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

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Denise Kane
Inspector General

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LETTER FROM THE INSPECTOR GENERAL

To Governor Ryan and Members of the General Assembly:

In many social work occupations, clinicians do not question information given to them by their clients. By working through a process of trust and acceptance, the clinician accepts the "reality" of the client's version of the truth. The use of this approach to child welfare cases is fraught with difficulties. Often we find that over-optimistic beliefs and faulty reasoning are critical failings in child abuse investigations. In one such case an over-optimistic belief in the credibility of the parent appeared to have been the underlying reason for the investigator to diminish the significance of multiple facial injuries and a puncture wound to an infant. The investigator did not rely on the principle of reasonableness-the greater or lesser probability of such injuries being caused by such action in such circumstances. Shortchanging critical reasoning, the investigator asked rather about possibilities-was it possible that these injuries could have been accidental or self-inflicted injuries? Yet, pediatric studies confirm the unlikelihood of multiple self inflicted or accidental bruises in infants.

Anything is possible. Not everything is probable. Our investigator did not distinguish between these two universes. It appeared less relevant to investigate the full circumstances or facts of each of the injuries than to quickly have the family agree to receive services. The investigator did not consider the probability or the degree of danger and risk that parents' conduct presents under certain circumstances. A parent's history of poor impulse control, violence and drugs do not bode well for the care of an infant that presents with numerous injuries. A reasonable person would question the high risk to the child. But this investigator held to an optimistic view of the family's circumstances.

In another investigation, a youngster was beaten and left with belt marks over his back. The parents justified their actions saying the eight-year-old lied about his schoolwork and that they were trying to make him a better student. According to the parents, the abuse served a higher principle, teaching the importance of not lying. The investigator accepted the parent's justification softening their brutality as good intentions. The local Assistant State's Attorney, after the child's death from prolonged abuse, still maintained that the parent's beating did not call for a protective order because the community's standard for corporal punishment was not

violated. The teacher who called in the abuse disagreed with these interpretations of good intentions and misguided corporal punishment. The child was truthful in school and was an A student. In several other investigations we found investigators minimizing parents' apparent substance abuse- a mother's .33 and .22 Breathalyzer measure of alcohol over a two-week period did not prompt the investigator to take her infant, who was born substance-exposed, into protective custody. The contention was that it did not appear to compromise her parenting.

Why did the fallacy of optimism operate in these cases? Dingwall (in Gambrill 1990), a British researcher, argues that workers may fall into the error of allowing the ideals of natural love (the parent/child love is a given) and cultural relativism (any style of child rearing is a justified cultural statement) to override the reality of behaviors that harm children when the workers are afraid fault lies "within them for failing to sufficiently empathize" with the alleged deviant parent. Thus, Dingwall found that the workers prefer to bridge the chasm between idealism and harsh realities by choosing an optimistic reading of the parent's behavior.

After some thought, I believe part of our workers' naiveté is based on misguided assumptions of hope and trust. While we may hope that each parent under investigation has integrity and shares in our common expectations for the caring of children, we cannot avoid our duty to reasonably investigate the facts and circumstances of the alleged abuse. If we reasonably investigate, we may lower the risk of a child being harmed in the future. Compassion is not burying our heads to the risks to the child. We cannot live in a world without risk or hope. While investigators may want to believe parents and preserve families, they cannot lose objectivity and reasoned thinking. Hope for our children's safety can be tied to trustworthy and reasonable investigations and evidenced-based ameliorative interventions. The public desires no less and we can give no more.

With hope for our children's future safety,

Denise Kane

Denise Kane, Ph.D.
Inspector General

INTRODUCTION

I. THE OFFICE OF THE INSPECTOR GENERAL (OIG)

The position of Inspector General was created by unanimous vote of the Illinois General Assembly in June 1993 to do more to reform the child welfare system and to strengthen the people who exist within it: DCFS employees, foster parents, private agencies, and most important, the children and their families. The mandate of the OIG is to investigate misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by Department of Children and Family Services employees, foster parents, service providers and contractors with the Department. To that end, this Office has undertaken numerous investigations and initiated projects designed to uncover wrongdoing, improve practice and professionalize the Department. The value and focus of the OIG is the individual life of the child.

1. General and Death and Serious Injury Investigations

The Office responds to and investigates complaints filed by the state and local judiciary, foster parents, biological parents and the general public. Additionally, the OIG investigates deaths and serious injuries of all Illinois children with whom DCFS had prior involvement within the preceding twelve months. At the request of the Director or when the OIG has noticed a particularly high level of complaints in a specific segment of the child welfare system, the OIG will conduct a systemic review of that segment. Investigations yield both case-specific recommendations and recommendations for systemic changes within the child welfare system. The OIG monitors compliance with all recommendations.

2. Child Welfare Employee Licensure Investigations

The General Assembly mandated that by January 2001, the Department of Children and Family Services must institute a system for licensing child welfare employees. Licensing is required for both Department and private agency child welfare and licensing workers and supervisors. The Office of the Inspector General of the Department of Children and Family Services was named to investigate Child Welfare Employee Licensure Complaints.

Allegations that could support licensure revocation include conviction for specified criminal acts, indicated findings of child abuse or neglect, egregious acts that demonstrate incompetence or a pattern of deviating from a minimum standard of child welfare practice. Department Rule 412.50 (89 Ill. Reg. 412.50) specifies the grounds for Licensure Action. If the investigation uncovers a basis for licensure action, the OIG will notify the licensee, who will be provided with a Child Welfare Employee Licensure Hearing.

3. Administrative Rules for the Office of the Inspector General

Rules of the Office of the Inspector General were adopted and published in the Illinois Register at 89 Ill. Reg. 430. The Rules govern intake and investigations of complaints from the general public, child deaths and serious injuries and allegations relevant to employee licensure action. The Rules also address Inspector General Reports to the Director

4. Criminal Background Investigations and Law Enforcement Liasons

The OIG provides training and technical assistance to the Department and private agencies in performing criminal history checks. In FY 01, the OIG performed 632 searches for criminal background information

from the Law Enforcement Agencies Database System (LEADS). In addition, in the course of an investigation, if evidence indicates that a criminal act may have been committed, the OIG may notify the Illinois State Police, Attorney General or other appropriate law enforcement agency or elect to investigate the alleged act for administrative action only. 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.

5. OIG Foster Parent Hotline

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:

- Complaints regarding DCFS caseworkers and supervisors ranging from breaches of confidentiality to general incompetence;
- Child Abuse Hotline information;
- Child support information;
- Foster parent board payments;
- Youth College Fund payments;
- Problems accessing medical cards;
- Licensing questions; and
- General questions about DCFS and OIG.

In FY 01, the OIG Foster Parent Hotline received 724 calls. Of those, 599 calls were for information and referrals, 59 calls were referred to the SCR hotline, and 66 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.

6. Ethics Officer

The Inspector General is the designated Ethics Officer for the Department of Children and Family Services. The Inspector General reviews Ethics Statements for potential conflicts of interest of those employees of the Department of Children and Family Services who are required to file Ethics Statements.

7. Consultation

OIG staff provide consultation to the Child Welfare System through review and comment on proposed rule changes and through participation on various ethics and child welfare task forces.

II. OIG INVESTIGATIVE PROCESS

The OIG investigative process begins when it receives a Request for Investigation or when the State Central Register notifies the OIG of a child's death or serious injury who had previous involvement with the child welfare system in the last year. Requests for Investigation and death or serious injury investigations are screened to determine whether the facts suggest possible misconduct by a DCFS employee, private agency employee or foster parent, or the need for systemic change. If an allegation is accepted for full investigation, the OIG will fully review records and interview relevant witnesses. When a non-licensure investigation is completed, the OIG reports to the Director of DCFS and the Governor,

with recommendations for discipline, systemic changes, or sanctions against private agencies. The OIG monitors the implementation of accepted recommendations. When recommendations focus on a private agency, the OIG may work directly with the agency and its board of directors to ensure implementation of the recommendations. In rare circumstances, the Inspector General may request that an agency be put on "hold" or that an employee be placed on "desk duty" pending the outcome of an OIG investigation, when the allegations are sufficiently serious to present a risk to children.

Referrals for Employee Licensure Investigations will be screened by a committee composed of representatives of the OIG, the Child Welfare Employee Licensure Board and the Department's Division of Employee Licensure. When an Employee Licensure Investigation is completed, the OIG will determine whether the investigation disclosed a basis for possible licensure action. If so, the OIG will schedule a hearing for the employee with the Administrative Hearings Unit.

The Office of the Inspector General (OIG) is mandated by statute to be separate from the Department. Thus, OIG files are not accessible to the Department. Therefore, the investigations and the Investigative Reports and Recommendations are prepared without editorial input from the Department or private agency. Once the Report is completed, the Inspector General will consider comments received and the Report may be revised accordingly.

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 Advocacy Office for Children and Families; or other state agencies such as the Department of Professional Regulation.

Confidentiality

A complainant to the OIG, or anyone providing information, may request that his or her identity be concealed from anyone outside the Office of the Inspector General until the investigation is concluded. If possible, the OIG will attempt to procure information from another source. Both the OIG and the Department are mandated to ensure that no one will be retaliated against for making a good faith complaint or providing information in good faith to the OIG. At the same time, an employee needs to have sufficient information to enable them to present a reasonable defense. Recommendations for discipline are subject to applicable due process requirements.

The private agency subject of an OIG report may review the Report (with confidential information deleted) and respond to any factual inaccuracies prior to the imposition of any discipline or sanction. OIG Reports contain various types of information that is confidential pursuant to both state and federal law. As such, OIG Reports are not subject to the Freedom of Information Act. 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 original Department or private agency records by the OIG. 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.

File Return Policy

Impounded files are returned as soon as practicable. 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 the DCFS Division of Legal Services to ensure that the Department maintains a central file for certain records.

OIG Reports

OIG 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 or private agency contact with the family. An analysis of the findings is provided along with recommendations.

When recommendations are made to a private agency, appropriate sections of the Report will also be submitted to the agency director and the board of directors. The agency may submit a response to address any factual inaccuracies in the Report. In addition, the board and executive director will be given an opportunity to meet with the Inspector General to discuss the Report and recommendations.

The OIG uses certain reports as teaching/training tools. The reports are redacted to ensure confidentiality and then distributed to private agencies, the schools of social work, and DCFS libraries as a resource for child welfare professionals to provide prudent professionals a venue for an ethical discussion on individual and systemic problems within the practices of child welfare. While there is always the risk of unscrupulous exploitation from any admission of human or bureaucratic error, for knowledge to grow and outcomes to improve we need the honesty and truthfulness that can only occur with introspection. 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. 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 implementing recommendations, which call 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.

Death Review

The OIG receives notification from the State Central Register of all child deaths and serious physical injuries in Illinois where the child was a ward of DCFS, the family was the subject of an open investigation or service case, or the family was the subject of an investigation or case within the preceding twelve months. The notification of a child death generates a preliminary investigation in which the death report is reviewed and computer data bases are searched. When prepared by the field, a chronology of the child's life is reviewed. When further investigation appears warranted, records are impounded or requested and a records review is completed. When additional investigation is necessary, a full investigation, including interviews, is conducted. Reports are issued to the Director when recommendations are made. In Fiscal Year 2001, the OIG received notification from SCR of 103 child deaths meeting the criteria for review. In 37 cases preliminary investigations were conducted. In 44 cases records were reviewed. In 11 cases reports were sent to the Director. Investigations are pending in another 8 cases. Three full

investigations were conducted that did not result in reports to the Director. Summaries of death investigations that resulted in major recommendations are included in the Investigations section of this report. See page 116 for a summary of all child deaths reviewed by the OIG in FY '01. The OIG is a member of Child Death Review teams around the state.

III. RECOMMENDATIONS

Through investigative reports, the OIG makes recommendations for both systemic reform and case specific responses. Systemic recommendations are designed to strengthen the child welfare system as a whole to better serve each child and family.

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 a recommendation regarding discipline has been made, the OIG will present it to the Director of DCFS. If accepted, the Department will initiate disciplinary proceedings with the employee. The employee will have a chance to review the evidence and submit a response. After receiving the response, the Department will determine whether discipline is appropriate. If the Department determines discipline is appropriate, it will be administered and noted in the employee's personnel file. In addition, 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.

At the end of the report, systemic reform recommendations are 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 child welfare system. 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.

Foster parents contact the OIG Foster Parent Hotline by calling (800) 722-9124

INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

ALLEGATION Two Department wards, a nine year-old boy and a sixteen year-old girl, died in separate incidents from severe asthma attacks. In both cases, the Department failed to develop comprehensive care plans to effectively manage the children's medical conditions.

INVESTIGATION The nine year-old boy had a history of acute asthma that predated his involvement with the Department. His asthma was diagnosed at three months of age and the case file listed numerous emergency room visits and hospitalizations throughout his life. For fiscal year 2000, the Illinois Department of Public Aid identified the boy as one of the top 200 users of asthma drugs by DCFS wards. While the child's records show follow-up medical appointments were scheduled, there was no indication the appointments were kept. There was no mention of the boy's asthma in the initial intake summary, completed when he first became involved with the Department, nor in the case histories completed by private agency workers for two placement transfers. The boy's case history showed he was known to have several allergies, which can serve as asthma triggers, however there was no evidence the correlation between these health complications was ever assessed.

The 16-year-old girl experienced an asthma attack during an initial health screening when she was first taken into protective custody, one year before her death, and was immediately hospitalized. The case record, including the intake summary, did not record the treatment she received or whether her new foster parents were counseled on how to manage her health care needs. The girl's case record is devoid of information regarding her medical history. A life skills assessment conducted two weeks prior to the girl's death showed she was acutely aware of the severity of her condition. During the assessment, she described an asthma attack as an "extreme emergency" and was familiar with 911 and emergency services. Despite the girl's emergency medical contacts while in the Department's care, her case record did not contain any unusual incident reports to correspond with her hospitalizations.

Although both children had extensive documented histories of medical treatments for asthma, neither child had an Asthma Action Plan or received a peak flow meter, which would enable them and their caregivers to gauge their respiratory strength on a regular basis. Overall, their case records contained scant information regarding hospitalization, emergency room visits, clinic appointments and medications, limiting the ability of the children, foster parents and child welfare professionals to effectively manage the children's asthma.

OIG RECOMMENDATIONS / RESPONSES **1. Child Protection investigators and case management staff need to be educated regarding the risk signs and red flags of a child's asthma condition. By learning to ask the right questions regarding children's medical needs, child welfare personnel can more effectively provide services to children.**

The Department agreed. Education for Department staff will be part of the asthma protocol which is currently being drafted.

2. The Department previously agreed with the OIG's recommendation to identify current and incoming wards with asthma or other serious or chronic illnesses (OIG's Asthma Report, June 1999). The Illinois Department of Public Aid's list of top 200 users of asthma drugs is a valuable source of information to identify wards with uncontrolled and/or inadequately managed asthma. The Department also agreed with the OIG's recommendation in the Asthma Report, that minors identified with uncontrolled asthma, in accordance with National Asthma Education and Prevention Program (NAEPP) guidelines, should receive a referral to DCFS Nursing Services. The cases of these two wards reaffirm the importance of these recommendations and the need for immediate implementation.

The Department agreed. This will be included as part of the Best Practice Initiative.

3. Adopt the OIG's previously proposed revisions to the health summary section of the Client Service Plan (See OIG report File No. 97-2749). The health summary serves as a source of information for early identification of wards that develop an illness while in the Department's care. Client Service Plans should reflect specific tasks for foster parents and caseworkers to ensure that wards are receiving medical services that manage their asthma.

The Department agreed. This will be included as part of the Best Practice Initiative.

4. Child welfare workers and foster parents should be provided educational programs regarding effective asthma management in order to advocate for their children to be cared for by physicians who follow the National Heart Lung and Blood Institute (NHLBI) guidelines for the diagnosis and treatment of asthma.

The Department agreed. This recommendation will be part of the asthma protocol which is currently being drafted.

5. In managing the medical needs of asthmatic children, mental health needs are often overlooked. Service provision should include mental health services that address the child's quality of life. By providing comprehensive, preventative medical and mental health care services, children with asthma should be able to lead normal and healthy life styles.

The Department agreed. This recommendation will be part of the asthma protocol, which is currently being drafted.

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

A five month-old girl died as a result of injuries inflicted by her father. At the time of the infant's death, there was a pending child abuse investigation and her family was receiving intact family services.

INVESTIGATION

The family's first contact with the Department occurred three months before the girl was born when the hotline received a call reporting substandard living conditions in her parents' home. In addition to the couple, the household included the mother's sister and the sister's one year-old son as well as a female roommate and her three year-old son. The couple were the guardians of the mother's sister's child. The Child Protection investigator assigned to the case inspected the home and conducted interviews with the children's caretakers which included completing Adult Substance Abuse Screens. None of the adults reported any substance abuse issues except for the girl's father who stated he had previously been hospitalized for alcohol and behavioral issues and was currently working with a counselor and receiving services. He told the investigator he drank beer regularly and often smoked marijuana as a substitute for the medicine he took for his bipolar disorder, particularly when he could not afford to fill his prescription. The father also informed the Child Protection investigator he had been arrested a number of times and once served time for violating probation.

In addition to the father's stated substance abuse and mental health issues, both he and his wife reported he had difficulty controlling his temper and that the couple received very little support from their families. There were also concerns regarding the health of the maternal aunt's son, including his size and immunization history. The Child Protection investigator unfounded the allegation of environmental neglect but arranged for the father to undergo a more comprehensive substance abuse evaluation and referred the family for a follow-up service assessment. The worker who conducted the follow-up assessment recommended the one year-old boy undergo a zero to three health evaluation and the father comply with the substance abuse referral, but concluded the family did not need services through the Department.

The family had no contact with the Department until another hotline call was made four months after the girl was born. The infant had been born with bronchial dysplasia and required the occasional use of oxygen to breathe. The reporter stated the mother had failed to bring her daughter to several doctor's appointments, was not at home for scheduled visits by a monitoring nurse and had attempted suicide on one occasion since the baby's birth. The case was assigned to another Child Protection investigator who went to the family's home that evening and interviewed the mother. The mother told the Child Protection investigator she took good care of her daughter and had not seen the nurse because she had too much to do to wait at home for anyone. She informed the investigator she would take the girl to the doctor's office the following Monday and that he could call to verify she was there. When questioned about the suicide attempt, the mother stated she had ingested a large quantity of her husband's prescription anti-depressants because she was angry at him for moving out of the house, but had no intention of harming herself. She told the investigator that two days before the incident she had taken two puffs of a crack cigarette, but that was her only experience with cocaine. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) listing no safety concerns. After the mother followed through with the medical appointment, the Child Protection investigator interviewed the physician, who had treated the infant since birth. The doctor told the investigator that while he did not believe the child was being medically neglected, the mother had admitted to him that she smoked crack while she was pregnant. Following this interview, the Child Protection investigator staffed the case

with his supervisor. It was determined the investigator would unfound the allegation but offer services to the family. The mother accepted services and a transfer to follow-up was scheduled. The father was not interviewed as part of the investigation because he was not living in the home at the time.

Intact Family Services accepted the case and a staffing was held at the home to begin the mother's involvement. The Child Protection investigator, the follow-up supervisor and a homemaker responsible for helping monitor the home were present, however the assigned caseworker was ill and unable to attend. The father had since returned to the home but was not present. A social history recorded at the time stated the mother had a child from a previous marriage who lived in another state with her father. The OIG learned the child had been prevented from returning to her mother several years before after reporting to her father she had been sexually abused by her mother's boyfriend. The follow-up supervisor noted that during the staffing, several friends and neighbors dropped by the house. She believed traffic in the home would inhibit the mother's ability to create a schedule for her daughter. The next day the follow-up supervisor returned to the home and met with both parents. A service plan was developed requiring the parents to meet all of the baby's medical requirements, work with the homemaker to ensure the girl was properly cared for and to maintain contact with the Department.

