency to handle dependency. However, as previously stated, we agree that training is necessary.

General Investigation 26

ALLEGATIONS

The biological mother of a three-year-old boy complained to the OIG that allegations of sexual abuse against the boy's father were improperly unfounded.

INVESTIGATION

The OIG investigation revealed that on three separate occasions the boy related stories of sexual abuse by his father. Medical records documented no physical evidence of abuse. No criminal prosecution was pursued and the allegations of sexual abuse were unfounded. This decision was apparently based on an analysis of prior unsubstantiated allegations the mother had made against the father involving her children. The hotline report, made by the mother, was then classified as an intentional false report.

The OIG contracted an outside evaluator and specialist in sexual abuse to conduct a paper examination of the DCP investigation. The evaluator concluded that although the case was convoluted, the fact that the child had told three separate professionals that he was abused by his father should have prompted the DCP investigator to look into the matter further before unfounding the allegation.

Arriving at a determination of whether or not abuse occurred in this case is complicated by the visitation battle between the mother and father. It is important to remember that even in the most acrimonious divorce/custody/visitation disputes, abuse can occur. The DCP investigator apparently determined that the mother had coached the child and therefore disregarded all disclosures. This may or may not be an accurate assessment. In cases where the evidence points in both directions, the more prudent path would be an "undetermined" finding, which leaves the Divorce Court free to consider the evidence in the context of the divorce proceedings and with the benefit of a clearer impression of the family situation.

RECOMMENDATIONS

(1) The Department should redraft Rules and Procedures to permit greater use of the "undetermined" finding in dual jurisdictional cases between Domestic Relations Court and the Department. To prevent overuse or abuse of the undetermined finding the procedures should specify preconditions for its use and require increased supervisory approval.
(2) Domestic Relations Court should have the benefit of this report as well as the unfounded DCP investigation to assist in its judgement concerning visitation.

STATUS

(1) The Department disagrees with this recommendation. The Department rules only allow for two final determinations, indicated and unfounded. A finding of undetermined is used only to allow child protection investigators additional time to complete investigations.
(2) The Department agrees with this recommendation.

OIG INITIATIVES

ADOPTION INVESTIGATION

Licensing, Matching and Placing Waiting Children in New Adoptive Homes:

The Office of the Inspector General has been involved in making recommendations to the Department concerning deficiencies in its adoption procedures since 1994. Many of these recommendations have resulted in substantial changes in the way the Department approaches finding permanent homes for wards. Since 1997, the OIG has continued to investigate adoption practices, specifically focusing on the Department's contract for $800,000 with a single entity to identify waiting children, recruit adoptive homes and match waiting children with adoptive homes. In addition, the OIG investigated adoption practices that may create barriers to successfully placing waiting children in appropriate adoptive homes.

One practice investigated involved the Department's compensation of adoption agencies. In the past, only the agency that licensed the adoptive family received reimbursement. This practice created an incentive whereby private agencies would look only to their own foster homes in seeking an adoptive placement for a waiting child. As a result, waiting children did not have the advantage of the resource of families licensed by other agencies. The OIG recommended compensating both the child serving agency and the family serving agency equally for an adoptive placement. The Department agreed with this recommendation and is in the process of implementing it.

Although the Department recently has been successful in completing adoptions with long-time foster parents (called adoption conversions), its performance is lacking with children whose foster parents cannot adopt them. While several efforts have been undertaken to identify waiting children, to date, the system is still so fragmented that it cannot identify children who need adoptive homes. The coordinating agency responsible for adoption recruitment, information/ referral, publishing the listing book, matching, post-adoption, and tracking/reporting services has not demonstrated judgment and understanding of children's needs in its allocation of resources. For example, *the strongest effort for recruiting families must be for children 6 years of age and over and sibling groups, since over 80% of the waiting children are in these categories. However, almost 50% of matching events are geared toward recruiting families for children 6 years and younger* This overemphasis misleads interested adoptive families about the availability of adopting children who are 6 and under. At the same time, it fails to allocate resources to the pressing problem of finding homes for our children who are over 6 years of age.

While more children have been listed, the coordination and personal contact required to place children with homes has not improved. *The coordinating agency continues to publish a listing book with inaccurate information about children (some of whom are not even available).* It is therefore difficult for workers to know which children are available for adoption at any given time. Photographs of children who are in adoptive situations are retained in the listing book month after month regardless of status. This is discouraging for workers and prospective adoptive parents and it denies children who really need homes the opportunity to be featured in a book only for waiting children. Agencies find that many children in the listing book are placed on 'hold' for too long a period of time, and they have no confidence that the

information is accurate. Accurate, current information must be available upon which workers and families can rely.

In response to the OIG's urging for accuracy, DCFS has designated a monitor to review the accuracy of the listing book. However, a user friendly database that is accessible to workers and families concerning the children who are available must be in place in order to expedite placement.

In addition, the coordinating agency's family album of prospective adoptive families is filled with families who want to adopt, however, matching efforts are not made with these families. The coordinating agency has called for increasing the number of families featured, however, there also must be procedures for follow-up with the families. Families do not need to be listed for the sake of being listed, but actually to have children placed in their homes. The Department and their contracting agencies generally present the public with an image of children needing homes urgently and then fail to act with any urgency when potential adoptive parents express interest.

Last year the coordinating agency received over $800,000. Despite the OIG's recommendation to bid out the contract, it was not and, this year, the contract amount has increased to over $1,200,000. While some measure of this increase is attributable to new responsibilities associated with a mentoring program -- *the decision to retain the agency as adoption coordinator -- along with the monetary increase shows a disturbing failure to hold the agency accountable for its past failures.* Until there is a coordinating agency that will competently and aggressively recruit adoptive parents and coordinate suggested matches with children in a timely fashion, children who need homes will not be placed and would-be adoptive families will continue to be frustrated or drop out of the search.

Chances for Children: An Adoption Festival

April 25, 1998 marked the second Chances for Children Adoption Festival sponsored by the Inspector General, the Cook County Presiding Judge for Child Protection and the Department of Children and Family Services. The event was supported by the Halas/Payton Foundation, the Chicago Community Trust, Polk Brothers Foundation and Jewel. Voices for Illinois Children served as the fiscal agent.

This year, 150 waiting children attended Chances although 250 were registered to attend. Many of the children who attended had not been included in the listing book, and were photographed at the Chances event. Over 500 potential adoptive parents, 200 volunteers, 100 foster parents and/or workers and approximately 150 additional children (non-waiting) attended the event with their parents or foster parents. One hundred and twenty families began the licensing process that day and 190 persons were fingerprinted. A total of 210 families were referred to Chances agencies (including pre-Chances orientations and day of event) and 73 families remain in the process. To date 25 children are placed or are visiting with their soon to be adoptive families due to the Chances festival.[1] We expect more children to be placed in adoptive homes due to Chances in the next few months - since many of the families are still engaged in the licensing and matching processes.

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[1]These statistics represent either children who met their adoptive families at the fair, children who were seen in the photo book at the fair, children whose adoptive families began the licensing process at the fair or children whose foster family decided to adopt with Chances being a factor in their decision.

One lesson learned from the first year of Chances was that agencies must be in place to respond quickly to the families who register to be adoptive families. In January of 1998, the OIG and the Department created a special contract that called for small adoption agencies who were not overwhelmed with foster care contracts. The Cradle, Family Resource Center and Bethany Christian Services all agreed to follow the rapid response techniques in the contract and become Chances agencies. With these agencies in place, the OIG organized a series of orientation sessions held in public libraries around the county to test the procedures prior to the Chances event. Over eighty families attended these orientations and most were fingerprinted on site. Chances agencies began the licensing with these families immediately. The publicity for the orientation sessions drew hundreds of calls to the Inspector General's hot line, tripling the usual number of calls.

The availability of fingerprinting at the orientations and the Chances event itself was very advantageous. Even though the number of fingerprint machines was doubled from the first to second year, lines were still too long and so more machines would be very useful for future Chances events. The fingerprint processing was done efficiently and speedily. Results were turned around in less than two weeks.

Throughout the process the Chances agencies were to report each contact that they had with the adoptive families and the OIG tracked the families and provided assistance when needed. We have learned that an enormous amount of time and energy must go into contacting and supporting families who show interest in adopting special needs children. The current monetary compensation is not adequate for the thorough and efficient effort required.

The management style of the agencies has an enormous impact on agency performance. Agencies that are most successful with licensing families, matching, and placing children have staff who work exclusively with the Chances project. These staff performed all of the adoption functions, i.e., recruitment, orientation, home study, training scheduling, collection of all paperwork, and matching efforts. This holistic management style provides the hands on continuity that is necessary for staff performance.

ETHICS

The Child Welfare Ethics Advisory Board met five times during the fiscal year. Due to her retirement, board member Betty Williams stepped down from the board. In her place, the Board welcomed a new member, pediatric psychiatrist Anthony Marchlewski, M.D.[2] Dr. Marchlewski is currently in private practice at Great Lakes Psychiatric Center and is the Medical Director of the Child/Adolescent Partial Hospitalization Program of Holy Family Memorial Medical Center, Manitowoc, Wisconsin. Also new to the Board is Dorothy L. Carpenter. Ms. Carpenter is the Education Coordinator for the Child Care Division of the Chicago Housing Authority. Ms. Carpenter is also a nationally recognized expert on early childhood education.

The Ethics Board addressed inquiries made by the Inspector General and by child welfare professionals. Some of these issues included: (1) the inappropriateness of handling dependency case as abuse/neglect cases; (2) ethical issues in the subsidized guardianship research project; (3) the obligations of the OIG when it becomes aware of misconduct through its noninvestigative projects (e.g., Best Practice, Intact Family Recovery, etc.); and (4) the ethical implications of child welfare professionals accepting degrees from non-accredited educational institutions.

The OIG ethics staff answered several informal phone inquiries from child welfare professionals and also participated in the DCFS Conflict of Interest Panel, addressing conflict of interest inquiries from DCFS employees.

The OIG also developed and implemented two ethics workshops for DCFS administrators (January 16 and March 27 at the University of Chicago) featuring Michael Davis, Ph.D of the Illinois Institute of Technology's Center for the Study of Ethics in the Professions. Several other distinguished ethicists assisted in moderating the discussion of the breakout groups: Daryl Koehn, Ph.D., Wicklander Chair of Professional Ethics, DePaul University; Paul Camenish, Ph.D., Department of Religious Studies, DePaul University; M. Carmella Epright, Ph.D. (Cand.), Philosophy Department, Loyola University of Chicago; Theodora Bryan, Ph.D., Philosophy Department, Loyola University of Chicago; Margaret Welch, Ph.D., St. Joseph Health Systems; Lee Cogburn Walsh, Ph.D. (Cand.), Philosophy Department, Loyola University of Chicago; and The Ethics Staff of the Park Ridge Center for the Study of Health, Faith, and Ethics (Philip Boyle, Ph.D.; Martha Holstein, Ph.D.; Edwin DuBose, Ph.D.; Larry Greenfield, Ph.D.; Rev. David McCurdy, D.Min.; David Sinacore-Guinn, Ph.D.; and Patrick Hill, Ph.D.).

As part of the commitment to ethics in child welfare the OIG, in partnership with the Park Ridge Center for the Study of Faith, Health, and Ethics, has written a grant proposal for a two-year research project on ethics

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[2] As of July 1, 1998 the members of the Child Welfare Ethics Advisory Board were:
Roberta Bartik, Commander, Youth Investigations Division, Chicago Police Department
Michael Bennett, Ph.D., Director, Msgr. John J. Egan Urban Center, DePaul University
Dorothy L. Carpenter, Child Care Services, Chicago Housing Authority
Esther Jenkins, Ph.D., Department of Psychology, Chicago State University
Phyllis Johnson, Ph.D., Office of Quality Assurance, DCFS
Anthony Marchlewski, M.D., Great Lakes Psychiatric Center
David Ozar, Ph.D., Director, Center for Ethics, Loyola University of Chicago
Ada Skyles, Ph.D., Chapin Hall Center for Children, University of Chicago
Eugene Svebakken, Executive Director & CEO, Lutheran Child & Family Services

in child welfare. If funded, this project will diagnose the sources of ethical problems in the child system and develop practical strategies with which child welfare professionals could address such problems. One important part of this project will be to establish a free-standing Child Welfare Ethics Consortium which will serve as a neutral forum for open dialogue on ethical issues in child welfare.

Another important OIG ethics project is the ethics handbook which the OIG is co-writing with social work scholar, Eileen Gambrill (University of California - Berkeley). As an accessible ethics resource and training tool for child welfare professionals, this handbook will serve as a companion work to the *Code of Ethics for Child Welfare Professionals*. The topics addressed include the nature of ethical decision making, client self-determination, informed consent, confidentiality, conflicts of interest, competence, termination of services, responsibilities to the court and responsibilities in management.

GRANDPARENT/OLDER CAREGIVERS REPORT

The OIG in the course of investigations of death and serious injury, found several cases where elderly caretakers were overwhelmed with the numbers and young ages of children placed in their homes. These caretakers often found it difficult to turn down workers who wanted to place yet another infant in their home. *See Appendix C for report.*

INTACT FAMILY/RECOVERY

Through a number of investigations which involved substance exposed infants, the OIG determined that current generic intact family services did not fully address the specific needs of substance affected families. The OIG recommended the Department develop a Request For Proposal (RFP) to fund several intact family service programs in order to test an integrated model of child welfare and substance abuse services. This recommendation was accepted by the Department and a proposal was developed and distributed in December 1997. The OIG worked with the Department's Clinical Division to insure that OIG findings and recommendations were incorporated into the proposal's requirements. The projects, which began accepting cases on June 1, 1998, are being tightly monitored by the Department's Office of Health Policy, the OIG and the Department's Clinical Division.

Significant features of the *Intact Family/Recovery* model include:

- A face-to-face handoff of case responsibility from the child protective investigator to the intact family child welfare worker and the substance abuse treatment provider. This handoff takes place in the client's home where all three workers meet together with the parent to discuss identified problems and an action plan with the parents;
- Coordinated and joint home visits between child welfare and AOD;
- Twice weekly home visits by the child welfare worker until the client enters treatment, focusing on building a safety net for the child, assisting the parent in meeting the child's health and developmental needs, and preparing the mother for entering treatment, including arranging for child care during treatment.
- Twice weekly home visits and frequent phone contact by the AOD worker focusing on preparing the mother for treatment.
- Weekly to monthly follow-up home visits by child welfare workers for the life of the case;
- Weekly to monthly follow-up home visits by AOD for six months, even after the parents have completed treatment;
- Weekly case staffings between child welfare and AOD; continued AOD involvement in staffing cases even after the parent has completed treatment.
- Coordinated child welfare and AOD assessments and intervention services for family members, including use of *Substance Abuse Recovery: Guides for Parents and Caretakers*;
- Involvement of fathers and the child's extended family in treatment planning and services and the development and maintenance of a safety net for the child;
- Linking parents to health care and family planning services;
- Aggressive casework to enroll all children in the home in appropriate child care, early child development programs, preschool or school;
- Worker observations of children and parents in the child's school setting;
- Bimonthly cross training on child welfare and substance abuse issues.

In addition, one of the most significant features of the IF/R model is a Memorandum of Agreement (MOA) which provides workers with the opportunity to fully disclose the program and its conditions to the parent, while providing a mechanism for immediate court intervention for noncompliant parents through the use of graduated sanctions such as protective orders, the use of moderated community services for parents and the ultimate sanction of taking custody of children. If relapse occurs, the AOD provider will reassess, and if appropriate, readmit the parent. The child welfare worker will reassess child safety, and if appropriate, petition the court for sanctions and/or placement of the children. Legislators wishing progress reports on the Intact Family/Recovery Project should contact the OIG at 312-433-3000.

FAMILY CONFERENCE MODEL

Prior to the State assuming custody and guardianship of abused and neglected children, the State should convene a Family Conference with all the extended family members and other supportive adults to develop a safety plan for the children that the Department can support without court intervention. The OIG has assisted in piloting two family conference mediation models: one in the urban area of Lawndale in conjunction with the faith community and one in Champaign in conjunction with the University of Illinois and a community agency. A full report of the findings of the two projects, which have involved over 50 families, will be forthcoming, however preliminary data suggests that extended families may be able to protect children without court involvement. Family Conference Mediation materials are being published and can be obtained by contacting the Office of the Inspector General.

The OIG continues its involvement in the initiatives described in last year's annual report. Copies of progress and outcome reports as well as the Illinois Family Conference Training Manual and the Substance Abuse Recovery Manual are available to the public and will be mailed upon request. In addition, as a supplement to the Code of Ethics for Child Welfare Professionals published in 1996, the OIG is currently developing an Ethics Handbook for Child Welfare Professionals that will be available in the next couple of months. Contact the Office of the Inspector General at (312) 433-3000.

RECOMMENDATIONS FOR REFORM

This section of the report organizes recommendations made by the OIG this fiscal year according to the function of the child welfare system that the recommendation is designed to strengthen.

I. SAFETY

ASSESSING RISK - Substance Abuse Issues

- The validity, reliability and usefulness of the Adult Substance Abuse Screen would be increased by requiring workers to verify certain information. The OIG recommended the Adult Substance Abuse Screen be revised so as to require child abuse/neglect history and criminal history checks to confirm information reported by clients.

- Reinforce training and Department Rules to ensure that neither a client's current participation nor their willingness to participate in a substance abuse treatment program are grounds for unfounding an abuse or neglect allegation.

- The Department must take demonstrable steps to implement and integrate the SEI protocol and use it in conjunction with Risk Assessment in the field.

ASSESSING RISK - Domestic Violence Issues

- In cases of domestic violence, the supervisor should confer with the Department's domestic violence consultant about appropriate services that can be incorporated into the case plan.

ASSESSING RISK - Pregnant and Parenting Teens

- The Department needs to use a standard assessment tool to develop intervention plans when clinical concerns arise over a pregnant / parenting teen's capacity to parent.

ASSESSING RISK - Sexual Abuse

- The Department must develop guidelines for when children who have suffered sexual abuse must be removed from their homes.

- Sexual abuse investigation supervisors and investigators should be made aware of the need to rule out the possibility of self-inoculation of herpes in young children, before making a finding of sexual abuse based on the presence of herpes.

DIVISION OF CHILD PROTECTION (DCP)

- The Department should redraft Rules and Procedures to permit greater use of the "undetermined" finding in dual jurisdictional cases between Domestic Relations Court and the Department. To prevent overuse or abuse of the undetermined finding, the procedures should specify preconditions for its use and require increased supervisory approval.

- Existing rules should be changed to allow DCP workers to investigate allegations of dependency and to take children into protective custody when a call to the State Central Register alleges only dependency. A specialized DCP unit could be responsible for handling dependency cases and training for DCFS and State Central Register workers regarding the handling of dependency cases.

- When an indicated party refuses services, the Department must actively pursue enforcement. With minors who have engaged in possibly delinquent behavior, a referral to Juvenile Justice Court must be considered.

LICENSING

- The Department must establish a system to ensure that an individual who has been denied a foster or day care license could not be licensed by another agency.

- Progressive discipline should be used and carefully documented when foster parents' job performance is in doubt. Department policy should include a provision for external appeal.

- The Department must ensure that private agencies do not relicense when there is information suggesting that a private agency foster home should not be relicensed.

- A foster parent license should be revoked or denied based on an indicated finding of some Priority II abuse allegations such as intentional acts of biting, scalding, or choking a child.

- A comprehensive physical examination not more than one year old should be required of all relative and non-relative foster parents and their assistant caregivers before licensing to rule out any medical condition that might prevent the person from being able to care for a child.

- In cases where health conditions might be a factor in providing adequate care, the maximum number of children to be placed in a foster home should be reduced.

- Policy and procedures should be developed to effectively distinguish foster home licensure from licensure for the sole purpose of adoption.

- Foster home licensing personnel should perform substantative assessments of prospective foster and pre-adoptive families.

- The proposed Placement Clearance Desk should be notified of all pending DCFS and Licensing investigations of foster homes and place a hold on the placement of children pending the outcome of the investigations. The agency conducting the investigation should submit a copy of the report to the Placement Clearance Desk before a hold can be removed.

- The Department needs to establish a database or enhance the FindHome system to include demographics on age, economic status, education and length of service/experience with foster care on foster parents. Such a database could also be capable of "flagging" foster homes where the maximum number of children has been exceeded so the home can be put on hold status for future referrals.

- DCFS has a duty to address the deficiencies in Agency and Institution Licensing including: a) establishing a Licensing structure, independent of other Department units, b) establishing a qualified, experienced, and capable licensing management team in Cook County and c) directing sufficient resources towards rectifying existing deficiencies and developing the capacity to license qualified individuals and facilities.

- The Department should develop a Request for Qualifications within Licensing units on a statewide basis.

- The Department should audit the records of all initial licenses issued in the past 3 to 5 years to ensure that they have been properly granted.

- The moral character of the director of an agency applying for licensing should be considered by licensing representatives.

- The Department's Agency and Institution Licensing personnel should verify academic and employment history of an agency's senior administrators. Verification of executive directors' credentials should occur anytime there is a change in that position.

SUPPORT FOR FOSTER PARENTS

- PSSW (Placement Stabilization Services to Wards) guidelines should be revised to provide that placement stabilization is not required when a team of professionals has already determined that there is a safety risk in the current placement. The guidelines should address allocating resources or designating broader network areas for minors with more complex needs.

- The SASS (Screening, Assessment and Support Services) Program Plan (which provides for assessment of children who may be in need of hospitalization) must be revised to include important elements of the SASS Protocol and SASS Best Practice. The revised Program Plan should include built-in safeguards to reduce clinical biases and specific procedures for referrals with inherent conflicts of interest such as roundtable discussions on common biases in diagnostic reasoning. The Department should consider differential diagnoses and strategies to reduce harm from errors.

- The SASS system needs to provide genuine substantive monitoring of compliance with the Program Plan. Currently, only one consulting agency reviews performance of SASS contracts and its review does not include quality assurance of clinical determinations or services or compliance with required components of the Program Plan, such as supervision, procuring necessary second opinions and timeliness of assessments.

- The Department should assemble a new committee to provide external review and consultation for foster care children with severe behavior management problems.

- Workers should be trained to identify safety issues and act on information in psychological reports that point to potential problems in caring foster children.

PLANNING FOR RETURN HOME

- When a decision is being made regarding reunification, a return home staffing should be held with the caseworker, supervisor, and all persons who have provided services to the family in the last year.

- Caseworkers should meet with a child's teacher or day care provider prior to the child returning home and advise the teacher or day care provider to notify the caseworker if the child is absent for two consecutive days. Caseworkers should confer with the child's teacher on at least a monthly basis.

- A conference, including all collaborating agencies, should be convened four to six weeks prior to a child's target return home date. The staffing should address the child's developmental, educational and medical needs.

- The Department should develop a format for a letter from foster parents to be given to parents prior to the child's return home, documenting important daily habits and other information about the child.

RETURN TO THE COMMUNITY

- The Department should establish formal clinical protocols to assist decision-makers in the process of identifying children who are good candidates for return to the community. The availability of a placement for the child should only be one component of that protocol.

- When clinically required, day treatment programs, respite and emergency hospital beds should be generally expected components of any wraparound plan for a minor returning in-state from a residential program. The Department needs to address the absence of these resources, in particular with regards to LANs (Local Area Networks).

II. RECOMMENDATIONS ADDRESSING CHILDREN'S HEALTH AND EDUCATIONAL NEEDS

DEVELOPMENTAL STAGES

- The article, "Seven Deadly Sins of Childhood: Advising Parents About Difficult Developmental Phases" (Barton D. Schmitt, M.D.) describing typically difficult developmental stages of young children should be used in the training of child welfare staff and families.

III. PERMANENCY

ADOPTION ASSISTANCE

- The Department needs to alter adoption assistance rules to change the adoption subsidy rule to allow for assistance in the absence of a judicial finding on a case by case basis when the child has been placed and monitored by DCFS and has special needs.

APPEALS

- Appeals of indicated abuse/neglect findings must be heard in a timely manner. The Department needs to assess each case and make decisions that may mean not pursuing appeals of less serious abuses in order to free up resources to ensure the Department can provide expedient hearings in more serious cases.

HOME OF RELATIVE PLACEMENT

- Placement personnel need to discuss permanency issues with relatives to enhance the likelihood of children being placed in permanent situations and make them less likely to re-enter the system in the future.

INCARCERATED PARENTS

- The Department should afford incarcerated parents the opportunity to consider permanency options for their children.

IV. COMMUNITY RESOURCES

PRIVATE AGENCY

- Prior to the first court hearing subsequent to a case transfer due to an agency closure, the judge should be informed of: a) the amount of time the case has been with the newly assigned agency and caseworker, b) the condition of the case record at the time of transfer and c) what the new caseworker has completed since receiving the case.

- DCFS Legal should assist in ensuring that when cases are transferred from closing agencies that the receiving agency has access to DCFS Legal's documents regarding the case at the time of transfer.

- DCFS Legal should maintain copies of the following documents on all cases; service plans, social histories, service reports, progress reports, diligent searches, evaluations, assessments, and court orders.

COLLABORATIVE DRUG TREATMENT SERVICES

- A collaborative service planning staffing should be held within three to four weeks of a client's admission to drug treatment.

- A discharge/planning staffing to prepare an aftercare plan should occur two weeks prior to a client's discharge from drug treatment.

SUPPORTIVE HEALTH SERVICES

- When a worker becomes aware that a client or significant family member is suffering from a chronic or acute medical condition, the worker should contact the medical provider to determine what supportive services are available to assist the family.

LANs

- The Department should develop a protocol delineating clear duties and responsibilities of all those involved in the Local Area Networks (LANs). The protocol should include guidelines charging the Department caseworker with the responsibility of ensuring that the delineated duties and responsibilities are met.

WEAPONS

- The Department should promulgate procedures and enlist the LANs network to locally support juvenile law enforcement's investigators and community-based initiatives to **set a zero tolerance standard for possession of weapons by children.**

MEDICAID CERTIFICATION

- The Department should review the criteria for Medicaid certification to determine how private agencies with serious financial management deficiencies are certified.

ACCREDITATION OF PRIVATE AGENCIES

- The Director should ensure that all child welfare agencies seeking accreditation submit questionnaires directly to the Office of the Director of DCFS for the Director's signature and approval.

CHILDCARE PAYMENTS

- The Department should generate a list of all school age children receiving full or part-time child care money to determine if there is over-payment. The list obtained should also be reviewed to see if any particular caseworkers' names appear consistently, suggesting patterns of behavior.

QUALITY TREATMENT SERVICES

- Therapists must receive and review indicated abuse/neglect reports in order to treat indicated clients.

- Case managers should not automatically assume that subcontractors provide clinically effective services to DCFS clients. Case Managers must constantly monitor treatment outcomes and be willing to explore alternative treatments.

- To ensure comprehensive and effective treatment, caseworkers must specify what issues must be addressed in therapy when referring a client for services.

V. PROVIDING GENERAL SUPPORT OF CHILD WELFARE CASEWORK

- The Department should consider establishing a central depository of names of child welfare professionals who have been discharged for misconduct to ensure that they are not employed by contracting private child welfare agencies.

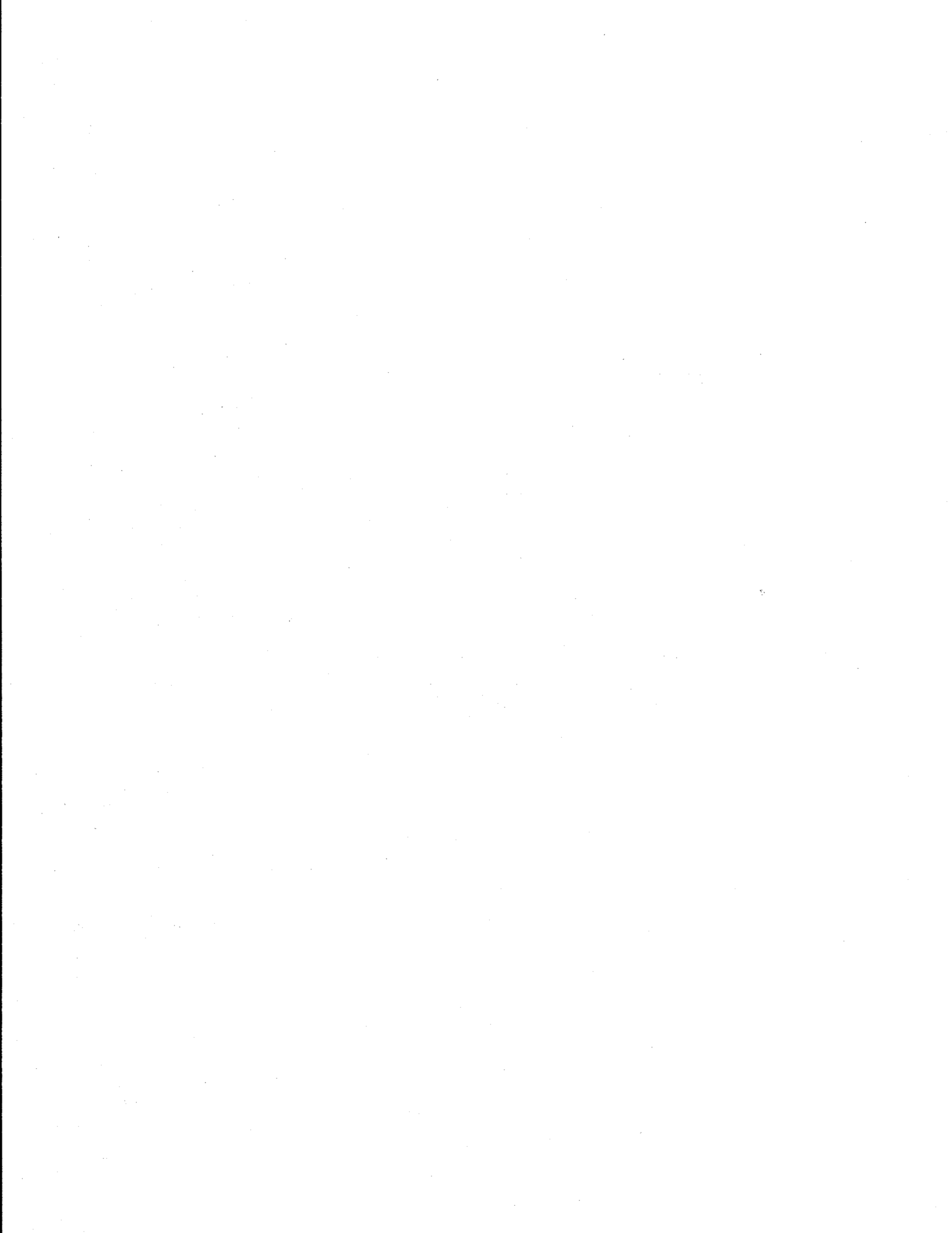
- The Department must forbid employees from referencing unaccredited educational titles in the workplace or community.

COURT ORDERS

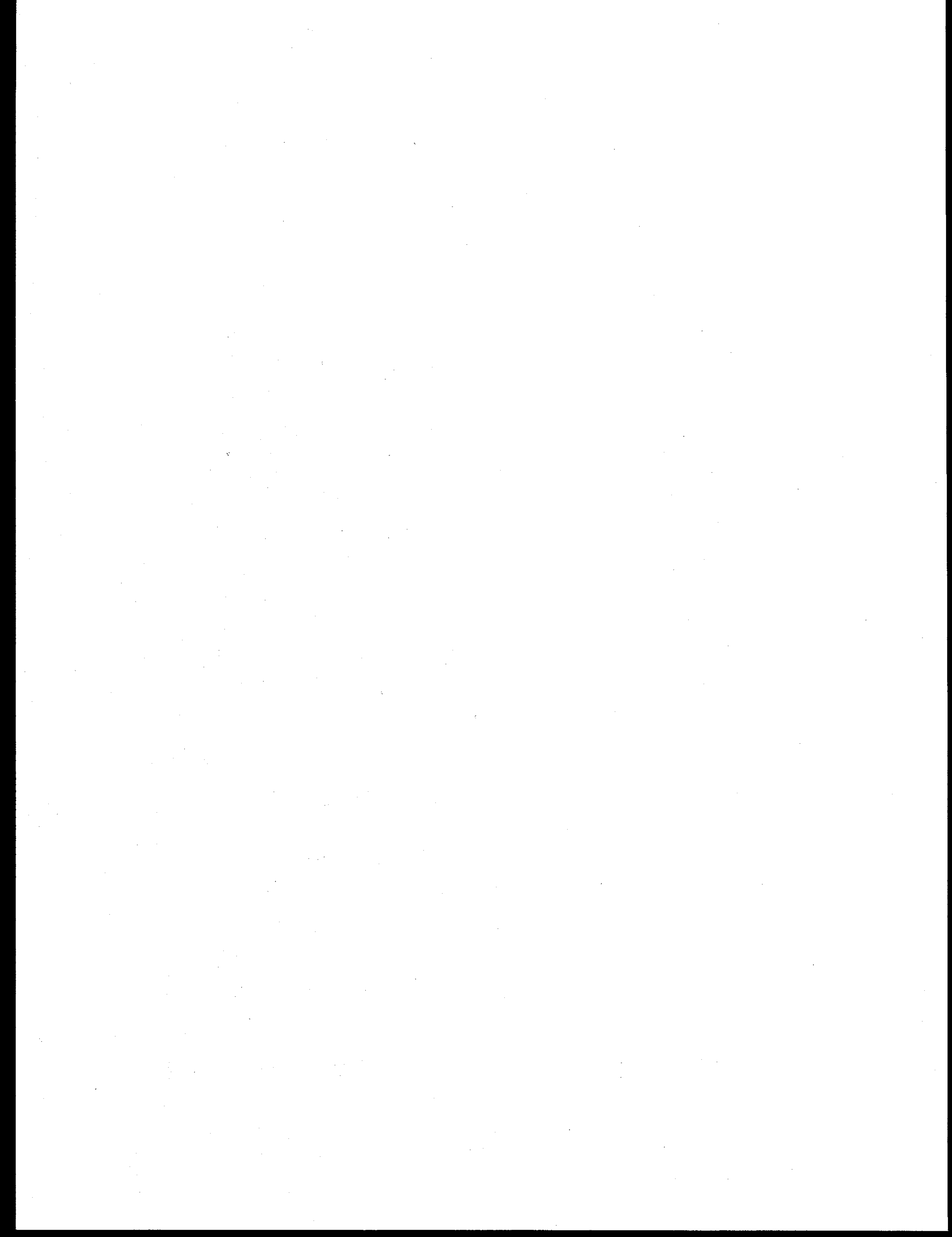
- DCFS Legal should track all court orders affecting the Department and ensure that supervisors understand the potential for contempt findings and the need for compliance regardless of pending appeals.

DISCIPLINE

- The OIG will continue to monitor the imposition of discipline. During the last year fiscal year, the OIG has noted certain cases in which a substantial period of time passes between the receipt of OIG recommendations and the imposition of discipline. The OIG will continue to work with the Department in identifying and lifting the barriers to swifter imposition of discipline arising out of OIG recommendations.



APPENDIX A: PATTERSON REPORT



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

Office of the Inspector General

REDACTED REPORT

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.

Date:	June 30, 1998
File No.:	971124 971170
Minors:	Lisa Patterson, DOB: July 27, 1978 Lauren Patterson, DOB: July 27, 1978
Children of the Minors:	Darren Patterson, DOB: May 5, 1997 Janice Patterson, DOB: May 20, 1997
Siblings of Minors:	Arthur Patterson, DOB: June 14, 1979 Rita Patterson, DOB: September 10, 1981 Dennis Patterson, DOB: November 5, 1991 Eric Patterson, DOB: September 24, 1992 Tina Gordon (renamed "Heather" at adoption), DOB: May 15, 1994
Foster Parents:	Betty Patterson, maternal grandmother Marcus Patterson, maternal grandfather (now deceased)
DCFS Personnel:	June Weaver, Child Welfare Specialist II William Boselli, Supervisor Margaret Sutton, Teen Parent Coordinator Sarah Turner, DCP Investigator Terrence Haynes, Intact Family worker James Matheson, consultant to DCFS Clinical Services

Agency Personnel: Carl Coakley, Quincy Center
Cheryl Sampson, Shoreline Center Fresh Start
Curtis McKinnon, Shoreline Center Fresh Start
Beatrice Gifford, Shoreline Center Teen Parents
Jeanette Van Meter, Shoreline Center Teen Parents
Linda Mischke, Shoreline Center Teen Parents
Suzanne DeWitt, Shoreline Center Teen Parents

I. Summary of Complaint

The Office of Inspector General ("OIG") became concerned after reading the status review of the Lifeworks program, prepared by Gail Lincoln. This review included information regarding three families receiving intact services through Lifeworks where the mothers had given birth to babies who tested positive for PCP and were allowed to retain custody of their newborns. The situation presented circumstances suggesting the possibility of employee misconduct or systemic problems. Accordingly, the OIG opened its investigation on January 29, 1998.

II. Case Summary

In 1991, Lisa and Lauren Patterson, twins, were placed in the foster home of their maternal grandparents, Marcus and Betty Patterson, because of their parents' extensive history of drug addiction. Their younger siblings were placed in the home at the same time or shortly thereafter. After Marcus' death in 1993, the children remained in their grandmother's care. In 1995, the permanency goal of Lisa and Lauren was changed to independence, and they were placed in independent living in March 1996. The maternal grandmother adopted the five younger siblings in January 1997.

Numerous attempts were made to provide a safe environment for the twins.[1] As the monitoring provided by the workers was very poor, the attempts to keep them safe failed.

While the twins lived with their grandmother, Quincy Center monitored their case and began noting the twins' drug problems. Nevertheless, Quincy Center changed the twins' goal to independence.

On March 13, 1996, the twins were moved to an independent living program through Shoreline's Fresh Start Program, and given an apartment that they shared. When placed into independent living, neither girl was in school or working, and it was suspected that both girls were using drugs. Fresh Start accepted them into the independent living program without adequately assessing their need for drug treatment. Fresh Start's failure to actively monitor this case meant that it did not address the twins' drug problems.

In March 1997, the twins were transferred to Shoreline's Teen Parents Program ("Teen Parents"). In May 1997, each girl delivered a PCP-exposed infant. Both twins were referred to drug treatment programs after the birth of the babies. However, neither twin received any significant substance abuse treatment until almost one year after the birth of the babies, when the circumstances became so serious that their workers could no longer ignore that the teens had drug problems and their babies were at serious risk of harm. Shoreline's Teen Parents Program did not adequately monitor this case.

June Weaver was the DCFS follow-up worker, but she had little contact with the twins and was inaccessible to the other service providers. She did not adequately monitor this case.

The DCFS Teen Parent Coordinator, Margaret Sutton, also failed to proactively monitor the Shoreline Center Teen Parent Program. She was not aware of the twins' drug problems until the OIG became involved in this case.

Lisa was referred to the Lifeworks program by Highland Hospital. However, the DCFS consultant to Lifeworks, James Matheson, failed to adequately monitor the situation. Matheson conducted a multidisciplinary staffing and made recommendations based on incomplete information.

Shoreline's calls to the Hotline regarding the twins' increasing drug use were met with a mixed response. One DCP worker failed to indicate one of the wards after collecting credible data concerning the extent of the ward's drug use and illegal activity. Investigating the same report on the other twin, a different DCP worker did indicate the report.

All safety attempts failed because of inadequate monitoring of this case. The absence of significant monitoring in this case meant two things: (1) the minors were not being properly prepared to live on their own once they left the Shoreline Center Program; and (2) the babies were placed at greater risk of harm which could have resulted in them becoming wards themselves.[2]

III. Investigation

During the course of this investigation, the OIG conducted numerous interviews.[3] The OIG consulted with a number of people in informal interviews.[4] The OIG reviewed a number of documents during this investigation.[5]

Case Narrative

A. Family History

Lisa and Lauren Patterson are twin sisters who were born on July 27, 1978. Lisa and

Lauren are the oldest of seven siblings. The biological parents of the children are Gillian Patterson and Maurice Gordon. Both parents had an extensive history of drug addiction.

On August 29, 1991, DCFS received a report that the Patterson children had been left by the parents without a care plan. During the investigation, the maternal grandmother reported that the children's mother had sent Lisa out to purchase four bags of cocaine. The grandfather reported that the mother had failed to attend to Lisa's medical needs. The grandparents believed that their grandchildren were at risk of harm. The parents were indicated for inadequate supervision, risk of harm and medical neglect.

Eventually, all of the grandchildren were placed with the maternal grandparents. Marcus Patterson, the maternal grandfather, died in early 1993. The children remained with the maternal grandmother; the five younger siblings were adopted on January 31, 1997. Lisa and Lauren, the two oldest children, remained in the home until March 1996 when they were placed in an independent living program through Shoreline Center.

On May 5, 1997, Lauren gave birth to a son, Darren Patterson. Darren was born exposed to PCP. On May 20, 1997, Lisa gave birth to a daughter, Janice Patterson. Janice was also born exposed to PCP.

On March 20, 1998, over the objection of the DCFS worker, June Weaver, the court ordered that the cases of Lisa and Lauren remain open until their twenty-first birthdays, or until further order of court.

B. Service Providers

The service providers assigned to this case are summarized in the following chart:

Exhibit 1. SERVICE PROVIDERS

Agency	Case Manager
Quincy Center	
March 1994 – October 1994	Reese Douglas
December 1994 – May 1995	Nancy Holloway
June 1995 – March 1996	Carl Coakley
Shoreline Center Fresh Start	
March 1996 – March 1997	Cheryl Sampson
Shoreline Center Teen Parents	
March 1997 – March 1998	Beatrice Gifford (Lisa), Jeanette Van Meter (Lauren)

1. Quincy Center

Betty Patterson was licensed through Quincy Center. Quincy Center had a responsibility to see that its case managers monitored this case. According to one of the case

managers,[6] the workers were to visit the family once a month, spending time with each ward. The family's initial contact with the agency was on March 8, 1994. The placement was relatively stable at first. However, as time progressed, the behavior of the twins became uncontrollable.

Reese Douglas was the first case manager who visited the Patterson family. According to the case notes, as early as April 1994, Douglas noted that Lisa was having difficulty in school and appeared "nonchalant" about failing. Douglas's case notes also reflected that Lauren reported that her report card was "bad." Douglas completed a service plan on September 3, 1994. On this service plan, Douglas reported that the twins hoped to graduate at the end of the 1994-1995 school year.

Several days after the service plan was completed, Lisa took a neighbor's car without permission, and kept it for approximately eight hours, damaging the car in a collision. This was reported in an Unusual Incident Report on September 20, 1994. Betty Patterson filed a fourteen-day notice because of this incident, but did not follow through on it.[7]

The following worker, Nancy Holloway, also noted escalating problems with the twins. For example, on February 11, 1995, the maternal grandmother gave a fourteen-day notice because of Lisa's continued disobedience and truancy from school. The grandmother did not pursue this notice after Lisa's behavior improved.

Holloway's notes reflect the first references to Lisa's drug problem. On March 20, 1995, Holloway talked with Lisa about her ten-day suspension from school. Although Lisa did not want to talk about why she had been suspended, Lauren told the worker that Lisa had been caught in the boys' room smoking marijuana.

On that same date, Holloway noted that Lauren would have to attend summer school to make up credits she had missed. According to Holloway's notes, Lauren would graduate from school in August instead of June.

Holloway noted that the grandmother was growing concerned about the twins' behavior. The grandmother asked if the twins could undergo psychological assessments. Holloway arranged for psychological evaluations, which were done on May 10, 1995. Lisa's psychological evaluation stated that she functioned "within the mildly retarded to borderline categories of intelligence." The examiner recommended that Lisa begin individual psychotherapy, and that she work with her therapist to develop vocational and career-related goals to improve her self-confidence and direction. Lauren's psychological evaluation stated that she functioned within the borderline to average range of intelligence. The psychologist thought it important to build her trust and self-confidence and to direct her attention to positive traits. The psychologist also recommended career counseling for Lauren. Most importantly, the examiner concluded by stating that both girls might have to move to a group

home placement with a transitional program to independent living. There is no notation that these recommendations were carried out.

Holloway completed a new service plan the next day, May 11, 1995. Holloway rated both Lisa and Lauren's progress toward their individual tasks as "unsatisfactory." However, on the service plan, she changed the goals for Lisa and Lauren to independence. She noted that the twins would be referred to the Preparation for Adult Living ("P.A.L.") program.

Holloway also noted that Lisa had dropped out of Council Rock High School in March 1995 and that she was enrolled in a GED program.[8] On the Child Summary, Holloway noted that Lisa's grandmother believed that Lisa might be using drugs. Holloway noted that a drug assessment should be completed by June 1, 1995. She indicated that the Quincy Center worker should follow whatever recommendations came from that assessment.

Carl Coakley became case manager of the case in June 1995. Coakley told the OIG that he had an undergraduate degree in computer science. He had worked for one year for a company that sells, leases, rents and services office equipment such as postage meters and copiers.[9]

Coakley told the OIG that, when he was first hired in June 1995, he received no training and had no orientation session. He could not recall a single training session that he had attended in the years of being employed with Quincy Center, although he assured OIG that there had been some. Coakley said that he could approach his supervisor any time he had a question. When first hired, he consulted her just about every day. He also said that he had weekly meetings with his supervisor where he was able to present questions. Coakley could not recall whether he had ever discussed the Patterson case with his supervisor.

Coakley was initially assigned to handle twenty-five cases, including the Patterson family. According to Coakley, he prepared himself for the Patterson case by reading through the case notes completed by the previous workers. He said that he did not talk to Holloway, as she had already left the agency.

Coakley told the OIG that he had not reviewed the May 11, 1995 service plan at the time that he took over the case. Coakley stated he was unaware that Lisa had dropped out of school in March 1995 and was not attending a GED program. He was also not aware that the service plan recommended that a drug assessment be completed by June 1, 1995.

Coakley documented on December 7, 1995 that the grandmother reported to him that both twins had stayed out until 6:00 a.m. Lisa explained to Coakley that things did not start getting "fun" until about 9:00 p.m., so she just stayed until the party was over. Lauren reported that she had been having too much fun at the party and she did not want to leave.

In a later note, Coakley recorded that the grandmother called him because both Lisa and Lauren had been slipping out of the home at 3:00 a.m. and had been "smokin' blounts."[10]

When Coakley asked the twins about school, his case notes reflect that he was given a number of excuses about why they were not attending or why they could not produce report cards. He told the OIG that, while he had the case, the twins were not attending school, were not attending a GED program, were not working, and were not in counseling. However, the twins repeatedly asked him about independent living, and Coakley stated that he refers youth to independent living programs "when they ask for it." Coakley did not explore the options of residential placement or group home and did not attempt to change the goal from independence.

At some point, Coakley began to work on preparing a package to refer the twins to an independent living program.[11] He sent the package to Shoreline Center. He could not recall whether he had considered any other independent living program or why he had chosen Shoreline Center to contact.

Although Coakley referred the twins to independent living, he did nothing to prepare them for this placement. Coakley's case note dated October 11, 1995 stated that he would be referring the twins to the P.A.L. program. He explained to OIG that P.A.L. is a pre-independent living program that would prepare the twins for the responsibilities that come with independent living. He could not recall if he ever completed the referral process. There is no record of the twins ever attending the P.A.L. program and the twins told OIG that they had not been prepared for independent living. Coakley stated that he could not remember preparing Lisa or Lauren for independent living himself, although he did state that he told them that they would have to comply with services once they were in independent living.

The Quincy Center file and the Shoreline Center file do not contain a copy of any service plan completed by Carl Coakley while the twins were in Quincy Center's program. No ACR was scheduled during the time that Coakley had this case.[12]

2. Shoreline Center Fresh Start

On March 5, 1996, Lisa and Lauren signed their contracts with the Shoreline Center Fresh Start program ("Fresh Start"). Fresh Start is an independent living program that contracts with the Department of Children and Family Services. It is funded as an intensive mental health and social support program for older adolescents who will receive case management services while living in their own apartments.

Everybody associated with Shoreline Center that was interviewed by OIG explained that Fresh Start accepts the toughest clients. As Cheryl Sampson, one of the case managers, explained, Fresh Start clients are the clients that nobody else wants to accept.

On the day they signed their contracts, Lisa and Lauren began the intake process for Fresh Start. The Shoreline Center files are incomplete and do not include all of the intake documents. The documents that are included show that in the initial interview, each of the twins was asked whether she had ever taken any drugs. Lauren replied that she currently smoked cigarettes, drank alcohol and started smoking marijuana when she was fifteen. Lisa denied ever doing any drugs. The Shoreline Center file does not show that any evaluation or assessment was conducted to determine if either of the twins was a substance abuser. Both twins signed statements in which they agreed to submit to random drug screens every 30 days.

Sampson explained that, if a client is accepted following this initial intake process, there would be a staffing where the new client would meet the new case manager. Lisa and Lauren's case manager was Cheryl Sampson. She worked with two Team Coordinators, who helped her monitor the twins. According to Sampson, at the time that the new case manager was introduced to the client, she would not have read any of the client's previous case records.[13]

Each twin became pregnant approximately six months after entering the program. According to Sampson, Lauren went to a clinic for a pregnancy test. When the clinic discovered that Lauren was pregnant, it gave her a schedule of prenatal appointments. Sampson said that she became aware of Lauren's pregnancy about this time. She did not discover Lisa's pregnancy until later. According to Sampson, Lisa stole some pregnancy tests from a drug store and took each one of the tests. Lisa never went to a clinic to confirm the positive tests. Sampson explained that the twins tried to hide Lisa's pregnancy from her, although she could not say why they would not want her to know.