Two weeks after the safety plan was established, the mother brought her daughter to a hospital emergency room suffering from a wide array of injuries. The baby had friction burns on her nose, a bruise on her left ear, a puncture wound to the bottom of her left foot, a split lip, fingertip bruises on her back and a tear along the underside of her tongue. The Child Protection investigator who handled the most recent hotline call was again assigned to investigate. The mother stated the wound underneath the infant's tongue resulted from a pacifier getting caught inside the girl's mouth and provided various explanations involving play-related accidents with the father and the baby's own activity to account for the other injuries. The mother stated the father had been present in the home, as were several other people, prior to the emergency room visit, but he did not accompany them because he had consumed "four or five beers" and they were concerned hospital staff might believe he was intoxicated. The Child Protection investigator created a safety plan requiring the mother and her daughter to spend the weekend at the maternal grandmother's house in another city while the father remained at the family' home. The investigator completed a Substance Abuse Screen of the mother reporting no substance abuse issues, despite his knowledge of her previous drug use.

Hospital staff determined the infant needed to be seen by an ear, nose and throat specialist and arranged a transfer to another hospital, advising the receiving health care providers the baby was a possible victim of abuse. After the girl was seen by the specialist, the Child Protection investigator interviewed the doctor who stated it was conceivable the tongue injury could have been caused by a pacifier if some kind of force was involved. In an interview with police following the baby's death, the specialist stated he examined the baby solely to determine whether the tongue injury required surgery, but mentioned to the Child Protection investigator the infant had more injuries at that time than his teenage daughters had experienced in their whole lives. The doctor determined the baby did not require surgery and scheduled a follow-up visit after the weekend. The Child Protection investigator then drove the mother and daughter to their house to gather some belongings before transporting them to the grandmother's home.

The following Monday, the Child Protection investigator staffed the case with his supervisor and informed him that a safety plan had been developed. The investigator said he had spoken with the emergency room physician, who was concerned about the injuries, and with a specialist who had seen the infant. The investigator said the specialist believed the child's injuries could have happened the way the mother said they did The supervisor instructed the investigator to interview the father and the roommate as soon as possible. At the time, the supervisor was unaware the protective plan had expired that day and believed the mother and child were still residing at the grandmother's home. That same morning, the homemaker picked up the mother and daughter and drove them to the Department office where the mother met her caseworker for the

first time. That afternoon, the caseworker and the homemaker went to the home and spoke with both parents about their daughter's care. The caseworker created a new safety plan which stipulated in part that the father would not consume alcohol while taking his medication.

Over the next three days the Child Protection investigator attempted to visit the home to conduct the interviews but was unable to contact the family at their home or over the phone. On the evening of the third day, the Child Protection investigator received a call from the Sheriff's Office advising him the infant had been brought to the emergency room with severe head injuries. The father later admitted to police he had shaken his daughter because she was crying and dropped her on the floor. The girl died as a result of her injuries and her father is currently awaiting trial for murder.

During this time period, two of the Child Protection units responsible for investigating cases in the region were understaffed because of unfilled vacancies, increasing the workload for active investigators. In addition, the Child Protection supervisor was charged with overseeing the work of investigators in both offices, reducing his ability to be actively involved in either office. One of the offices was also preparing for accreditation which further taxed the resources of available staff in the region. An OIG review of the Child Protection investigator's work records showed an extremely high volume of overtime weekend hours as well as a great deal of time spent on call. Despite the number of cases he was assigned and the large geographic area his unit encompassed, the Child Protection investigator spent a vast majority of his time in the office rather than in the field. The investigator had also previously been issued a dictating machine to improve the poor quality of his interview documentation, however he discontinued using the machine after the Department ceased contracting with the typist who transcribed the tapes.

OIG RECOMMENDATIONS / RESPONSES

1. The Child Protection investigator should be counseled and retrained on how to conduct comprehensive, well-reasoned, well-documented child protection investigations.

The Department agreed. The investigator was retrained on July 17, 2001

2. The Child Protection investigator's supervisor should review with the Child Protection investigator the fact that only 20% of his time investigating is spent in the field. The supervisor should advise and plan with the Child Protection investigator to increase his time spent in the field on investigative activities and decrease the time spent in the office on paperwork. A time management study on the Child Protection investigator should be considered to provide specific information about his activities.

The Department agreed. During the counseling session with the investigator, his supervisor emphasized that appropriate time be spent interviewing subjects and collaterals, and that information be recorded accurately on his daily time sheets.

3. During a three-month period (August, September, October 2000) the Child Protection investigator worked 77% of the weekends. the Child Protection investigator should be restricted from accepting after-hours and weekend on-call responsibility beyond that made mandatory under the union contract. He should be restricted from volunteering for additional after-hours and weekend on-call responsibility.

The Department agreed. The investigator will work the stand-by mandated by the union contract and be available to volunteer for one additional weekend per month if approved by his supervisor.

4. Management should consider, on an informal, practical basis, whether getting the Child Protection investigator a voice-activated computer program would reasonably improve his documentation in his

child protection investigations.

The Department agreed and has encouraged the investigator to request a voice activated computer program.

5. The Department should develop with Southern Illinois University a mobile forensic Parenting Assessment Team for the far south and southeast areas of the Department's Southern Region.

The Department agreed and is working on implementation with the OIG.

6. Department procedures should be clarified to require that when a case is already open with the Department and a new child protection investigation is begun, the child protection investigator must be responsible for any safety plan until the investigation is completed. Follow-up should receive a copy of the plan to assist Child Protection in monitoring the safety plan. The continuous process of weighing new information against what is already known may require a change in the safety plan at any time, including taking protective custody which caseworkers cannot do.

The Department agreed. This will be part of the Best Practice Initiative.

7. Southern Region field offices often seem short-staffed of child protection investigators. The Department should explore the feasibility of hiring permanent overlapping four day shifts as is done in Cook County and East St. Louis to ensure weekend coverage. These added shifts could assist with the increased demand for child protection visits required by the new paramour policy during a pending investigation and make necessary contacts to assure safety when the regular shift has been unable to make contact.

The Department agreed. Efforts are underway to alleviate the shortage of Child Protection investigators in the Southern Region. These efforts include additional positions that have been allocated to the Southern Region. In addition, consideration is being given to redesigning the on-call system in the downstate regions.

8. Homemakers should be trained on how to do task-centered activities. They should receive more detailed instructions about the expectations for services in a particular case and closer supervision of their activities.

The Department agreed. The Department is reviewing existing rules and policies on homemakers and revisions are forthcoming.

9. Child protection investigators and follow-up workers who experience a child's death should be offered assistance with their caseload.

The Department agreed.

10. The body chart used in the Child Protection investigations should be changed to incorporate new information on children's bruising. The information should be incorporated into Child Protection trainings.

The Department agreed to review current medical research on bruising and incorporate that information into the body chart as well as Child Protection training.

11. When the mother gives birth, the Department should investigate to consider if the baby should be taken into temporary custody for risk of harm because of the dangerous situation in which she placed

the infant in this case and her demonstration of her failure to protect her as well as her older daughter.

The Department agreed. The Child Protection investigator implemented a safety plan for the mother and her new infant who are currently living with the baby's grandmother. The mother is participating in services through the Department.

12. Strategies to decrease bias and increase the reliability and validity of child protection decisions should be included in child protection training.

The Department agreed.

13. During the course of an investigation, a Child Protection investigator should ask alleged perpetrators for the names, dates of birth, and living arrangements of any of their children who are not members of their household. The CPI should investigate the reason such children are not living with their parent(s). In this investigation and others, the reason the children are not living with their parent(s) has been relevant to the safety and well-being of the children currently living with the alleged perpetrators. This recommendation should also be followed when follow-up or foster home licensing becomes aware of the existence of additional children not living with their parent(s).

The Department agreed. This will be part of the Best Practice Initiative.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

A ten month-old girl died from asphyxiation after an object was forcibly lodged in her throat. Two child abuse investigations involving the family were conducted in the two months prior to the girl's death.

INVESTIGATION

The first abuse investigation was initiated after the infant's maternal grandmother brought the baby to a hospital emergency room with bruises on her buttocks. The grandmother told the nurse she had previously observed bruises on the girl's head and that, according to the mother, the mother's boyfriend was responsible for the current injuries. A nurse reported the possible abuse to the hotline. The Child Protection investigator assigned to the case interviewed the mother who initially expressed hostility at the intervention but later admitted she had spanked her daughter when she was "stressed out." The mother expressed regret for her actions and denied her boyfriend had ever inflicted any harm against the baby. The mother agreed to have the baby placed with the grandmother temporarily. The Child Protection investigator informed the mother that due to the infant's age and the presence of her boyfriend in the home, the case would be referred for follow-up services. The mother was familiar with a caseworker who had previously served as her private therapist and requested that she service the case. The caseworker was assigned to work with the mother and the child was then returned to the mother's custody.

The caseworker believed her existing relationship with the mother and familiarity with her family could aid in providing services. The caseworker stated to the OIG that she and her supervisor discussed the possible difficulties inherent in the arrangement, however the caseworker was confident she could separate her previous patient / therapist relationship with the mother from her new role. In reality, the caseworker's previous knowledge of the mother's history informed many of her decisions and influenced her assessment of the case. The caseworker accepted all of the mother's self-reports regarding substance use, employment and the baby's health care and neglected to verify information when obvious discrepancies arose. After the second abuse investigation was initiated following the discovery of mysterious injuries to the baby, the caseworker identified the maternal grandmother as the likely source of aggravation to the mother and suggested to her that relatives were setting her up for child abuse allegations. A second Child Protection investigator assigned to handle the report summarily accepted the family's theory that the injuries were self-inflicted by the toddler while in her crib without allowing for other possible scenarios.

The caseworker recommended to the mother that she discontinue allowing the grandmother to care for the baby. In doing so, the caseworker isolated a concerned relative who had expressed a willingness to ensure the infant's well-being. The caseworker based this decision on her knowledge of the family's history from her time as the mother's therapist rather than on the facts relevant to the child abuse investigations. In addition, both Child Protection investigators acknowledged deferring to the caseworker when making judgments about the mother and her extended family because they were aware of her knowledge of the family. By substituting the caseworker's existing opinions for critical evaluations of the family's situation, both Child Protection investigators compromised the integrity of their work and failed to conduct complete assessments of the infant's safety.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should work to include extended family, when possible, in working with an intact family. If legislative change is necessary for the Department to include extended

family in working with intact families in indicated cases, the changes should be pursued.

The Department agreed. Family meetings are a critical component of Best Practice for achieving permanency. Family meetings are being recommended for every case with meetings initially being conducted every 45 days and later being reduced to once per quarter. The Department issued a policy clarification to alert workers to the importance of working with extended family and to set criteria for getting and sharing information with family.

2. The Department should review whether the expansion of the Office of Alcohol and Substance Abuse initiative is sufficient to meet the demands of the growing substance abuse problem of the Southern Region.

The Department agreed. The Division of Health Policy will conduct a statewide assessment of service gaps. The assessments will be shared with the Office of Alcohol and Substance Abuse.

3. The caseworker should be disciplined for not documenting and discussing with her supervisor her visit and role in advising the mother to call the grandmother and tell her that she could no longer babysit for the infant.

The Department agreed. The caseworker resigned from the Department before discipline was initiated.

4. The caseworker and her supervisor should be counseled on ethics violations. Specifically, the caseworker should be counseled on responsibilities to clients and the priority of child safety over confidentiality. The caseworker and her supervisor should be counseled on dealing with multiple relationships.

The Department agreed. The caseworker resigned from the Department. The region will provide counseling to the supervisor on ethics violations.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION A seven year-old girl and her six year-old sister were placed with a foster family in another state through the Interstate Compact on Placement of Children. Six months after the girls were placed in the home, the seven year-old was beaten to death by her foster father.

INVESTIGATION The sisters were two of seven siblings who were removed from their parents following numerous abuse and neglect reports. The two sisters and their 12 year-old brother were initially placed in the same foster home, however, the foster mother asked that the 12 year-old be removed and he was placed in the foster home of a Department employee. Shortly after the brother was removed, the foster mother stated she was not interested in adopting the girls and Department workers began efforts to identify a new placement. The foster parents who accepted the other siblings were considered but each placement was determined to be unsuitable for more children for various reasons. Some relatives were identified as possible placements, however those that expressed interest proved to be unsuitable while others, who may have proved to be viable options, did not step forward. As a result of the sisters' inclusion in several adoption-related media initiatives, the Department received numerous inquiries regarding the girl's availability from families both throughout Illinois and in other states. Ultimately, the girls' caseworker and her supervisor selected a couple from out of state as a pre-adoptive placement, even though two families in Illinois had stated their willingness to accept all three children and had followed proper procedures.

Neither the girls' caseworker nor the adoption specialist assigned to assist on the case could articulate why the particular family was chosen other than that they "just seemed right." The couple, who already had four sons, was licensed through a small private agency. The couple told workers from the out-of-state agency that they had recently cared for the daughter of a deceased friend and expressed a great desire to have a girl placed in their home. Although the couple's home state requires potential adoptive parents to complete a 10-week, 30-hour course, private agencies are allowed to administer a level of training they deem comparable in lieu of the instruction provided by the state. The foster parents' training consisted of eight interviews conducted by the private agency's executive director with various combinations of family members. The agency completed a home study and background checks on the parents and subsequently issued a license to the home 10 weeks after the couple first inquired about the girls. The couple's caseworker then forwarded their information to the Department. The couple was informed that workers in both states would have to work in accordance with the ICPC in order to place the girls in their home.

The Interstate Compact is a contract between states that allows for children to be placed across state lines for the purposes of foster care or adoption. Usually, such moves are precipitated by the location of relative placements in other states or the movement of a family from one state to another. The Compact Administrator for Illinois told the OIG that while placing children with non-relative strangers out-of –state was unique at the time, these cases are becoming increasingly common. Throughout the handling of this case, Department workers demonstrated difficulty complying with the Interstate Compact and uncertainty about the delegation of responsibilities among involved workers. This confusion was exacerbated by the absence of an explicit definition in either the Illinois statute or Department rules outlining the Interstate Compact Division's role in facilitating these placements.

At the time the placement was first being considered, the Department did not have a contract to pay for services performed by the private agency that licensed the foster parents. An employee of the Department's

Foster Care and Permanency Services division was asked to draft a specialized adoption contract. The contract composed by the employee was created using elements of previously existing contracts that had no relevance to the issues of the case at hand. The contract entered into by the Department with the private agency was written to encompass the recruitment of prospective foster parents, a task that had already been completed. The contract neglected to include requirements for the agency to provide services to the girls or afford any level of meaningful monitoring of their foster placements. In addition, a section of the contract lifted from another document included race-related language which was inappropriate for inclusion in a Department contract.

After the foster mother established direct contact with the girls' caseworker, the foster parents were permitted to travel to Illinois to meet the children. Neither staff from the out-of-state private agency nor the assigned adoption worker were aware the caseworker had arranged a meeting. Following the foster parents' return home, the foster mother began making frequent phone calls to the private agency and involved workers in Illinois urging them to expedite the placement. After being told repeatedly that any placement would have to take place according to protocol, the foster mother initiated a telephone campaign and contacted various Department administrators to express her dissatisfaction with the pace of the process. The foster mother eventually reached an administrator in the Department's Division of Operations who accepted her complaints as valid without investigating their legitimacy or ascertaining the facts of the case. The administrator intervened on the foster parent's behalf and exerted pressure on the regional administrator overseeing the workers handling the case. The regional administrator, in turn, instructed the caseworker's supervisor to ensure the girls' placement with the foster parents by an arbitrarily selected date. The girls were subsequently taken to the out-of-state placement by an uninvolved worker in the absence of a court order. Department personnel never conducted visits to the foster home and instead relied on the assessments of the out-of-state private agency.

One month after the girls were placed in the home, the foster parents began registering complaints with a private agency caseworker assigned to monitor the family. The foster parents claimed the six year-old was exhibiting disruptive behavior. The private agency caseworker reported her belief that the foster parents were unprepared to cope with behaviors the girls presented related to incidents of sexual abuse committed against them in a previous foster home. Soon after these complaints were made known, the foster parents requested that the six year-old be removed from their home. Although the private agency caseworker, the Department caseworker and her supervisor all initially agreed that the girls would only be moved together, the supervisor decided to approve the six year-old's removal from the home after just two months in the placement. The supervisor stated to the OIG he based his decision on the rapid deterioration of the home environment and only intended the girls' separation to be a temporary means to alleviate the situation. The six year-old was placed in another foster home licensed through the private agency. The Department did not request the required approval from the Interstate Compact Division to change the girl's placement. Compounding the problems in this case, all of the workers involved with the children and/or the family changed, with the exception of the adoption specialist. Five days prior to the six year-old's placement in the new home, the involved Department caseworker left her position and responsibility for the case was given to another worker. Two weeks after the new caseworker accepted the case, she was transferred to another team under a new supervisor who was on leave at the time. Neither the new caseworker nor her supervisor was familiar with the case and did not understand the circumstances of the placement or what actions were required to stabilize the family. Though counseling was recommended by the private agency caseworker, the new caseworker did not act to ensure it was initiated. Upon her return, the new supervisor failed to contact the previous supervisor regarding the case and neglected to arrange a case review with involved workers. The private agency did not pay the private agency caseworker for six months which prompted her to resign, ending her involvement with the case. The caseworker was replaced by another agency employee who was the son of the agency's executive director.

Four months after the girls were separated, the foster parents became upset with the seven year-old after she acted out in public during a shopping trip. The foster father spanked the girl after they returned home but continued to be agitated by her behavior. The foster father punched the girl several times and, after she fell to the floor, began kicking her repeatedly while his sons attempted to pull him away. The foster mother later called paramedics after the girl collapsed. She was transported to the hospital where she was pronounced dead. The foster father was arrested and subsequently convicted of murder and sentenced to 40 years in prison.

Following the seven year-old's death, Department workers in Illinois attempted to determine how to proceed with the six year-old's case. A caseworker traveled to the state to assess the girl's safety in the home. After meeting the family and observing the home, the caseworker recommended the girl remain with the family. A child interviewer from the Office of the Public Guardian also traveled to the home. The child interviewer had previously scheduled the visit but had not informed child welfare professionals from either state of her planned visit. The child interviewer was unaware of the seven year-old's death until the six year-old informed her about it during their discussion. The child interviewer did not meet with the foster parents or view their home but recommended the girl be removed from the placement based on her conclusions from their conversation. During the ensuing weeks, the Department held a number of staffings to discuss the case but neglected to maintain meaningful contact with workers in the other state. Ultimately, the Department decided to remove the six year-old from her placement, almost one year after she joined the family, and returned her to Illinois to live with a foster family that adopted one of her sisters. The girl remains in the pre-adoptive placement.

While Department workers were searching for an Illinois placement for the six year-old, they assessed the home of the Department employee who was caring for the girl's 12 year-old brother. During this review, the workers realized the boy's foster mother's foster home license had expired. A change enacted in Department rules over two years prior required Department employees to be licensed for foster care through private agencies rather than the Department. The employee had failed to complete the license transfer. In addition, she failed to inform her licensing worker when she married and her husband moved into the house. The 12 year-old was removed from the employee's home and placed with a paternal aunt.

OIG RECOMMENDATIONS / RESPONSES

1. A redacted copy of this report should be utilized within the Department as a teaching tool. A copy of the report should be shared with all supervisors involved in the management of this case. It should also be shared with the Interstate Compact Division, as the Compact Administrator has the statutory authority to promulgate rules necessary to administer interstate placements, and the supervisor of the Department of Foster Care and Permanency Planning.

The Department agreed. A redacted copy of the report was shared with all supervisors and Interstate compact unit staff involved with the case.

2. This report should be shared with the Governor of the state where the girls were placed.

The Department agreed. The OIG shared this report with the Governor of the state where the girls were placed.

Placement Concerns

3. Adoption Specialists should be part of the team that monitors the interstate placement. The Adoption Specialist should be involved in all out-of-state pre-placement visits. In the event that the caseworker familiar with the children cannot attend a pre-placement visit, the Adoption Specialist

should make the pre-placement visits. The Department should amend Rules and Procedures to reflect this change.

The Department agreed. The Department's Division of Operations and Foster Care and Permanency developed a joint proposal for interjurisdictional adoptions that was approved by the Director.

4. When a case changes teams, a staffing should be required to include the former worker and supervisor, the new worker and supervisor, and the Adoption Specialist, where applicable.

The Department agreed. Administrative Procedure 9, which governs case transfer policy, is currently being revised. This will be included in those revisions.

5. The Department must establish guidelines for facilitating out-of-state adoptions of Department wards with families unknown to the children. Included in these guidelines will be the requirement of the caseworker meeting with pre-adoptive parents in their home before sending a child, and pre-placement visits and evaluation should never be waived. Visits must occur in both Illinois and the pre-adoptive family's home state. The worker and/or the Adoption Specialist must accompany the child at all times.

The Department agreed. A policy guide will be issued to implement the new process.

<u>Contracts</u>

6. The Department should not enter into any future contracts with the private agency.

The Department agreed and is not involved in any contracts with the agency.

7. The Department should amend Rule 357 or draft a new rule that would require that out-of-state agencies meet specific standards such that the Department has adequate information about the out-of-state provider. At a minimum, this would include ensuring that contracts for out-of-state placement cannot be considered individualized foster care contracts such that they are exempt from some of the requirements of Rule 357. This means that the Department should ensure that program plans reflect that the agency has provided and maintains a list of the qualifications of staff members, the length of each staff member's employment with the agency, etc. In light of the anticipated increase in out-of-state placements because of tools such as the Internet, the Department should convene a work group to further assess that sufficient protections are built into Rule 357.

The Department agreed. A policy guide will be issued to implement the new process. The Interstate Compact Administrator will work with the OIG to develop this process.

8. The Department should prepare a standard contract for out-of-state adoptive placements that could be used as a template for future out-of-state placement contracts. The Department should ensure that the contract properly delineates the responsibilities of the out-of-state agency.

The Department agreed. A new out of state adoption agency standardized program plan is being developed. Additionally, a more rigorous pre-contracting review process, including an on-site review of the agency, will be implemented.

9. The Department should examine all contracts and contract templates to ensure that no language excluding the placement of any racial or ethnic group exists.

The Department agreed. There is no language in the contract boilerplate that excludes placement of any racial or ethnic group.

Crisis Response Team

10. The Department should assemble a Crisis Response Team.

The Department agreed. The Crisis Response Protocol was implemented June, 2001. The OIG has been working with the Department's Division of Clinical Services on amending the protocol.

Clarification of Interstate Player Roles

11. The Department should determine the scope of the Compact Administrator's role in interstate placements, and should communicate this determination to all Department employees. The Department should consider whether it is necessary to amend Rules and Procedures to reflect the parameters of the role of the Compact Administrator.

The Department agreed. The Director has authorized a more assertive role for the Compact Administrator and/or his designee in approving contracts with out of state adoption agencies and guiding workers before an interstate request is initiated for a pre-adoptive placement of a child with a family not known to them. The policy guide will address this issue.

12. When the Department arranges for the interstate adoptive placement of a child from Cook County, it should send a letter to the receiving agency, explaining that this child has legal representation through the Office of the Public Guardian. The letter should provide the name of the Cook County Public Guardian, and the telephone number of the office. It should be explained that if the receiving agency has any questions about this representation, it should forward questions to the Public Guardian. Rules and Procedures should be amended to reflect this practice.

The Department agreed. All future adoption placements will include a letter explaining that the child has legal representation through the Office of the Public Guardian.

Employee Foster Care Licensure

13. The Department should notify, in writing, all Department field offices and private agencies that Department and Agency employees must not be licensed for foster care by their employer or an entity with which they have a working relationship. All employees currently licensed for foster care by their employer or an agency with which they have a working relationship must transfer their license immediately. The Department should conduct a random audit to verify implementation of this recommendation.

The Department agreed.

14. If the Department employee who served as a foster parent to the 12 year-old boy attempts to renew her Department foster care license, her license renewal should be denied.

The Department agreed. The Department employee's foster care license expired on November 18, 1997. Policy Guide 2001.07, Foster Home Licensing Violations and Enforcement History Review ensures that when there is an application for licensure from a previously licensed individual.. the current foster home

representative reviews and assesses all previous licensing history, including strengths, violations and enforcement actions, before making a recommendation on the current license.

Use of the Advocacy Office

15. The OIG has investigated several cases in which a disgruntled individual has mobilized multiple levels of the Department to focus on his or her case. The Department would operate more efficiently if complaints were managed through a centralized office. The Advocacy Office was established for this purpose. All upper management personnel should be notified that any complaint received should be referred to or coordinated with the Advocacy Office. Advocacy Office personnel should inquire into the complaint and report to the Director or the referring party.

The Department agreed. Executive staff will be informed to refer complaints received to the Advocacy Office for Children and Families to eliminate duplication of effort.

Discipline

16. The following individuals should be counseled because of their failure to properly discharge their responsibilities in this case:
- The Department supervisor did not use sound clinical judgment when he made the decision to leave the seven year-old in the foster home pending completion of a bonding assessment.
- The new caseworker did not proactively manage this case. She failed to notify the GAL that the six year-old's placement had disrupted, she did not request ICPC approval after the placement disrupted, and she did not follow up on the recommendations of the private agency worker.
- The new supervisor did not schedule any staffings or reviews of the case before the seven year-old's death. She did not consult with the previous supervisor on critical issues at the outset of her assuming supervisory responsibilities.
- The Division of Operations administrator imprudently jumped to conclusions without a thoughtful investigation into the facts of the adoption case.

The Department agreed. The Regional Administrator counseled the Department supervisor on July 18, 2001. The new caseworker transferred to another region and her new Administrator will ensure the issue is addressed. The report was shared with the Division of Operations Administrator.

17. The following individual should be disciplined for failing to adhere to DCFS rules:
The Department employee who served as a foster parent for the 12 year-old boy violated Rule 437 by failing to transfer her foster care license to a private agency. She allowed her foster care license to lapse, but agreed to accept a child into her home. She failed to notify the Department, the licensing agency, when she married and her husband moved into the home. She allowed her husband to use corporal punishment on the child in her home, although Department rules state that corporal punishment should not be used by foster parents. There is a nexus between the acts in which the employee engaged as a foster parent and her role as a Department employee.

The Department agreed. Appropriate disciplinary action is being pursued.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION Two 10 year old male wards suffered severe burns as a result of a fire in their foster home. Both boys died from their injuries after lengthy hospital stays (A third child who resided in the home also died in the fire). Following the boys' deaths, the OIG received a complaint alleging that while the two boys were in the hospital, an experimental medical procedure had been performed on one boy and an inappropriate procedure was conducted on the other.

INVESTIGATION The OIG reviewed all medical records pertaining to the boys' care while they were in the hospital. The extreme nature of the boys' injuries necessitated ongoing intensive medical intervention by hospital staff. One of the boys, who was burned over 80% of his body, was brought to the hospital on the day of the fire with elevated pressure in the abdomen which can lead to organ failure. The alleged experimental procedure performed by physicians that day was an emergency exploratory laparotomy which served to release internal pressure in the burned areas of the boy's body. This procedure was performed four more times during the ensuing weeks to treat related health problems. The other boy, who was burned over 50% of his body, was allegedly subjected to a full-body dressing change. No evidence of an order to perform such a procedure was found in the boy's medical records. All dressing changes noted included burn diagrams to document the child's condition throughout his time in the hospital. The OIG found that the allegations were unsubstantiated as all actions taken by medical staff were warranted due to the critical nature of the boys' conditions.

The investigation did, however, raise concerns regarding the lack of familiarity of Department workers and medical personnel with procedures for obtaining consents for treatment. The physician who conducted the laparotomy mistakenly believed she received a "blanket consent" to perform medical procedures. While steps deemed necessary may be taken by medical personnel in times of emergency, formal consents must still be obtained. The OIG found that the Department's Consent Flow Chart is a confusing document that identifies multiple agents vested with the authority to consent to medical treatment of a ward. Such a system could contribute to the confusion of hospital staff attempting to identify the agent to contact in order to obtain a proper consent. In addition, consents for treatment must be preceded by informed decisions based on medical consultation. At least four different authorizing agents consented to various procedures performed on the boys during their time in the hospital, however some of these consents were not documented in the files of either the hospital or the Guardianship Administrator's Office.

In the case of the more severely burned child, the Guardian's Office consented to a Do Not Resuscitate (DNR) order after his condition was deemed terminal, meaning the boy would only receive treatment aimed at alleviating his suffering. Although the physician and the boy's family supported discontinuing nutritional support, a doctor's note in the record states the Department mandated continued nutrition. The Guardianship Administrator confirmed that consent for withdrawal of nutrition is never granted. Records obtained from the Guardian's Office and the hospital do not reflect that the Guardian's Office sought a medical ethics consultation on this matter. The OIG learned that accepted medical knowledge in the field of severe burns has found that in some cases, providing nutrition can increase pain and swelling in burn victims. While it is not known if such would be true in this case, seeking burn specialty and medical ethics consults in the matter could have ensured that the most effective measures were taken to decrease the boy's suffering.

The OIG's investigation of this case also confirmed the need for the Department to establish a Crisis Response Team to assume responsibility for the multitude of tasks that arise in the immediate aftermath of an

extraordinary crisis. The private agency caseworker assigned to both children had only had one boy's case for one month and had no contact with his family prior to the fire. The worker experienced difficulty locating the boy's mother and was finally able to find her only after reaching his older sister. The mother had another son in the foster home who was taken to a different hospital after the fire, further adding to confusion surrounding the events and hindering efforts to coordinate support and services. In one instance, no one from the private agency or the Department was at the hospital to meet the families when they arrived. Family access to the boys was problematic and communication between the private agency, the Department and the families was inadequate. The biological mother's name was not provided to the hospital and staff prevented her from visiting her son. The boys' siblings were not offered the opportunity to visit their brothers in the hospitals.

During the weeks that followed, the caseworker became overburdened as she attempted to maintain control over the other 21 cases she was assigned while being almost solely responsible for attending to the two families dealing with a tragedy. At the time, the private agency was understaffed and the caseworker received almost no support or supervision to assist her in ensuring that the needs of the boys and their families were met in a timely and consistent manner. The caseworker told the OIG that communication between the agency, the Department and the hospital was generally poor. The implementation of a team approach to crisis intervention would have greatly benefited the children and their families.

OIG RECOMMENDATIONS / RESPONSES

DCFS Consent Procedure

1. DCFS Procedure 327.5, which details current protocol for obtaining medical/surgical consents, is complicated and confusing. The procedure should be reviewed and simplified, if possible, to address the following issues:

- Use of multiple authorizing agents (Consent Unit, ERC, Gatekeepers, other DCFS Authorized Agents, i.e., supervisors, and the State Central Register for urgent requests); use of multiple agents by region, type of request for consent, DCFS versus private agency cases, and exceptions.

- Multiple phone numbers and varying staff availability, i.e., during and after business hours. Access to a 24-hour phone line should be considered for physicians.

- In addition to consents for routine, medical/surgical procedures, consents for extraordinary measures need to be entered into a centralized database. All consents should be entered as they are granted to ensure that all prior consents are viewed before granting subsequent consents.

The Department agreed. The Guardian is working with her staff to ensure that in all serious, medically complex cases either she, the Assistant Guardian or the Consent Unit Supervisor are personally involved. Additionally, they have begun to work more closely with the regional nurses who are assisting in visits and reporting back to the Guardian on the status of these children. The Guardian has also requested from SACWIS that a centralized database be created.

2. For medically related crises, the Guardianship Administrator's Office should consider having a fact sheet available that outlines the protocol for obtaining consents and the limitations of consents. A fact sheet can be immediately faxed to the hospital and made part of the child's medical chart. In extraordinary medically related crises similar to the one experienced in this case, the Guardianship Administrator's Office should consider establishing special arrangements to accommodate medical staff and ensure that consents are properly handled where ongoing multiple procedures and emergency treatments are imminent. For example:

- The Guardian or her staff should immediately conduct a face-to-face contact with the crisis response

team leader and physician. When a child is critically injured, guardianship staff should immediately go to the hospital to ensure that the consent procedure is understood and to determine what special arrangements are warranted.

- Assign one staff member from the Office of the Guardianship Administrator to handle consents for the child in crisis

- The child's case manager should not be given responsibility regarding medical consents for the child in a life-threatening crisis

The Department agreed. A fact sheet has been created and will be distributed in each medically complex case where the Guardian or Guardian's staff is involved.

Consent Procedure for DNR Orders

3. In order for the Guardianship Administrator to make informed decisions pertaining to removal of life support measures, every aspect of a physician's recommended DNR directive must be subject to a medical/ethical debate by the medical providers' ethics committees and an independent ethics consultation before granting or denying consent. DCFS Procedure 327: Guardianship Services and Policy Guide 2001.4: Consent Procedure for Foregoing Life Sustaining Treatment and/or DNR Order should be amended to reflect this policy.

The Department agreed. The Guardian has begun to develop a list of individuals to assist her with ethical decisions. Additionally, the OIG has agreed to assist the Guardian with identifying individuals when the need arises. The Guardian and Assistant Guardian will also attend a training presented by the Center for BioEthics in the summer.

4. The protocol should offer guidance as to how one should obtain recommended support of treatment from physicians unrelated to the case and to the attending physician. The protocol should explain what information is required by a physician in order to make a determination on recommended treatment. Procedures are needed for allowing the physician access to the child's medical records if necessary in order to provide a statement of support. Guidelines may be needed to address those instances where the medical opinion of a specialist is most appropriate. Responsibility for obtaining the support of a DNR Order from unrelated physicians should not be assigned to the children's caseworkers. They are not equipped to discuss complicated medically related issues with physicians who are being asked to review DNR directives.

The Department agreed. A procedure concerning the identified issues is currently being drafted. Prior to the issuance of the procedure, a notice will be sent to all Department staff.

5. A separate form should be created for the request of consent for a DNR Order. This form should call for information that verifies a conference was attempted with the biological and foster family, that consultation was obtained from attending physicians, the DCFS Medical Director, a medical specialist, if appropriate, and that consultation on the medical issues was obtained from an ethicist.

The Department agreed. Until such time as SACWIS has designed the type of system that is needed to track these cases, the Guardian has instructed staff to keep all notes of actions taken by staff on sheets of paper that are labeled with each day's date and then completed with that day's work.

6. Information on the biological parents should be obtained regardless of status of parental rights. The

information should be reviewed to assess the appropriateness of the relationship between the biological parents and the child to determine the best interest of the child.

The Department agreed. This process will be followed

Crisis Response Services (Procedure 302.387)

7. The Department should exercise fiduciary oversight of a crisis response regardless of whether the Department has primary case management responsibility for the child. The protocol should be amended in each of the major areas of Planning, Communication and Implementation to reflect the level of authority and role that a team leader must have in order to carry out crisis response services in an effective and expeditious manner. Guidelines should be developed to address a crisis that occurs out of state.

The Department agreed. The Crisis Response Protocol has been amended in accordance with the OIG's recommendations.

8. In order for a child's worker to be an integral part of a crisis response team, the DCFS or private agency must commit to relieving the worker from his/her caseload, at least during the initial and intensive period of the crisis. The protocol should also delineate who will assume the responsibilities of the child's worker and/or supervisor who are significantly affected by the crisis and would not be expected to provide crisis response intervention.

The Department agreed. The Crisis Response Policy Guide has been revised to relieve caseworkers from direct casework responsibilities and duties during a crisis. The worker and/or supervisor will not be expected to provide crisis intervention directly if he/she is significantly affected by the event.

9. The crisis response protocol should reference Policy Guide 2000.06: Required Notification to GAL to ensure that the child's Guardian ad Litem (GAL) is notified at the outset of a crisis requiring team intervention. When a child is not represented by a GAL, DCFS Legal Services should notify the juvenile court parties.

The Department agreed. When a GAL does not represent a child, the Department's Office of Legal Services shall notify the involved court parties. Policy Guide 2000.06 now references this.

10. The protocol should expand the pool of specialists to be available to a crisis response team to include ethicists, education specialists, and other experts as required by the crisis.

The Department agreed. The pool of specialists available to the crisis response teams now includes the involvement of an ethicist, education specialists and other experts as deemed appropriate to the crisis.

11. Pastoral support should be made available to the child and family, and should be utilized within the hospital or community in which the crisis occurs. The child and/or family should be provided linkage to any needed support services after the crisis. Brothers and sisters should be given every consideration and opportunity to visit a sibling in a life-threatening crisis.

The Department agreed. The policy guide has been revised to ensure the involvement of pastoral support if so desired by the family. In addition, the response team will ensure linkage to needed support after the crisis. Visitation with brothers and sisters will be given every consideration.

General

12. DCFS, the private agency involved in this case, and all private agencies should offer post-crisis support to affected employees, i.e., time off, post-crisis support counseling of the worker's choice, or other employee assistance considerations.

The Department agreed. The amended policy guide now encourages Department and private agency clinical staff to assess the impact of crisis events on workers and supervisors to make available immediate and post-crisis clinical support.

13. This report should be shared with the Guardianship Administrator.

The Department agreed. The report was shared.

14. This report should be shared with the private agency.

The Department agreed. The OIG will share the report with the private agency.

15. This report should be shared with the hospital's Child Protective Services Team.

The Department agreed. The OIG will share the report with the hospital's Protective Services Team.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

Three foster children died of injuries they suffered during a fire in their foster home.

INVESTIGATION

The foster home had been licensed through a private agency for two years prior to the fire. The private agency licensing worker who first inspected the home initially recommended rejecting the application because the house did not meet safety standards. At that time, the foster mother included a fire protection-evacuation plan with her application that affirmed there were working fire alarms on each floor of the home. During the licensing inspection, the foster mother and her natural children demonstrated their fire evacuation procedure for the licensing worker. The foster mother was given a 30-day period to improve the condition of her home. A second licensing worker conducted another inspection before the 30-day period expired.

The second licensing worker determined the substandard conditions had been corrected and the foster mother's home was licensed. Both licensing workers neglected to answer the specific question on the licensing compliance form regarding the presence of fire hazards in the home and neither worker noted whether smoke detectors were present and functioning. In an interview with the OIG, the second licensing worker said she could not recall if smoke detectors were installed and admitted she was unfamiliar as to how to check them to find out if they are operational. The licensing worker stated she rushed through her inspection of the home because the foster mother was in a hurry to leave for another appointment.

The second licensing worker was the wife of the agency's executive director. While there is no evidence that this relationship directly affected the licensing worker's thoroughness or her supervisor's willingness to objectively assess her output, the situation would appear to create an atmosphere within the agency that would compromise the organization's ability to maintain a uniform standard for all employees.

Although the home was originally licensed for four foster children, the second licensing worker increased the capacity to five in order to place a set of twins in the home. The worker followed improper procedure in expanding the license and did not take into account the presence of the foster mother's biological children or her daughter's young child who all spent a significant amount of time in the home. The foster mother worked the overnight shift at a factory. Her licensing application stated that her 27 year-old daughter would be present in the home from 7:00 p.m. until noon the next day as an alternate caregiver on nights the foster mother was working. A background check was never conducted on the foster mother's daughter. A check run by the OIG found that two months before the home was licensed, the daughter was convicted on two separate charges of cocaine possession. These convictions would have barred the daughter from being approved as a caregiver.

On July 19, 2000, a fire destroyed the house and killed the three foster children who were sleeping in the home that evening When investigation of the cause of the fire began, attention turned towards a 15 year-old ward who had previously lived in the home. A neighbor reported seeing the boy in the yard behind the house shortly before the fire started and he was witnessed standing in the crowd that gathered outside during the blaze. The Child Protection investigator assigned to the case focused his investigation on the 15 year-old's possible involvement and neglected to examine the possibility that the foster mother had failed to adequately protect the children. The Child Protection investigator told the OIG that after speaking with staff from the private agency, he was under the impression that supervision of the children was not an issue in the case. The Child Protection investigator indicated a child abuse report against the 15 year-old based on the investigator's interpretation of the Abused and Neglected Child Reporting Act (ANCRA). However, this action was

inappropriate as ANCRA applies to individuals who provide care to minors while the boy was not a caretaker and no longer lived in the home.