At the beginning of December, Sampson completed a 497 service plan. The plan was dated December 5, 1996, eight months after the twins had entered the program and eighteen months since the previous service plan was completed on May 11, 1995. The December 1996 service plan was the only service plan completed during the time that the twins were part of the Fresh Start program.

Cheryl Sampson, from Fresh Start, prepared the new service plan and evaluated the twins on the individual tasks that had been identified on the May 11, 1995 service plan. The Shoreline Center file reflects that Carl Coakley, from Quincy Center, also evaluated portions of the May 11, 1995 service plan. Neither Coakley nor Sampson could explain why they both worked on service plan evaluations that contained approximately the same dates. They both denied having worked on the plans together.

The case managers evaluated the May 11, 1995 service plan completed by Nancy Holloway, of Quincy Center. On that service plan, Holloway had noted that the Quincy Center worker needed to schedule a drug assessment for Lisa by June 1, 1995. Carl Coakley

evaluated this goal as unsatisfactory and noted that he had been unaware of the tasks.

Cheryl Sampson rated the twins' progress toward their individual tasks as unsatisfactory.[14] She prepared a new service plan that was dated December 5, 1996.[15]

The next month, Curtis McKinnon, Program Manager of Fresh Start, performed a random check of Lisa and Lauren's apartment. Fresh Start had a program policy in which random apartment checks were done by either the Housing Director or the Program Director. These random checks were videotaped. At the bottom of the page evaluating the apartment, McKinnon wrote that the condition of the apartment was "appalling." According to the case notes included in the file, the apartment was filthy and there were remnants of drug use visible in the room. There was a meeting to discuss the condition of the apartment and to view the videotape. The case notes also show that present at the showing of the videotape were McKinnon, Sampson, Lisa, Lauren, and the Housing Director. The twins were told that their children could be taken from their custody and that their placement in Fresh Start could be jeopardized if they were unwilling to maintain their apartment sufficiently.

McKinnon told OIG that problems with housekeeping were often one of the signs that a teen had a drug problem. However, no random urine toxicology screens were ordered. Sampson explained that Fresh Start's policy is that, when it appears that a Fresh Start client has a drug problem, the client is taken for a urine drop. If the first drop is positive, then the matter is referred to the client's therapist, whether or not the client is attending therapy. The therapist is expected to engage the client in therapy to address the drug problem. According to Sampson, none of the Fresh Start clients participated in therapy. Subsequent drops could be done, but were not required.

Sampson told the OIG that she never became aware that the twins had a drug problem. Sampson also told the OIG that she was not present when the video was shown to the twins, but if the video did contain evidence of drug use, she could not be sure that the drugs belonged to the twins. The drugs could have been left by one of their boyfriends. Therefore, there was never any need to take the twins for drug drops to ascertain whether drugs were being used by these two pregnant teenagers.

Throughout the time that the twins participated in Fresh Start, Sampson and the two Team Coordinators, Gina Bassett and Ann Foster, visited the twins frequently. Fresh Start's policy is that one of the workers must see the client every week.

As the case notes prepared by these workers reflect, during the entire time that the twins were with Fresh Start, they never attended high school. They never attended a GED program. They did not attend counseling sessions with regularity. They held jobs at a fast food restaurant for a very short period of time. There was little discussion of vocational training. The twins' apartment was dirty on most occasions when the workers came to visit.

Appendix A

The Fresh Start workers infrequently discussed birth control or sexuality issues with the twins. Despite a Fresh Start policy giving the program the right to make its clients undergo random drug drops every 30 days, the files do not reflect that any drug screens were completed for the twins.

Although there were indications that Lauren reported domestic violence issues, the workers did not address this. During one home visit, the workers had observed scratches on her face. Lauren explained that she had gotten into a fight with another girl. At that time, it was speculated that the father of the baby was another ward.

In addition to 497 DCFS service plans, Fresh Start requires that the case managers complete Rehabilitative Service Plans ("RSP") for each client. Sampson often noted the twins' problems when she completed the RSPs, and often indicated that the twins were not complying with services. A schedule of the RSPs completed in this case is included below.

Exhibit 2. REHABILITATIVE SERVICE PLANS

Lisa				
Date	***Case Manager***	***Tasks***	***In File?***	***Rating***
3-8-96 Master RSP to be evaluated 9-8-96	Cheryl Sampson	Mental Health Education Addictions Employment	✓	U U U U
9-6-96 to be evaluated 3-6-97	Cheryl Sampson	Education Employment Mental Health Addictions	✓	U U U U
3-21-97 to be evaluated 9-21-97	Cheryl Sampson	Mental Health Addictions Parenting Skills Employment	✓	not evaluated
Lauren				
Date	***Case Manager***	***Tasks***	***In File?***	***Rating***

3-8-96 Master RSP to be evaluated 9-8-96	Cheryl Sampson		no	
9-23-96 to be evaluated 3-23-97	Cheryl Sampson	Mental Health Education Addictions Employment	✓	S U U U
3-23-97 to be evaluated 9-23-97	Cheryl Sampson		no	

Sampson told OIG that she tried to implement consequences to make the twins comply with services, but that she was not effective. Sampson also explained that a client who is not participating in services might be moved out of their apartments to a Charitable Housing Facility or an Assessment Center. She could not explain why the twins had not been moved.

Despite this, in March 1997, the twins were transferred into the Teen Parents Program. When asked if she was aware of any teens that had *not* been accepted into Teen Parents from Fresh Start, Sampson replied that she was not.[16] Sampson stated that a client would need to show that she had the *capacity* to comply with services in order to be transferred. This referral criterion did not mean that they necessarily had to be complying with services.

From March 1996, when the twins were placed in independent living, until May 1997, when the twins gave birth to their babies, DCFS was not monitoring this case. This will be discussed in greater detail in Section C.1.

3. Shoreline Center Teen Parents

Lisa and Lauren were discharged from Shoreline's Fresh Start program and were transferred into the Teen Parents on March 1, 1997. The Teen Parents program was originally part of the Fresh Start program, whose Program Manager was Curtis McKinnon. In March 1997, the Teen Parents program became a separate program, with its own Program Manager, Suzanne DeWitt. Teen Parents has its own program plan.

When a minor who is participating in an independent living program gives birth to a child, or is in the final stages of pregnancy, the minor is referred to Teen Parents.[17] The program has a staff of six case managers. As of October 1997, this staff was supervised by Linda Mischke. Mischke reports to DeWitt. The program also employs home monitors, a

parent educator and a supplemental case manager. The program typically provides services to between 25 and 30 clients, so the client to staff ratio is no more than 6:1. The Department pays the program approximately $4500 per month per client.

Lauren's case manager was Jeanette Van Meter. Lisa's case manager was Beatrice Gifford. Both case managers were assisted by Shirley Carter, the supplemental case manager, and various home monitors. Although Van Meter and Gifford had primary responsibility for these cases, all of the workers conducted visits. These visits occurred regularly.

Once the girls became part of the Teen Parents program, their drug problems became more evident. In April, Lauren had a positive urine screen. Lisa was tested in May, but the results cannot be located.

Lauren gave birth to her son on May 5, 1997, at General Hospital. The baby was positive for PCP and Lauren was positive for PCP.[18]

***Unusual Incident Report** Jeanette Van Meter filed an Unusual Incident Report concerning the birth of Lauren's baby. On May 4, 1997, Karyn Sweet, the Shoreline Center Teen Parent Home Monitor, had notified Van Meter that Lauren had been taken to the hospital to give birth. When Sweet called the hospital to inquire about Lauren's condition, she was told that Lauren had tested positive for PCP in April. When Van Meter visited the hospital, she was told that they were waiting for the results of the tests to see if the baby had been born with drugs in his system. Lauren admitted to Van Meter that she had smoked marijuana, but claimed that she had not taken any PCP. On May 6, Van Meter received information from the hospital telling her that the baby had tested positive for drugs. Van Meter noted that she had notified DeWitt of the situation and had phoned Cheryl Sampson to get the DCFS worker information.*

The hospital notified the State Central Register ("SCR"), and an investigation was initiated. The report of the A sequence was indicated.

***Hotline call** General Hospital called the SCR to report that Lauren's baby, Darren, had been born positive for PCP and that Lauren had been positive for PCP at the time of delivery. The report indicated that Lauren had admitted only to marijuana use, but had tested positive for PCP and cannabis on April 11, 1997.*

Jaime Garcia was the DCP investigator who investigated this matter. When he spoke with Lauren, she only admitted to using marijuana during her first two months of pregnancy. She told Garcia that she had used again when she was seven or eight months pregnant. Lauren spoke with the worker about the fact that she had undergone a drug screen in April and the results were positive. During this conversation, Lauren agreed to attend drug

treatment and follow recommendations. Garcia told Lauren that the case would be indicated because the baby was born with drugs in his system.

Garcia's notes show that he spoke with Lauren's case manager, Jeanette Van Meter, and Van Meter agreed that the baby could go home with Lauren.

Garcia also noted in this report that it was imperative that the natural mother attend drug and alcohol treatment to ensure that the newborn was not placed at risk.

Terrence Haynes was assigned as Lauren's Intact Family worker from DCFS. Haynes told OIG that he was assigned to Lauren's case for about six months. During this time, Haynes told OIG that he referred Lauren to the drug treatment program of Westfall Services, but there was a delay in starting because Lauren said that she was involved in school, therapy and work. Despite her assurances that she would attend a drug treatment program, Lauren did not attend, and Westfall did not provide OIG with a record indicating she attended any sessions.

Lisa gave birth to her daughter, Janice, at Highland Hospital on May 20, 1997. The baby tested positive for PCP.

*** Unusual Incident Report** On May 20, 1997, Beatrice Gifford from Shoreline Center filed an Unusual Incident Report concerning the birth of Lisa's baby.*

There is no mention in this report about the child being born with drugs in her system.

Highland Hospital called the SCR and an investigation was initiated. The report, the A sequence, was indicated.

*** Hotline Call** On May 22, 1997, Highland called the SCR and reported that Lisa's baby had tested positive for PCP. This case was indicated.*

The DCP worker was Shane Lynch. During the investigation of this report, Lisa told the DCP worker that she had last used drugs one month before the birth of the baby. She told the worker that she used marijuana. Lisa told the worker that she stopped smoking "weed" when she found out she was pregnant, but that she was in a car with friends and took a couple of "pulls." The worker also noted that Lisa was willing to cooperate with drug treatment and had been referred to Lifeworks.

Before releasing the child from the hospital to the mother, the DCP worker consulted with Allison Murphy. DCP interview notes reflect that Murphy agreed that the child could be released to the mother.[19]

Appendix A

According to the DCP notes, although Lisa was referred to Lifeworks, the Lifeworks program referred her to Westfall Recovery Project because it was closer to her home. The services to be provided included counseling and parenting classes.

Lisa began attending Westfall Recovery Project in June. She attended only four sessions. During the time that she was supposed to be enrolled in this program, Lisa tested positive for PCP. Lisa was eventually discharged from the program on July 31, 1997 because of her poor attendance and her continued use of drugs. The Shoreline Center workers did not have any direct contact with Westfall during the time that Lisa was in treatment. The Shoreline Center workers told OIG that they were unaware that Lisa had tested positive.[20]

On July 31, 1997, Lisa and Lauren's mother died of breast cancer. Lisa did not attend her Lifeworks staffing, held on August 6, because of her mother's death. The twins suspended the therapy sessions they had been sporadically attending after their mother's death. They never returned to therapy and Burnside discharged them from the program because of their failure to attend.[21]

Later that summer, Lisa's child, Janice, became ill and the Shoreline Center workers were concerned because the child was "wheezing." When Lisa failed to take the baby to the doctor, the workers called the SCR and reported Lisa's medical neglect. This report, Lisa's B sequence, was unfounded.

***Hotline call** On September 16, 1997, the SCR recorded a call reporting medical neglect. The report noted that Lisa's baby had been wheezing, and that the Shoreline Center workers had asked Lisa to take ber baby to the doctor for five weeks, but Lisa did not do this. Lisa did take her baby to the doctor after the DCP report was made and the DCP worker noted that Lisa understood the need to promptly respond to her daughter's medical requirements.*

During the investigation, Beatrice Gifford, the Shoreline Center worker, told the DCP worker that Lisa was not attending her drug treatment program and had possibly dropped positive while she was enrolled in the program. Lisa admitted to the DCP worker that she smoked "weed." Lisa also noted that she did not smoke PCP. Lisa admitted that she was not attending her drug treatment program.

The report was unfounded because Janice was in good health and was receiving all the necessary medical care. The DCP worker noted that the doctor did not diagnose bronchitis or asthma. The Shoreline Center worker told the DCP worker that she would continue to monitor this case.

Throughout the time that the workers made home visits, the twins expressed

difficulties living together. On October 10, 1997, Lauren was placed in her own apartment.

When the twins were discharged from Fresh Start, Cheryl Sampson had evaluated their service plan and rated them as unsatisfactory. No new service plan was completed upon their entrance into the Teen Parents program. No ACR was ever conducted.[22] On October 15, 1997, the DCFS worker, June Weaver, the Shoreline Center workers and the clients were finally all present in court. (Weaver had been assigned this case on May 23, 1997. Her notes reflect that this court appearance was her first in-person contact with her clients.) On that date, the court ordered Lisa and Lauren to participate in a drug treatment program. The court also ordered them to attend school. Shortly after the court hearing, the girls enrolled in Westfall for drug treatment and in a GED program.

According to the Shoreline Center notes sent to OIG, Beatrice Gifford, of Shoreline Center, and June Weaver appeared in court on November 20, 1997. (Although the court file is not clear on this, the Shoreline Center workers indicated that the court lifted the order concerning the twins' attendance and school and drug treatment at some point before the December ACR was conducted. Presumably, the court order was lifted at this November hearing.) According to the notes of the Lifeworks consultant, both twins were taken for drug drops at the end of November, while they were enrolled in Westfall. The Lifeworks consultant noted that those drops were positive for PCP and cocaine.

An ACR was finally held in December 1997, one and one-half months after the court order was entered. She rated the twins as satisfactory in going to school and participating in drug treatment.

In December, the Court's orders were lifted. The twins immediately stopped attending classes and drug treatment.

In January 1998, Gifford and Van Meter made random home visits to each of the twins. While Lauren's apartment was relatively neat, Lisa had had a recent party and there was evidence of drug use at the apartment. Both twins admitted to being present at the party. Both twins were taken for urine drops; the results came back positive for PCP and cocaine.[23] The workers completed Unusual Incident Reports and a Hotline call.

***Unusual Incident Report** Jeanette Van Meter filed an Unusual Incident Report concerning the twins' drug use. Van Meter reported that she had made a random home visit to Lisa's apartment on January 5, 1998,[24] and that she had observed empty beer bottles, an open beer bottle, marijuana seeds and what appeared to be a marijuana cigarette and the remains of a blunt cigar. Van Meter reported that the apartment was in total disarray. Lisa explained to Van Meter that she had been drinking and smoking "leaf"[25] with her sister, Lauren, the night before. Lisa also informed Van Meter that she had gotten high with her*

sister on New Year's Eve. After asking Lisa some questions about her attendance at her drug treatment program, Van Meter called Lisa's counselor and was informed that Lisa was not attending Westfall's program regularly and that her last drop had been positive for cocaine. Gifford then took Lisa for a urine drop and called the Hotline.

The workers also called the SCR. Beatrice Gifford called in identical reports for Lisa and Lauren. Lisa's report, her C sequence, was indicated for risk of harm. The DCP worker investigating this report, Martin Sullivan, focused his inquiry on Lisa's drug use and her choice of drugs. In contrast, Lauren's report, her B sequence, was unfounded. Lauren's DCP worker, Sarah Turner, told OIG that the report concerned the conditions found in *Lisa's* apartment. Because Lauren's apartment was clean and because her baby was not at Lisa's apartment at the time that Lauren admitted to being there and doing drugs, her supervisors told her to unfound the report.

***Hotline Call** On January 5, 1998, Beatrice Gifford called the SCR and reported that she had made a home visit and saw open beer bottles and remnants of drug use (marijuana). Lisa had admitted to Gifford that she had been smoking marijuana and would probably "drop positive" if tested. Beatrice Gifford also reported that Lisa was supposed to be attending out-patient drug treatment, but is not going and that Lisa had tested positive on November 27.*

When Lisa was interviewed by the DCP worker, she told him that her caseworker had come over on January 5 and found a couple of empty bottles of beer and a marijuana blunt on her table. Lisa admitted she had had some friends over and she had smoked "leaf" but denied that she had a drug problem. Lisa told the worker that she had smoked a kind of marijuana joint called a "Wicked Stick."[26] Lisa told the DCP worker that she had random urine drops done at Westfall. She told him that she had not attended drug treatment at Westfall since early December.

The DCP worker interviewed Lisa's substance abuse counselor, Alice Tyler. The counselor told the worker that she recommended inpatient treatment because Lisa had not been attending her outpatient treatment. Tyler also told the worker that Lisa had tested positive for cocaine, PCP and marijuana. When the DCP worker questioned Tyler about the effects of PCP on Lisa's ability to parent, he was told that PCP can cause Lisa to hallucinate, which puts her baby at risk of harm.

After the DCP worker obtained a consent to release information from her drug treatment program, he discovered that Lisa had tested positive for cocaine, marijuana and PCP. The worker noted that her substance dependency can cause her to seriously neglect Janice, because the child was only eight months old and very dependent on Lisa. The DCP worker noted that Lisa must complete her drug treatment and be monitored closely. He

noted that in-patient drug treatment was required to avoid removal of the minor.

The same Hotline call was made for Lauren. A different DCP worker investigated this call and focused on the cleanliness of her apartment, instead of on Lauren's drug use.

***Hotline call** On January 5, 1998, Gifford called the SCR to report that she had made a home visit and found open beer bottles and remnants of drugs (marijuana) in the home. Lauren admitted to smoking marijuana and admitted she would probably "drop positive" if tested. Gifford also reported that Lauren was supposed to be attending drug treatment but is not.*

According to the DCP notes, Turner interviewed a friend of Lauren's named Andre. Andre told Turner that Lauren was "whoring" in the bedroom "while the kid was in the living room." Andre said that he had seen a man come in to the apartment and ask, "how much to turn a trick." Andre also told Turner that he had seen Lauren "smoke a mixed reefer with something black in it." Turner concluded her note by stating, "[h]e did not share any abuse or neglect issues toward the child."

On January 6, Turner spoke with Lisa. Lisa told Turner that Lauren had come over for a party and "did drink and do marijuana," but Darren was back at Lauren's apartment with a babysitter.

Turner spoke with Lauren by phone. The interview note appears to say that Lauren did not understand the report, because her caseworker knew that her apartment was clean. Lauren told Turner that she had done marijuana at her sister's apartment. Lauren also said that she did not see the need to go for drug treatment.

Turner also spoke with Gifford, who had reported the incident. Gifford told Turner that Lauren was still doing drugs and not in treatment. Gifford told Turner that the case had been brought in because Lauren had given birth to a PCP-exposed baby and had tested positive herself for PCP and marijuana. Turner then noted, "I asked what abuse and neglect allegations are evident concerning this report. She said there are none." Two days later, Turner spoke with Van Meter and indicated that Van Meter saw no signs of abuse or neglect.

The DCP worker interviewed Linda Mischke, supervisor of the Teen Parents case managers, during her investigation. Turner noted that Mischke indicated that there was a concern about Lauren's denial of drug use and there would be a staffing to move Lauren from outpatient drug treatment to inpatient hospitalization. Turner's note concluded, "[s]he understands now this is a service issue not a abuse/neglect issue [sic]."

In a related report, Nora Katz reported that she believed that Lauren was leaving crack around her apartment and blowing smoke from the crack pipe into Darren's face to

try to get him high.

The twins were taken for a second drug drop on January 15, 1998. Again, both twins tested positive. According to the Shoreline Center case notes, Shoreline Center called a staffing on January 23, 1998. After this second drug drop, Turner unfounded her report. Weaver was also present at this staffing. The twins were told that they would have to participate in in-patient drug treatment, or they were in danger of losing their children. However, according to Mischke, the program had difficulty finding a drug treatment program that would accept the twins and their babies.

On January 30, the Inspector General called New Town drug treatment program and got the twins admitted into the program, an intensive in-patient substance abuse program. The twins were discharged from Shoreline Center while they were in this program. According to the twins, at the time of discharge, the twins each received clothing vouchers worth approximately $600.00.[27]

The twins told OIG that before they entered the drug treatment program, they had been manufacturing PCP-laced marijuana in their apartment and selling it in order to pay back a debt they owed.

C. DCFS Involvement

The history of DCFS involvement in this case is summarized in the chart below.

Exhibit 3. DCFS INVOLVEMENT

DCFS Involvement	Assigned DCFS Worker
DCFS Monitor of Case	
March 16, 1996 – May 22, 1997	No Assigned Worker
May 23, 1997 – Present	June Weaver
Teen Parent Consultant	Margaret Sutton
Lifeworks (Lisa only)	James Matheson
DCP investigations	Martin Sullivan (Lisa)
	Sarah Turner (Lauren)

1. DCFS Monitor

The twins were transferred into Shoreline's Fresh Start on March 16, 1996. When they were transferred into the program, their cases were split from those of their siblings, who were being adopted by their grandmother. The siblings' cases were being monitored by Quincy Center. The Quincy Center case manager assigned to the case was Carl Coakley.

Carl Coakley told OIG that, when he transferred the twins' case to Shoreline Center, he drew up the paperwork to close their case. He told OIG that he sent that paperwork to his supervisor. Nonetheless, Coakley remained listed as the DCFS case worker assigned to monitor this case. Coakley could not tell OIG why he remained listed as the worker. During this time, no other DCFS worker was assigned to this case.

The GAL's court file reflects that in March 1997, the court entered an order to compel the appearance of Coakley on Lisa and Lauren's case.[28] Coakley appeared in court in April and the court rescinded the order to compel.

Lauren and Lisa both gave birth to substance-exposed infants in May. An Intact Family case was opened for Lauren at around that time and Lisa was referred to the Lifeworks program after the birth of her baby and was to begin in a drug treatment program starting in June.

Following these events, June Weaver was assigned to this case on May 23, 1997. Weaver was supervised by William Boselli, a SWEP student, who was out of the office from March until August 1997, working on his field placement. Because of Boselli's absence, Weaver had been assigned to work as the TA of the team, assuming supervisory responsibilities. Boselli was therefore absent during the first few months that Weaver monitored this case.

During those first few months, the DCFS file and OIG interviews reflect that several workers had unsuccessfully attempted to reach Weaver. Terrence Haynes, who was assigned as Lauren's Intact Family worker in May, told OIG that he and his supervisor had attempted to contact Weaver, because they both felt that it did not make sense to have so many workers assigned to this case. Haynes told OIG that he and his supervisor both made several attempts to call her, but they were unsuccessful in reaching her.

Letters in the DCFS file supplied to OIG by Weaver reveal that several workers had attempted to contact Weaver during this time. Letters from Westfall, Lisa's drug treatment provider through Lifeworks, and from Carl Coakley all indicated that the workers had been unsuccessful in reaching Weaver.

Weaver attended the August 6, 1997 Lifeworks staffing scheduled by James Matheson. According to Matheson, at that staffing, Weaver explained to him that she had not yet met the client, but the client could not be present because her mother had recently died. Matheson told OIG that he was concerned about this, and that he made two recommendations for Weaver at that time: (1) Weaver should follow up on the public health nurse's recommendation concerning medical care for Lisa's baby and (2) Weaver

should attempt to re-engage Lisa in drug treatment services. Weaver did not get back to Matheson on these recommendations.

Weaver also missed several court hearings on this case. According to the GAL's notes, no DCFS worker was present at the hearing in July. The court continued the matter until September 11. The GAL noted that, at the September 11 hearing, the court entered an order to compel the appearance of Weaver.[29] The matter was continued to September 25, 1997. According to both the GAL and the court file, another order to compel Weaver's appearance was entered at this time. The matter was continued to October 8, 1997.

During this time, Lisa had been reported to the SCR by the Shoreline Center workers because of medical neglect. The DCP investigator notes on this hotline call reflect that the DCP worker had unsuccessfully attempted to contact Weaver on approximately four occasions. The DCP notes also reflect that Beatrice Gifford had unsuccessfully attempted to contact Weaver for drug referrals.

Weaver appeared at the October 8 hearing, although no Shoreline Center worker was present. On October 15, all the workers and the clients were finally present in court. Weaver's notes from this hearing state, "This was the worker's first contact with the minors." On this date, the court ordered the twins to enter drug treatment and to enroll in an education program. The GAL noted that Weaver gave referrals for drug treatment at that time.

On October 23, James Matheson, from Lifeworks, attempted to call Weaver. He left a message concerning Lisa's case. Weaver did not return this call.

On December 9, 1997, the twins' ACR was scheduled.[30] This is the only ACR scheduled by Weaver in this case.

Weaver participated in the staffing that the Shoreline Center workers had called in January 1998. At that staffing, the twins were told that they would have to attend in-patient drug treatment because of their failure to consistently attend outpatient treatment at Westfall.

Weaver's contacts with this case are summarized in the chart below.

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Exhibit 4. CHRONOLOGY OF WEAVER INVOLVEMENT

Chronology of Activities of DCFS worker, June Weaver, with Patterson Case[31]

Date	Event	Response from Weaver
May 23, 1997	Case assigned to Weaver	No contact made with client
June 1997	Court ordered ACR for July Court date	Not done
June 30, 1997	Letter to Weaver from Westfall requesting assistance in re-engaging Lisa in services	None
July 1997	Court date	No appearance
July 7, 1997	Letter from Coakley- he has made numerous attempts to contact her for staffing	None
July 8, 1997	Fax request from Matheson requesting Weaver confirm a date for the 30-day staffing on Lisa.	None
Aug. 4, 1997	Letter from Westfall saying Lisa has been discharged from program	None
Aug. 6, 1997	Lifeworks staffing	Appears, but does not bring client
Sept 11, 1997	Court date Order to compel appearance of Weaver	No appearance
Sept 17, 1997	Overbrook tried to reach Weaver by phone regarding DCP investigation	None
Sept 23, 1997	DCP Worker tried to reach Weaver by phone regarding DCP investigation	None
Oct 3, 1997	DCP Worker tried to reach Weaver by phone regarding DCP investigation	None

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Oct 8, 1997	DCP Worker tried to reach Weaver by phone regarding DCP investigation	None
Oct 9, 1997	DCP Worker reaches Weaver by phone regarding DCP investigation	Talks with Worker
Sept 25, 1997	Court date	No appearance
Oct 8, 1997	Court date	Appears, but matter continued
Oct 15, 1997	Court date	Appears (*First contact with twins.*)
Oct 23, 1997	James Matheson leaves message re: Lifeworks records	None
Nov 20, 1997	Court date	Appears
Dec 9, 1997	ACR	Completed
Jan 25, 1998	Shoreline Center staffing	Appears

2. Teen Parent Coordinator

Margaret Sutton was the Teen Parent Coordinator who was assigned to this case. Sutton's position was created because of the Hill-Erickson litigation.

> As defined by *Hill v. Erickson*, Sutton had responsibility:
> "For coordinating the development of programs and services set forth in this Decree. The Teen Parent Coordinator also may provide information and expertise concerning pregnant and parenting minors to other staff and agency units within DCFS." *Hill v. Erickson* Consent Decree, (January 30, 1994, p. 10).

Sutton's efforts at monitoring these programs can be identified as follows. Curtis McKinnon, the Program Manager of Fresh Start, told OIG that he had to call Sutton every time he had a client that needed to be transferred to the Teen Parents Program.

Sutton told OIG that she had created a form on which the Teen Parents program was supposed to report to her information about their programs. This form requested the

numbers of clients that the program services, the numbers of children that those clients had, how many wards were enrolled in or attending school or a GED program or college or working.[32] The form did not request information on Unusual Incident Reports or other critical situations. The form does not identify fathers of children of the wards (including whether the father was a member of the class). In her interview with OIG, Suzanne DeWitt, Program Manager of Shoreline's Teen Parents Program, told OIG that her understanding was that Sutton only wanted information on births, deaths and termination of pregnancies. Although Sutton conducted monthly meetings at which she and the programs could share information, she did not make it a requirement of these meetings that the programs turn in data on their clients. Sutton acknowledged to OIG that she did not receive most of the monthly reports on a timely basis.

Sutton identified no other attempts at meaningful monitoring. Sutton told OIG that she felt that it would be a conflict for her to monitor the programs.

Sutton told OIG that she was not aware of the DASA Initiative. She was not aware of the SEI protocol. She had only recently discovered the Cradle to Classroom program.

Shoreline Center monthly report forms indicate that approximately 30 clients enrolled in their program. The Shoreline Center monthly reports show that approximately 20% of these wards were enrolled/attending school or a GED program.

3. Lifeworks

Lifeworks is based at Highland Hospital and is a joint effort between the Department of Public Health, DCFS and the Department of Alcohol and Substance Abuse (DASA)/Drug treatment agencies. "The primary goal of Lifeworks is to get the mother quickly involved in a well-coordinated set of services to address the mother's drug abuse and the safety/risk issues involved in having the baby go home with the mom." The DCFS consultant to the program is James Matheson.

When a mother participates in Lifeworks, the DASA provider does outreach services for the mother, performs a drug screen and tells her where to go for treatment. A public health nurse also visits the new mother and does assessments concerning her care of the child and the child's health.[33] The public health nurse is to conduct a visit every week at the mother's home during the first 3 months that the client participates in the program. According to Matheson, the Lifeworks program requires a multidisciplinary staffing to be conducted 30 days after the client enters the program, and the program requires that the client attend the staffing.

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Matheson's notes reflect that, in this case, the 30-day mark for Lisa's staffing was June 24, 1997. This staffing was not held until August 6, 1997. Present at the staffing were Matheson, Weaver, and Rhonda Fisher, the public health nurse.[34] Lisa was not present. Weaver explained that Lisa could not attend because her mother had recently passed away. Matheson told OIG that he believed that this was a valid reason for not attending. Weaver also told Matheson at this time that she had not yet met Lisa. Matheson told OIG he was concerned about this, but continued with the meeting nonetheless because the public health nurse had met with Lisa.

Fisher had told Matheson that she had seen Lisa. Matheson's notes reflect that Fisher had seen Lisa on July 5, 1997. OIG asked Matheson if Fisher had seen Lisa on more than one occasion. Matheson's notes reflected that Fisher had also seen Lisa at some point in June. The public health records reflect that Fisher made her initial home visit to Lisa on *June* 5, 1997, and not July 5, as Matheson's notes reflect. Fisher's notes record no other visit that summer.

While she was enrolled in the drug treatment program, Lisa had dropped positive for PCP on June 16, 1997. She was discharged from the program on July 31, 1997 because of her non-attendance. Matheson told OIG that he had this information at the staffing.

Matheson made two recommendations for Weaver to follow up on at this meeting. One was to follow up on medical care for the infant. The second was to attempt to re-engage Lisa in drug treatment services.

Matheson told OIG that on October 22, 1997, he was at a meeting at Highland Hospital and he noted that he had not heard from Weaver and he did not have any information about Lisa. The next day, he attempted to call Weaver, but he was unable to reach her so he left a message.

His next attempt at follow up did not occur until January 6, 1998, when he called the Shoreline Center worker, Beatrice Gifford. Beatrice Gifford reported that Lisa had dropped out of a second drug treatment program and had "dirty PCP drops" on November 26, 1997 and January 6, 1998. Gifford informed Matheson that she had called the Hotline on January 6, and that she had called Weaver and a staffing was scheduled for January 23, 1998.

Matheson then called Weaver's supervisor and informed him of the status of the case. He informed the supervisor that he was concerned about the lack of "assertive follow up by Ms. Weaver." On January 28, Matheson met with Meg Bollinger, the clinical manager at Cook Central, to express his concerns about the case.

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Exhibit 5. JAMES MATHESON'S INVOLVEMENT WITH LISA'S CASE

Date	*Event*
5-21-97	Lisa signs consent to participate in Lifeworks
6-16-97	Lisa tests positive for PCP
6-24-97	Lisa's 30 day staffing due date
7-31-97	Lisa discharged from program
8-4-97	Date of letter written by Westfall Services to Weaver informing her of Lisa's discharge
8-6-97	Actual date of the 30 day staffing Present: James Matheson June Weaver Rhonda Fisher, PHN (Matheson discovers at this meeting that Beatrice Gifford is case worker from the private agency)
10-22-97	Matheson attends a meeting at Highland; Matheson has no new information on Lisa
10-23-97	Matheson attempts to call June Weaver; Matheson is told the office is moving
1-6-98	Matheson calls Gifford and they discuss the dirty PCP drops and second aborted start in drug treatment
1-16-98	Matheson calls Boselli
1-28-98	Matheson meets with Meg Bollinger

4. DCP investigators

The SCR was called on several occasions throughout the time that the twins were with Teen Parents. Reports had been made about Lisa on three occasions, reports on Lauren on two occasions.

The first two reports were called in after the twins gave birth to substance-exposed infants. These reports were both indicated. Lisa's second report alleged medical neglect. Because she took her baby in for medical care, this report was unfounded. These reports are not at issue.

In January 1998, Beatrice Gifford, the Shoreline Center worker, called the SCR to report both twins. In this report, it was alleged that Lisa's apartment was filthy and there were remnants of drug use in the apartment. Both girls had admitted to taking drugs and told

the worker that they would probably drop positive if taken for a urine drop.

Different DCP workers were assigned to investigate the report on Lisa and the report on Lauren. According to the DCP report, Lisa's DCP worker, Martin Sullivan, indicated the report for risk of harm, because of Lisa's drug use. Lauren's DCP worker, Sarah Turner, unfounded this report. She told OIG that the focus of her investigation was the fact that the call was made about Lisa's apartment, Lauren's apartment was clean, and the baby was clean and well-fed. She therefore did not see that the baby was at risk of harm.

The DCP reports are summarized in more detail under "Service Providers," Section IVB of this report.

A summary of the Hotline calls is provided in the chart below.

Exhibit 6. DCP REPORTS

DCP Reports

Lisa	**Sequence**	**Indicated?**	**Allegation**
May 20, 1997	A	Yes	Substance-exposed infant
September 16, 1997	B	No	Medical neglect
January 5, 1998	C	Yes	Risk of harm
Lauren	**Sequence**	**Indicated?**	**Allegation**
May 5, 1997	A	Yes	Substance-exposed infant
January 5, 1998	B	No	Risk of harm

V. Analysis

Lisa and Lauren have been part of the child welfare system since 1991. A number of child welfare professionals had responsibility for monitoring the girls at various times.

The workers were given access to the twins, their families and their child welfare files. All the workers had access to information that should have made them aware of the risk factors present in this case. The workers should have realized that the girls needed to be closely monitored and managed in a proactive fashion. However, this was not done. Rather, in many instances, the workers assumed someone else was doing the monitoring. The result was that nobody monitored the case closely.

The poor monitoring of this case and the risk factors combined to: (1) set the twins up to fail instead of preparing them to live independently; and (2) needlessly exposed their babies to the possibility of harm.

Appendix A

A. Risk Factors

Exhibit 7. RISK FACTORS
Risk Factors
1. Drug lifestyle environment in which the twins were raised
2. Evidence of the twins' drug use
3. The choice of drug
4. Their current lifestyle

The risk factors that were present when the girls were placed in independent living should have shown the workers that they were not appropriate candidates for such a program. They were girls that, even at 17, needed very close supervision. No evaluation was made to determine their ability to behave responsibly on their own. No preparations were made to help them develop such a sense of responsibility for themselves.

1. Drug Lifestyle Environment in Which The Twins Were Raised

The first risk factor is the environment in which the twins were raised. The workers should have immediately noted that this case required close monitoring because of the parent's history of chemical dependency.

Chemical dependency interferes with a parent's ability to consistently provide a nurturing environment that supports the physical and emotional development of children. Growing up in a chaotic and dysfunctional home places children at risk for numerous problem behaviors, which can include truancy, educational delays, early sexual activity, violence and, as this case demonstrates, drug abuse.

Here, the parent's chemical dependency exposed the twins to drugs at an early age. According to the August 1991 DCP report, Lisa was sent out by her mother to purchase four bags of cocaine. One of the twins reported to the Burnside therapist that the twins had smoked marijuana with their mother.

2. Evidence of the Twins' Drug Use

The second risk factor is the fact that the twins were polydrug users over time (marijuana, PCP, cocaine, and, eventually, heroin). There was evidence that the twins were using drugs before they became pregnant. Case managers from Quincy Center and Fresh Start knew that the twins were using drugs. Quincy Center's case manager, Nancy Holloway, included the need for a drug assessment on the service plan she completed in May 1995. Carl Coakley, from Quincy Center, told OIG that he knew the twins were using drugs and his case notes reflect that. Case managers from Quincy Center and Fresh Start had noted the grandmother's suspicion that Lisa was using drugs.

When the twins were transferred into the Teen Parents Program, the case managers

became aware of more significant drug use. For example, Lauren had a positive urine drop in April 1997. Each twin gave birth to a substance-exposed infant in May and tested positive for drugs. Lisa had a positive urine drop in June 1997, while enrolled in a substance abuse treatment program.

3. Choice of Drugs

The twins' choice of drugs was another risk factor in this case. The twins' urine toxicology screens repeatedly reported evidence of PCP (also known as Phencyclidine) and their babies tested positive for PCP. As reported by DCFS's AOD Administrator, PCP use in adolescents is often a gateway drug to heroin. Subsequent drug testing revealed one of the twins tested positive for heroin in May 1998. Both girls have tested positive for cocaine. Heroin was their parent's drug of choice.

PCP is an illegal drug that can be snorted, smoked, swallowed or injected intravenously. Webber, R., *PCP Pharmacology: An Overview*, Chestnut Health Systems, Lighthouse Institute, copyright 1998, page 2. In small doses, PCP can create a sense of euphoria and relief from anxiety. *PCP Pharmacology*, page 3. In larger doses, however, most users experience confusion and difficulty thinking clearly. *Id.* Delusions are common among PCP users. *Id.*

4. Their Current Lifestyle

The twins' lifestyle was the fourth risk factor that was evident. References in the record indicate that the twins were adopting lifestyles controlled by their drug use. Curtis McKinnon, Program Manager of Shoreline's Fresh Start, told OIG that poor housekeeping is one of the things that could trigger a drug screen of a Fresh Start client. Shoreline Center workers frequently noted the twins' poor housekeeping skills. The twins led unstructured lives. Additionally, Lisa and Lauren did not go to school, did not enroll in a GED program, did not look for employment, and did not attend vocational training.

The twins also became involved in illegal activities. Lisa was arrested for drug possession on December 22, 1997. The charge was dismissed after a finding of no probable cause. Lisa's landlord evicted her from her apartment in January 1998 because of the high volume of traffic through her apartment and because he believed that she was dealing drugs. Allegations were made to the SCR that at least one of the twins was prostituting.

B. Failure of the Workers and Programs

There were a number of child welfare professionals that had the responsibility for monitoring this case. Each of the workers, and the programs for which they worked, can be described as a "safety net." That is, each worker and program should have seen that a safe environment was provided for the girls and their children. Each worker and program had an obligation to recognize the risk factors presented and respond to them.

Each safety net failed because of the poor monitoring and supervision provided by the worker.

1. Safety Net #1 -- Quincy Center

Exhibit 8. QUINCY CENTER
Responsibility: To protect the twins by monitoring the Patterson family and see that the twins' permanency goals are appropriate.
Failures:
Quincy Center's failure to train the case manager resulted in:

1. Inadequate assessment of twins
2. No preparation for independent living
3. No preparation of service plans

a. Responsibilities

Quincy Center, a private child welfare agency, began monitoring the Patterson family case in 1994. Quincy Center case managers were to visit with the Patterson children each month and ensure that the children were receiving proper services. This responsibility is realized by completing service plans every six months, scheduling Administrative Case Reviews, and making referrals for such things as, for example, psychological assessments, therapy and drug evaluations.

In carrying out these responsibilities, the case managers had a duty to be informed about this case and to see that decisions were made on the basis of reliable information. This includes making sure that items included in the service plans were based on informed decisions. Permanency goals needed to be realistic. Through this monitoring, Quincy Center was to protect the minors.

b. Failures

The OIG investigation determined that Quincy Center failed to effectively monitor this case to ensure that the twins' permanency goals were appropriate. The OIG determined that the failures in this instance are properly assigned to Quincy Center for failing to properly prepare its case manager to make the appropriate decisions.

When Coakley was hired, he had no experience in child welfare. His degree was in computer science. He was given no training or preparation for case management as a child welfare worker. He was immediately assigned 25 cases, one of which was the Patterson family.

Coakley was able to confer with his supervisor. However, his inexperience as a case

manager meant that he was not able to recognize the kinds of questions to ask or recognize problematic issues with regard to the children. The case was badly mishandled. The fault lies with Quincy Center for handing this case over to an inexperienced worker and not training him.

Coakley' inexperience led him to make three mistakes. First, he did not properly assess the twins as appropriate for independent living. Second, he did not prepare them for independent living. Third, Coakley failed to prepare a service plan while the twins were monitored by Quincy Center.

i. ***Failure to Properly Assess for Independent Living***

Within six months of his hiring, a case manager with very little experience made the decision to transfer the twins into an independent living program.

Coakley was aware of behavior problems Lisa and Lauren were presenting. Lisa and Lauren's grandmother had told him that they were smoking "blunts." Coakley knew that the girls were ungovernable and were truant from school.

It should have been clear that the twins were not ready for independent living. Coakley pursued the goal of independent living without evaluating whether the twins were responsible enough to benefit from an independent living program. He followed along with decisions made by previous workers, without giving any thought to whether he should transfer this case.

Independent living is designed to assist youth that have already shown that they are capable of living responsibly on their own. Appendix H of Sub-part C of DCFS procedure 302. Department procedures require that youth participating in independent living must meet certain minimum requirements before they can be accepted into such a program. Among other things, the youths must demonstrate some money management skills; must be able to live in the community without continuous adult supervision; must be willing and able to cooperate with the agency to develop further independent living skills; must have the ability and motivation to complete a training or educational program regarding financial independence; and must have the ability to manage day-to-day living skills in an apartment, such as being able to prepare meals, maintain proper nutrition, care for clothing and maintain a reasonable degree of cleanliness. Appendix H of Sub-part C of P302, Section B. The twins had achieved none of these skills.

ii. ***No Preparation for Independent Living***

Coakley failed to adequately prepare these girls for an independent living program. They were given no demonstration of how to budget money, how to keep a clean home or how to prepare meals. The girls never became involved with the P.A.L. program, which was a pre-independent living program that prepared wards to participate in independent living.

iii. No Preparation of Service Plans

In addition to not preparing the twins for independent living, Coakley also failed to develop a new service plan. Coakley received the case in June 1995, one month after a service plan had been completed. The next service plan would have been due in November 1995.

He did not prepare a service plan at that time.[35] He did not prepare a new service plan when he transferred the twins to Shoreline Center, and therefore allowed them to enter the program without a current evaluation of their participation in services.

2. Safety Net #2 -- Shoreline Center Fresh Start Program

Exhibit 9. SHORELINE CENTER FRESH START

Responsibility: To protect the twins by monitoring their cases and preparing them to live independently of the child welfare system

Failures:

1. Inadequate screening
2. Inadequate substance abuse policy
3. No preparation of service plans

a. Responsibilities

Shoreline Center Fresh Start began monitoring the twins in March 1996. Fresh Start is an independent living program for older adolescents. Its responsibility is to provide services to the twins to prepare them for independent living. Through its monitoring, Fresh Start is to protect the twins.

b. Failures

The OIG investigation determined that Fresh Start failed to properly monitor this case because it failed to address the substance abuse of the twins. The program was not prepared to handle the case of two clients with substance abuse problems. Fresh Start failed to properly assess the substance abuse situation and to properly identify and deal with the problems that arose because of it.

i. Inadequate Screening

The Fresh Start program is not appropriate for active substance abusers. This is clearly stated in Fresh Start's program plan.[36] However, when the twins were referred to the Fresh Start program, the intake process revealed that they had substance abuse problems.

The May 1995 service plan of Quincy Center stated that Lisa was in need of a drug assessment. It is unknown if this service plan was included in the referral materials and given to Fresh Start. However, Curtis McKinnon told OIG that the program would ordinarily review a current service plan as part of the intake process, and he expressed

surprise when it was pointed out that the most recent plan was completed in May 1995. Carl Coakley did not complete a new service plan for the twins before transferring the case to Fresh Start. Therefore, the May 11, 1995 service plan was probably included in the referral materials. Additionally, during her initial interview, Lauren told the interviewer that she had used marijuana since she was fifteen.

Fresh Start did not do any further assessment of the twins' drug use before agreeing to accept the twins into the program. It did not address the concerns that were raised during this intake process.

ii. Inadequate Substance Abuse Policy

Fresh Start did not have an adequate substance abuse policy. When a new client comes to the program, that client is assigned a case manager and a therapist. Together, these workers are responsible for implementing the drug abuse policy. When there is evidence that a client is involved in drugs, the client is made to take a urine drop. When the drop is positive, the client is referred to the assigned therapist for drug counseling, whether or not the client is participating in therapy. There is no further procedure to follow when subsequent drops are positive. This policy is tantamount to having no policy.

Shoreline Center basically ignored the evidence that the girls were doing drugs. Sampson ignored all indicators that the girls were using drugs regularly even though it was known that they were pregnant. Such behavior on the part of a child welfare worker is inexcusable.

iii. No Preparation of Service Plans

There was no current service plan when the girls were transferred to independent living. The last service plan was written in May 1995. No new service plan was developed until December 1996, eighteen months later. Because there was no service plan, the workers did not address the twins' failure to participate in substance abuse services. The workers did not review the May 1995 service plan, which required a drug assessment for Lisa, until Lisa had been part of the program for eight months and had already become pregnant.

3. Safety Net # 3 -- Shoreline Center Teen Parents Program

Exhibit 10. SHORELINE CENTER TEEN PARENT PROGRAM
Responsibilities: To protect the twins by supervising their progress and ensuring that their children are not at risk of harm.
Failures:
Poor judgement of Program Manager/ poor management decisions resulted in:
1. Inappropriate attitudes/perceptions of workers
2. Failure to follow program plan
3. Failure to provide required services/adhere to budget

Appendix A

a. Responsibilities

The Shoreline Center Teen Parents Program ("Teen Parents") began monitoring the case in March 1997. Teen Parents is an independent living program for teens that have given birth to a child or are expecting a child. Its responsibility is to provide services to the teen to prepare her to live independently and to keep her baby from risk. Through its monitoring, Teen Parents is to protect the teens and the babies of the teens.

b. Failures

The OIG investigation determined that Shoreline Center Teen Parents program failed to proactively monitor this case and ensure that the teens were participating in services. Because of this, the program failed to protect the teens and their babies.

Many of the problems with the Teen Parents program were caused by poor management decisions. Suzanne DeWitt, the Program Manager, often exercised poor judgment in supervising her workers and in monitoring the teens.

DeWitt made inappropriate decisions about spending the money that DCFS paid to this program. DCFS paid the program over $160.00 per day per client. This came to over $4500 per month for each twin. The twins were part of the Teen Parent program for approximately one year. Therefore, DCFS paid Teen Parent approximately $108,000 to provide services to the twins.

DeWitt exercised poor judgment in how this money was spent. At one point, accountants had told DeWitt that she had to be careful about how she spent the money. When the accountants told her that the problems had cleared up and there was now a surplus of money, DeWitt made a decision to give each teen $200 per month in clothing vouchers. This policy remained in place for eight months. Teen Parents ordinarily provides services to 25-30 clients at a time. This means that DeWitt paid out almost $40,000 in clothing vouchers.[37]

Additionally, DeWitt organized many trips for the teens. Curtis McKinnon told OIG that these trips were supposed to be educational and were supposed to motivate the teens to participate in services. However, it is difficult to see the educational purpose behind some of the trips that DeWitt planned. DeWitt organized a trip to the Mall of America in Minneapolis. Approximately fifteen teens went on the trip, and half of those teens brought their children. Shoreline Center paid for air fare, hotel rooms and three meals a day. Additionally, the program gave the clients $200 apiece to spend at the mall. Jeanette Van Meter told OIG that Shoreline Center also took the teens to the Wisconsin Dells.

The clients were encouraged to attend an Assessment Workshop in Florida, which was arguably an educational program. However, in addition to air fare, hotels and meals,

Shoreline Center paid for admission into Disney World and Universal Studios.

During most of this time, according to Van Meter, the majority of the teens who were part of the program were not participating in services. Lisa and Lauren, who received a number of clothing vouchers, in addition to receiving $200 a month in stipends and grocery vouchers, were using drugs and not receiving substance abuse treatment, not attending school or a GED program, not attending vocational training and not working, not attending parenting classes, not attending therapy, and not scheduling pediatric appointments for their babies. DeWitt told OIG that these trips were necessary because the teens were entitled to recreational therapy. In essence, the twins were paid a substantial sum of money to take drugs and stay at home.

DeWitt's management also failed because of her failure to develop policies to address concerns that should have been apparent to any program that had a responsibility to a parenting population. The program did not stress prenatal care. Consequently, Lisa received no prenatal care. The doctor had to explain to her the process of childbirth *while she was in labor.*

The program does not stress pediatric appointments and has no requirement that the case managers confirm a schedule of pediatric appointments for the children of the teens. The Shoreline Center case managers did not see to it that Lisa or Lauren's babies received any pediatric care. In fact, pediatric appointments are not even mentioned in the case notes until four-month old Janice becomes so sick that she is "wheezing" and the workers have to call the Hotline to get Lisa to take her to a doctor. At a staffing conducted in the spring of 1998, when Janice and Darren were approximately one year old, the OIG discovered that both babies were six to nine months behind in their immunization schedule. The failure of the program to stress pediatric appointments caused the babies to be at risk.