The second licensing worker, the wife of the agency's director, was instructed to conduct an investigation in response to licensing complaints received by the private agency. In her report, the licensing worker concluded that the foster home had not violated any licensing standards. She determined that there were functioning smoke detectors in the home based on the statements of the foster mother's three children and her granddaughter's aunt who claimed they heard an alarm going off during the night. Attached to the second licensing worker's analysis was the Fire Department's report which found that there was no evidence of smoke detectors other than mountings on the walls where they would be hung.

The Fire Department identified a number of potential causes of the blaze and located the point of origin in the kitchen below the foster children's bedroom. The OIG contracted mechanical and electrical engineers to study the fire and develop a more conclusive finding. The further investigation found that the fire had been caused by a damaged electrical cord. Although fire investigators had been leaning toward this conclusion for nine months before the final report was released, they were unwilling to make a final determination about the cause until they spoke with the 15 year-old ward who was seen near the home. When the boy first came under scrutiny in this case, the Department's Office of the Guardian retained an attorney to represent the boy. The attorney prevented the boy from providing any information to police, fire marshals or the Child Protection investigator. The decision, while perhaps legally savvy, prevented the boy from being exonerated much sooner. In an effort to ensure that the ethical obligations of professionals in various fields involved with child welfare issues can be reconciled to serve the needs of wards, the OIG has assembled a multi-disciplinary task force to examine the issue.

OIG RECOMMENDATIONS / RESPONSES

1. The following individuals should be disciplined for their misconduct in this case:

- The second licensing worker should be disciplined for nonfeasance in this case. The worker's admitted failure to check for fire hazards in the home may have cost three children their lives. In addition, it is obvious that she does not know and has failed to familiarize herself with procedures and rules necessary to perform the fundamental functions of her job.
- The Child Protection investigator should be counseled because he neglected his responsibilities when he failed to make proper inquiry into whether the children were adequately supervised on the evening in question.

The Department agreed. The OIG will share the report with the private agency to initiate discipline with the second licensing worker. Appropriate disciplinary action is being pursued against the investigator.

*Private Agency Response: The licensing worker resigned her position.

2. ANCRA and the corresponding DCFS rules should be amended to qualify the words "immediate family member."

The Department is taking this recommendation under consideration.

3. The contracts of private agencies should reflect the anti-nepotism rule that relatives may not work within the same hierarchy of supervision in an agency.

The Department agreed. The Department will implement this recommendation effective in Fiscal Year 2003.

4. DCFS should work with the Illinois Youth Fire Safety Association (IYFSA) to develop a training program for licensing supervisors to increase their knowledge of fire safety. At a minimum, licensing workers should know about identifying fire hazards and testing smoke detectors. DCFS should choose twelve licensing supervisors, from both DCFS and private agencies, to participate in a pilot training program.

The Department agreed. The Department's Licensing Division will work with IYFSA on a training program. Licensing supervisors from across the state are being identified to participate in the training.

5. All licensing workers should be trained on how to test whether smoke detectors are in working condition.

The Department agreed. An action transmittal will be sent to instruct all Department and private agency licensing and child welfare workers to verify the presence and appropriate functioning of smoke detectors in foster family and relative caregiver homes. The action transmittal provides instructions on proper testing.

*Private Agency Response: The private agency agreed. The agency will participate fully in any planned Department training to address fire safety.

6. DCFS Rules should be amended to reflect that foster homes should comply with all state and municipal codes regarding fire safety.

The Department agreed. Rule 402: Licensing Standards for Foster Family Homes is under revision. The rule will require that foster homes comply with all state and municipal codes regarding fire safety.

7. DCFS procedures should be amended as follows:
- Procedures should require that the Office of Child Development should be required to review LEADS checks on alternate childcare providers, in addition to CANTS checks, before any payment to the childcare provider is issued. OCD can either review the print-out of the LEADS check completed by the licensing worker, or should have authorization to conduct its own LEADS checks if there is no completed LEADS check or if there is a need to verify information contained in a suspicious LEADS check.
- Procedures should reflect effective fire protection/evacuation plans. Such plans should incorporate suggestions of the State Fire Marshall and the fire department of a major municipality, such as identifying two escape routes from each bedroom, and should include floor plans of the home that clearly delineate those escape routes.
- Procedures should require at least two fire drills by foster parents each year.
- Procedures should require that licensing workers review evacuation plans and conduct fire drills whenever the Placement Clearance Desk authorizes the placement of a child in a foster home.

Per previous OIG recommendations, the Department's Division of Support Service is working on a strategy to implement changes in the functioning and organization of the Office of Child Development. The Department agrees with the intent of the recommendation regarding fire protection plans and will explore the best way to ensure that fire evacuation plans and fire safety precautions are utilized in foster homes.

8. To avoid conflict of interest, where there is death or serious injury, workers who license a foster home should not be the same worker assigned to conduct a licensing investigation complaint against that home.

The Department agreed. The New Policy Guide on Concurrent Investigations requires that all licensing complaint investigations that are conducted in conjunction with Child Protection investigations are to be conducted by Agency and Institution Licensing staff.

*Private Agency Response: The private agency agreed.

9. The Department should revise its Licensing Compliance Record form (form CFC-590) to require that workers note whether foster homes have working smoke detectors, and to show the dates on which the licensing worker checked the smoke detector.

The Department agreed. The Licensing Compliance Record form will be revised.

10. The private agency's Board of Directors should receive a copy of this report.

The Department agreed. The OIG will share the report.

11. DCFS should send out a memo as soon as possible requesting that all DCFS and private agency licensing workers should immediately check for the presence of smoke detectors and to check whether the smoke detectors are in working condition.

The Department agreed. An action transmittal will be sent to instruct all Department and private agency licensing and child welfare workers to verify the presence and appropriate functioning of smoke detectors in foster family and relative caregiver homes.

12. The private agency's Board of Directors should seek assistance to train its foster care licensing division in identifying fire hazards and licensing foster homes.

The Department agreed. The OIG will share the report.

*Private Agency Response: The private agency agreed. The agency will participate fully in any planned Department training to address fires safety and inspection training.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

An 11 year-old girl died of asphyxiation after being physically restrained by adult staff of the residential facility where she lived.

INVESTIGATION

The girl's family had been involved with the Department since a hotline call was made one week after she was born to report physical abuse of her brother by her parents. When the girl was five years old, the Department assumed guardianship of her and her three siblings. The children were placed in the home of their paternal grandparents. The girl was found to be moderately mentally retarded and was diagnosed with Attention Deficit Disorder. She was placed in a school program for students with severe learning disabilities, however her consistent exhibition of inappropriate and aggressive behavior in the classroom resulted in her transfer to a more specialized program for students with cognitive delays.

After five years in the paternal grandparents' home, the children were removed following an indicated report of physical abuse and placed in an emergency foster home. The emergency foster parent requested the children be moved after reporting the girl had performed oral sex on a four or five year-old neighborhood boy. Based on this report, the girl was referred for a Sexually Aggressive Children and Youth (SACY) screening. The SACY intake form recorded that an adult had witnessed the incident, though the emergency foster mother stated she was told about it by other children. When the emergency foster mother was finally interviewed, two months after the initial SACY referral, she told evaluators that she could not recall if the children's allegation involved the girl or her sister and was unsure if the incident occurred at all. The girl continually denied taking part in any sexual behavior. The evaluators completing the assessment determined there was insufficient evidence to pursue a SACY classification, however a SACY screening conducted the day before the assessment began recommended the girl be placed in a "more restrictive" environment because of her past sexual aggression and developed a SACY protective plan. Despite the evaluators' findings, the girl was classified as a SACY ward throughout her involvement with the Department.

The girl was subsequently placed in a traditional foster home. She continued her extremely disruptive behavior both at home and in her new school. Her behavior continued to deteriorate until she was hospitalized and a diagnosis of Impulse Control Disorder was added to her medical history. Following her discharge she was placed in a residential facility. Her physical and verbal aggression towards staff and residents quickly manifested itself and persisted throughout her stay. Her outbursts often prompted staff members to resort to physically restraining her in order to bring her under control. Facility staff documented their use of restraints, but often did so in vague, subjective terms rather than by type, duration or intensity of the methods employed or by events preceding the incident, or day, time or location of the incident. Incidence of physical restraints was not evaluated for the purpose of developing a crisis management plan to reduce the frequency of physical restraints, with the goal of avoiding their use entirely.

Many of these incidents resulted in the girl being hospitalized for treatment and observation. She was hospitalized a total of four times prior to her death. She was prescribed psychotropic medications to control her behavior, however her pattern of disruptive, violent behavior continued each time she returned to the residential facility. Physical and mental problems, such as bedwetting, severe weight gain, extreme fluctuations in blood pressure and heart rate, and hallucinations were not evaluated as potential side effects of psychotropic medications. Neither the treating psychiatrist, pediatrician or Director of Nursing Services were aware of the girl's bedwetting or the fluctuations in her heart rate and blood pressure until the symptoms had been present for some time.

On the day of her death, two staff members transported the girl and another ward off campus for a SACY assessment. The workers and the minor were in a waiting room while the other ward was meeting with a counselor. The girl initiated a verbal confrontation regarding planned contact with her family. She threw her shoes at one of the workers and, after crawling across the floor to retrieve them, began scratching and attempting to bite the worker. The second worker intervened and the two women attempted to restrain the girl. After subduing her and receiving assurances she would discontinue the behavior, the workers released the girl, at which time the child began to attack the worker. The case managers again attempted to gain physical control of the girl by moving her onto her stomach on the floor and holding her arms behind her while one worker straddled the girl's back. The counselor called the police while the workers refused to release the girl until she stopped struggling. When the police arrived they found the girl and the workers in the same position. The police called paramedics who attempted to revive the girl and transported her to the hospital where she was pronounced dead of asphyxiation. The residential facility's internal investigation determined that staff had failed to use proper crisis intervention techniques during both the verbal and physical aspects of the incident. Subsequently, one worker's employment was terminated by the facility; the other worker resigned her position.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should require the use of developmentally appropriate behavioral monitoring and tracking for any child on psychotropic medication by using reporting forms similar to those used by the Illinois State Board of Education. In addition, the Guardianship Administrator's Authorizing Agents should gather vital information from the contracting agencies prior to authorizing the approval of medications for the children in their programs. This information would include, but is not limited to: baseline weight, weight gain/loss, blood pressure, cardiac measures, and dyskinesia. Baseline information pertaining to the targeted behaviors and programming used to target the behaviors should also be obtained.

In addition, the Department should require that children on psychotropic medication be taught how to keep a daily Mood Diary to encourage self-monitoring of their own behaviors. The tool must be adapted for the developmental level of the child.

Staff should be trained on how to use the tool and on how to assist children to keep the diary and reinforce their self-monitoring.

The Department agreed with the intent of this recommendation and it will be included in the amendments to Rule 325.

2. The Department must enforce the development of behavioral intervention committees and should oversee the development of effective behavioral management committees and monitoring of restraints for contracted facilities. The committees should adapt the Illinois State Board of Education's recommended guidelines of behavioral interventions for their facilities and adopt the use of ISBE's sample Functional Analysis Summary, Behavior Management Plan Summary, Emergency Report, Restrictive Behavioral Interventions Parent and Guardian Notification, and Time-out Reports Forms. The Department should require every facility to have on staff competent behavior analysts with training that reflects appropriate academic and ethical preparation, and who can report to the behavioral intervention committees.

The Department agreed. This will be included in Rule 384.

3. The OIG stands by its previous recommendation that the Department needs to develop guidelines to implement Rule 325: Administration of Psychotropic Medications to Children for whom DCFS is

Legally Responsible.

The Department agreed. Rule 325 revisions are pending.

4. The Department must set the overall tone for defining and applying crisis management procedures in the following ways and review and revise Part 384: Discipline and Behavior Management in Child Care Facilities and at a minimum, *prohibit any weight being placed on the child's upper torso, neck, chest or back during a restraint and any positioning that restricts a child's breathing.*

The Department agreed. Rule 384 will include these specific prohibitions.

5. The Department should certify Crisis Management Training Programs. In order to establish consistent and accurate criteria for training facility personnel in using crisis management procedures, the Department should develop a set of criteria that contractors with such training programs must follow to deliver a program to a contracted facility and Department personnel. The program should include but not be limited to:

Classroom and supervised applications of at least a specific range of crisis management procedures recommended by the Department that do not require physical restraints.

The Department agreed and this will be incorporated into the Child Care Worker Institute curriculum currently in development.

Classroom demonstrations and thorough discussions for no less than a specified number of hours on the dangers of physical restraints, a how to ameliorate these situations with physical restraints and practice of a range of prone, single person and two-person procedures, and communication and reporting procedures.

The Department agreed and this will be incorporated into the Child Care Worker Institute curriculum currently in development.

Development of a management and supervisory training or seminar series for the purpose of developing facility-based accountability and a tracking system for physical restraints.

The Department agreed and this will be incorporated into the Child Care Worker Institute curriculum currently in development.

Documentation of a facility-specific plan to reduce the incidence of physical restraints to a target number over no more than 90-day intervals and evidence of implementing plans to reach these goals.

Agencies with COA/JCAHO accreditation are required as part of ongoing quality assurance to develop plans to reduce the use of restraint and seclusion. For agencies not accredited by COA/JCAHO, the Department will require the inclusion of a plan to reduce restraint and seclusion as part of the agencies' behavior management plan.

6. The Department should consider the following related areas concerning crisis management plans and physical restraints:

Stipulation that all personnel that work directly with children be certified and regularly re-tested in CPR and that appropriate medical equipment are provided for staff on supervised off site visits and

field trips.

A policy that defines how much about the residential crisis management program should be shared with external treatment and other facilities that work with the residential facilities.

The Department agreed to incorporate this into licensing standards.

7. Nursing and Clinical Medical Management:

Nursing and clinical staff in residential programs should be required to attend annual seminars regarding psychotropic medications in pediatrics for CEU credit. The material covered should include use, administration, side effects, monitoring, and polypharmacy (the effects of multiple drugs being taken at one time).

Nursing and clinical staff should be evaluated at least twice per year through the use of an evaluation tool that assesses their critical thinking skills pertaining to pediatric psychotropic medication use. These evaluations should be kept in their personnel files, and require at least an 80% accuracy to pass. If they score below 80% they should then be required to review appropriate articles or text related to the topic and be reevaluated.

Nursing staff in residential programs should be required to attend at least annual seminars for CEU credit pertaining to pediatric nursing assessment skills. Follow-up evaluation using a critical thinking tool should be completed at the residential facility twice per year, requiring 80% accuracy. If less than 80% accuracy is obtained than the nursing staff should be required to review articles or text pertaining to pediatric nursing assessment and reevaluated. All evaluations should be placed in personnel files.

In all instances of physical restraint, a nurse or other medical personnel should examine the child for physical injuries immediately or no more than one hour following the incident.

The Department agreed to incorporate this into licensing standards.

8. Regarding significant weight gain, the Department needs to enforce strict dietary guidelines for children in residential facilities who are recommended or ordered to be on special diets, including but not limited to general diets with portion control and Healthy Choice Diets. These guidelines need to include clear specifications of foods that can and cannot be eaten by the child with the diet recommendation.

Staff who work in the residences need to be provided appropriate instruction regarding dietary guidelines and weight management programs that are recommended or ordered for a participant. Nursing staff for the residential programs should be directly involved in staff education and monitoring of dietary guidelines.

When a child is to be on a special diet and exercise regimen for weight loss or control, the residential facility needs to provide a structured exercise program for the child. This could include, but is not limited to, the playing of games such as soccer, baseball, basketball, that the child could play on a regular basis.

Reasonable exercise goals should be established between the dietician and the child and reward provided for the child reaching the goals.

Weight monitoring needs to be done on a weekly or at least every other week and recorded on a flow sheet for children with specific weight loss goals as determined by a dietician. This flow sheet should be kept in the same place as the vital sign flow sheet and medication administration forms.

The residential facility should provide exercise equipment that could be used by the participants and the staff alike. This equipment might include an exercise bike or row machine. This equipment would be available for children who are placed on an exercise program for weight loss or control.

Exercise goals should be established between the appropriate staff (dietician) and the child and written on a care plan or other form that house staff would have access to. These goals might include distance walked, time or distance ridden on an exercise bike, number of rows on the row machine. An appropriate reward system should be established for reaching goals.

The exercise equipment should be available for staff use, particularly night staff, during breaks or at other appropriate times, in order to help them stay awake and alert.

The Department agreed. This recommendation is included in the revisions to Rule 325.

*Private Agency Response: The private agency agreed. Opportunities for exercise are provided to the children through the recreation center.

9. Regarding vital sign monitoring, the Department should consider requiring blood pressure monitoring prior to every dose of Clonidine for those children who are on this medication because of the possible serious side effects related to this medication.

Residential staff responsible for administering medications such as Clonidine need to be instructed regarding not only the low blood pressure parameters of when to hold the medicine, but also need to be provided education pertaining to blood pressure and heart rate values that are higher than what is normal for a child according to age. Tables containing this information could be placed in the logbook of each child requiring routine blood pressure and heart rate monitoring. Reporting of high or low values needs to be not only written but verbal to the appropriate persons, in a prompt manner.

The residential facility needs to develop guidelines for the prompt reporting of vital health information between house and nursing staff, and subsequently with other medical staff. This would include, but is not limited to, the reporting of possible signs and symptoms of health problems that could be related to medications or other organic cause, changes in weight status, fluctuations in blood pressure and heart rates.

The Department agreed. This recommendation is included in the revisions to Rule 325.

*Private Agency Response: The private agency agreed. Staff are trained on taking vital signs during the medication administration training provided by nursing staff. There is a parameter sheet in the medication log.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION

A 13 year-old female ward fatally stabbed an 11 year-old female ward who lived with her in the same foster home.

INVESTIGATION

The 11 year-old, who had been a Department ward since 1996, was placed in the foster home 10 months prior to her death. Five months after she was placed she began exhibiting disruptive behavior in the home, including several physical altercations with another female foster child. The girl was referred to a counselor for regular sessions in order to address her behavioral problems. During one of the initial sessions, the foster mother told the counselor she planned to "get rid" of the girl because she had visited a relative without permission, although the foster mother later relented because she said the girl was generally well behaved and her conduct greatly improved after the other foster child left the home.

Two months later, the 13 year-old girl was placed in the home and soon afterwards she and the 11 year-old began engaging in fights. After arriving for a session with scratches on her face from an altercation with the 13 year-old, the 11 year-old told her counselor that the foster mother frequently left the two girls home alone with nothing to do. At the time, the girls were out of school for the summer, however the foster mother had not arranged for them to participate in any activities. In an interview with the OIG, the counselor stated the 11 year-old voiced a great deal of frustration with the foster home but was reluctant to express these feelings to her caseworker for fear it would jeopardize her placement and delay her impending reunification with her mother. The counselor told the OIG she relayed the complaints regarding the lack of structure and supervision to the 11 year-old girl's caseworker and asked to arrange a meeting with him. The caseworker declined, stating his belief the girl was stable in the home and that she would be returned home following a scheduled court date one month later.

The OIG met with the caseworker who demonstrated a shocking unfamiliarity with the girl's case. The caseworker described the 11 year-old to the OIG as argumentative but not a behavior management problem. The woman he identified as the 11 year-old's counselor had only met with her on one occasion and actually provided services to the girl's sister. He knew the actual counselor had some involvement with the girl but was not aware it consisted of weekly visits. The caseworker had no knowledge of the fighting that had taken place between the girls in the home, including the incident which left the 11 year-old with serious scratches on her face. The caseworker stated he had spoken to the counselor no more than three times and that while they had discussed some of the girl's concerns about the foster home, he did not consider it a serious matter because the girl had never raised the issue with him. The caseworker also told the OIG that when he finally did ask the girl about her complaints, she stated she could handle staying in the home because she was going to be returned to her mother soon. The case record contained scant notation of the caseworker's contacts with the involved parties. Although the foster mother substantiated the worker's claim he conducted monthly home visits, there was no documentation of such in the case file. In addition, the worker stated his belief that the girl's return home was imminent, however there was no evidence any staffings or planning sessions had been held with family members or child care professionals in anticipation of the girl being returned home.