The program does not provide a plan for when a teen gives birth to a substance-exposed infant. Having no plan in place for this eventuality meant that no provisions were developed when each of the twins gave birth to drug-exposed infants. No one monitored the two teen mothers' attendance at the substance abuse treatment program. Everybody assumed that the monitoring was being handled by somebody else. Thus, nobody assured that the twins were receiving the treatment that they were supposed to receive to keep the twins and their babies free from harm.

Much of this failure to provide services was the result of DeWitt's management. As discussed below, she instructed her workers that there were no consequences if the teens failed to participate in services. DeWitt also failed to follow her program plan and failed to provide the services that the program had told DCFS it would provide when DCFS awarded the contract to the program.

Appendix A

i. ***Inappropriate attitudes/Perceptions of workers***

DeWitt communicated to her workers that there could be no consequences if a client refused to participate in services. The workers told OIG that Teen Parents had a "no eject/reject" policy. According to the workers, this policy meant that a client could not be refused acceptance into Teen Parents and, once they were admitted into the program, they could not be ejected, even if they failed to participate in services.[38] The workers relied upon rewards to motivate the clients to participate in services, such as trips to different locations. The trips were intended to be educational. However, it is doubtful that that is how they were perceived.

The attitude permeated all levels of staff at the program. The clients were harmed by this attitude.

This attitude ultimately meant that the program received $108,000 for the twins from DCFS and the twins received no services.

ii. ***The Teen Parents Program Plan***

Shoreline Center Teen Parents program plan existed on paper, but never was implemented with program integrity.

The Shoreline Center workers were either unaware of the content of the program plan or ignored it. Teens who were active substance abusers were not to be accepted into the program. (Shoreline Center Fresh Start Teen Parents Program Plan, Provision 3.2, hereinafter referred to as "Program Plan.") In the case of the twins, their substance abuse was not a barring factor in their intake and they were accepted into the program with no provisions made to deal with their substance abuse.

There are valid reasons for not accepting an active substance abuser into a particular program. The Teen Parents program provides services to women who are expecting children or who already have children and, therefore, accepts the responsibility for making sure that the children are protected from risk of harm. A woman who has children and who is an active substance abuser creates a new set of concerns for the Teen Parents workers, because the babies are placed at greater risk. Substance abusing clients who have custody of minors require additional services.

Consequently, there should have been a rigorous screening procedure in place to make sure that substance abusers do not become part of the program and are referred to other placements. Although the program plan did have a referral process, see Program Plan 3.3, Jeanette Van Meter told OIG that Shoreline Center failed to conduct any significant screening during the Intake process at the time that the twins were admitted into the program. In this case, at least, the lack of integrity with the formal intake process resulted in two teens

with substance abuse problems being inappropriately accepted into an ill-prepared and ill-managed program.

The program plan also states that service plans were to be developed at various stages of participation in the program. A provisional initial service plan was to be developed within the first week; a service plan was to be developed within 30 days of the preliminary assessment. Program Plan 4.2.1. No such plans were formulated for the twins.

The program plan says, "Sex and Drug education will be aggressively employed with each adolescent." Program Plan 6.6. Such education was never provided for the twins. No substance abuse services were provided. The workers did not work to get the twins into services until after the court ordered them to participate in services in October 1997.

The program plan then discusses such issues as staff development. According to the plan, all new employees must participate in initial training and orientation that takes 30 days. Program Plan 10.1. The program plan also requires in-service training. Program Plan 10.2. From the interviews conducted by OIG, it is clear that the workers had not received any of the required training.

Teen Parents was also required to provide quarterly progress reports for DCFS. Program Plan 11.1. Such reports were not completed on the twins. Shoreline's file for Lisa contains no quarterly progress reports. There are two quarterly reports in Lauren's file. The first shows a date of June 1, 1997. However, the report notes that Lauren's mother died on July 30, 1997, one month *after* the report was allegedly written.[39] The second report is not completed and is not signed or dated.

iii. Failure to Provide Services/Adhere to Budget

In late 1995, DCFS entered into its contract with Shoreline Center to establish an independent living program for pregnant and parenting teens. Curtis McKinnon, Program Director of Fresh Start, negotiated this contract. McKinnon negotiated the higher per diem rate that the Teen Parents program was paid.

Shoreline Center submitted to DCFS a listing of additional services that the Teen Parents program would provide and how much those services would cost. The list of enhanced services, and the additional amount of money these services would require is included, in relevant part, below:

- $24,000 was needed to pay for larger apartment units required by a mother and her child;
- $7,000 was needed to cover client clothing during and after a client's pregnancy;
- $56,160 was needed because of client parenting education, including information about sex and drug intervention, birth control alternatives, parenting classes and parenting

literature;

- $13,200 was required because of the need for intensive client employment training and programs;
- $10,500 was needed as salary for a part-time nurse/mid-wife;
- $70,000 was needed because of home visitor salaries;
- $12,000 was needed for pre and post natal equipment;
- $50,000 was needed to pay for increased training sessions for the staff; and
- $5,000 was needed because of increased random prenatal drug testing.

However, the additional money paid to Shoreline Center Teen Parents Program was not necessarily used to cover the services that were identified in this list. McKinnon told OIG that these were simply targets and DCFS understood that all these services would not be put in place immediately. The date imprinted at the top of the facsimile transmission indicates that this itemization of services was completed and sent to DCFS in April of 1996. In over two years, Shoreline Center has not implemented most of the additional services.

For example, according to the Program Manager, Suzanne DeWitt, the program has still not hired a part-time nurse/midwife. DeWitt could not identify the pre and post natal equipment she had purchased for her program. DeWitt told OIG that the program has yet to implement a training program for its case managers and other workers. DeWitt told OIG that she did not do increased random prenatal drug testing.

DeWitt told OIG that the increased per diem for Teen Parents is because the clients need additional clothes because of the changes in their bodies during the various stages of their pregnancies. That was the only additional service that DeWitt could identify.

Evaluation of Shoreline Center by the Illinois Caucus for Adolescent Health

The recent certification process completed by the Illinois Caucus for Adolescent Health ("Caucus") also points out problems with the Shoreline Center program. According to its literature, the mission of the Caucus includes providing public education, policy advocacy and technical assistance on issues relating to the health and well-being of adolescents, especially teenage parents. The Caucus has developed a comprehensive system for evaluating pregnant and parenting programs, and is to provide certification of the programs. The Caucus has a contract with DCFS that runs through August 1998.

The certification system addresses basic issues such as staff, ratio of staff to clients, staff training, service provided, intake process, service planning, case management, assessment of the client, provision of preventive services, health care, discharge planning and quality assurance. Programs are asked to perform a self-assessment, answering seventy-two questions. The next step is for the certification team to gather information about the program. After that, a visit is made to each agency, and the Caucus reviews documents and interviews various workers at the agency and various teen clients.

Appendix A

Shoreline Center underwent certification in May 1998. It was given provisional certification. Although the Caucus noted several program strengths, the Caucus certification team scored Shoreline Center low on such items as assessment of clients, service planning, ensuring that health care records are maintained, offering information on child care, and quality assurance plans.

Because of the weaknesses in self-reporting, the OIG believes that collateral contacts with professionals and family should be built into the certification process.

4. Safety Net #4 -- DCFS Monitor

Exhibit 11. DCFS MONITOR
Responsibilities: To protect the twins by monitoring the Shoreline Center case management and ensuring that ACR's are scheduled
Failures:
1. No DCFS worker assigned for first year of independent living
2. Lack of meaningful DCFS worker involvement due to:
   a. Inaccessibility of DCFS worker
   b. Failure of DCFS worker to attend court
3. No ACR's scheduled on timely basis

a. Responsibilities

June Weaver, a Child Welfare Specialist II, began monitoring this case in May 1997. Weaver was the DCFS follow-up worker. Weaver was required to see her clients quarterly and to have phone contact with them each month.[40] Through her monitoring, Weaver was to ensure the safety of the twins.

b. Failures

The OIG investigation determined that there was no significant monitoring of this case by a DCFS worker.

i. No DCFS worker assigned for first year of independent living

No worker was assigned to monitor this case for the first year that the twins were in independent living. After Carl Coakley transferred the twins to independent living, he drew up all the paperwork for closing the case and turned it in to his supervisor. However, Coakley remained listed as the DCFS worker assigned to monitor Lisa and Lauren. Coakley was, therefore, treated as the worker with the responsibility of monitoring this case. For example, an order to compel his appearance in Lisa and Lauren's case was entered by the court in March 1997. It was subsequently rescinded when the court learned that he was no longer the worker.

All of the workers were under the impression that a DCFS worker should be assigned

to monitor this case. The Fresh Start staff tried on several occasions to learn who was the assigned DCFS worker. Nobody was able to provide such information. During his interview with the OIG, William Boselli also expressed confusion over this.[41]

Because of the confusion, no one monitored the case for over a year. A DCFS worker was finally assigned on May 23, 1997, after both Lisa and Lauren had given birth to their babies and had been transferred to Teen Parents.

ii. Lack of meaningful DCFS involvement

June Weaver was the DCFS worker assigned to monitor Lisa and Lauren's case on May 23, 1997. Weaver was supervised by William Boselli, a SWEP student working on his master's degree. Boselli was out of the office for six months, working on his field placement. Because of Boselli's absence, Weaver was working as the TA of her team and had supervisory responsibilities, in addition to case management responsibilities. However, Boselli returned to the office in August 1997. Therefore, Weaver was only burdened with supervisory responsibilities for a few month after she had been assigned the case. Weaver failed to proactively manage the case at any time during her involvement. In fact, her case monitoring was virtually nonexistent.

A. Inaccessibility of DCFS worker

Once Weaver was assigned, she was not accessible to any of the workers assigned to this case. Her inaccessibility made the work of other service providers more difficult. It also delayed the referral for the twins' substance abuse treatment, as she had to make the referral.

The difficulties encountered by the service providers in reaching Weaver are recounted below.

Weaver failed to keep in contact with the drug treatment program. On June 30, 1997, Lillian Springer, Outreach worker at Westfall Services, sent Weaver a letter relating that Lisa had been absent from the program on 13 days in June. She had, in fact, attended only four sessions. Springer asked Weaver for assistance in impressing upon Lisa the importance of attending group on a regular basis. Weaver did not respond to this request. In fact, Weaver had no contact with the twins until October 1997.

On August 4, 1997, Amy Thompson, of Westfall, sent a letter to DCFS relating that Lisa had been admitted to the program because her child tested positive for PCP. The letter noted that Lisa had attended only four sessions since her admission and had tested positive for PCP on June 16, 1997. The letter further noted that several attempts had been made to re-engage the client, *including contacting the DCFS worker, June Weaver,* but all had been unsuccessful. Therefore, Lisa was discharged from the program on July 31, 1997.

Weaver had no contact with the Lifeworks program. James Matheson, consultant to DCFS Clinical Services, sent a fax to William Boselli on July 8, 1997, concerning Lisa's involvement in the Lifeworks Program based at Highland Hospital. Matheson asked Boselli to make sure that Weaver confirm a date for the 30-day staffing on Lisa. Matheson stated that he expected the staffing would be held within 14 days from the date of the fax. The staffing was not held until August 6, 1997. Matheson scheduled the staffing and not Weaver.

At the staffing, Matheson made two recommendations that Weaver was to follow through on: (1) ensure medical care for the infant and (2) get Lisa re-enrolled in drug treatment. Matheson waited several months, but did not hear from Weaver. On October 23, Matheson called Weaver to inquire about the recommendations he had made at the staffing. He was only able to leave a message, and was told that Weaver's office was relocating the next day. That call was never returned.

Weaver did not return calls from the DCP workers or the Intact workers that were handling various aspects of the twins' case. In the middle of September, Lisa was reported to the SCR for medical neglect. The DCP worker assigned to investigate the neglect, Kim Overbrook, tried to call Weaver on September 17. She tried again on September 23, October 3, and October 8. Overbrook finally spoke with Weaver on October 9, almost one month after the investigation began. When she spoke with Weaver, she informed her of the medical neglect report and that the report had been unfounded. Weaver's inaccessibility interfered with the DCP investigation. Because Weaver did not return calls, she could not provide information to the DCP worker that might have assisted in making a decision.

Martin Sullivan, who investigated the January call to the SCR, noted in his report that he had left messages for the Intact worker, presumably referring to Weaver, but his calls were not returned.

Weaver did not communicate with the case managers handling the case. Quincy Center's case manager, Carl Coakley, unsuccessfully tried to contact Weaver. On July 7, 1997, Carl Coakley sent Weaver a letter stating that he had made several attempts over several months to set up a staffing with her, but had been unsuccessful. He also stated, "[I]t is imperative that the staffing take place," and asked her to contact him. She never called Coakley.

Beatrice Gifford, the Shoreline Center Teen Parents case manager, tried to reach Weaver in order to get Lisa re-enrolled in drug treatment, but had been unsuccessful.

B. Failure of DCFS worker to appear in court

Weaver failed to appear at several court hearings and two orders to compel her appearance were issued.

Appendix A

The court ordered the workers to conduct an ACR in June 1997 and report on the ACR at a hearing in July. At the hearing held in July 1997, the court noted that there was no current service plan and no workers were present in court. The court continued the matter until September 11, 1997. At the September 11 hearing, only Jeanette Van Meter appeared. The court entered an order to compel the appearance of June Weaver and continued the matter until September 25, 1997. At the September 25 date, only Beatrice Gifford from Shoreline Center appeared for Lisa. The court entered another order to compel the appearance of Weaver and continued the matter until October 8. On October 8, 1997, Weaver was present, but no Shoreline Center worker appeared. The matter was continued to October 15.

On October 15, all the workers and the minors were present. This hearing was the first contact Weaver had with the twins.

Weaver failed to attend court on three occasions. Her failure to appear resulted in a delay in the court receiving progress reports and service plans being put in place.

iii. No ACRs scheduled on timely basis

Weaver's failure to monitor this case resulted in delays in scheduling the ACRs. A timely ACR would have meant that all the workers involved were aware of the services that the clients required and would be able to work toward making sure that the twins were participating in services.

In May 1997, the court ordered the workers to conduct an ACR in June. No ACR was conducted at that time. According to the computer, the ACR was not completed until December 9, 1997.

5. Safety Net #5 -- Teen parent Coordinator, Margaret Sutton

Exhibit 12. TEEN PARENT COORDINATOR
Responsibilities: To protect the twins by assuring integrity of the Teen Parents Program and offer technical assistance
Failures:
1. No significant oversight of the Teen Parents Program
2. No technical assistance on the DCFS/DASA Initiative

a. Responsibilities

Margaret Sutton, the DCFS Teen Parent Coordinator, had the responsibility of assuring the integrity of pregnant and parenting programs and offering technical assistance. Through her monitoring, she is to protect the twins.

b. Failures

The OIG investigation determined that the Teen Parent Coordinator, Margaret Sutton, failed to critically assure the quality of the services provided by the Shoreline Center Teen Parents Program.

i. No significant oversight of Teen Parents Program

In the 1997 DCFS Teen Parent Consultant's report, submitted as a requirement of the Hill Consent decree, the Consultant reported collecting information about the teen pregnant and parenting population "via the Unusual Incident Report system" and ACRs received by the Teen Parent Coordinator. Page 12, Section IV, PROGRAM DEVELOPMENT, Data Collection/Special Needs of Population. However, the OIG determined that Sutton did not monitor Unusual Incident Reports on class members. While she acknowledged that she should get copies of unusual incident reports, she stated that she only received reports from two agencies on a regular basis, without repeated requests.

Sutton also did not hold agencies accountable for the provision of services of class members. She was unaware of the number of class members who had given birth to substance-exposed infants. She reported to OIG that she has no statistics on the numbers of mothers who attend school. In her interview with OIG, Sutton deferred the responsibility of assessing educational services of the class members to the Teen Parent Consultant and the Coordinator of the Illinois Caucus for Adolescent Health. Sutton also reported that generally programs do not work with the fathers of the children. The system of data collection that she developed does not even include a way of identifying fathers who are wards. (There is some speculation in this case that the father of one of the babies might have been a ward or fellow resident of the Fresh Start program.)

It is true that the Teen Parent Coordinator requires a monthly reporting form from the service providers in which the providers are to report the number of women in their programs and how many are enrolled or attending school, a GED program or college and how many are working. This form, developed by Sutton, does not require descriptions of critical incidents including high-risk incidents such as hotline calls, domestic violence and arrests. In fact, it does not include any way for the service providers to note that a pregnant and parenting ward had been the subject of an unusual incident report that month.

In addition to requiring a monthly written report from agencies, the Coordinator holds monthly meetings in Cook County for Cook County providers. While this venue offered a regular process for collecting critical data on the class, it was not used for this purpose. (The comprehensive report prepared by the Teen Parent Consultant refers to these monthly meetings as training meetings and refers to additional quarterly round tables as providing a forum for "lively feedback from providers.") Accountability and critical monitoring of tasks do not appear to be on the agenda for the monthly meetings.

Appendix A

Sutton acknowledged that she was involved in the development of the Shoreline Center Teen Parents Program. Shoreline's monthly report forms, supplied to OIG by the Coordinator, documented that less than 20% of the Shoreline Center Teen Parents clients were enrolled/attending school or a GED program. There is no documentation that technical assistance on the educational services referenced in the Hill report was provided or a system of reliably monitoring these educational services was built into the provider's negotiated contract. There was no formal communication developed between the Teen Parent Coordinator, Teen Parent Consultant, or DCFS liaison with the Chicago Board of Education to proactively remedy the dismal educational outcome of this Shoreline Center Teen Parents program.

ii. No Technical Assistance on the DASA/DCFS Initiative

Part of Sutton's job duties included providing information and expertise concerning pregnant and parenting minors to other staff and agency units within DCFS. However, Sutton informed OIG that she was not aware of the DASA Initiative. She was therefore not able to refer any of the programs for which she had responsibility to this service.

6. Safety Net #6 -- Lifeworks

Exhibit 13. LIFEWORKS
Responsibility: To protect Lisa and her baby by referring Lisa's case to a drug treatment program through Lifeworks and monitoring her case
Failures: No significant oversight of Lisa's case

a. Responsibilities

Highland referred Lisa to the Lifeworks program after she gave birth to a substance-exposed infant, and Lifeworks was to monitor Lisa's progress in drug treatment. Lifeworks is a program whose goal is to get the mother of a substance-exposed infant quickly involved in services. The responsibility of the DCFS consultant to the Lifeworks program was to monitor Lisa's progress in drug treatment services. Through his monitoring, the DCFS consultant is to protect the twin.

b. Failures

The OIG investigation determined that the Lifeworks program failed to proactively monitor this case.

Lisa was referred to Lifeworks by Highland Hospital when her baby was born drug-exposed. Lifeworks failed to monitor Lisa's involvement in drug treatment.

James Matheson, the DCFS consultant to the Lifeworks program, failed to proactively monitor this case. The 30-day staffing that is required of the Lifeworks program did not occur until six weeks after the 30-day mark, and after Lisa had already been

discharged from the drug treatment program because of her failure to attend. At the staffing held in August, Matheson recommended that the DCFS worker attempt to reengage Lisa in services, but he did not call her to check on Lisa's progress until more than two months later. Although he received absolutely no information from the DCFS worker about Lisa's participation in services when he called, he waited another three months before calling the Shoreline Center worker to inquire about her progress in drug treatment. When he finally spoke with the Shoreline Center worker, he was told about the extent of the problems and he then began work on this case.

Had the staffing been conducted in a timely manner, Matheson and the other workers would have known of the positive drug test in June and may have been able to encourage Lisa to remain in drug treatment before she was discharged on July 30, 1997. Matheson recommended that the DCFS worker secure documentation of the infant's follow up medical care and assist Lisa in getting back into drug treatment. Matheson did not attempt to call Weaver until October for follow up, but he did not reach her. She did not return his call.

Moreover, Matheson allowed his recommendations from this meeting to be based on unreliable information. Present at the staffing were Matheson, June Weaver and the public health nurse, Rhonda Fisher. Neither Lisa nor the Shoreline Center worker was present at the meeting. Weaver told Matheson that she had not seen the client. The Public Health nurse conducted her initial home visit with Lisa on June 5, 1997. There were no further visits through July, although the Lifeworks program requires a weekly nurse visit to the home for the first three months that a mother is in the program. Therefore, nobody was present that had had any significant contact with Lisa or her problems.

Matheson failed to provide services to Lisa. Matheson recognized the risk factors in this case, but failed to keep cognizant of them in monitoring the case. He had a duty to proactively manage this case and failed to exercise that duty. In fact, in a January 16, 1998 report to the Director authored by Joanie Adams, Adams noted,

> "Of the three primary PCP users, one is an adolescent. Again, this is to be expected, since in Chicago, PCP is often a 'gateway' drug used by teens, prior to heroin use. *James Matheson reviewed all six cases with DCFS staff. When these cases were investigated, the parents who kept their children all had strong support systems in which other adults appeared to be willing to be the primary caretakers of the infants. All cases are still being followed in Lifeworks. [sic.]*" January 16, 1998 report from Joanie Adams to the DCFS Director, p.2 (emphasis added.)

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7. Safety Net #7 -- Hotline calls

Exhibit 14. HOTLINE CALLS
Responsibilities: To protect the twins and their babies by assessing conditions to determine whether abuse or neglect exists
Failures: Lack of reliability of DCP assessments

a. Responsibilities

On several occasions, as part of its monitoring, the Shoreline Center workers made calls to the SCR, reporting the behavior of the twins. DCP workers assigned to this case were to investigate allegations of abuse and neglect and ensure that minor children are protected.

b. Failures

The OIG investigation determined that the response and investigation of the DCP workers assigned to this case was unreliable and that the DCP workers failed to protect the babies of the teens from risk of harm.

On January 5, 1998, Beatrice Gifford made a call to the SCR to report that she had made a home visit and found open beer bottles and remnants of drugs in the home. Separate reports were made for Lisa and Lauren. The report raised allegations of risk of harm. Sarah Turner and Martin Sullivan were each assigned to investigate this same report called in to the SCR.

Martin Sullivan, who investigated Lisa Patterson, indicated the report for risk of harm. During his investigation, Sullivan spoke with Lisa's substance abuse counselor at Westfall and discovered that Lisa was using PCP, which could cause her to hallucinate. He therefore indicated the report, noting the type of drug used and saying that Lisa's choice of drug placed her baby at risk of harm.

In contrast, Sarah Turner unfounded her report. She told OIG that the report that had been made had concerned *Lisa's* apartment being messy and containing drug remnants. Turner's reasoning was that Lauren's baby was not present at the party; Lauren's apartment was clean; Lauren's baby was clean and well-fed, and there were no issues of abuse or neglect. She therefore did not see that there was risk of harm and the report was unfounded.

However, Lauren had admitted to Turner that she used drugs. A number of her friends had also noted that Lauren used drugs. Had Turner called the drug counselor, as Sullivan had, she would have discovered that Lauren had tested positive for PCP twice during the time that Turner was conducting her investigation and that Lauren was no longer attending drug treatment.

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Turner limited her investigation. She was not able to recognize that her investigation should not have stopped with an assessment of the cleanliness of the apartment. The narrowness of her focus led to her not being very thorough. Unlike Sullivan, she made no inquiry into the twin's substance abuse problem.

The result, then, is that two workers conducted investigations on the same report, which involved many of the same individuals. Because one considered his job to have a broader scope than did the other worker, he asked more questions and conducted a more extensive investigation. This led to him indicating a report. When the investigation was more limited, the DCP report was unfounded.

A side issue arose out of Sarah Turner's investigation, which is the use of the term "Dr." before her name. Sarah Turner signed the bottom of each page of her interview notes with "Dr. Sarah Turner." Turner's personnel file reflects that she received a doctorate in ten months. According to her employment application, her degree is in the Philosophy of Counseling. The literature obtained from the school states that it is accredited by an organization not considered to be a valid accrediting institution. To allow Turner to continue to use "Dr." before her name misleads a vulnerable population and causes confusion among her colleagues. Through the use of "Dr.," Turner confers upon herself a technical knowledge base that she does not have.

RECOMMENDATIONS:

The OIG makes the following recommendations.

1. An in-depth analysis with collateral interviews should be conducted on a random sample of Lifeworks cases to assure meaningful program integrity and training needs.

2. All supervisors of Teen Pregnant and Parenting Programs should receive training on the SEI protocol. During this training the supervisors should bring data on class members with substance abuse problems, develop intervention strategies for their clients and design a system of accountability and contingencies for compliance with drug treatment services and life activities that are incompatible with a drug lifestyle.

3. When special clinical concerns arise over a Hill class member's capacity to parent, the De Paul/DCFS Project's psychosocial assessment tool should be used to develop a relevant intervention plan.