The 13 year-old girl became a ward of the Department in 1990 after her mother, who had an extensive criminal history as well as numerous indicated abuse reports, was indicated for cuts, welts and bruises against her daughter. During her involvement with the Department, the girl moved through a number of placements. She had a history of aggressiveness, depression, anxiety and poor academic performance. While testing showed her intellectual functioning was within the low average range, it was believed prevailing emotional issues prevented her from fully utilizing her cognitive abilities. After one of her foster parents witnessed the

girl exhibiting sexualized play, she was taken for a medical examination at which time the physician found physical evidence suggesting previous sexual abuse.
One week after the girl was placed in the foster home with the 11 year-old she made an unauthorized visit to one of her former foster mothers. The worker who was dispatched to pick the girl up recorded in her case notes that the girl complained to her about she and the 11 year-old being left alone for extended periods of time. The girl also stated that their foster mother locked the telephone while she was away and would not allow them to prepare food. Shortly thereafter, a different worker received a call from another former foster mother relaying similar complaints from the girl. A hotline call was made, but the assigned Child Protection investigator unfounded the case after visiting the home and speaking with the foster mother. The 13 year-old also repeated her frustrations with the placement to her therapist who shared her concerns regarding the foster home with the girl's caseworker. However, the therapist reported that during subsequent sessions she observed that the girl and her foster mother had developed a bond as a result of the girl's participation in church activities and commitment to her faith. The foster mother told the therapist the girl was the best foster child ever placed in her home.

The fight between the two girls that resulted in the fatal stabbing allegedly stemmed from an argument over clothing. According to the foster mother, as the dispute escalated, the girls began fighting violently and throwing objects at each other. At some point, the 13 year-old grabbed a knife and stabbed the 11 year-old as she lunged at her. The 13 year-old was charged with first-degree murder and the Public Defender's office was appointed to represent her. The girl's attorney explicitly instructed her not to discuss the stabbing incident with anyone and sent a letter to the Department stating, "no one, including any caseworker, social worker, therapist, psychiatrist, or DCFS employee should question [the girl] about what happened [on that day]."

Following her initial court date, the girl moved through a succession of placements in hospitals, health centers and specialized foster homes. During this time she alternately exhibited impulsive aggressiveness and detached sadness. The girl was in constant contact with doctors, therapists, facility personnel and child care workers, but was unable to talk about the most pertinent issue in her life with them. On several occasions she expressed her desire to speak with somebody about her feelings and a number of involved professionals reported the girl's inability to discuss the stabbing incident with anyone made it virtually impossible to provide her with any meaningful counseling. Observers noted she became increasingly anxious and agitated as court dates approached. At one point while she was a hospital in-patient, the girl attempted to strangle herself with a sock prompting her physician to place her on suicide watch. Three days later, the girl's attorneys insisted she participate in a previously scheduled psychological evaluation, which she did, over the objections of her doctor. Although the girl frequently read the Bible while she was in care and her previous religious activity was well known, no attempt was made to engage her in related activities as an outlet. One of the girl's older sisters, a 21 year-old former ward, remained in contact with her sister throughout her placements and attempted to visit as much as possible. Despite the fact that involved professionals noted the sister was a calming and reassuring influence on the girl, steps were not taken to facilitate meetings between the siblings or to make arrangements for the sister, who lived far from the girl's placements and could not secure transportation to visit.

At a staffing held with a number of involved workers when the girl was being discharged from a hospital placement, her treating physician recommended she receive home schooling, a recommendation that was accepted by all in attendance. When the Department's education consultant began attempting to proceed with the plan, she was informed that the girl would have to prove medical necessity if the school district were to fund her home schooling. The education consultant was not informed of the girl's situation by the Department, so the girl was enrolled in the local public school. The girl's behavior began to deteriorate almost immediately and soon after she began attending classes, the girl confided in an administrator about the stabbing. The school responded by moving the girl into a self-contained classroom which led to a further

worsening of her behavior, including fights with other students.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should develop a protocol to apply to those situations in which there is a genuine possibility that wards may be charged with a crime that would subject the ward to automatic or discretionary transfer to adult court. The following should be included in the protocol:

The Department's Guardianship Administrator (Guardian) should develop a system to identify those cases in which a ward is accused or seriously suspected of a crime for which, if charged, the case could be transferred to adult court.

For those cases, the Guardian should fully familiarize herself with the child and do the following:
- determine to whom the child is emotionally tied;
- determine the limits of the child's ability to make important decisions;
- become acquainted with the child's mental health history and issues;
- determine the child's ability to withstand a long wait for trial; and
- determine the child's need for therapy and spiritual or moral guidance.

The Guardian should ensure appropriate communication with and direction of any attorney representing a ward in such cases. Specifically:

- Contracts with defense attorneys for wards should be entered into and managed by the Guardian.
- Attorneys should understand that wards should be allowed to make difficult decisions only to the extent they are able, and that otherwise the Guardian should direct the attorney's actions. The Guardian and the attorney should work together to determine to what extent the child is capable of directing the attorney.
- The Guardian should meet with the child's attorney to ensure that the attorney has full knowledge of the child's history and developmental needs (non-legal best interests).
- Attorneys should enlist the assistance of appropriate individuals with whom the child shares the closest relationships so that the child has moral and emotional support during the legal process.
- The Guardian must intervene whenever the Guardian believes that there is a genuine possibility that the child will harm self or others, or that the child will suffer irreversible emotional harm without Guardian intervention.
- Attorneys should be advised to take the ward's developmental, therapeutic, and spiritual/moral needs into account when determining the ward's legal needs, and should work cooperatively with the Guardian to lessen the traumatic impact of the legal process.
- DCFS should develop a list of steps that private defense attorneys and public defenders representing wards should take to ensure that the above goals are met.

The Guardian should have a team of knowledgeable clinical caseworkers who can proactively direct and/or provide needed services. In such cases, the field should receive a directive from the Director informing them to take clinical direction from the Guardian's office.

The Guardian may seek outside consultation of experts in mental health, child development and ethics to advise the Guardian on difficult decisions.

The Guardian should determine whether there is any conflict of interest in her role in each case: e.g., did any action of the Guardian or of DCFS (such as a bad placement decision) possibly contribute to

the child's dilemma?

The Guardian should, in the appropriate cases, ensure the child's right to spiritual counseling from a legitimate representative of the child's faith and protect the child's religious rights including the right to know about the clergy exception to confidentiality provisions.

The Department agreed. A workgroup was created consisting of the OIG, Cook County State's Attorney, Cook County Public Defender's Office, Cook County Public Guardian's Office, and the Department's Office of the Guardian to develop a protocol to address these types of situations.

2. When a conflict arises between the Clinical Division and DCFS Regional Legal Counsel concerning the sharing of information and confidentiality issues, the matter must be referred to the General Counsel for a final determination. The General Counsel shall provide a statement, which shall be included in the child's case file, explaining the basis for her decision.

The Department agreed.

3. The foster mother's license is valid until June 8, 2002. Licensing should complete an investigation regarding her absences from the home and other concerns noted in this report. The licensing representative shall include in his investigation interviews of the foster parents who reported the foster mother's absence from the home and the 11 year-old's mother as well as statements made to others by the foster children and caseworkers familiar with the home.

The Department agreed. A licensing investigation was completed and found no violations of Part 402: Licensing Standards for Foster Family Homes and no violations of the Child Care Act of 1969.

4. Although the caseworkers' conduct does not rise to a level that would require discipline, the OIG has concerns regarding the caseworkers' minimal involvement with the wards, their lack of responsiveness, and the quality of their work. A copy of this report should be shared with the supervisors who should discuss the contents of the report with the caseworkers.

The Department agreed. The report will be shared with the caseworkers.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION A foster father allegedly sexually abused his three adopted sons and twelve male foster children placed in his home at various times. A supervisor with the private agency that licensed the foster father interfered with investigation of the sexual abuse allegations and was involved in a personal relationship with him.

INVESTIGATION A Child Protection investigation was initiated after a 13 year-old boy, who had recently been removed from the home, told his caseworker that the foster father had engaged in fondling, oral sex, anal sex and masturbation with all of the boys in his care. The Child Protection investigator assigned to the case, who had been in his position for one month and had little investigative experience, went to the home to assess the family. The investigator spoke with both the foster father and his sister, who served as a primary caretaker in the home. Both stated the 13 year-old had fabricated the abuse story as revenge for his removal and had made a similar false report to police one year prior. Despite receiving this information, the investigator did not attempt to verify the existence of a previous report. The investigator then conducted his interviews with the boys in the presence of the foster father, the alleged perpetrator of abuse against them. All of the boys denied experiencing or witnessing any abuse. Police asked the investigator to discontinue his interviews until the officers could question the boys. The investigator deferred to police and allowed them to assume control of the inquiry. Although police later shared the information they obtained with the investigator, including statements made by several of the boys referencing specific incidents of abuse, the investigator gave no credence to their reports. The investigator neglected to interview the caseworker who reported the abuse allegation to the hotline or another worker who called with related information one month later after overhearing two of the boys confirming the sexual abuse allegations. The investigator indicated the allegations, but based his indication solely on the fact that the court had found "probable cause" to continue the case. Since the finding appeared to be based on nothing other than an interim court finding, the foster parent was able to convince workers involved in the case that the indication was meaningless.

In an interview with the OIG, the investigator stated he believed the police were biased against the foster father. Neither of the investigator's two supervisors recalled viewing the police's notes from the investigation and both were under the impression the police had refused to share the information they had obtained. Both supervisors shared the investigator's belief the police were unfairly targeting the foster father but could not offer evidence to justify their reasoning. The investigation was ultimately indicated for risk of harm because the investigator's supervisors felt there was insufficient evidence to support the sexual abuse allegations. The foster children were removed from the home and placed in a voluntary placement agreed upon by the foster father.

The case was transferred to a follow-up worker for an evaluation of the home. The follow-up worker's assessment failed to identify the need to address sexual abuse issues in the home or possible therapy for the children. The assessment made no mention of pending abuse allegations. Although the follow up worker stated to the OIG he found the foster father's sister to be an unsuitable caretaker and would not allow her to watch his own children, there is no information in his case notes reflecting this conclusion. The follow-up worker placed the boys in the home of a woman the foster father claimed was his aunt. The follow-up worker did not verify this information and did not conduct a background check on the woman, who had a felony conviction for forgery. The follow-up worker also did not ensure that the foster father would be denied access to the boys, as it was later learned that the woman took the children on a week-long vacation to a resort where the foster father was also staying. When the OIG learned that the woman was, in fact, not related to the foster father, the children were removed from her custody.

The OIG's investigation into this case found that on two previous occasions, children in the home had

accused the foster father of sexual abuse. In both instances, the private agency supervisor who oversaw the agency's involvement with the home provided false and misleading statements to investigators. The supervisor portrayed the boys who made the statements as untrustworthy and suggested they had histories of lying about sexual abuse when, in fact, no such histories existed. The supervisor consistently minimized the likelihood of abuse to the children and dissuaded other workers at her agency from aggressively pursuing the investigation. Although the boys made references to the supervisor's frequent presence in the home and their observance of her romantic involvement with their foster father, staff and administrators of the private agency did not thoroughly pursue questions regarding the nature of the relationship. The supervisor also denied the existence of any relationship between herself and the foster father to the OIG. Although the boys claimed the supervisor had accompanied them on vacations, she acknowledged she and the foster father owned time share property at the same resort, but stated she had never seen him there. The OIG obtained records from the resort which showed that on two occasions, the foster father and the private agency supervisor had reserved neighboring rooms at the same time. When confronted with the evidence, the supervisor changed her story about seeing the foster father at the resort but maintained her denial of a relationship. A review of phone records showed that the supervisor and foster father made frequent, late-night calls to each other and that on the day the abuse was reported to the hotline, the supervisor spoke to him seven times leading up to the arrival of the Child Protection investigator at his house. After these facts came to light, the private agency removed the supervisor from the case and reassigned her to other duties. Prior to the completion of this investigation, the supervisor died of natural causes.

Despite the severity of the allegations, the private agency did not refer the boys for specialized sexual abuse counseling. An administrator from the private agency stated to the OIG that the counseling the boys received from agency therapists was sufficient and did not require outside referrals. During an interview with the OIG, the therapist who treated two of the boys stated he had never treated a child dealing with sexual abuse issues. At the time of his interview, the therapist was under the impression that the sexual abuse allegations only pertained to the brother of the children he was treating, not his patients. Although the agency had removed the supervisor from direct involvement in the case, the agency did not place her on leave or instruct her not to interact with the boys. The agency continued to allow the supervisor to have contact with the children within their building and scheduled for two of them to meet with a therapist whose office was located across the hall from hers. The agency administrator informed the OIG that when the boys arrived for their sessions, the supervisor would often invite them into her office and have them sit on her lap.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Child Protection investigator should be disciplined for interviewing the victims in the presence of the perpetrator, failing to note "Others Present" on the interview notes, failing to evaluate the disclosures of two of the boys and failing to interview sources and reports of hotline calls.

The Department agreed. Appropriate discipline was pursued.

2. The Child Protection investigator's supervisors should be counseled for failing to supervise the investigator in ensuring that the disclosures of two of the boys were evaluated by the investigator and failing to ensure that the investigator interviewed both reporters of the hotline calls, failing to ensure a complete investigation and allowing a judicial finding of temporary custody to serve as a sole basis for indicating a case.

The Department agreed. The report was shared with the supervisor.

3. The follow-up worker should be disciplined for preparing an inadequate home assessment that failed to note the existence of pending Child Protection and criminal investigations, for placing children

at the suggestion of the alleged perpetrator without adequately assuring that the perpetrator would not have access to the children and for placing the children in a non-relative, unlicensed home.

The Department agreed.

4. The private agency should revamp its Specialized Adolescent Program to provide clear distinctions between supervision, licensing and casework functions. Licensing workers and supervisors should be retrained on licensing investigation procedures and monitoring. Retraining should focus on the importance of verifying all critical information provided, seeking information on all issues relevant to licensing compliance during annual reviews and noting patterns. The private agency should provide training to all personnel regarding boundary issues and the importance of verifying critical information in casework as well as licensing.

The Department agreed. The OIG met with the agency who agreed to more clearly delineate role functions of licensing and direct service workers.

5. The private agency must counsel the following persons regarding their actions in this case:

- The boy's therapist must be informed of the necessity of exploring critical events in client's lives.
- The private agency administrator must be informed of the importance of ensuring that children's therapeutic needs are not ignored.

The Department agreed. The agency has counseled the therapist and the administrator

6. The Department should support the private agency's revocation of the foster father's foster care license.

The Department agreed.

7. The private agency should ensure that the case plan for the foster father's sister's relative foster daughter include a prohibition of contact with the foster father, based on the Indicated Finding for Risk of Sexual Harm. Portions of this report should be shared with the private agency staff responsible for monitoring the sister's home, to evaluate the possible trust issues raised in her denial of knowledge of anything improper occurring in the foster father's home and the possibility that she failed to answer honestly in court when asked whether the private agency supervisor accompanied the family to a ski resort. In addition, monitoring entities should investigate workers' concerns about the sister's caretaking abilities.

The Department agreed. The OIG met with the agency who agreed to share relevant portions of the report with their licensing staff.

8. Procedures for coordinating investigations with law enforcement should be redrafted to include the following requirements:
- any investigative restrictions requested by law enforcement should be documented and shared with law enforcement prior to the close of the investigation, to ensure joint understanding.
- information provided by law enforcement should be documented and provided to law enforcement prior to closure, to ensure joint understanding.

The Department agreed that workers should carefully and specifically document any investigative restrictions requested by law enforcement. In addition, before closing a case, the worker should contact law enforcement

and request that any restriction be lifted. If that request is denied, the worker will let law enforcement know that the Department is closing their investigation. Communication between the Department and law enforcement has been tremendously enhanced due to the increasing number of investigations that are facilitated at Child Advocacy centers.

9. Licensing should investigate the daycare license of the woman the foster father claimed was his aunt in light of the possibility that she allowed him unlimited access to the boys after he had been indicated for risk of sexual harm.

The Department agreed. A redacted copy was used for the licensing investigation.

10. This Report should be shared with Department's Legal Division to provide background for the court proceedings around the Motion for Clarification as well as the administrative proceedings for expungement and service appeal.

The Department agreed. The report was shared with the Department's Legal Division.

*The private agency prepared a Corrective Action Plan in response to the OIG Report. Plan highlights include emphasis on licensing's role in investigating licensing complaints, follow-up staffings to promote compliance with requirements for continued licensing, clearer delineation between licensing and direct service roles, and retraining on importance of pattern analysis to identify problem trends. The OIG supports this plan and the agency's ongoing effort to reduce incidents of abuse or neglect in foster care.

*As part of the agency's corrective measures, the agency should re-evaluate its foster care program to determine where collaboration between Units is necessary. Placements are an important first step in foster care services and improved communication between licensing, intake, and follow-up staff is necessary to ensure the best match of foster family and child(ren).

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION A one year-old boy died from blunt trauma to the head inflicted by a man with whom he and his mother were living. The boy's mother had an extensive history of drug use and non-compliance with child welfare services.

INVESTIGATION The boy was born six weeks premature, tested positive for opiates and cocaine and suffered from symptoms of withdrawal. His mother tested positive for the same substances and admitted using drugs up until the day she delivered. During the subsequent Child Protection investigation, the mother stated she had used drugs at least every weekend for the previous five years and acknowledged she had a drug problem. She told the Child Protection investigator she had completed a drug treatment program, but could not recall the name of the facility where it was conducted. Despite these admissions, the Child Protection investigator completed an Adult Substance Abuse Screen that reported the mother did not use drugs or alcohol to get high and had never perceived her own drug use as a problem. The screen also failed to record the mother's positive drug test at the time of her son's birth. The Child Protection investigator also recorded that the mother had no criminal history, based solely on her own self-report, without conducting a background check. In fact, the mother had been arrested 48 times since 1992 for a variety of offenses, many drug-related, and had three felony convictions. In addition, the mother told the Child Protection investigator she had another child who was not in her care, but did not volunteer that the child had been removed from her care by the Department as a result of neglect due to her drug addiction. No follow-up was done to determine the whereabouts of this child. The Child Protection investigator indicated the mother for substance misuse and substantial risk of physical injury. The newborn remained in her care.

The mother agreed to enter a drug treatment program and the case was referred for Intact Family services. The intact family caseworker's first attempt to locate the family was unsuccessful, and though she was instructed by her supervisor to perform a diligent search, the caseworker made no attempt to locate the family for three months. Eventually the caseworker learned that because of the mother's unstable living arrangements and lifestyle, the boy had been in the care of his father and paternal grandmother since he was six weeks-old, a period of five months. The father and paternal grandmother indicated that they would be interested in the paternal grandmother assuming private guardianship. This process was not initiated and the boy remained in the home while the mother's whereabouts were unknown.

Four months later, the caseworker learned that both the boy's mother and father had been incarcerated for manufacture/delivery of a controlled substance. She spoke to the paternal grandmother who confirmed the report and told her she needed daycare for the boy because she had suffered an injury that would require a long period of recovery. A few weeks later, the paternal grandmother was hospitalized for her injury. The boy was cared for by several different relatives through informal arrangements before the caseworker attempted to screen the case into court for dependency. This request was denied, however, because the mother was scheduled to be released from prison the following week. The caseworker met with the mother, whom she had not had any contact with for 10 months, following her release. The caseworker instructed the mother that she would have to adhere closely to the service plan which included drug treatment and close contact with child welfare professionals. If she failed to fulfill the requirements of the plan, the caseworker stated she would lose custody. The mother resumed caring for her son when she was released.