4. It is imperative that the five agencies awarded the Network for Parenting Project be given a copy of this report and critically inquire into the issues raised in this report. Quincy Center, a member of this Network, is negatively cited in this report. Under this Network agreement, Quincy Center will provide full case management and supportive services to the

Hill class, will be subcontracting with and assisting a second agency receive its child welfare license and will provide, "a comprehensive training curriculum for working with pregnant and parenting adolescents." Accountability for effective services must be frankly discussed by the partnering agencies to prevent any unrecognized bias for self-interest. This critical inquiry must identify relevant sensitive and feasible outcomes and candidly review program's knowledge and skills to help clients and improve services.

5. DCFS Office of Internal Audits should conduct an audit on Shoreline's Teen Parents Program.

6. Because of the significant program problems with the Shoreline Center Teen Parents Program, this program should be closely monitored. If the program is unable to meet Illinois Caucus of Adolescent Health certification standards within 60 days the contract should be terminated.

7. To avoid a conflict of interest between the Partnering agencies' monitoring functions and their own services the Caucus should continue to be the independent certifying body. The certifying process should be amended to add outside collateral contacts (such as schools, health providers, pediatricians and fathers and extended family members).

8. Sarah Turner should be instructed to cease referring to herself in her work documents and in employment related duties as doctor. In its next revision to its personnel handbook, the Department should forbid employees from referencing unaccredited educational titles in the workplace or in the community during work related business.

9. Sarah Turner should be disciplined for her failure to conduct a full investigation into the allegations that the subject of the investigation was prostituting, and exposing her child to the effects of drugs. She failed to contact the drug treatment professionals and she failed to fully identify collateral interviewees in her DCP investigation. Consequently, she was unaware that her client had once again tested positive for PCP and cocaine.

10. June Weaver should be disciplined for her failure to perform her duties. She was unavailable and did not return calls to professional colleagues including DCP and private agency workers. She failed to visit her clients for over 5 months even after the death of their mother. She failed to follow through with the Lifeworks recommendations, causing significant delays in her clients receiving drug treatment.

Denise Kane
Inspector General

Appendix A

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

Office of Inspector General

Addendum

Date: August 11, 1998
File No.: 97 IG 1124
97 IG 1170
Minors: Lisa Patterson, DOB: July 27, 1978
Lauren Patterson, DOB: July 27, 1978

On June 30, 1998, the OIG submitted the full report concerning the participation of Lisa and Lauren Patterson in Shoreline's independent living programs. This report, which includes additional recommendations, is an addendum to the previous report.

1. Shoreline's Fresh Start Independent Living Program should be retooled. The program should provide greater emphasis on providing education and job training to the youth it serves. The program should place greater emphasis on seeing that the fathers of minors (who are participants in the independent living program) receive parenting classes and participate more fully in the development of their children. The program should provide closer supervision of teens who are under the age of eighteen and who are participating in independent living. The supervision provided to the Patterson teens would not have met the requirements of the Public Aid rules and the Department should use the same standards that Public Aid has adopted.

2. Shoreline's Fresh Start Independent Living Program should see that each of its employees receives substantial substance abuse training. In particular, Cheryl Sampson should participate in a substance abuse training program. McKinnon should counsel her concerning her reaction to the evidence of the twins' drug use and her failure to identify a need to enforce the drug testing policy.

3. Shoreline Center should take appropriate action concerning the poor management of the Teen Parents Program. This action could include removal of the Manager of the Program, Suzanne DeWitt, or appropriate discipline.

4. The position of the Teen Parent Coordinator should be abolished.

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[1] All the workers and programs designed to protect the twins are referred to in this report as "safety nets."

[2] Lisa and Lauren are currently involved in a drug treatment program through New Town. However, both of their cases have recently been screened into court because of their failure to cooperate with drug treatment in the past.

[3] The OIG interviewed the following persons in the course of the investigation: Beatrice Gifford, case manager, Shoreline Center Teen Parents; Jeanette Van Meter, case manager, Shoreline Center Teen Parents (now Quality Assurance Specialist at Alms Children's Services); Linda Mischke, case manager supervisor, Shoreline Center Teen Parents; Suzanne DeWitt, Program Manager, Shoreline Center Teen Parents; Cheryl Sampson, case manager, Shoreline Center Fresh Start; Curtis McKinnon, Program Manager, Shoreline Center Fresh Start; June Weaver, CWS II; William Boselli, supervisor of Weaver; Carl Coakley, case manager, Quincy Center; James Matheson, consultant to DCFS Clinical Services; Margaret Sutton, DCFS Teen Parent Coordinator; Lauren Patterson, minor; Lisa Patterson, minor; Sarah Turner, DCP investigator; Terrence Haynes , DCFS Intact worker.

[4] In addition to the above listed persons, the OIG consulted with a number of individuals in gathering information for this investigation.

[5] The OIG reviewed the following documents during the course of this investigation: Quincy Center case record for the Patterson family; Shoreline Center case record for Lisa and Lauren Patterson; Department case record; New Town case record; drug screen records; Public Health records for Lisa Patterson; Shoreline Center Teen Parents Program Plan; Shoreline Center Fresh Start Program Plan; medical records for Lauren and Lisa from Highland Hospital and General Hospital; school records for Lauren and Lisa; personnel records for Beatrice Gifford, Jeanette Van Meter, Linda Mischke, Sarah Turner, and June Weaver; Memorial Institute STEPP Assessment; court file for Lauren and Lisa Patterson; DCFS contracts with Shoreline Center; Shoreline Center reports to Margaret Sutton, Teen Parent Coordinator; initial accreditation report of Shoreline Center program, prepared by Illinois Caucus for Adolescent Health; Evaluation of Teen Parents Programs; proposal of the Network for Pregnant and Parenting Teens; DCFS Supervised Independent Living Program rules, PT 90.9. (The OIG copied the Shoreline Center and DCFS records twice, because so many of the necessary documents appeared to be missing. Despite this, many of the documents still cannot be located.)

[6] Carl Coakley reported this to the OIG when he was interviewed.

[7] Subsequent Unusual Incident Reports and calls to the SCR will be reported in italics.

[8] Another note on the service plan indicates that Lisa told her worker that she *planned* to enroll in a GED program.

[9] OIG obtained the information on the company by calling its toll-free number and asking the operator.

[10] A "blount" or a "blunt" is a kind of marijuana cigar.

[11] A copy of this referral packet is not included in the Quincy Center file or the Shoreline Center file. Coakley could not tell OIG where a copy of this referral could be located.

[12] OIG checked the ACR schedules on CYSIS on June 25, 1998.

[13] However, Sampson also explained that at the time that Lauren and Lisa were accepted into the program, there was also a policy that the new client would be brought to meet the President of Shoreline Center. The President would have the final say about whether a candidate would be accepted into the program. Because the case manager would introduce the new client to the President, the case managers often read the

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files so they would be prepared if they were asked any questions. Sampson told the OIG that she was not aware of any time when the President had rejected a client.

[14] For some reason, many of the pages of Lauren's service plan are not included in her file.

[15] Sampson evaluated this service plan on April 1, 1997, after the twins were transferred to Teen Parents Program. She rated the twins' progress toward their goals as primarily unsatisfactory.

[16] The Teen Parents case managers, Beatrice Gifford and Jeanette Van Meter, also stated that every referral was accepted.

[17] According to the case managers interviewed by OIG, until recently, all referrals to Teen Parents came from Fresh Start. This policy was recently changed.

[18] According to Jeanette Van Meter, during her interview with OIG, Lauren confided to her that, a year later, she had been told at the hospital that her membrane had ruptured and she had delivered her baby early because of all the drugs she had been doing while she was pregnant.

[19] The OIG did not interview Murphy as part of this investigation.

[20] Notes from a later DCP report show that Gifford told the DCP worker in September that Lisa may have had a positive drop while enrolled in the drug treatment program.

[21] Shoreline Center had referred the twins to Burnside. They attended a few sessions in July, but were discharged from the program.

[22] According to the GAL's notes, the court had ordered the workers to complete an ACR in May.

[23] Copies of Lisa's urine screens were supplied to OIG; Shoreline Center case notes for Lauren reflect that she was positive for PCP and cocaine.

[24] According to the DCP reports and the Unusual Incident Reports, the call was made on January 5, 1998. However, according to Gifford's notes, she made a random home visit on January 6, 1998.

[25] "Leaf" is marijuana laced with PCP.

[26] "Wicked stick" or "wicki stick" is a kind of PCP-laced marijuana.

[27] After the twins completed the treatment program, they were allowed to go to Florida with their grandmother, who is suffering from breast cancer. Upon their return, the DCFS worker allegedly told the twins they could stay with their grandmother while their new placement in an independent living program was arranged. In addition, the twins were referred to the Intact Family Recovery program to provide intensive drug treatment, as well as close monitoring of child welfare. Since this referral, Lisa tested positive for PCP, heroin and cocaine. Her case was screened into court, and the initial court date is July 7, 1998.

[28] The OIG did not read the GAL's court file. During a telephone conversation, the Assistant Public Guardian currently assigned to this case reviewed her court file and related this information to the OIG investigator.

[29] Although Weaver told OIG that no compel order had been entered against her in this case, a copy of this order was found in the DCFS file.

[30] This is according to the CYSIS screen.

[31] The OIG attempted to call Weaver to re-affirm Weaver's failures in this case. The OIG was unsuccessful in reaching her.

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[32] Interestingly, the 1997 Teen Parent Consultant's report to the court vaguely discusses the issues of education for wards. The report states that 82% of the I.L.A. "offered some type of guidance for education services." No enrollment or attendance baseline is offered to the court. Likewise, the report offers only generalized information and brochures on programs such as the Chicago Board of Education's Parents As Teachers First home visiting program. The report further states there are 1,000 PATF slots available for adolescent parents. Neither of the subjects of this report were referred to this program.

[33] This information was taken from James Matheson's facsimile transmission sent to inform DCFS workers about the Lifeworks program. Matheson is the DCFS consultant to the program.

[34] Weaver told OIG that no staffing was ever conducted. According to Weaver, although she and Matheson tried to schedule staffings on two occasions, they could never coordinate their schedules. However, Matheson's notes contain a sign-in sheet for the staffing and Weaver's signature is on this page. Additionally, Matheson had a copy of the recommendations he made at the staffing. This sheet also indicated that Weaver was present.

[35] The service plan evaluated by Coakley in December 1996 was written in May 1995. Therefore, it is safe to conclude that no service plan had been prepared between May 1995 and December 1996.

[36] The OIG presumes that this plan is Fresh Start's most recent program plan. Shoreline Center General Counsel could not locate a copy of the program plan that was in place at the time that the twins were part of Fresh Start.

[37] Additionally, even though the teens were using drugs, they were given $100 in stipends and $100 in grocery vouchers each month.

[38] During her interview with OIG, Linda Mischke explained her perception of the "no eject/reject" policy. The general counsel for Shoreline Center interrupted the interview and explained that the intent of the program's philosophy was not as the worker had stated it. He said that the teens who participated in the program were acknowledged to be difficult clients, but that the case managers should make efforts to get them to participate in services before they tried to discharge them. Counsel recognized that the workers had a different perception of the policy.

[39] This report is not signed or dated at the end.

[40] Weaver was unaware of this responsibility.

[41] This is not an isolated incident of a case monitored by Shoreline Center not having an assigned DCFS worker. OIG has had difficulty locating the DCFS case file of another Shoreline Center Fresh Start client because no DCFS worker is listed in the CYSIS screen. Instead, the Fresh Start worker is listed as the worker.

Denise Kane

Date

Inspector General

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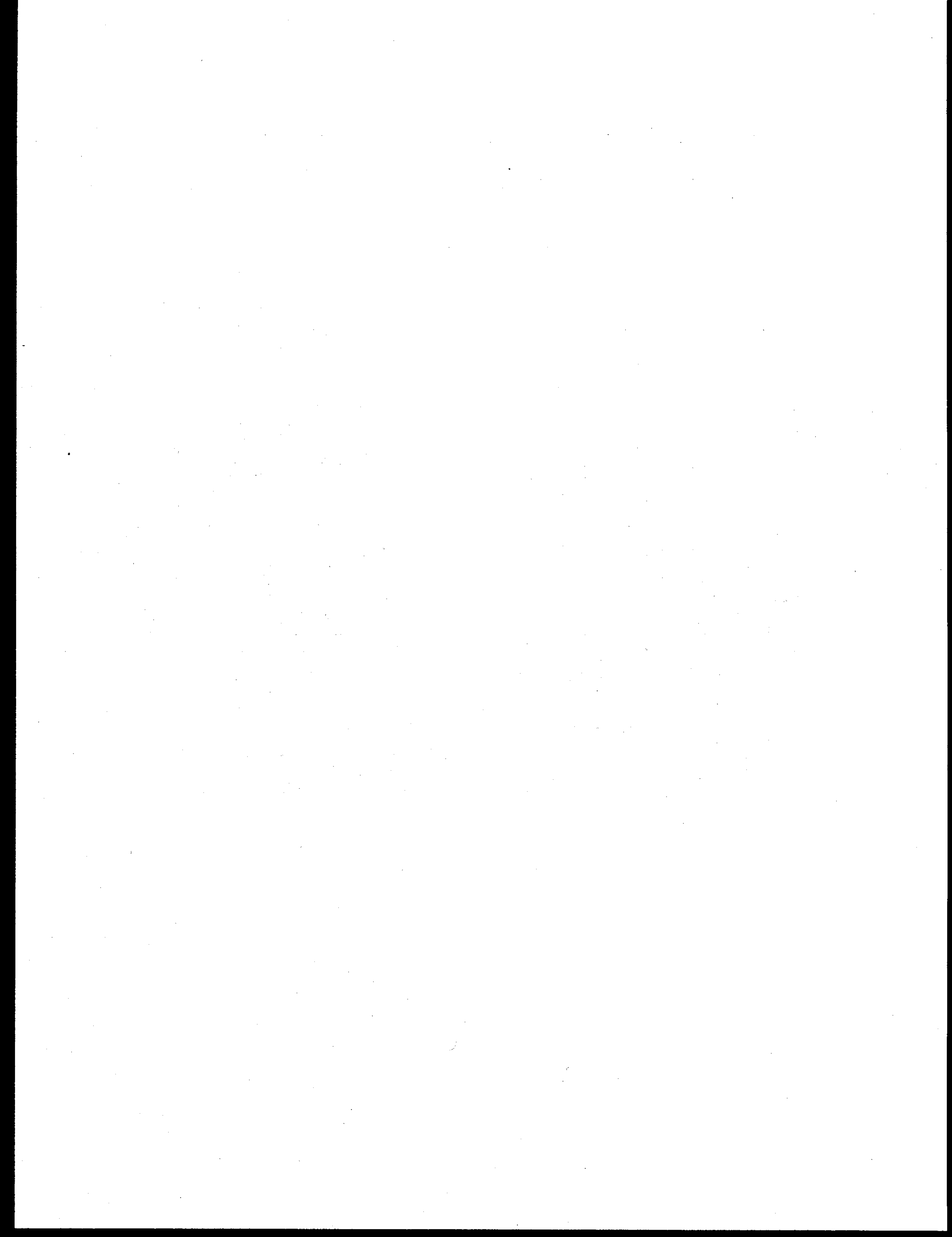
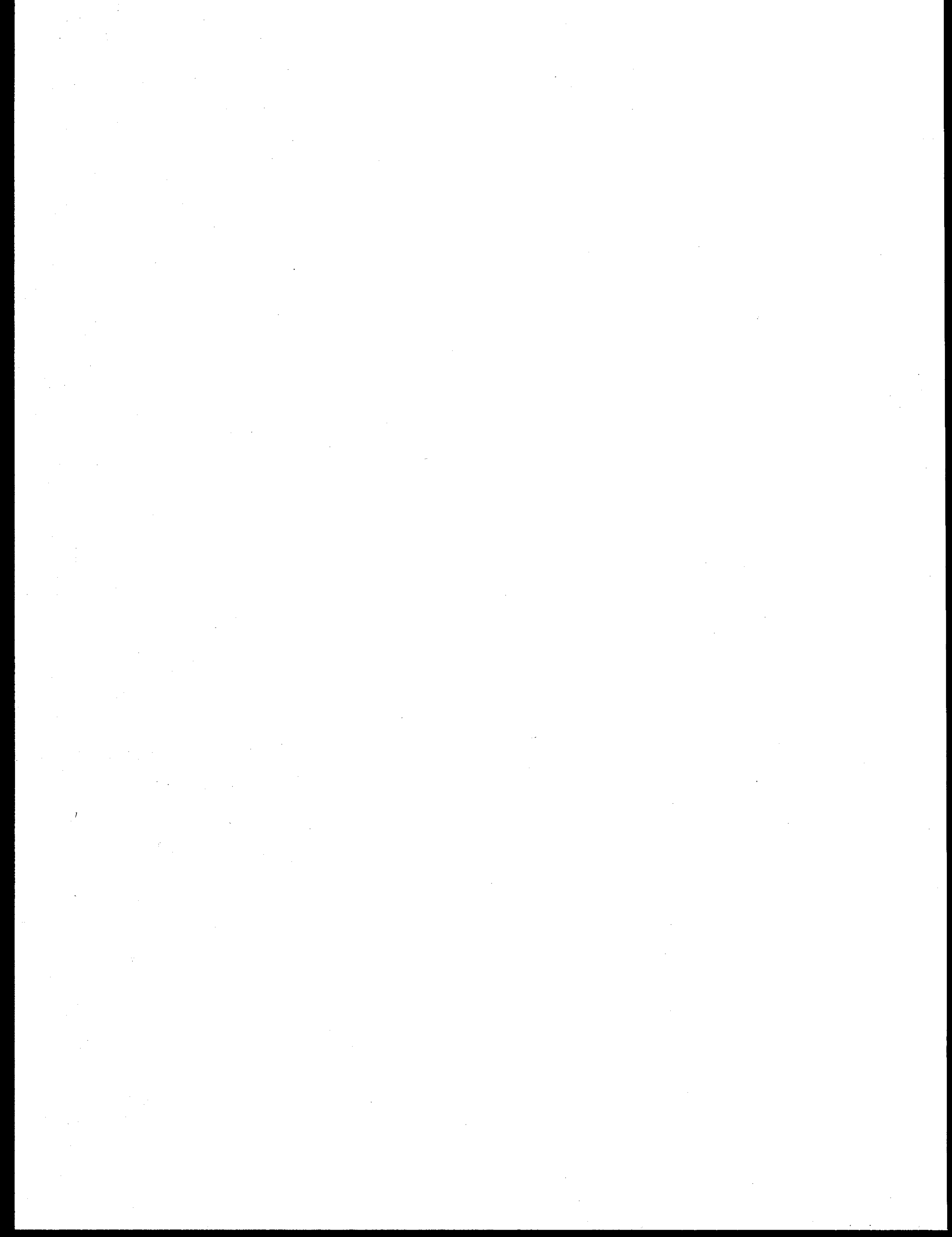


APPENDIX B: POTTER REPORT



Department of Children and Family Services
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OFFICE OF THE INSPECTOR GENERAL

REDACTED REPORT

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 Nos:	971040
	971049
Minors:	Hillary Potter
	Wayne Graham
Subject:	Dependency
Date:	June 30, 1998

PROBLEM

Sometimes, parents, through no fault of their own, are simply unable to care for their children. No one would suggest that these children should not be taken into protective custody by the State or that the State should not provide services to these families. However, in these dependency situations, parents and other care givers *who have never had the opportunity to take care of their children* are being indicated for abuse and neglect. Primarily, the parents are indicated for risk of harm, an abuse allegation. Because they have been indicated, they will now have a report of their abuse retained by the State for five years. Through no fault of their own, these parents may find their job opportunities limited and their ability to retain other children threatened.

These rules are written so broadly, however, that DCP investigators are given the ability to indicate for abuse a parent who has never taken care of his or her child. However, it was never intended that the "risk of harm" category be used to encompass such cases.

BRIEF ANSWER

"Department minor" is defined, in relevant part, as a minor under 18 years old "who is without proper care because of the physical or mental disability of his parent, guardian or custodian ... or who is without proper medical or other remedial care recognized under State Law or other care necessary for his or her well being through no fault, neglect or lack of concern by his parents, guardian or custodian." DCFS Rule 304.2. The rules and procedures need to be changed to limit the use of the "risk of harm" category and to allow DCP workers to indicate a report for "dependency." DCP workers should be trained to use the dependency category.

BACKGROUND OF CASES[1]

Hillary Potter

Hillary Potter was born to Madeline Potter, who has a chronic seizure disorder that is not controlled by medication. Because Madeline's disorder would not allow her to care for Hillary, the DCP worker indicated Madeline for inadequate supervision and risk of physical injury. When Hillary was discharged from the hospital, DCFS took protective custody.

The Child Protection Investigator discovered that Madeline suffered from a chronic seizure disorder. Madeline's disorder might have been caused by encephalitis. According to one of the medical workers interviewed during the investigation, people who suffer from encephalitis have permanent brain damage and the seizures continue to cause brain damage. Everyone acknowledges that Madeline's seizure disorder was not controlled by medication. Despite taking the medication, Madeline suffered two to three seizures every week. After seizures, Madeline became disoriented and experienced memory lapses.

Madeline stated that she gets no warning before a seizure occurs. She simply finds herself "on the floor" after a seizure. She would then call 911 to take her to the hospital.

Madeline's seizures had caused her significant physical harm. She had once fallen out of a fourth floor window at the hospital while having a seizure, resulting in a broken neck. Another time, she had a seizure while mowing the lawn and flipped the lawn mower on top of herself. Madeline lost a finger and part of her arm.

Madeline's doctor told the DCP worker that the only way that Madeline could care for the child was with 24-hour supervision. The doctor was afraid of Madeline dropping the baby or falling on it. And, despite Madeline's protests, she acknowledged that she could not take care of the baby by

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[1]A Commander of the Chicago Police Department informed the Office of the Inspector General that the Chicago Police force has encountered this problem on a regular basis. Apparently, the State Central Register has told the police force that there is nothing that can be done for a dependent child. (This information is included with the Commander's permission.) However, in order to demonstrate the kinds of cases that have recently surfaced in the Office of the Inspector General, only a few such cases will be discussed in detail below.

herself.

The DCP worker repeatedly tried to encourage Madeline to turn over guardianship and care of the child to a relative. Madeline refused to do this. The Child Protection Investigator noted that if the child was to go home with the mother, she believed that the child would be at risk of great harm. DCFS therefore decided to take protective custody.

Madeline was indicated for inadequate supervision and substantial risk of harm. When the DCP worker presented and explained the CANTS 8 letter and CFS 1050-54, Madeline complained that she wanted to know who had accused her of abuse and neglect. Madeline pointed out, "my daughter is still in the hospital and cannot come home yet." It should be noted that Madeline had never taken the infant home.

Wayne Graham

Twenty -two year old Kathleen Graham gave birth to her son, Wayne Graham, on September 11, 1997. Shortly thereafter, Wayne was diagnosed with Fraser Syndrome.

Fraser Syndrome is a serious disease that manifests itself in many ways, but defining characteristics include craniofacial abnormalities, cryptophthalmos, syndactyly and abnormalities of the ears, nose, genitalia and urinary tract system. (See J. Gattuso, M.A. Patton, and M. Baraitser, "The Clinical Spectrum of the Fraser Syndrome: A report of three new cases and review," Journal of Medical Genetics 1987, p.549). The Condition is believed to result because of an inherited autosomal recessive disorder. (p.554) Fraser Syndrome is therefore not the result of improper prenatal care or drug use during pregnancy.

As a direct result of the disease, Wayne was born with multiple congenital defects. Briefly summarizing the extent of his problems, he had no openings for his eyes and was therefore blind. Further testing revealed that he possessed no globe for his right eye and, though a left globe was probably present, it was unclear whether surgery would be effective in giving him any eyesight. He was born with a closed larynx and an emergency tracheostomy had to be performed in the delivery room. The trach tube that was inserted required monitoring and cleaning. One doctor noted that if it became clogged, the child would die within six to seven minutes. The doctors believed that Wayne would need the trachea tube and would be on a monitor for the rest of his life.

Wayne was unable to make any sounds. There were questions about whether he was also deaf. Wayne had no right kidney. He had numerous anomalies of the head, limbs and genitalia, including having many of his fingers and toes fused together. He had a soft spot on his head of approximately 9 centimeters, and doctors theorized that he had no skull covering at that point. At some point, it was noted that it was likely he had suffered a cerebral hemorrhage.

The mother, Kathleen, had expressed an interest in caring for the child at home. Before allowing her to take the baby, the hospital had required that Kathleen and her mother undergo training to learn

to attend to Wayne's needs. However, after observing Kathleen, the hospital grew concerned about whether she could adequately care for the child. A social worker at the hospital called the State Central Register to report Wayne's situation in November 1997.

A Child Protection Investigator was assigned to look into the situation. The following facts were contained in the DCP report. The mother expressed interest in caring for Wayne and told the DCP worker that she felt that she could adequately care for the child. However, Kathleen was also caring for her other two children, ages one and three.