Over the next three months, the mother consistently missed scheduled substance abuse treatment sessions without notice and without re-scheduling. Several times she told the caseworker that she was unable to attend these sessions because of her new job, however the worker learned that the mother had only been briefly employed and used this excuse long after she stopped working. During this time, the mother and her son moved through several residences and had infrequent contact with the caseworker. The mother's relatives often gave conflicting accounts of where she and the baby were living at any given time. Despite almost

absolute non-compliance with the service plan, the caseworker did not attempt to re-screen the case into court.

On one occasion when the caseworker arrived at a location where she believed the mother and baby were residing, she encountered a Child Protection investigator assigned following a hotline report alleging that the mother had arrived intoxicated at a hospital emergency room seeking treatment for her son who was suffering from an asthma attack. The mother had flagged down a stranger to drive her to the hospital. Hospital staff reported that in addition to appearing inebriated, she seemed disinterested in her son's condition to the point that the stranger felt compelled to stay with the child. The Child Protection investigator attempted to contact the mother at the maternal grandmother's house and was told by her that the mother didn't live there but was staying with, "a man who didn't want to get involved, so [the Child Protection investigator couldn't] go there." It was later determined that the maternal grandmother was referring to the man who ultimately killed the child.

The Child Protection investigator contacted the caseworker and the two made further attempts to locate the mother without success. The caseworker attempted to screen the case into court, but was instructed by the State's Attorney's Office to wait for a finding in the pending Child Protection investigation. The Child Protection investigator ultimately unfounded the case based on the fact that the mother had enlisted assistance to get her son to the hospital and obtained medical attention for him. While the Child Protection investigator was aware of the mother's criminal history, he did not consider that information in arriving at his decision to unfound the case. There is nothing in the case record to suggest that at any time during the investigation the caseworker informed the Child Protection investigator of the mother's drug use, her failure to cooperate with services or that she had another child in Department custody.

The caseworker then made a third attempt to screen the case into court and, for the first time, advised the State's Attorney's Office that the mother had lost custody of another child. The State's Attorney's Office accepted the case and scheduled a temporary custody hearing. The child was killed three weeks prior to the hearing.

OIG RECOMMENDATIONS / RESPONSES

1. The Department's Legal Division should collaborate with State's Attorney's Offices to conduct trainings for DCFS and private agency staff on how to screen cases. These joint trainings should focus on the pertinent information that a caseworker should provide to the State's Attorney at court screenings.

The Department agreed. The Department's Legal Division will work with the OIG on these trainings.

2. Supervisors should be required to sign off on all screening packets prior to a worker presenting the information to the State's Attorney. In a case where the State's Attorney does not accept the case for screening or where the worker does not present sufficient information, the supervisor should be required to attend subsequent screenings on that case with the worker.

Supervisors will be involved in all cases that are being presented to a State's Attorney for screening.

3. This report should be prepared as a learning tool and discussed with the Regional Administrator.

The Department agreed. The report was shared with the regional Administrator.

DEATH AND SERIOUS INJURY INVESTIGATION 11

ALLEGATION

A six month-old girl died of multiple blunt trauma injuries to the head inflicted by her father. A Child Protection investigation into possible abuse of the infant by the father had been open for one month at the time of her death.

INVESTIGATION

The mother brought the infant to a medical center in order to receive treatment for diarrhea. The physician noticed the girl's elbow and upper right arm were swollen. The mother told the doctor she was unaware of how the injury might have been caused. The doctor informed the mother that the arm appeared broken and arranged for her to have the infant X-rayed at a nearby hospital. After the mother and child failed to arrive at the hospital, the doctor called the hotline. Although a mandated reporter suspected serious injury, the hotline recorded the call as a medical neglect report, a lower priority report than suspected abuse.

The Child Protection investigator assigned to the case attempted to locate the family at a known address. A woman in the home told the investigator the mother did not live at that address. The Child Protection investigator did not note who the woman was or her relationship to the family. The investigator then began contacting various members of the mother's family who gave differing accounts of the mother's place of residence, none of which resulted in the investigator locating her. He did not return to the address initially identified as her home but continued to telephone relatives, whose levels of cooperation were consistently low. Following the infant's death, it was determined that the house the investigator first visited was the father's family's residence and that the woman he spoke with was the infant's paternal aunt. The mother, father and child resided in the home until the infant's death.

The Child Protection investigator never availed himself of the assistance of law enforcement agencies to locate the mother and infant, though such efforts are required by Department Rules and Procedures in order to meet the standard of a "good faith attempt" to locate a family. Three weeks after the case was opened, the Child Protection investigator contacted the physician who made the report. Even though the doctor suggested the investigator call the police for help, no such communication was made. According to police representatives contacted by the OIG, given the facts of this case, youth division officers as well as local and state police would have been available to assist the investigator in the search.

The Child Protection investigator also neglected to examine the parents' criminal histories. A background check would have revealed the father had prior arrests for violent crimes and an Officer Safety Alert notice attached to his name reporting his suspected gang activity while the mother had an outstanding warrant for Delivery of a Controlled Substance. The Department subsequently initiated discharge proceedings against the Child Protection investigator and his supervisor.

OIG RECOMMENDATIONS / RESPONSES

1. Rules and Procedures and Training adequately advises workers and supervisors of the necessity of contacting law enforcement when there is a safety risk to a child. However, procedures could be amended to clarify existing policy and procedure regarding requests to law enforcement for their assistance in locating the alleged child victims.

The Department agreed and is in the process of amending policy.

DEATH AND SERIOUS INJURY INVESTIGATION 12

ALLEGATION

A three year-old girl's death from head injuries was ruled a homicide related to child abuse. In the three weeks prior to her death, the girl was the subject of five hotline calls and a pending Child Protection investigation.

INVESTIGATION

The first hotline call came from a physician after the girl's mother brought her into his office screaming and crying uncontrollably. The doctor observed multiple, round bruises on the child's chin, chest, back and collarbone at different stages of healing. The doctor told the OIG in an interview that the mother's behavior during the visit was a factor in his decision to call the hotline. He stated though she emphatically insisted she was a "good mom" and did not cause the injuries, her explanations that the marks were rashes and the result of rough play with her brother did not coincide with his observations.

The case was given a "J" priority requiring the assigned Child Protection investigator to visit the minor within one hour of the hotline call. The Child Protection investigator met with the girl and her father at their home. The girl was physically handicapped and had several chronic medical problems. The father told the Child Protection investigator the marks were an allergic reaction to the girl's medication prescribed by her regular physician, who was away on vacation. The Child Protection investigator completed body charts on both children and noted the girl's marks could be either bruises or a rash. He found no sign of injuries on her brother. The Child Protection investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) and determined the children were safe in the home.

Two days later the case was handed over to another Child Protection investigator for completion. The second investigator visited the home the next day and met with the mother and both children. The mother told the investigator she had taken the girl to her regular physician the previous day, a Monday, and that he could explain the girl's condition. The Child Protection investigator called the family's doctor from the home. The doctor confirmed the parents contention the marks were caused by an allergic reaction. He added that the girl was diagnosed with a congenital defect which slowed her growth and contributed to her medical problems. Based on the doctor's confirmation and the apparent absence of other risk factors in the home, the Child Protection investigator determined no safety plan was necessary. Although Department regulations require Child Protection investigators to interview individuals who make hotline calls, the Child Protection investigator in this case only made one attempt to contact the doctor who first observed the bruises and never spoke to him prior to the girl's death.

The day after the Child Protection investigator's visit to the home, the girl was brought to the family physician's with a swollen leg, her second trip to the doctor's office that week. X-rays showed the girl had a fractured right femur. The mother stated her daughter had fallen over the weekend while in her maternal grandmother's care and attributed the injury to the accident. Hospital staff did not believe the fracture was the result of abuse, but the hotline was called because the mother mentioned the pending Child Protection investigation. The call was classified only as related information to the pending report and the details were forwarded to the Child Protection investigator handling the case. The Child Protection investigator spoke with the reporter as well as the maternal grandmother, a registered nurse, who both stated they did not suspect abuse. In assessing the new information, the Child Protection investigator failed to recognize the fact that if the girl had broken her leg over the weekend as the mother claimed, the injury would have been present when she took her daughter to the family physician on Monday.

The hotline received three more calls regarding the girl within the next two weeks. The first was made by an anonymous caller alleging abuse, but was disregarded as erroneous because of inaccurate information provided by the reporter. The second call was made by the girl's maternal aunt. The aunt stated she had

questioned her sister several times as to how the girl broke her leg and received differing and seemingly improbable answers. The aunt had also spoken to the grandmother who refuted the mother's version of events because the girl continued to run and play after the fall that supposedly caused the broken leg. The information was taken as a subsequent oral report to the continuing investigation and provided to the Child Protection investigator. The investigator contacted the aunt who related to him the various stories she had been told by her sister. In an interview with the OIG, the aunt described the Child Protection investigator's attitude as being dismissive of her concerns and stated he told her, "in his professional opinion, there was no danger in that house." The third hotline call was from the hospital when the girl was brought in with the injuries that resulted in her death.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should counsel the second Child Protection investigator for failing to add an abuse allegation when he learned 1) that the mother's explanation of the injury would have meant that the family's physician saw the girl when her leg was broken and failed to note it (the mother said it occurred over the weekend when the maternal grandmother was babysitting; the family physician saw the girl on Monday for the "rash"); and 2) that the aunt had received four different stories from the mother and the mother could not provide her with a time that the injury occurred.

The Department agreed. The employee was counseled.

2. This report should be shared with Department's Best Practice division.

The Department agreed. The report was shared with Best Practice.

INVESTIGATIVE REFERRAL

The OIG reviewed the medical records of the family physician and found no apparent basis for the determination that the marks were an allergic reaction. The OIG referred the question of the doctor's diagnosis to the Medical Examining Board.

DEATH AND SERIOUS INJURY INVESTIGATION 13

ALLEGATION A one year-old boy with signs of on-going physical abuse died of blunt force trauma to the head. Nine months prior to his death, the boy's mother had been the subject of an unfounded Child Protection investigation of child neglect.

INVESTIGATION The child neglect allegation was initiated after the mother brought her two children to a friend's house and asked her to watch them for a brief time. When the mother did not return for two days and could not be reached, the friend called the police who took the children into custody and transported them to the Emergency Reception Center.

The mother and a male friend arrived at the local Department office and met with a Child Protection supervisor who was not assigned to the case. The mother denied the allegation and explained to the Child Protection supervisor she had been attending a private agency program for teen parents and arranged for her friend to care for the children. During the interview, the mother received a page and subsequently had a phone conversation with a person she claimed was the friend who had been watching the children. When the Child Protection supervisor took the phone and identified himself, the other party hung up. The Child Protection supervisor informed the mother that he would have to transfer the case to the Department office in her home area but assured her that the investigation would be unfounded and the children were returned to the mother's custody.

In an interview with the OIG, the Child Protection supervisor stated he was only vaguely familiar with the private agency and was unaware the mother's program served clients with mental health problems. Although the Child Protection supervisor did speak to the mother's program worker, he did not address the specific issue of inadequate supervision related to the report. The Child Protection supervisor told the OIG that he did not believe the mother was at the teen parent program during the time she could not be contacted but rather that she spent the weekend with friends. The Child Protection supervisor did not verify the mother's whereabouts during that period but asserted that she had constructed a valid care plan. He accepted the mother's phone conversation in his office with the person she claimed was the children's caretaker as proof she could have been contacted, but did not speak with the mother's friend to confirm that she had in fact been the party on the other end of the line.

The case had been assigned to a Child Protection investigator in the mother's home area. The investigator attempted to locate the mother at one of her stated places of employment, but was told by other employees that no such person worked there. He traveled to her home address as stated in the police report and was told by individuals at the residence they had never heard of the mother. The investigator called the Child Protection supervisor who had first accepted the case and explained his difficulty in finding the mother. The Child Protection supervisor stated he had spoken with the mother who assured him the children were fine and provided him with contact information for the male friend who had accompanied her to the Department office. The Child Protection supervisor went to the male friend's home and spoke with him regarding the mother, who was not present. The friend stated that the mother was living with him and that his girlfriend sometimes cared for the children. The Child Protection supervisor called the Child Protection investigator and told him the family was secure and expressed his belief the case should be unfounded. The Child Protection supervisor did not conduct background checks on the male friend or his girlfriend. A check conducted by the OIG found the friend had previous convictions for attempted murder and battery and was the subject of an outstanding criminal warrant issued in another state.

Based on the information he received from the Child Protection supervisor, the Child Protection investigator completed a Family Assessment Factor Worksheet Summary without having observed the children. In the summary, the worker failed to answer several critical questions and neglected to assign an overall risk rating.

The Child Protection investigator's direct supervisor signed off on the summary and closed the investigation. The investigator's supervisor acknowledged to the OIG that he relied on the Child Protection supervisor's conclusions on the assumption his investigation was complete and accurate.

OIG RECOMMENDATIONS / RESPONSES

1. The Child Protection supervisor who intervened in the case should be disciplined for his failure to determine any facts pertaining to the reported incident. His conclusions were made without sufficient basis and his decisions were based on a set of assumptions rather than facts.

The Department agreed. Appropriate disciplinary action is being pursued.

2. The Child Protection investigator should be disciplined for failing to investigate the report assigned to him. He improperly prepared a family assessment document without ever having seen the parent and children.

The Department agreed. Appropriate disciplinary action is being pursued.

3. The Child Protection investigator's supervisor should be disciplined for failing to provide adequate supervision and ensuring completion of a Child Protection investigation prior to giving his approval to unfound and close the report.

The Department agreed. Appropriate disciplinary action is being pursued.

4. A redacted version of this report should be shared with Child Protection management and investigators and Quality Assurance staff for learning purposes.

The Department agreed. A redacted version of the report has been forwarded to the appropriate individuals and will be shared with all Child Protection management and investigators as well as Quality Assurance staff.

DEATH AND SERIOUS INJURY INVESTIGATION 14

ALLEGATION A seven month-old girl died from multiple injuries caused by severe physical abuse. The girl's mother admitted to inflicting the injuries and was convicted of murder. The mother had been a ward of the Department until four months before the child's death.

INVESTIGATION The mother became a ward at age 14 after her father passed away. Her mother's history of substance abuse and non-compliance with services prevented her from being considered as a possible placement. After entering care, the 14 year-old daughter and her 12 year-old sister were first placed with relatives who were already caring for their younger siblings. While in the home, the 12 year-old alleged she was sexually abused by her uncle and ran away. Following her return, the children were removed from the home and assessed for possible sexual abuse. While in the hospital, one of the younger siblings told a therapist that two years prior, the 14 year-old had forced her and their other younger siblings to engage in sexual acts. The 14 year-old denied being either the victim or perpetrator of any sexual abuse. Though another sister denied the allegation and the investigation against the 14 year-old was unfounded, she was given a Sexually Aggressive Children and Youth (SACY) designation. After the children were returned to the maternal aunt and uncle's home, restrictions were placed on the 14 year-old's interaction with her siblings based on her SACY status. Two months later, she ran away from the home, resulting in her transfer to a foster home. On the day three months later when she was to be moved from the foster home to a more structured setting, she attempted suicide by ingesting pain pills.

Subsequent psychological evaluations found that the girl had a great deal of difficulty dealing with her emotions. She demonstrated oppositional behavior and aggression. Cognitive testing found that she had a Full Scale IQ in the borderline to low average range which adversely affected her ability to employ judgment and reasoning. The girl reported she used alcohol and marijuana to help settle her emotions and that she was sexually active. She frequently ran away and numerous Unusual Incident Reports (UIR) were completed for her unauthorized absences. After she and a boyfriend were arrested for disorderly conduct and unlawful use of a weapon, she was found delinquent and remanded to a juvenile detention center. Although the girl was to be placed in a group home following her release, there is no record that the placement ever occurred.

The girl's whereabouts were unknown for five months before her case was assigned to a caseworker new to the Department. The girl contacted the worker periodically in order to receive assistance and obtain documents. When the girl confirmed she was pregnant and requested a medical card, the caseworker informed her she would have to be in an approved placement to receive services. The girl would not divulge her location and the caseworker did not speak to her again until she learned the girl had delivered twins and located her at the hospital four months later. At that time, the girl persisted in refusing to tell the caseworker where she lived. The caseworker informed her supervisor of the situation and was instructed to inform the girl that the twins would be taken into custody if she did not provide an address. If she did, the caseworker was to visit the residence and complete a risk assessment of the home. Neither the caseworker nor her supervisor completed an Unusual Incident Report recording the births as required by rule.

The new mother ultimately told the caseworker she was living with the twins' father and his family. The caseworker visited the home and recorded in her notes that she completed a Child Endangerment Risk Assessment Protocol (CERAP) although none could be found in the case record. The caseworker met the babies' father but did not obtain his full name or social security number which would enable her to complete a background check. The Client Service Plan stated the mother was living in an unlicensed home, was refusing placement or services and was still on runaway status. The Department's database system showed that the mother remained on runaway status for a year until her guardianship was terminated, four months before her daughter's death.

At a permanency hearing a few months after the home visit, the hearing officer directed the caseworker to refer the mother to the Teen Parenting Services Network (TPSN), but the referral was never made. The caseworker told the OIG she was unclear as to how the referral process operated. The caseworker's supervisor told the OIG the referral was not made for two reasons. One was because of the mother's refusal to participate in services. Secondly, the supervisor believed the mother's relationship with the caseworker and supervisor was more beneficial than beginning with new TPSN workers and the supervisor had had past negative experiences with TPSN. The supervisor told the OIG she was unaware the Department is legally bound to refer pregnant and parenting teens to the TPSN.

At a subsequent permanency hearing, the caseworker learned upon arriving at court that the mother's guardian ad litem (GAL) had filed a motion to close the mother's case since she had turned 18 the previous month and did not wish to continue her involvement with the Department. The caseworker told the GAL she had no opinion on the subject and court transcripts show the Department attorney was not in the courtroom when the case was heard. When asked by the court whether she had any position on the motion the caseworker responded that she did not. The court granted the motion and the mother's case was closed. The caseworker stated to the OIG she had no position on the matter because she did not know the motion to close had been filed and wanted to speak with her supervisor before offering an opinion on such a critical decision.

OIG RECOMMENDATIONS / RESPONSES

1. Family conferences are utilized by the Department to develop informal support systems for parents by involving their extended family members. Prior to case closure, family conference/mediation should be a requirement for parenting teen wards where there are concerns regarding the safety and welfare of the children of the teen.

The Department agreed. The Best Practice Initiative requires a staffing with service providers and family meetings prior to a return home in all cases.

2. DCFS Legal should inform all caseworkers (DCFS and private agencies) that when an oral motion is made by any attorney representing a party that takes the caseworker by surprise and the DCFS attorney is not present in the courtroom, a caseworker must ask for a short recess to consult with DCFS Legal Services staff. A redacted copy of the report should be shared with the providers of courtroom training for Department and private agency personnel for the purpose of incorporating and addressing the issues of oral motions and caseworker preparation.

The Department agreed. A redacted copy was forwarded to the Office of Legal Services to share with the providers of courtroom training for Department and private agency personnel.

3. The caseworker's supervisor should be disciplined for inadequate supervision of the mother's case and of the caseworker. In her position, the supervisor failed to impart relevant information and direction to the caseworker. The supervisor did not make necessary and critical decisions required of her. She failed to ensure that DCFS Rule/Procedure was followed pertaining to unusual incident reporting, runaway status of a ward whose whereabouts are known, and referral of a Hill class member to the Teen Parent Services Network for specialized intervention.

The Department agreed. Appropriate disciplinary action is being pursued.

4. The report should be used as a learning tool with the caseworker.

The Department agreed. A redacted copy of this report will be used as a learning tool with the caseworker.

DEATH AND SERIOUS INJURY INVESTIGATION 15

ALLEGATION

A three year-old girl died as a result of severe head trauma. At the time of her death, there was a pending Child Protection investigation of the girl's mother for inadequate supervision.

INVESTIGATION

The Child Protection investigation was initiated after a Deputy Sheriff who served an eviction notice reported that the girl and her 10 year-old brother were home alone. The mother returned at the same time police arrived at her home.