The Child Protection Investigator took Wayne into protective custody on November 13, 1997. At that time, Wayne's mother was indicated for risk of injury. In the DCP report, the Child Protection Investigator noted the following:

"Indicated against Kathleen Graham for substantial risk of injury to her son Wayne***. The child has a complex medical condition that requires constant care and supervision.*** Ms. Graham *** was not able to provide an adequate level of care for the child (as determined by hospital staff) while the child was still in the hospital and while Ms. Graham had the supervision and back-up of hospital staff. Concerns were also raised regarding Ms. Graham's ability to assess and act on the needs of her son, Wayne."

The report noted that Kathleen deeply cared for her son and had obtained the proper equipment to take care of him. Kathleen had a strong family support system that would be able to provide care assistance and respite. Kathleen and her mother had gone through training to learn to care for her son.

DCFS took protective custody of Wayne and placed him in a long-term care facility. On December 28, 1997, Wayne died. Wayne had never been in the care of his mother.

Roger and Jackie Higgins

Lynn and Matthew Higgins, the parents of Roger and Jackie, were the victims of a double homicide in March 1998. Although the bodies of the victims were found in their apartment, their children were missing.

The children were missing for several days. When the children were recovered, news reports of the homicides recounted this story explaining the children's disappearance: Danielle Stewart, a young married woman, had desperately wanted a child. It was alleged that Stewart had seen Mrs. Higgins with the children at the doctor's office and followed her home. It was further alleged that she then hired her cousin and a friend to accompany her back to the Higgins' home to kill the parents. Stewart and her companions then took the children.

The children were recovered and taken to area hospitals. DCFS was called after Chicago police officers took protective custody of the children.

On April 3, 1998, the Chicago Police Department called the State Central Register concerning Roger and Jackie Higgins. At the top of the CANTS 1 report is noted "MEDIA." Below this notation, there is an additional note stating, " 't' response -- dependency." Further, the box for child welfare service referral is checked. There is no DCP report accompanying this CANTS report.[2] Because of the dependency, DCFS handled the Higgins case as a child welfare case, which was appropriate.

DISCUSSION

The DCFS Rules clearly state that child welfare services are available to Illinois children under the age of 18, and that children come to the attention of DCFS through reports to the Department that the child is abused, neglected or *dependent*. *See* DCFS Rules and Procedures 304.50.

Procedures for Abuse/Neglect/Dependency Calls

There are specific rules outlining the procedures to be followed when the State Central Register receives an abuse or neglect allegation. The result of such a call is an investigation. *See* Rule 300.40(b)(1). The investigation may result in the worker taking protective custody. *See* Rule 300.120(a).

Calls which do not constitute allegations of abuse or neglect follow a different procedure. Section 300.40(b)(2)(A) in the DCFS Rules and Procedures states that calls by certain mandated reporters (i.e., police, social service agencies, schools, medical personnel, or other public or private agencies) *that do not involve allegations of abuse or neglect* are treated as service referrals. As the Higgins case demonstrates, dependency calls would be included in this category. A call alleging dependency does not result in an investigation where a DCFS worker is sent out. Furthermore, the rules do not allow a DCP worker to take a child into protective custody unless there is an allegation of abuse or neglect.

The Dilemma the Procedures Create

The report-takers at the State Central Register are referring calls alleging that a parent cannot take care of a child to a DCP worker. Where there is an allegation that a caretaker may not be able to care for a child, an investigation *should* be conducted to determine whether the child is dependent and needs the services of the State. An investigation is necessary to determine whether the parents are willing to place the child in the care of relatives.

The procedures do not allow for a DCP worker to indicate a case for "dependency." There is no rule allowing DCP to investigate a dependency call or to take protective custody in a dependency matter. Further, there is no appropriate category alleging "dependency."

When there is no appropriate caretaker for the child, the DCP worker has no choice but to take protective custody. The worker is then required to indicate for abuse or neglect. Therefore, at least

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[2]Both the DCP worker and the Chicago Police Department were investigating to determine a proper care giver for the children.

in the two cases described above, the workers indicate parents who have never taken care of their children for "risk of harm."

Misuse of "Substantial Risk of Harm"

"Substantial Risk of Harm" was never intended to be used in this broad fashion. The Chief of the Juvenile Justice Bureau of the Cook County State's Attorney's Office originally proposed this category to be added to the Illinois statutes to cover situations where a child was in immediate danger of harm by a caretaker, but was prevented from doing harm by intervention.

Moreover, the over-use of the allegation "risk of harm" has been recognized by the Diversion Subcommittee of the Child Protection Advisory Committee. This subcommittee was created to make recommendations to the Juvenile Court Child Protection Division and its Presiding Judge. The subcommittee was to look at topics such as "screening of cases into Juvenile Court, the development of safe and reasonable alternatives to Juvenile Court adjudication for specifically identified cases, and safe, reliable ways to lessen the length of time in which particular cases may enter and exit Juvenile Court jurisdiction." Report and recommendations, page 4. Their report was released in January 1997.

One of the issues this report considered was the over-use of the "substantial risk of harm" allegations. The subcommittee noted that the frequency of "substantial risk of harm" allegation "mushroomed" in 1995 and 1996. Normally, abuse petitions constitute 30% of the entire child protection caseload. However, in 1995 and 1996, the caseload has increased because "substantial risk of harm" has been added to so many petitions.

The subcommittee noted that "risk of harm" is an allegation of abuse and the improper use of such an allegation can have serious consequences. The subcommittee noted that the allegation affects the availability and supervisory nature of visitation, the petitioning into court of siblings and the willingness of all the parties to return the child home and close the case.

The subcommittee recommended, "that the allegation 'Substantial Risk of Harm' be used in the screening unit at Juvenile Court in its original, clear, restricted manner [indicated by legislative report] as immediate risk of death or substantial bodily harm to a child." Report and recommendations, page 7.

Moreover, the list of examples of incidents or circumstances following the definition of risk of harm, included in the DCFS rules, while not exhaustive, clearly outlines situations entirely unlike the cases described above. The examples of cases where "risk of harm" should be indicated include choking the child, smothering the child, pulling the child's hair out, violently pushing or shoving the child into fixed or heavy objects, throwing or shaking a smaller child, or other violent or intimidating acts directed toward the child which cause excessive pain or fear. These are unlike simply being unable to care for the child because of disabilities.

PROPOSED CHANGES

The OIG recommends the following steps be taken to correct this problem.

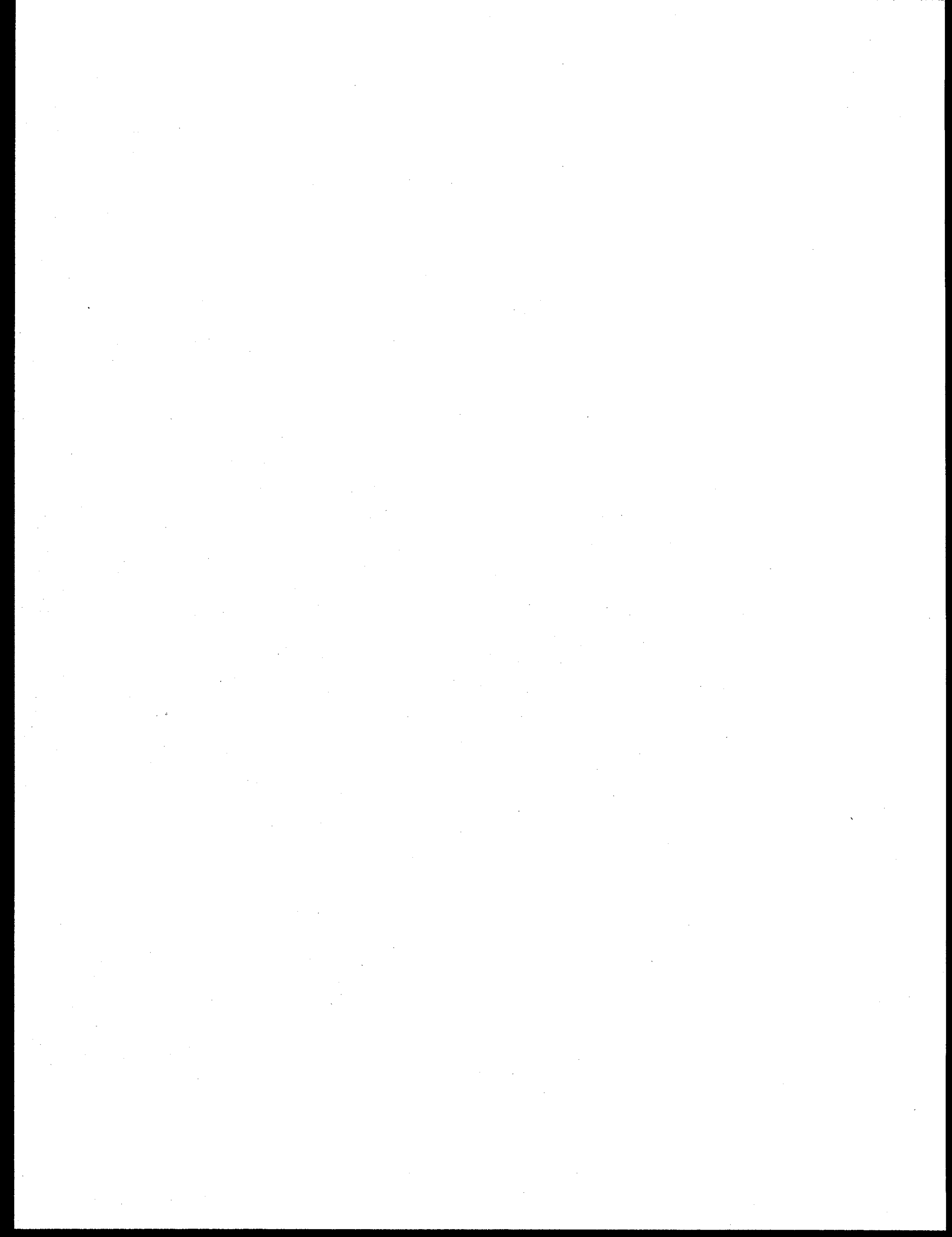
1. DCFS Rules and Procedures should be amended. There must be some limit placed on the application of "risk of harm" to restrict its use to those situations which it was originally intended to handle. The definition should require some overt act on the part of the parent before substantial risk of harm can be found. A new category needs to be added to the list of allegations labeled "dependency." The Rules also need to be amended to clarify that DCP workers can investigate a possible allegation of dependency and to allow a worker to indicate a caretaker for dependency. An amendment is needed to allow the DCP worker to take a child into protective custody where the allegation is dependency.

2. DCFS should consider contracting with a private agency that would establish a specialized DCP unit which would handle dependency cases. Cases referred to this unit would involve solely allegations of dependency. The DCP unit would be responsible for investigating to determine a proper care giver and for providing child welfare services to families that have been reported to the State Central Register as dependency cases.

3. DCP workers need to undergo training in order to understand (1) the changes in the rules; and (2) how to implement the rule changes. Workers at the State Central Register need training to recognize dependency matters and to learn to refer these cases to the specialized DCP unit.

Denise Kane
Inspector General

APPENDIX C: GRANDPARENT/OLDER CAREGIVER REPORT



GRANDPARENT/OLDER CAREGIVERS REPORT

A REPORT FROM THE OFFICE OF THE INSPECTOR GENERAL-DCFS

June 17, 1997

Revised, July 28, 1997

Appendix C

"Where there is room in the heart, there is always room on the hearth."
(Dudman-Doucette, xi)

There are 3.4 million children in the United States whose primary caregivers have taken the above quote literally. Social problems that traverse the spectrum of society have made it necessary for grandparents to become the primary caregivers in their grandchildren's lives. The causes of this national issue are wide in scope and have devastating effects for our children and country's future.

Historical tradition is no longer the norm on the parenting landscape and change has come rapidly. Many grandparents are stepping in and raising permanent "second families" at a time when their physical abilities are being challenged by the onset of age. All children deserve a healthy, safe and nurturing environment. For that to happen, one must comprehend the full parameters of the dilemma. There are many obstacles and concerns the primary caregiver must overcome to attain a positive environment for the children.

We will examine these complicated issues in order to implement change in a system that is in need of repair. Whether cared for by a grandparent, older caregiver, or foster parent, the children's needs are the same. Understanding the scope of the dilemma enables us to proceed with healthy results.

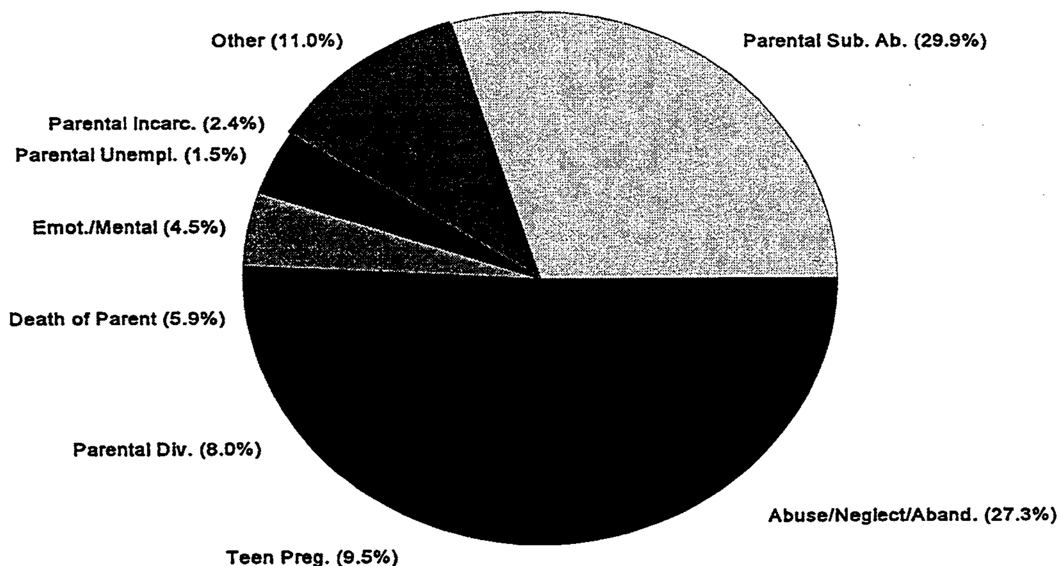
Analysis of the data makes it is apparent that changes need to be made by the Department. We have included several that will benefit the children, the caregiver, and the agency. The Department has the power to implement positive change and to do it in such a manner that benefits are reaped by everyone.

INCREASING NUMBER OF GRANDPARENTS RAISING GRANDCHILDREN

A growing number of children depend on their grandparents for their primary care. This number has increased by 40 percent in the last decade (Mullen:1995). In 1970, more than 2.2 million children under 18 lived in grandparented households with the mother present in half of these homes. By 1993, the number was nearly 3.4 million; of these one million lived in households with neither parents present, an increase of 17 percent. In 1994, at a national meeting of Generations United, it was estimated that the numbers of grandparents raising grandchildren exceeded seven million (Kornhaber: 1996). "Influencing the shift of custody from birth parents to grandparents are these factors: More than 500,000 children live in some form of alternate-funded care arrangement, i.e., foster care, group homes or institutional care; Over half a million babies are born to teenage mothers every year; At least 80 percent of incarcerated women are mothers; Within five years, it is estimated that 125,000 children will be taken in by grandparents or other extended family members" (Dudman-Doucette, 1).

REASONS FOR RISE IN NUMBERS

Grandparents have steadily increased in responsibility and supporting roles as more women entered the workforce, yet the rapid rise in numbers is due mostly to endemic social problems within our society. Social problems such as drug and alcohol addiction, joblessness, street crime, homelessness, incarceration, death, AIDS, child abuse and neglect, parental immaturity and poverty have led to more grandparents raising their grandchildren (Kornhaber: 1996; Mullen: 1995; Detoledo: 1995). Parental substance abuse and child abuse/neglect/abandonment are the most often cited causes for grandparents becoming full time caregivers. The graph below demonstrates the reasons most often cited by Illinois grandparents as to why they are now primary caregivers (IL Dept. Of Aging Survey Statistical Data:1996).



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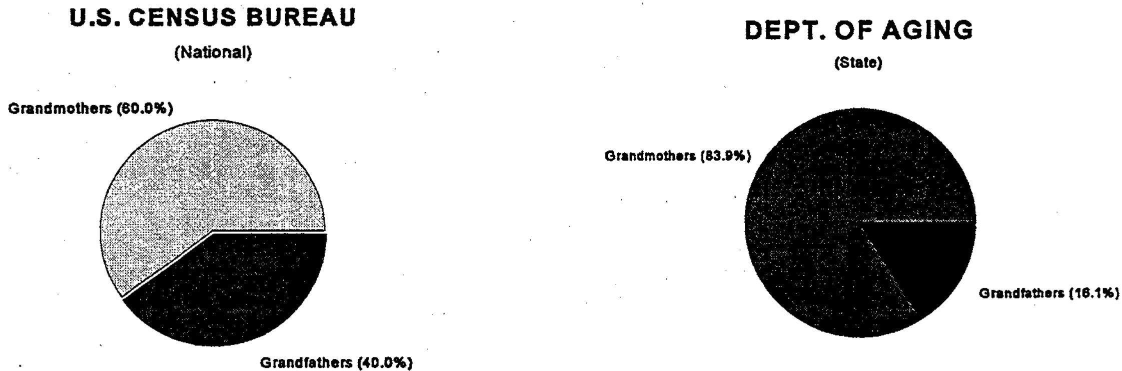
DEMOGRAPHICS

It is imperative to have accurate data regarding grandparents raising their grandchildren. In this section we will compare and analyze data from the U.S. Census Bureau, which is national in scope, versus Illinois data from the Illinois Department of Aging. A myriad of obstacles face grandparents in their attempts to raise of their grandchildren in a healthy, safe, and productive environment.

Gender

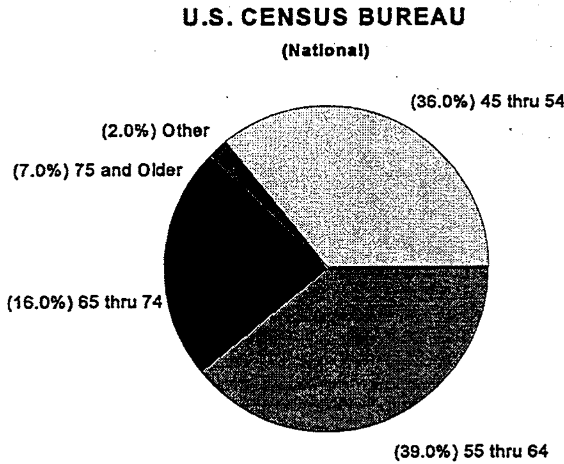
Grandmothers are considerably more likely to be primary caregivers. Data collected on both the national and state level conclusively shows that when grandparents raise their grandchildren, the responsibilities most often are assumed by the grandmother. The difficulties are evident as it is much harder for one parent, let alone an elderly caregiver, to assume all the tasks and responsibilities of raising a child.

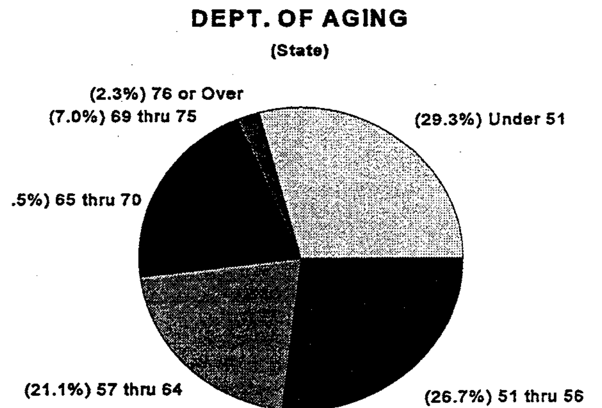


Age

The average ages of grandparents raising their grandchildren are similar in national and state statistics. More than 22% of the grandparents who are primary caregivers are over the age of sixty-five. The Department of Children and Family Services has no statistical database to determine the ages of grandparents raising grandchildren or of the ages of foster parents, relative or non-relative. The Department needs to establish a database with age as a factor in determining placement. Physical and mental standards need to be studied and adopted in order to provide a safe and nurturing environment. The ages of the children and the number of children being raised by elderly caregivers, relative to their age, can also be a concern.

AGE OF GRANDPARENTS RAISING GRANDCHILDREN

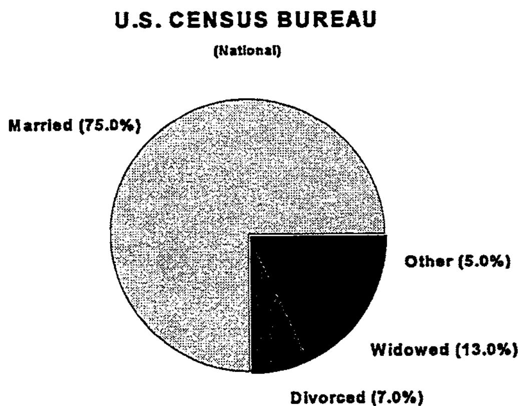


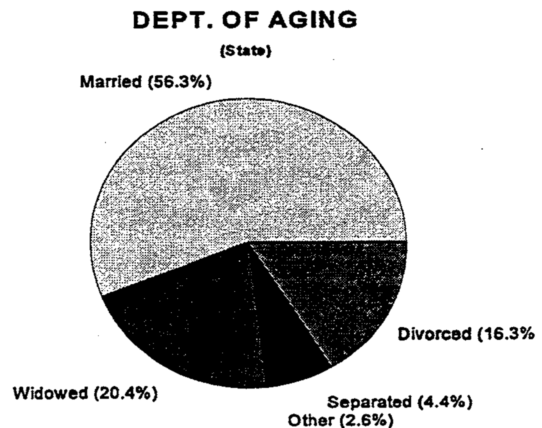


Marital Status

Grandparents raising grandchildren in Illinois are more likely to be divorced and widowed, when compared to the national average. This data presents particular problems for Illinois grandparents. A grandparent who is widowed or divorced often faces economic difficulties, because of the one parent household. The quality of life for the grandparent is often minimized or non-existent because of time constraints and responsibilities inherent with raising children by oneself.

The marital status of the elderly will change as they age. The number of grandmothers will be much higher than the number of grandfathers and will increase as they age. "Since much of the informal caregiving is provided by the spouse, more elderly men will have a spouse to assist them if their health fails than will elderly women" (Lindley, 17). An elderly grandparent not only has to raise the children, but often is the caretaker of an elderly spouse. Conflicts of time, energy, and resources are apparent.





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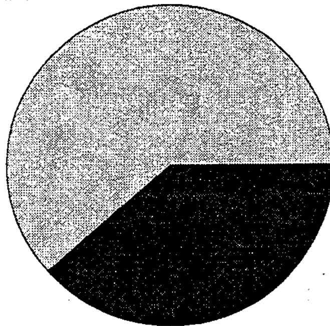
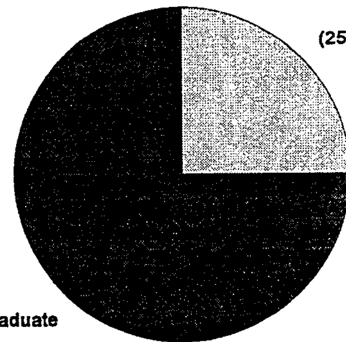
Education
Grandparents in Illinois are almost twice as likely as grandparents nationally to have their high school degree. However, one-fourth of the Illinois grandparents raising their grandchildren do not have their high school diploma. Their current economic status and future earning productivity can be severely limited. The financial burdens of raising additional children are often overwhelming for the elderly who are on fixed or limited incomes.

U.S. CENSUS BUREAU
(National)

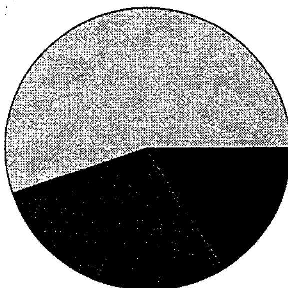


DEPT. OF AGING
(State)

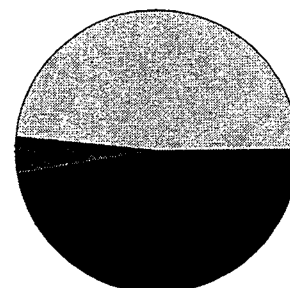


Employment
Almost half of the grandparents raising grandchildren are unemployed. The additional burdens of fiscal responsibilities are severe when one has limited means and resources. A study of all non-traditional households found grandparent caregivers to be the poorest financially for a variety of reasons such as their education, employment, age, etc. (Chalfie:1994).