The Child Protection investigator attempted to reach the Deputy Sherriff as well as the police officer who responded to the call but neither was available to speak with him. He learned from local police that no criminal charges were filed against the mother for her actions. The Child Protection investigator then tried to contact the mother prior to visiting her home, but was unsuccessful. That evening, the investigator arrived at the house but found no one home. He spoke with a neighbor and left a letter for the mother under her door. Over the next six weeks, the Child Protection investigator visited the home on numerous occasions at different times of the day, but never found anyone present in the home.

The Child Protection investigator spoke to neighbors to gather information about the family's whereabouts. He also used those opportunities to gain entry to the building's interior so he could knock on the apartment door rather than ring their bell from outside. The Child Protection investigator first learned from the building's management that the mother had been evicted, but staff was unsure whether she had moved out. When the Child Protection investigator was later informed that the mother had been granted an extension on her eviction, he returned to the apartment but still could not find her. The Child Protection investigator did not expand his search to include visits to the 10 year-old's school or by determining whether the mother was a beneficiary of public aid in order to prevent her from receiving her check until contact was established. The Child Protection investigator continued his efforts to locate the family until learning of the girl's admission to the hospital, six weeks after the hotline call was made.

OIG RECOMMENDATIONS / RESPONSES

1. This report can be used as a training tool for Child Protection workers as it illustrates additional resources that can be useful when trying to locate a family. Child Protection investigations involve the safety of children and the investigators need to think creatively when it becomes necessary to locate a family.

The Department agreed. A redacted copy of the report has been forwarded to the Division of Training for implementation.

DEATH AND SERIOUS INJURY INVESTIGATION 16

ALLEGATION Three infants born to two sisters died within 18 months of each other. The first child died of a bronchial infection while the causes of death for the other two children were undetermined. The OIG opened an investigation following the third child's death in light of the family's history and both sisters' involvement with the Department.

INVESTIGATION The day after the second child, a five month-old boy, was found dead, the State Central Register received a hotline call alleging that the apartment the sisters shared was hazardous and unsuitable for young children. The complainant additionally stated the sisters smoked marijuana in the presence of their other children, a boy and a girl, in the home. The call was accepted as an environmental neglect report and the case was assigned to a Child Protection investigator. The investigator obtained the findings of an autopsy performed on the boy which noted the presence of a healing skull fracture and previous head trauma. Although it was determined these injuries did not cause the child's death, they were indicative of previous physical abuse against the boy. The Child Protection investigator reported the autopsy information to the hotline and spoke with her supervisor who advised her to take both women's children into protective custody.

Three days later the Child Protection investigator located the sisters and their children at their apartment. The investigator interviewed both women who related similar accounts of the night the boy died and stated the child did not exhibit any outward signs of distress though their babysitter had reported he seemed ill that evening. The Child Protection investigator reported the boy's mother expressed surprise when she informed her of the injuries found during the autopsy. The mother then told the investigator that the boy's father, who also resided in the home, was present in the apartment. When the Child Protection investigator asked to speak with him, however, the father refused to come out of his bedroom. The Child Protection investigator then left the home with the woman's daughter and her sister's son and transported the children to a shelter. After completing interviews with the reporter and the children's babysitter the next day, the Child Protection investigator met with the follow-up worker and transferred the case to her.

Three weeks after the children were taken into custody, the daughter was removed from foster care and placed with her father, who was not the father of the boy who died. The follow-up worker referred the sisters for homemaker services and recommended that the mother and her daughter's father attend parenting classes. She also requested transportation so the daughter could attend visits with her mother at a Department field office. While the girl's father diligently attended the parenting meetings and maintained frequent contact with the follow-up worker, the mother neglected to contact the facility where the parenting classes were being held and never scheduled visits with her daughter. She also failed to participate in a required drug treatment and counseling program. When the follow-up worker arranged a meeting for all involved parties to discuss the case, the mother did not show up. At that meeting, the girl's father stated the mother was pregnant with another child. Although the follow-up worker documented letters and phone calls to the mother urging her compliance with services, she did not initiate aggressive efforts to locate the mother at any time. The follow-up worker had almost no meaningful contact with the mother while she was handling the case and did not even attempt to speak with the mother while both were present in court when the case was opened. The mother remained uninvolved in services and ultimately delivered her child which died of undetermined causes at six weeks of age.

The follow-up worker's employment history showed evaluations that rewarded her with high marks in areas of relating to and interacting with clients but poor grades regarding practical application of basic casework principles. Though the follow-up worker had been employed by the Department for five years, she demonstrated a pronounced inability to perform the essential fundamental requirements of her job, even with intensive supervision. The follow-up worker stated to the OIG that she sought to rectify these shortcomings

by attending training sessions, however her attendance at numerous trainings conflicted with her responsibilities as a service provider. In addition, her obvious deficiencies required her supervisors to devote an inordinate amount of time to overseeing her activities, reducing the supervisors' ability to provide guidance to other personnel. The follow-up worker's supervisors eventually began assigning her less demanding tasks which increased the workload given to other members of her team.

OIG RECOMMENDATIONS / RESPONSES

1. While the follow-up worker seems to show a genuine desire to serve as a child welfare worker, this investigation confirms that she consistently demonstrates difficulty in functioning as a capable CWS II. General job performance as evidenced by her evaluations, does not meet expectations, has not shown improvement with corrective action plans and most significantly puts children and families at risk, and overburdens her team members and supervisor.

The Department agreed. Disciplinary action was initiated against the follow-up worker but was delayed following her request for a medical leave for mental health reasons. Subsequently, the follow-up worker was given clearance by a physician to return to work. Pending discipline will commence upon her return. Daily supervision will also be provided for the worker.

2. When a mother with previous indicated child abuse and neglect reports who is currently involved with DCFS is pregnant but cannot be located, the assigned caseworker and/or supervisor should make efforts to contact hospitals where (1) the mother has previously given birth (if known); and (2) hospitals within the mother's geographical vicinity to request that they contact DCFS should the mother give birth at the hospital.

The department agreed that hospitals in the immediate vicinity should be notified.

DEATH AND SERIOUS INJURY INVESTIGATION 17

ALLEGATION

A caseworker in another state contacted the OIG expressing concern that his client, who had three children in foster care in Illinois, had not been offered proper support or appropriate services to facilitate regaining custody of her children.

INVESTIGATION

The mother, who had six children in total, was developmentally disabled and had a history of involvement with mental health and child welfare services in Illinois. One of her children had been adopted. Another remained in foster care although the mother's parental rights had been terminated. Though the three younger children were in foster care in Illinois, she retained parental rights. She also had a two year-old son who was born after she moved out of state.

When the mother first came into contact with the Department her participation was minimal despite attempts to engage her in services. An evaluation from 1991 conducted a few months after her children came into care concluded she had a personality disorder, mild mental retardation and severe depression.

While the mother had limited interaction with her children or caseworker, she expressed interest in parenting. The mother was incarcerated in 1993 for robbery but called her caseworker in late 1994 to tell her she was pregnant. She began participating in services through the Department in mid-1995 following the birth of her fifth child. She successfully completed alcohol treatment and parenting programs and case records indicate she was effectively parenting her child. However her mental impairment led to periodic lapses in judgment and conflicts with service providers. In 1997 she moved out of state with her daughter. The state filed a petition for custody and, after the mother was located, the daughter was returned to Illinois and placed with a foster family. Since then, the mother has given birth to her youngest child and continued to participate in services in another state.

Although professionals identified the mother's cognitive disabilities, she was not recommended for services that would enable her to function effectively as a parent. The mother was steered towards standardized programs geared for individuals without her limitations. Professionals she was later referred to relied upon previous diagnoses to formulate their determinations regarding her fitness to parent rather than developing plans geared towards her specific needs. The out-of-state organizations she was involved with recognized her ability to function as a suitable parent, provided the proper support structure was in place.

OIG RECOMMENDATIONS / RESPONSES

1. This report should be shared with the Department's expert in developmental disabilities. The Department's expert should develop a proactive plan for identifying developmentally disabled parents who could benefit from programs specifically directed to parents with developmental disabilities.

The Department agreed. Clinical Services is creating a special unit, headed by the Department's expert, to focus on issues regarding children and caretakers with developmental delays in the child welfare system.

2. The Department should review current contracts and resources to ensure that parenting enhancement programs specifically designed for developmentally disabled parents are available.

The Department agreed. Contracts are under review.

3. The Department should ensure that the new computer database system track developmental deficits of parents.

The Department agreed. The database system will have the capacity to track developmental deficits of the parents.

DEATH AND SERIOUS INJURY INVESTIGATION 18

ALLEGATION An eight year-old boy was removed from his foster placement when his foster mother was indicated for physically abusing him. After the indicated report was reversed on appeal, the private agency that licensed the foster mother sought to resume placing children in her home.

INVESTIGATION The boy became involved with the Department after the hotline received a report that he and his four siblings had been sexually abused by an adolescent neighbor. The reporter further stated the boy's mother was aware of the sexual activity and that when she became aware the boy had told others of the abuse, she whipped him with a belt. The mother was indicated for physical abuse and the children were removed from her custody.

The boy's case was transferred to a private agency who placed him with a woman who had been a foster mother for eight years. The boy was enrolled in school where he frequently physically and verbally assaulted other children. He was suspended repeatedly for misconduct and insubordination and school staff reported he chronically used profanity and lied. The foster mother stated the boy's behavior was also a problem at home, where he often started fires, stole and refused to adhere to rules. The boy was subsequently prescribed Adderrall and both the school and his foster mother reported a dramatic improvement in his behavior. However, following an incident in which he accidentally stabbed a teacher with a pencil, the boy was transferred to a therapeutic school.

One month after beginning classes at the new school, the boy had to be restrained after he attacked a teacher. Following this event, the foster mother told the caseworker that she had run out of patience with the boy, she could not transport him to all of his therapy sessions and that the private agency was not giving her enough money to care for him. She informed the caseworker she wanted the boy removed from her home and submitted an official notice for termination of placement. The caseworker informed the agency's licensing representative of the foster mothers intention. The licensing representative went to the home the next day and encouraged the foster mother to reconsider, explaining that, "children will be children and...she [would] be tested by the child to see how far [he] could go." The foster mother agreed to allow the boy to remain in her home and withdrew the notice. The following day, the boy's caseworker called the hotline to report that the boy told her the foster mother had hit him with a cane, an extension cord and sticks.

The Child Protection investigator assigned to the case interviewed the foster mother, her daughter, the caseworker and staff from the school. She also reviewed statements made by the boy and examined hospital charts diagramming his injuries. The Child Protection investigator determined there was sufficient evidence of abuse and indicated the report against the foster mother for cuts, welts and bruises. In an interview with the OIG, the Child Protection investigator stated she had a difficult time with the case because of the boy's history of behavior and the foster mother's insistence that she had not abused him and that the marks on the boy were present when he first came to live in her home. The investigator said that after extensive consultation with her supervisor, she felt comfortable indicating the report.

The foster mother appealed the investigator's decision on the grounds that the boy had scars on him prior to entering her care and that his boisterous behavior often resulted in self-inflicted injuries. The Department's child protection manager reviewed the investigation and reversed the indicated finding. The child protection manager told the OIG she based her decision on the fact that the boy had been physically abused by his biological mother, which increased the likelihood his scars were old, and the stress the foster mother was under caring for a difficult child. The child protection manager believed that even if the foster mother had abused the boy, her actions did not rise to the level of severity to warrant indicating the case.

Following the initial indication of the report, the foster mother's home was put on hold status by the Department, preventing children from being placed in her care. The private agency determined the foster mother had inflicted corporal punishment on the boy and recommended she attend parenting classes in order to learn alternate methods of discipline. After the mother had successfully completed the class and the indicated finding had been overturned, the private agency requested that her home be removed from hold status. Three months later, however, the private agency stated to the OIG it would no longer place children in the foster mother's home. The agency said the decision was not based on abuse or neglect concerns, but rather other issues surrounding the woman's performance as a foster parent. Her home remains on involuntary hold status.

OIG RECOMMENDATIONS / RESPONSES

1. A new licensing assessment should follow any expungement of an indicated finding. In addition, due to changes in Department Rule 336, Child Protection supervisors will no longer be a part of the review process.

The Department agreed. New procedures have been developed between the Department's Licensing Division and the Division of Child Protection to assure the most comprehensive concurrent investigation and licensing review. Under these new procedures, licensing will have already completed a licensing review by the time an appeal is filed.

2. The foster mother might not have been a suitable foster parent for such a demanding and difficult child. This, in combination with the agency's inadequate response to her increasing frustration with the boy, indicates a need for the private agency to review the kind of support it gives to foster parents. This report should be forwarded to the agency and shared with licensing and follow up staff. The private agency's policy and staff training materials should be reviewed to ensure that they clearly describe the supportive role case managers and licensing staff should assume relative to foster parents. This material should be circulated to all agency case managers and included in the curricula for regular in-service training.

The Department agreed. The OIG shared the report with the agency.

3. The boy's therapy should focus on his victimization and behavioral issues that will help him cope with authority, get along with his peers, instill discipline, and promote social skills. It should not continue to rehash issues regarding the boy's "offending sexual behavior." Nor should it require him to attend other SACY group sessions. In addition, given the fact that the boy's has not engaged in "offending sexual behavior" for two and a half years, his SACY Protective Plan should be discontinued and his removal from the SACY database should be considered. The therapist should discuss with the foster parent, teachers, and day care providers the behaviors they want to address. In the event that the boy's behavior problems escalate, private agency staff should provide more direct assistance to the foster parent in the home.

The Department agreed. The Department's Clinical Division held a staffing to identify and address the boy's initial and ongoing designation as a sexually aggressive youth, status and possible treatments. The staffing resulted in a determination to remove the boy from the database of sexually aggressive youth. Counseling will be provided to the boy as well as training for the foster parent on sexual abuse and victim issues and behaviors.

DEATH AND SERIOUS INJURY INVESTIGATION 19

ALLEGATION A six year-old boy died after being struck in the head multiple times by his stepfather. The boy's parents had previously been involved with services through the Department as a result of an indicated abuse report. The family's case was closed one year prior to the boy's death.

INVESTIGATION The Department began working with the family after the State Central register received two separate hotline calls claiming the boy had several bruises on his body and behaved strangely when questioned about them. The Child Protection investigator assigned to the case contacted one of the reporters, a relative babysitter, who told her she had begun noticing bruises on the boy since his mother's recent marriage. The stepfather regularly watched the boy on Tuesday nights and it was after these occasions when the babysitter noticed fresh injuries. The Child Protection investigator then interviewed the boy, who was present in the babysitter's home. The Child Protection investigator observed a number of irregular bruises on the boy's face, torso and legs. When asked how the injuries occurred, the boy stated that the bruise on his face was caused by his stepfather body slamming him on his bed onto a toy truck while some of the others were the result of accidents. After contacting her supervisor, the Child Protection investigator took the boy into protective custody and, following a medical examination, placed him with his maternal grandmother.

The Child Protection investigator then conducted separate interviews with the mother and stepfather. Both parents stated the body slamming incidents were part of a wrestling game the stepfather and the boy played and that the other injuries were accidental. After consulting with the physician, who said that while he could not be certain the boy was abused but that his bruising was, "apparent and very suspicious," the Child Protection investigator indicated the allegation against the stepfather for cuts, welts and bruises and substantial risk of physical injury. The case was transferred to a private agency and the assigned caseworker began arranging services which included individual counseling, parenting classes and supervised visitation with the boy. The caseworker developed the service plan based on conversations with the parents, who stated that the injuries were the result of accidents during rough play between the boy and his father. The caseworker never reviewed the full Child Protection report regarding the incident.

The caseworker reported that visits between the boy and his mother were very positive and believed he was safe in her care. Another worker who took the boy to visit the stepfather reported the child was extremely apprehensive on the way to the meeting. The boy stated to the worker his grandmother told him his stepfather was "bad" and had instructed the boy to stay away from him. The parents objected to what they perceived to be the grandmother's interference in the case.

Each parent was referred to a therapist for counseling. In the stepfather's sessions, he related to his therapist he was reluctant to touch the boy when, soon after he married the boy's mother, he gave him a spanking that left bruises. The stepfather stated he worked long hours as the manager of a business in another town which limited his time with the family. He described himself as an intense person and expressed his desire to fire everyone that worked under him in order to make his store the most successful in the region. The therapist noted the stepfather was personable and was clean-cut in appearance, but did not offer assessments of his statements regarding his work or family. The therapist had very few sessions with the father but, after observing one interaction between the father and his stepson, expressed his belief the rough play would not continue.

The mother had been seeing a private therapist, who was also a Department employee, for seven years. In an interview with the OIG, the private therapist stated she was aware that, given her position with the Department, it would be a conflict of interest for her to provide services to the mother in pursuit of having her

son returned home. However, the therapist believed it would be unethical for her to discontinue their established relationship while the mother was experiencing a tumultuous period in her life. The private therapist consulted with the appointed therapist and the two concluded the appointed therapist would deal strictly with issues related to the mother's involvement with the Department while the private therapist would continue counseling the mother on other issues. In her sessions with the appointed therapist, the mother steadfastly contended there was no reason for the Department to be involved with her family. She maintained that her husband had never abused her son and that his injuries resulted from accidents and the rough behavior of the babysitter's children. The appointed therapist discharged the mother from counseling after four sessions because of her unwillingness to consider issues regarding the possible abuse of her son.

Shortly after the sessions were discontinued the boy was returned home and, seven months later, the family's case was closed. One year after the Department's involvement with the family ended, the boy was brought to a hospital with massive cerebral edema. The boy died from his injuries a few days later. His stepfather pled guilty to aggravated battery of a child and is currently serving a 20 year sentence.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should assure that, in practice, Child Protection investigations are sent to private agencies and follow-up units servicing the case. When parents are referred for therapy as part of a service case opened following an indicated report, therapists should be given copies of the Child Protection investigation. In addition, in cases where the family is currently or has been previously involved with intact family services, the intact family service records for the family should also be forwarded to the follow-up team and therapists to which the family has been referred as part of the service plan.

The Department agreed. A reminder was sent to Child Protection staff emphasizing the requirement that all previous Child Protection investigations are to be reviewed during the course of any investigation. In addition, Child Protection should forward all indicated reports to intact and placement workers. A reminder will also be sent out to intact and placement workers regarding the need for them to obtain copies of any current or past investigation. This is also part of the Best Practice Initiative.

2. The Department and its designees should work to include extended family members in working with families both during the Child Protection investigation and during the follow-up case.

The Department agreed. This is included in the Best Practice Initiative. The Department supported legislative reform which permitted expanded communication between investigators and extended family members.

3. This report should be shared with the private agency.

The Department agreed. The OIG will share the report with the private agency.

4. This report should be shared with the private therapist. The private therapist should be offered an opportunity to discuss the ethical issues raised in the report with the Child Welfare Ethics Panel.

The Department agreed. The report will be shared with the therapist.

5. This report should be redacted and used as a teaching tool.

The Department agreed. A redacted copy of the report was sent to the Division of Training for implementation.

DEATH AND SERIOUS INJURY INVESTIGATION 20

ALLEGATION

A newspaper report claimed the Department had failed to ensure that adequate treatment was provided to a five year-old boy with cancer. The boy, whose mother was a ward, had been involved with the Department since his birth.

INVESTIGATION

The mother, who was known to have limited intellectual functioning and developmental delays, dropped out of school after the ninth grade. The boy was born one week after his mother turned 16. The mother and her siblings had been removed from their home three months prior after several years of extensive Department intervention resulting from a number of indicated abuse and neglect reports. Subsequent to their removal, a Department caseworker was assigned to provide services to the siblings who were then living in the home of a maternal aunt. Shortly before the caseworker was assigned, the mother participated in a psychological evaluation which reported she needed specialized education services and counseling. The evaluation also suggested she undergo a psychiatric examination and recommended she be placed in a supervised living environment in order to ensure proper care of her then unborn child. An OIG review of the case record found no indication the caseworker considered the evaluator's conclusions or followed-up on the recommendations. The mother and her son were later moved to a residential group home for pregnant and parenting teen wards, however the transfer occurred while the case was temporarily assigned to another worker. The caseworker was provided with little guidance for making decisions at the time because her supervisor was pursuing an advanced degree and her responsibilities were being shared with substitute supervisors. The primary supervisor told the OIG her direct involvement in cases was limited to particularly difficult cases that were brought to her attention.