JENDREK:1994
(National)



DEPT. OF AGING
(State)



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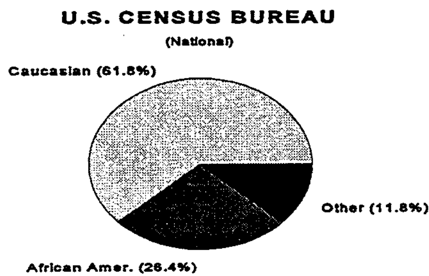
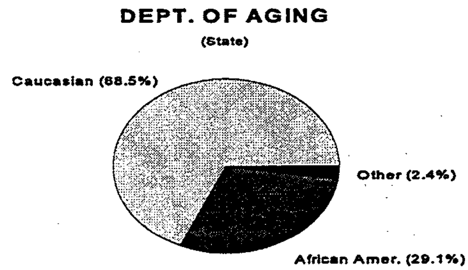
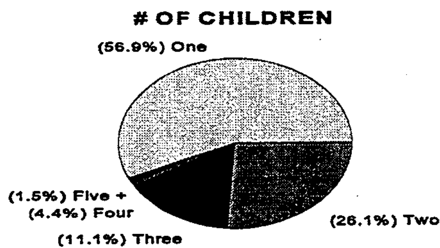
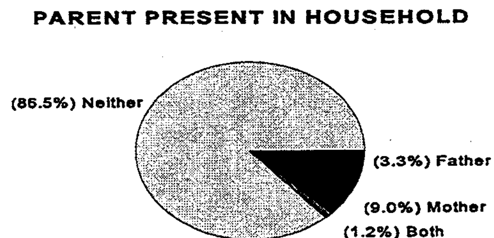
Ethnicity
Middle aged and older African Americans are nearly twice as likely as whites of the same age to be grandparent caregivers (9% compared with 5%). More than 12% of African American children are raised by their grandparents compared with 6% of Hispanic children and 3.6% of white children (U.S. Bureau of the Census:1990). There are biases that exist in society, such as it is an urban problem or a poor problem, when in fact every grandparent is a tragedy away from being the primary caregiver. "Parenting a grandchild is a necessity born of tragedy, and tragedy has no regard for race, class, ethnicity, location, or religion" (DeToledo).

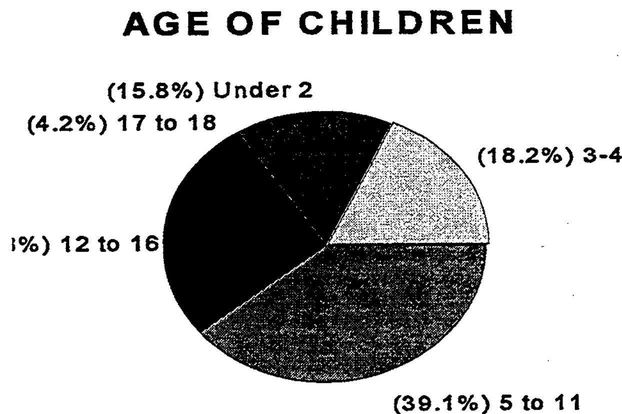




The following **Illinois** data is important to understanding the dilemma and hardship that many grandparents are facing. In more than 86% of the households neither the father nor mother is living in the house. Over 33% of the grandparented households have two or more children being raised by them. Most of the children living in the household are between the ages of three and eleven. Young children can at times be difficult to handle for anyone. Yet, combine the ages of children cared for with the number of children cared for, any special needs of the children, and the ages of the grandparents, and one has a picture of formidable obstacles for the grandparents to surmount.







Appendix C

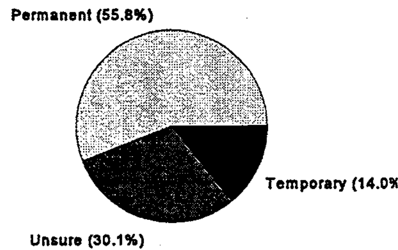
LIFESTYLE CHANGES

The dramatic increase in the number of grandparents finding themselves in the role of primary caregivers presents new and sometimes difficult dilemmas. In a survey by the Illinois Department of Aging (1996) there were several issues and concerns that were of fundamental importance. These issues are rated in order pertaining to the degree of concern by the grandparents:

1) Grandchildren's Education
2) Financial Issues
3) Child Rearing/Parenting Skills
4) Child Care
5) Health Insurance
6) Health Issues
7) Emotional Counseling
8) Legal Issues
9) Substance Abuse Treatment

"The growing contingent of grandparent caregivers encounters a wide array of difficulties that are not readily amenable to being addressed by public policy, difficulties such as increased physical demands at a time when physical health may be deteriorating or fewer opportunities to socialize with friends. Often, grandparent caregivers sacrifice retirement plans and financial security by stepping up to pinch-hit for absent or incapacitated parents" (Chalfie, 12). Several sources referred to the quality of grandparenthood as being affected by the time in life when grandparenthood is achieved and the time an individual gives to the role. The concept of "on-time" and "off time" (Troll:1985) has been used to differentiate two categories of grandparents and can influence satisfaction in the role and readiness to grandparent. "On time" grandparents were those whose adult children were over 21 years of age; while "off time" grandparents were those whose adult children became parents at ages between 11 and 18. Troll (1985) noted greater satisfaction among grandmothers of the "on time" group versus the "off time" group. Becoming a fulltime custodial grandparent as a result of high-risk behaviors of the adult child/parent increases parent-grandparent conflicts. The "on time" grandparents have put their own life on hold, sometimes putting a strain on the marriage, and sacrificing friendships and socialization with peers their own age, in order to devote time to caring for the grandchildren (Minkler:1992). Some may even have to retire early, therefore lessening the amount of money set aside for future use. "Off time" grandparents are often psychologically unprepared to become grandparents and cannot afford to sacrifice or quit their jobs/education; but when the responsibility of caring for the grandchild requires more time, these grandparents also have to put their own lives and dreams on hold. "Every aspect of work, from a thriving career to a well-earned retirement can become a casualty of a second parenthood. Raising a child will change your life at any age, but raising a grandchild will turn it upside down" (DeToledo:1995).

Grandparents raising grandchildren are generally committed to permanent situations, as the following Illinois Department of Aging survey graph indicates. The problems and concerns of these grandparents and children are not temporary in nature, and need permanent solutions to what is often a lengthy role as a primary caregiver.



HEALTH CONCERNS OF THE ELDER CAREGIVERS

Effective research needs to be conducted on the effect of caregiving on the mental and physical health of grandparents and their grandchildren. This was a recommendation submitted to the White House Conference on Aging in January 1995 by Kornhaber, a leading researcher in the field of grandparenting. Interestingly, the small amount of research which has been done seems to indicate some beneficial effects that positively affect the quality of life for these older caregivers (Kornhaber:1992; Solomon:1995; Minkler:1992).

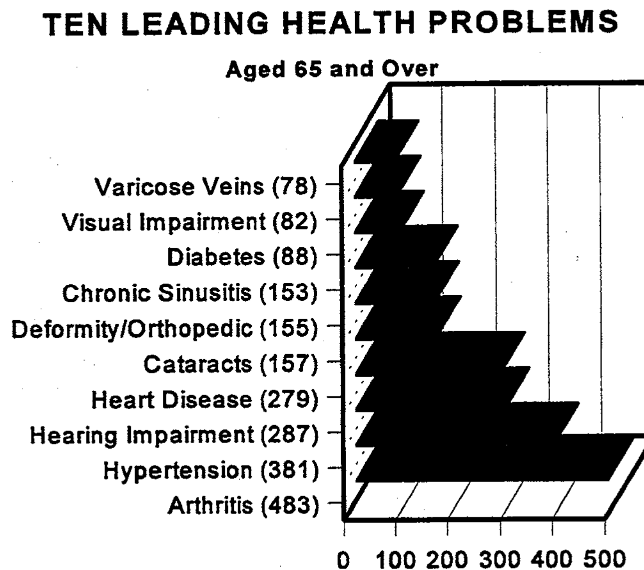
Minkler and her associates (1992) surveyed a sample of 71 African American grandmothers in the Oakland, California area about their physical and emotional health before and after assuming fulltime care of their grandchildren. The median age for this study was 53 with an age range of 41-79. Seventy-five percent of this group cared for at least two grandchildren, one of whom was an infant/preschool aged child. These grandparents assumed fulltime responsibility for caregiving as a result of their own adult children abusing crack cocaine and consequently becoming unable to adequately care for their children.

When asked to compare their current physical health with their health before taking over as caregivers, about one-fifth reported a change for the better; and just more than a third reported that their health was worse. When asked to compare their health to a year ago, 25% reported improved health; 28% reported their health was worse. For those who reported improved health, several reasons were attributed to the consequences of new caregiving responsibilities (i.e., more exercise, loss of weight, limiting or stopping smoking because of respiratory concerns for the grandchild). Those who had worsening health attributed reasons such as missed medical appointments, stopping the use of their prescription medications which tended to decrease alertness, and increasing their drinking and smoking to deal with the additional stress. Interestingly, these grandmothers did not totally attribute their stress to the caregiving but rather attributed the stress directly to the knowledge and reluctant acceptance that their own children could not be responsible caregivers. On the one hand, their emotional health improved knowing that their grandchildren were safe in their custody. On the other hand, their emotional health

declined while watching the deterioration (and sometimes death) of their own adult children on crack.

In another study, grandparents cited factors such as protecting their grandchildren from the environmental dangers of their neighborhood, caregiving commitments to other family members (ailing parents or spouses), the presence of other children in the home, and their own personal needs as additional stressors. These grandparents were concerned about resuming their role as parents again, feeling overburdened with the care of a grandchild with special needs or feeling inadequate and frustrated in keeping up with the school, social and physical activities of their grandchildren. Eighty-six percent reported feeling "depressed or anxious most of the time"; 61% were smoking more; 36% had increased medical problems such as arthritis or diabetes; 8% had suffered a slight stroke; and 5% had suffered a mild heart attack within the last year. On the other hand, several grandmothers emphasized that having these grandchildren under their care was the "Lord's blessing" and gave them a reason for living despite varied health concerns (Burton: 1992).

Life expectancy for all age groups has been steadily increasing since 1900. As the age of a caregiver increases, the chances that an elderly adult will suffer disease, illness, or a disabling condition increases. "The possibility of experiencing multiple chronic health problems increases with age. Four of five people over the age of 65 years suffer from at least one chronic health problem" (Lindley, 15). The following graph indicates the leading health problems for those age 65 and over.



Rates per 1,000 persons

Source: National Center for Health Statistics, 1990.

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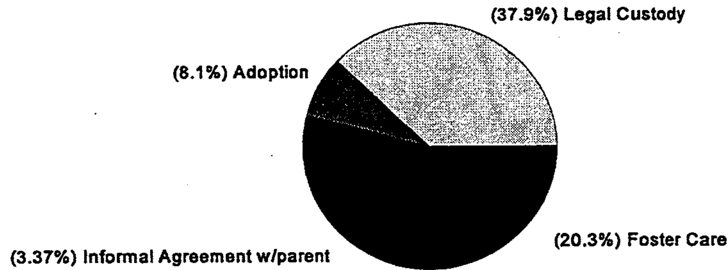
The ability of an older person to perform daily tasks can be impaired due to the physical constraints that often accompany advancing age. Add the rigorous duty of caring for children in the home and the caregiver can find himself or herself overextended and overburdened, creating the potential deterioration of the health of the caregiver and the health and safety of the child.



The Department of Children and Family Services needs to implement changes in the medical report form. It is not the policy or intent of the Department to restrict caregivers in their effort to take care of children. However, we must set some form of standards as it is inherent upon us to regard the health and safety of the child while at the same time keeping in mind the abilities and health of the older caregiver.

Changes needed on the medical report form are highlighted in black.

(See next page)

Appendix C

STATE OF ILLINOIS
Department of Children and Family Services

MEDICAL REPORT ON AN ADULT IN A CHILD CARE FACILITY

(Includes employees and volunteers in child care institutions, group home, or day care center; foster parents or operators of day care homes, and other adult members of their household.)

____

(Name of person examined) Birthdate

Position (check one)

___ Day Care/Home Caregiver
___ Child Care Worker/Assistant
___ Staff/Volunteer
___ **Foster Parent***
___ Member of Household
___ Food Handler
___ Child Care Facility Driver

(*presumes 24-hour availability to care for child(ren)

Name of Licensee/Relative
Applicant for License Approval ____
Address ____

I. TESTS

	Date	Results
Tuberculin skin, or chest X-ray in a positive reactor	________	________________
Other (specify) ____________________	________	________________
____________________________	________	________________

II. ASSESSMENT OF STRENGTH, MOBILITY, FLEXIBILITY

Able to lift weight 20-30 pounds YES NO Type of assistive device needed ________________
Able to walk/maneuver 50-100 feet without major difficulties YES NO Type of assistive device needed ________________
Able to bend/stoop, kneel, reach YES NO Type of assistive device needed ________________

III. FINDINGS AND RECOMMENDATIONS

A. <u>Findings</u>: Summary of health problems or conditions, along with medication use, if any which may affect the adult's ability to maintain alertness, endurance, and performance of tasks and responsibilities to serve or reside in a facility caring for children* (Ages: ________).

____
____
____
____

* If a foster parent, presumes 24-hour availability to care for child(ren)

B. Any conditions which contraindicates a person serving as a Food Handler or Child Care Facility Driver
YES NO If yes, please specify ____

C. <u>Recommendations</u>
The above individual was found free from symptoms of communicable disease, and is otherwise physically and emotionally fit to serve or reside in a facility caring for children.
YES NO Explain "NO" ____
____
____

________________ ________________________________
Date of Exam Physician's Signature and State License Number
Address ________________________
Telephone ________________________

Appendix C

PERMANENCY PLANNING

Findings from the grandparent studies (Burton, 1992; DeToledo, 1995; Jendrek, 1994; Minkler & Roe, 1993; Kornhaber, 1996; Pinson-Milburn & Fabian, 1996) mentioned throughout this text reveal the scope of issues facing grandparents raising their grandchildren in today's society. The OIG supports the researchers' recommendations and also advocates the provision of services such as respite care, support childhood and adolescent development classes for seniors at local and community colleges, and support groups for older caregivers caring for the children in DCFS care.

The findings from the Relative Caregiver Social Assessment (RCSA) study (Testa, 1996) revealed that permanency preferences and decisions were related to the age of both the child and caregiver. The most consistent predictor was age of the children. Relative caregivers were most likely to favor children age 12 and over remaining until adulthood as compared with younger children; this group of children was also seen as less likely to be adopted than younger children. Caregivers between ages 36 and 65 were considered the most appropriate group to consider adoption. (Testa, 1996).

Other factors which affected long term caregiving and/or adoption were the length of time the children were in care, size of the family and whether the biological parent had an alcohol/drug problem. Relative caregivers were more likely to favor keeping the children if the children had been with them for all or most of their lives as compared with those who had lived with them for less than half of their lives. Parental abuse of alcohol/drugs increases the caregiver's willingness to care for or adopt the child. Caregivers with minor children of their own seem more willing to adopt, but the more children in the home who were in state custody, the less likely caregivers were willing to keep them. Poor health also affected desire to adopt. Oddly enough, these factors did not seem to affect the worker's recommendations.

Permanency planning must be future planning; how will the child's developmental needs be met in their early years by caregivers who in some cases may have less than 10-15 years in their expected lifespan and who must face challenging needs of their own? Because the numbers for the very young (under 5) placed with the very old (over 70-75) are relatively low (below 3% in Illinois according to the Dept. Of Aging; and less than 7% in the U.S. Census Report), none of the reports cited above addressed future planning for these cases. The subject is a difficult but necessary one to address given that many of these arrangement are temporary because of the possibility of the caregiver's death while the child may still be preschool or elementary school-aged. Rather than subject these children to a crisis situation or "transfer trauma" when the caregiver becomes too ill to care for the still dependent youngster, planning ahead for a smooth transition is crucial. The Department has an ethical obligation to prevent sending these children out into a foster care or guardianship drift situation simply because of our poor planning.

Currently, decisions to place very young children (under 5) with very old caregivers (over 75) are still occurring with the Department. Without accurate data, it is difficult to determine how many

such placements occur. What is of concern here, regardless of actual numbers, is that these will be short-term arrangements, not the permanent solution to the dilemma of where the child should remain for the rest of his/her growing years. Future planning should be discussed between all parties concerned at the outset of the placement with the elderly grandparent and arrangements for adoption should begin right away, ideally with younger relatives who can adopt. The grandparent can still be involved with caregiving but legal custody would be transferred to the adoptive relative.

An imaginary look into the lives of the young child, the older caregiver and their developmental needs over the next 5 to 10 year period can aid in deciding how to plan for the child's permanent placement. The very old will become more dependent on others to help them with their own needs such as bathing, shopping, household chores --- is it realistic to expect this same individual to adequately give care to a very young child who is also dependent on others? Also, an important developmental task for late adulthood is a life review and the preparation of one's own death in terms of "finishing one's business or setting one's affairs in order." The developmental tasks of the young child range from learning the physical skills of mobility, language, and social adaptation to those their own age as well as others (Havighurst, 1972), all areas which require physical and emotional intervention and involvement of the adult caregiver.

Predictable life changes for others in their age group do not occur on schedule for these grandparents raising grandchildren. The unexpected transition of raising infants, young children, and adolescents can be very stressful. The physical and psychological consequences can be enormous and their stamina or resiliency to these stressors exhibited by older caregivers is more likely a function of their determination rather than their innate reserves (Pinson-Milburn & Fabian, 1996). The Department can help our grandparent caregivers by facilitating open communication among all members of the *extended* family/kinship group to participate in realistic permanency planning for the children that truly looks at the future of all those involved.

ETHICAL CONCERNS

The recent addition of subsidized guardianship as a permanency option coupled with the department's effort to convert informal kinship care to permanency has created an increase in the formal placements of children with elderly grandparents as guardians. Such placements can be perfectly appropriate when the child is approaching the age of majority, but raise serious ethical concerns in the placement of preadolescents. It is imperative that the department remains focussed on its fiduciary responsibility to secure permanency for children. The primary value of permanency is that it provides the continuity and sense of security integral to a child's well-being. However, although placement of young children with elderly caregivers achieve the short-term goal of removing a child from the guardianship of the State of Illinois, such children

are more likely to drift back into the system when the grandparent's health inevitably declines. Such an outcome undermines the very continuity and sense of security which permanency is designed to provide.

Admittedly the placement of children with grandparents is attractive for a few reasons. First, placing a child with grandparents does provide continuity to a child's life since he/she likely already has a relationship with them. This also keeps the child in closer contact with other family members. Second, in a social service-oriented profession such as child welfare, a client's right to self-determination is of significant value. In those instances in which a grandparent requests that a child be placed in their home, allowing such a placement respects the grandparent's right to self-determination.

Nonetheless, elderly caregivers frequently cannot provide permanency in any *long-term* sense. The temporary continuity gained by being placed with a grandparent guardian is undercut when he/she passes away or becomes unable to care for the child. When this happens the child has an increased risk of permanency drift, including a return to foster care. Moreover, since parental rights may not have been terminated, the possibility exists that the parent responsible for the abuse or neglect might reassert residual rights at the time of the guardian's death, when a reliable assessment of the parent's capabilities is difficult. In the child welfare profession the well-being of the child must override all other competing values. This means placing a child in the best *long-term* situation available.

The benefits of placing a child with an elderly grandparent can be provided equally well if the child is permanently placed with, for instance, a younger relative, preferably by adoption. This, however, would require frank discussion with extended family to determine if such a placement is possible. Such a discussion should openly acknowledge the issue of the mortality of prospective caregivers and its effect on the child. Though the subject of death is understandably unpleasant, it is crucial to any sound long-term child care strategy. A thoughtful long-term plan which considers the life-expectancy of prospective caregivers offers the best hope for appropriate formal placement.

RECOMMENDATIONS

1. **Amend Section 402.14 Health of Foster Family** - This section was last amended on November 1, 1983. These requirements do not adequately address the changing needs of either foster children or caregivers. The recent drug and AIDS/HIV epidemic has expanded the caseload of children with special needs requiring child protective services while at the same time, placing them in the care of guardians who need to demonstrate physical stamina, flexibility, and mental alertness to cope with the caregiving responsibilities of these children. This section would be amended to reflect the following:

   A comprehensive head-to-toe physical examination shall be required of all relative and

non-relative foster parents and their assistant caregivers before licensing. This medical exam shall not be more than one year old. In addition to ruling out any medical condition which might prevent the person's ability to care for a child such as a communicable disease, debilitating illness, or mental instability, the physical exam should include assessment of that person's ability to:

A. **Lift over 20-30 pounds using proper body mechanics or assistive devices** (rationale: to ascertain if the foster parent can lift a toddler or equipment for a special needs child such as a wheelchair, special furniture, carseat, stroller, etc.)

B. **Walk/Maneuver with an assistive aid a distance of 50-100 feet** without complaints or signs/symptoms of shortness of breath, rapid breathing (>24), rapid heart rate (>100 BPM), or exhaustion/fatigue (rationale: be able to retrieve child/items as necessary to maintain hygiene, nutrition, and safety for self and others).

C. **Maintain alertness, clarity of focus and attention while on medications** (rationale: not be on or at least have tolerance for medications which might reduce mental alertness or cause excessive sedation, especially while operating a car, equipment, or supervising an active youngster).

D. **Understand and manage a diagnosed acute/chronic medical/mental condition** by following the doctor's prescribed treatment such as medications, diet, exercise, and follow-up care (rationale: to reduce exacerbation of the condition which might hinder caregiving).

E. **Demonstrate flexibility to bend, stoop, and reach or use an assistive device to aid in these activities** (rationale: be able to retrieve young child/items as necessary to maintain safety, hygiene, and home maintenance for self and others).

The previous statements expand upon the currently existing requirements. Current DCFS Licensing standards for foster family homes (#402.14) state: *Foster parents and all members of the household shall provide medical evidence that they are free of communicable diseases or physical and mental evidence which affect the ability of the family to provide care. Rule 301 states: No member of the household appears to have a communicable disease which could pose a threat to the health of the related child(ren) or an emotional or physical impairment which could affect the ability of the caregiver to provide routine daily care to the related child(ren) or to evacuate them safely in an emergency.*

2. Specify the condition for the number and age of children placed in a foster home.

Where age/health condition does not appear to be a factor in the caring of children, Rule/Section 402.15 Number and Ages of Children Served can remain as follows:

(amendments re:functional age and abilities of children are currently being considered along with just number and age of children in placement consideration).

The maximum number of children permitted in foster family homes is eight, unless all of the foster children are of common parentage...the maximum number includes the foster parents' own children and all other children under the age of eighteen cared for on a full-time basis...no more than four children under age of six, including the foster parent(s)' own children, shall receive full time care at any one time.

However, in cases where age/health conditions might be a factor in providing adequate care and supervision for the above number of children, the Department's rule for independent foster homes should be followed: Independent foster homes receive children by independent arrangement...these homes shall not be licensed for more than a maximum of four children unless all of the unrelated children are of common parentage. No more than two of these children, including the family's own children, shall be under the age of two unless of common parentage.

3. **The Department needs to train placement team personnel on the subjects of permanency and the lifespan approach.** Placement personnel needs to sit with a selected list of family relatives to discuss these issues i.e., adoption, permanency, lifespan of primary caregivers, and the best interests of the child. These approaches will enhance the child being placed in a permanent situation, and less likely to re-enter the system in the future.

4. **Establish a database (or enhance the FindHome system) to include demographics, such as age, economics, education, length of service/experience with foster care on our foster parents.** Such a database would be helpful in determining the service/needs of our foster parents currently providing care for our children as well as providing data for research on foster care in Illinois. At the same time, this database could have a way of "flagging" whether the maximum number of children in the foster home may have been exceeded so that this home can be put on a "hold" status for any future referrals.

At present, the Department does not have information on the ages or relationships of the foster parents to the foster children, but it might be useful to ascertain how many might be over age 50-55, for example, or are related as the grandparents of the foster children, in order to link these persons with support systems which help the "older caregiver". In response to the increasing numbers of grandparents raising grandchildren, the AARP along with the Brookdale Foundation established the National Grandparent Information Center and support groups such as Grandparents as Parents (GAP), Raising our Children's Kids (ROCKING) to help grandparents rearing grandchildren deal with issues such as raising a second family; interrupting retirement plans; accessing financial resources to help raise these children; as well as working on future planning for these children in the event of illness/death of the grandparent caregivers. **The DCFS Permanency Planning Checklist should be revised to include ages of caretakers and ages of all children in the home.**

The Department should not have to rely on the Department of Aging's data, when we have had ample opportunity to implement a database system which would allow us to have this data about our own clients. The database would be helpful to the Department in their foster parent recruitment efforts as well. The Department might better determine what the attrition rate might be due to the "aging out" of the current number of foster parents; or the relationship of the foster parent to the child(ren) who may not want to take any other children after their own relative foster children have grown up or have been returned to the biological families.

This database would be able to tell us which older caregivers do not feel comfortable with full-time primary care, yet would like to help on a part-time basis, or might be interested in volunteer work with other primary caregivers. Respite care, reading programs, and babysitting while the primary caregiver has medical appointments are all examples of endless possibilities the Department could utilize. Resources could be used more efficiently and effectively, and the older caregiver could still function as a much needed blessing to society.

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