At age 16 months, the boy was diagnosed with Wilm's Cancer which had caused a cancerous tumor to develop on one of his kidneys. Doctors removed the kidney as well as several surrounding lymph nodes that tested positive for cancer. The boy then required hospitalization every three to four weeks to undergo chemotherapy treatments. The boy's recovery was complicated by serious side effects of the treatments, including an increased risk of infection and diminished resilience of his bones. The case record shows the mother was actively involved with her son's medical care during the initial stages, however, over time her participation level diminished and her son often missed scheduled appointments or was brought to them by other, sometimes unknown, caretakers. In addition, several physicians involved with the boy expressed concerns regarding the mother's ability to comprehend the extent of her son's illness and accommodate his complex medical needs. Despite these shortcomings, the caseworker failed to obtain a reliable assessment of the mother's capacity for managing her son's health care or take steps to identify hospital services that could be utilized to provide assistance. The caseworker made no effort to learn about the boy's disease and did not consult with his physicians. She consistently relied on the mother's reports that the boy was attending his medical appointments instead of contacting medical personnel for confirmation. The caseworker did not pursue the doctor's recommendation for a psychiatric evaluation and never assessed the mother's preparedness to be a developmentally delayed teen parent caring for a child with cancer.

After the mother was discharged from the group home for failing to return from a weekend pass, the caseworker placed the mother and her son in the home of a licensed foster parent who had previously been identified as a family friend. A month after she was placed in the home, the mother told her caseworker she had become pregnant by the foster mother's son. The caseworker allowed the mother to remain in the placement because the foster mother reported her son no longer lived in the home, however the caseworker did not visit the home. It was later learned the son still regularly resided in the home when the mother left temporarily after the son made violent threats against her. She subsequently returned to be with her children and the caseworker allowed the placement to continue for another six months before another threat of violence prompted her to move the mother and her children to another foster home.

Medical non-compliance with the boy's cancer treatments caused the Department to take protective custody of the mother's children, who were returned to the previous foster home. The caseworker assumed responsibility for handling the children's cases while retaining responsibility for the mother. The caseworker continually referred the mother for parenting classes for which she was ill-suited due to her cognitive constraints, but neglected to enroll her in any specialized education programs. Meanwhile, the boy was treated numerous times for broken bones resulting in several hotline reports alleging physical abuse. Because the caseworker failed to assume an active role in documenting and monitoring the boy's medical condition, hospital workers and child care professionals were unaware that chemotherapy had made his bones particularly brittle and susceptible to breaks, resulting in erroneous indicated abuse reports against his foster parents and other caregivers.

The mother's case was subsequently transferred to a private agency which participated in the Teen Parent Services Network (TPSN). The assigned private agency caseworker referred the mother for yet another psychological evaluation. This evaluation determined the mother should submit to a psychiatric assessment because she exhibited severe depression and expressed suicidal thoughts and also suggested a group home placement. The private agency caseworker failed to follow through on either recommendation, instead allowing the mother, who had given birth to two more children who were in her custody, to move between several homes, including those of her former foster mother and her boyfriend at the time. The private agency caseworker told the OIG she did not contact the hotline to report the mother's unstable living arrangement because, "[her] baby looked clean." The OIG also questioned the worker about inconsistent testimony she gave in juvenile court regarding her knowledge of the mother's whereabouts during a specific period of time. The private agency caseworker stated she misunderstood the questions presented to her.

OIG RECOMMENDATIONS / RESPONSES

1. The OIG will continue its investigation of inadequate medical case management by the involved health care provider and the role of Healthworks of Illinois in the management of acutely ill wards.

2. The Department caseworker should be required to read this report. All issues pertaining to her casework practices should be discussed with her for teaching and supervisory purposes. Employee discipline is not recommended because of the amount of time that has lapsed since the caseworker was assigned this case and because of an absentee supervisor.

The Department agreed. The report was shared with the caseworker.

3. Portions of the report that relate to the private agency will be shared with the agency.

The Department agreed. The OIG shared the report with the private agency.

4. The private agency caseworker should be disciplined for her failure to service the mother and for misrepresenting case information to the court and during the OIG interview. Discipline should be carried out within the personnel policies and procedures of the private agency.

The Department agreed. The OIG shared the report with the private agency.

*Private Agency Response: The agency agreed to discipline the worker and document the discipline in her personnel file.

5. This report should be shared with the Department caseworker's supervisor for teaching and supervisory purposes.

The Department agreed. The report was shared with the supervisor.

6. All indicated reports and undetermined findings of abuse pertaining to the bone fractures should be unfounded and expunged because his bone condition, resulting from his cancer and chemotherapy treatment, was documented at the time of all reported fractures.

The Department agreed to review all of the indicated reports and undetermined findings of abuse for possible expungement.

7. While DCFS is developing a database to identify and track wards with serious and chronic illnesses, in the interim, the Department should establish an interim system to identify and track wards with acute or chronic complex diagnoses.

The Department agreed to develop a means of manually identifying and tracking Department wards with acute or chronic complex diagnoses using a variety of data sources. The Department's regional nurses will be informed of these wards when appropriate.

COMPOSITE INVESTIGATIONS

FRAUDULENT VOUCHERS

ALLEGATION

Expense vouchers issued by the Department intended for use by clients to make emergency purchases were falsified and redeemed at department stores by unknown individuals.

INVESTIGATION

The OIG examined 2,300 vouchers used to obtain hundreds of thousands of dollars worth of merchandise over a three year period. The vouchers had been filled out in accordance with Department procedure, indicating the complicity of a Department employee. The OIG found six recurring names that did not match with individuals receiving Department services at the time. The OIG analyzed the vouchers and searched various databases to identify suspects.

OIG investigators interviewed a woman who acknowledged the identification used with a voucher was hers, but denied using the voucher or purchasing any goods from the store. The OIG conducted a background check on the other individuals in the woman's home and found that the woman's daughter was another of the six previously identified as frequent users. The OIG then interviewed the daughter who also denied ever using vouchers or obtaining any merchandise. The daughter stated that during the previous four years she had worked for four temporary employment agencies but had never been assigned to a Department office. OIG investigators obtained the woman's employment records and found that on her application to one of the agencies, she had listed a Department employee as a reference.

The OIG learned the employee named on the application had been responsible for preparing vouchers for Child Protection investigators. The employee's name was identical to one of the original six and appeared as the authorized purchaser on fraudulent vouchers from the time period in question. During that time, the employee had worked at a Department office in the immediate area of the stores where the vouchers were used and the residences of the two women the OIG had questioned. The apartment building where the two public aid recipients lived was also near the Department office.

During a meeting with loss prevention investigators from one of the department store chains involved, the OIG was informed that a seventh woman had recently used fraudulent vouchers to purchase $1,300 worth of merchandise at two stores. The department store chain's market investigation's team leader later provided the OIG with a store surveillance tape which recorded the woman using fraudulent vouchers to make purchases at one of the stores. A criminal background check found the woman had a previous arrest on theft and deception charges.

The Department has redesigned its vouchers with traceable imprinted serial numbers. The Department has also taken measures to refine procedures regarding the handling and dispersal of vouchers. The OIG has also worked with retailers in order to familiarize their employees with the Department's voucher system and safeguards against accepting fraudulent vouchers.

OIG RECOMMENDATIONS / RESPONSES

1. DCFS should conduct training for loss prevention personnel of the major department stores that are used for purchases with vouchers. The Department should meet with such personnel on a quarterly basis to work with loss prevention on how to identify fraudulent vouchers and explain why it is necessary to have store personnel secure IDs from customers using vouchers to purchase merchandise. The OIG met with the loss prevention personnel of one department store chain and will arrange to meet with loss prevention personnel of other retailers.

The Department agreed. The Division of Support Services will work with the OIG on this issue.

2. The Department should create an internal control database to track purchase vouchers that are distributed to office managers and subsequently show to whom the money is paid and the name of the purchaser. A separate list of fraudulent vouchers should be maintained.

The Department agreed. The Department will create an internal control process for all pre-approved vouchers. Non pre-approved vouchers submitted to the Department for payment will be returned to the store unpaid. Copies of these vouchers will be forwarded to the OIG.

3. The voucher form with a tracking number should be the only one used for Department clients. Former vouchers should only be used for state employees with employment ID and never used for clients.

The Department agreed. Pre-approved form 932 will only be used for Department clients. No C-13 vouchers will be used for pre-approved purchasing.

4. The Department should consider recommending to Central Management Services that CMS use a numbering system for the C-13s (which are used statewide by the code agencies) and include with the numbering system a letter designation for each different code agency. (for example, A123456 for DCFS, B123456 for Department of Human Services, C 123456 for Department of Transportation, etc.)

The Department agreed to consider this recommendation.

5. The Director should issue a bulletin to all personnel regarding the necessity of maintaining tight controls on the issuance of vouchers to clients to minimize the possibility of fraudulent use. Employees should be informed that the Department will use all means to see that employees that misuse Department money for fraudulent purposes will be criminally prosecuted.

The Department agreed. The Department will issue a bulletin to clarify the pre-approval process.

6. The Department should send a letter to the department store chain's corporate office commending the investigations team leader and loss prevention personnel for their cooperation during this investigation.

The Department agreed. A letter commending the investigations team leader was sent to the corporate office.

7. The Department should commend the Department's Director of Cook Central Services on his continuous efforts to eliminate fraud in the use of vouchers and for his full cooperation with the Office of the Inspector General in this investigation.

The Department agreed.

INVESTIGATIVE REFERRAL

The OIG provided the information it had accumulated regarding the fraudulent vouchers to the Illinois State Police for criminal investigation. Following the Illinois State Police's acceptance of the case, all seven women identified by the OIG confessed to their roles in the fraudulent voucher scheme and have been indicted for their roles in the crime.

RE-ABUSE STUDY

ALLEGATION

In response to a number of cases in recent years involving children who died from abuse after previously being the victims of abuse reports, the OIG reviewed the cases of children who survived multiple abuse reports.

INVESTIGATION

The OIG identified 24 cases in which one or more children in a family were the victims of multiple indicated abuse reports. By studying common elements among these families, certain recurring elements emerged. Almost half of the families involved (46%) had incidents of adult domestic violence documented in their case records. The prevalence of mental heath problems and behavioral disorders, previously identified as stressors in the home, appeared to greatly increase the likelihood for abuse. Forty-six percent (46%) of families involved in the study included at least one parent with a diagnosed mental illness or cognitive impairment. In addition, Twenty-nine percent (29%) of the families had one or more children who exhibited learning, behavior or developmental delays.

A disproportionate number of cases originated in Southern Illinois (58%) despite its lesser population density when compared with the Northern part of the state. The OIG found that the responsibility of employees to provide services to larger geographic areas and the more limited availability of resources were likely contributing factors to this disparity.

The OIG found that many of the involved families demonstrated a willingness and ability to improve their parenting skills if the support of family and close friends was utilized to offer encouragement and assistance. Forty-six percent of families (46%) had family support available to them, however child welfare workers only included extended family members in safety plans for the children in half of those cases. A proactive effort on the part of workers to engage extended families in services can provide additional support to a family attempting to overcome child abuse issues.

OIG RECOMMENDATIONS / RESPONSES

1. Fifty-eight percent of re-abuse cases originated in Southern Illinois, thus, the Department must address the needs in this area. The OIG recommends that the Department replicate a Parenting Assessment Team in Southern Illinois.

The Department agreed.

2. The OIG's training "Working with Physically Abusive Families" addresses many of the factors described above. The OIG will present the training in Southern Illinois.

The Department agreed.

3. The Department must report re-abuse data in a way that promotes useful analysis. Currently, the re-abuse data is folded into data reports that include abuse and neglect, making information difficult to isolate, review and analyze, in addition to being misleading.

The Department agreed.

4. When extended family are available to provide support, family meetings should be held to create a plan for the children using family members assistance.

The Department agreed. Family meetings are a critical component of Best Practice on permanency. They are being recommended for every intact and placement case.

5. The OIG Best Practice Unit will work with the Department in developing specialized substance abuse treatment/child welfare services in Southern Illinois.

The Department agreed.

NORMAN FUNDS

ALLEGATION A private agency employee misappropriated Department funds designated to provide financial assistance to impoverished clients.

INVESTIGATION Norman funds are intended for families in need to ensure that children will not be removed from their parents custody solely because of poverty. The OIG was contacted by the Department's Norman Program Coordinator regarding suspicious requests for funds submitted by a private agency employee.

The OIG contacted the agency and learned the worker had been terminated as a result of an unrelated matter. The OIG reviewed copies of 16 requests for Norman funds submitted by the worker while she was employed by the agency. Eight of the individuals named on the requests were located and each client signed affidavits indicating they either received less than the promised dollar amount from the worker or no assistance funds at all. The worker's former supervisor told the OIG it would be possible to request funds without the knowledge of clients or the Department caseworkers assigned to assist them. The OIG identified six landlords who cashed checks requested by the worker to cover housing costs. Two landlords were the worker's sisters while the other four were roommates and acquaintances. The OIG also found that none of the properties listed on the fund requests were owned by any of these individuals. The combined value of Norman fund requests submitted by the worker totaled $16,000.

INVESTIGATIVE REFERRAL The OIG forwarded the information gathered in this case to the Illinois State Police and the Office of the State's Attorney. Indictments are pending against the worker and others involved in the fraud.

TEEN PARENT SERVICE NETWORK

ALLEGATION

The OIG investigated the lack of basic services provided to Department wards who are pregnant or have already become parents.

INVESTIGATION

In an effort to evaluate the quality and extent of services offered through the Teen Parent Services Network (TPSN), the OIG examined the services provided to 167 parenting wards residing in a high-need geographic area. The OIG found that the educational needs of parenting wards suffered greatly and the Department failed to provide adequate services to ensure their academic progress.

Many of the wards did not attend school and the length of their extended absences ranged from six months to four years. A majority of pregnant and parenting teen wards surveyed stated they were not in school because of "personal choice". Only 43 of the 167 parenting wards were known to have completed or were participating in high school or General Education Degree (GED) programs. The educational status of 54 wards was unknown. Sixty six wards were not enrolled in any type of educational or vocational program or pursuing additional training. Nearly 40% of the teen wards included in the survey did not qualify for alternative school enrollment because of reading skills that fell below the fifth grade level. More than half of the wards fell well below expected reading grade levels, some by as much as nine years. Only two wards were enrolled in a public school "Cradle to Classroom" program which allowed mothers to attend a high school that provided day care for their children.

Thirty two of the wards included in the survey presented a developmental or learning disorder and it was believed that many more may have unidentified learning disability. Department wards who have learning disabilities must receive proper educational assistance as well as any financial benefits they may be eligible to receive. A private agency should be used to evaluate wards with low reading levels to determine if they have learning disabilities.

The OIG found the existing process for identifying pregnant and parenting wards and referring them for services through the Department's Division of Education and Transition Services (DETS) to be unreliable. Unusual Incident Reports and ACR reports, which are used to identify these teens, are not regularly delivered for consideration. DETS does not identify wards with special needs or clinical issues that may require special services, such as mental health or substance abuse treatment. DETS relies on the private agency that maintains the TPSN database to identify special needs or clinical issues. Cases are often transferred without critical information such as medical records, IEPs and case histories. Caseworkers submit quarterly reports on the status of wards to the private agency, which updates the tracking system based on these reports.

Failure to identify, track and analyze critical issues in a timely fashion minimizes a teen ward's need for assistance and delays appropriate intervention. In addition, oftentimes appropriate resources are not identified or developed in order to meet the needs of this population, including casework training on adolescent and parenting issues, developmental disability, functional illiteracy or educational advocacy. As a result, wards with identified special needs or wards having an unidentified disability are denied services that could address their disability.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department must be more proactive with the public school system to address the current educational status of pregnant and parenting wards, the lack of case studies for wards with low academic achievement and reading levels and access to educational alternatives. Discussions should include access to services for special need wards attending alternative schools.

The Department agreed. The Department has authorized the OIG to work directly with the Teen Parenting Services Network to address deficiencies in the current system.

2. Caseworkers should notify the Legal Assistance Foundation Disability Law Project, when a special needs student is expelled or is dropped from high school.

The Department agreed. The Department has authorized the OIG to work directly with the Teen Parenting Services Network to address deficiencies in the current system.

3. The Department should help identify critical issues and services specifically relating to pregnant and parenting wards. The Department should work more closely with schools to ensure the evaluation of wards with low reading levels or wards with outdated Individual Education Plans. Determination of a disability is critical for documenting future Social Security Insurance benefits and to ensure income for the ward beyond wardship.

The Department agreed. The Department has authorized the OIG to work directly with the Teen Parenting Services Network to address deficiencies in the current system.

4. The Department should ask an expert psychologist to do a presentation on program and casework strategies for the private agency that maintains the TPSN data base and TPSN staff.

The Department agreed. The Department has authorized the OIG to work directly with the Teen Parenting Services Network to address deficiencies in the current system.

5. During the initial TPSN staffings, the educational liaison should do educational plans. Caseworkers should confirm with the school, on a weekly basis, the attendance of their high-risk clients. The educational liaison should receive attendance reports from the Public Schools.

The Department agreed. The Department has authorized the OIG to work directly with the Teen Parenting Services Network to address deficiencies in the current system.

6. A copy of this report should be shared with Monica Mahan, Hill Class Consultant; Tom Vandenberk, President, Uhlich Children's Home; Maggie Jablonski, Vice President, TPSN; Sister Barbara Forrester, Program Director, Maryville Academy's Stepping Stones; Laurene Heybach, Director of the Law Project of the Chicago Coalition for the Homeless; Wallace Winters, Legal Assistance Foundation Disability Law Project; Jack Wuest, Director, Alternative Schools Network; Michael Quintance, DCFS Adolescent Education Coordinator; and Catherine Wiggins, Director, Cradle to Classroom.

The Department agreed. The report has been shared. To date, school enrollment in the targeted area has increased 30%.

SEXUAL HARASSMENT

ALLEGATION

The OIG received a complaint that a male employee in a Department field office created an atmosphere of sexual harassment in the office.

INVESTIGATION

Because the complaint did not address specific incidents of sexual harassment, the OIG was unable to investigate particular occurrences or identify any individuals who may have been involved. The OIG reviewed the training history of the 10 management employees in the office and found that two had never received any training in the Department's polices regarding sexual harassment in the workplace. The eight other managers received their training prior to 1998, when a United States Supreme Court decision resulted in significant changes in sexual harassment case law.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should revise policy on sexual harassment to reflect an intent to comply with the most strict of the various statutory prohibitions which apply to the Department.

The Department agreed. The policy is currently under revision.

2. The management staff in the field office should immediately be retrained on what constitutes sexual harassment and how to avoid, in the workplace, behavior that can be construed as sexually harassing; and the management staff then train all the remaining staff in the field office on the same subjects.

The Department agreed. Sexual harassment training for management staff was held on April 24, 2001.

GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

ALLEGATION Two adoptive children were subjected to physical and emotional abuse and substandard living conditions in the home of their adoptive parents. Despite two hotline reports regarding the home and the involvement of multiple Department employees, no action was taken to ensure the children's safety.

INVESTIGATION The two children, a brother and sister ages 14 and 15, had been adopted by the parents 10 years prior. The Department became involved after the girl's school counselor called the hotline to report the girl's allegations of abuse. The girl told her counselor that her mother had slapped her, hit her with a shoe, bit her finger, cut her hair as punishment for misbehavior and was verbally demeaning and abusive. The Child Protection investigator assigned to the case interviewed the girl, who was residing in a respite home at the time. The investigator determined that the darkened area on the girl's finger she claimed was bitten did not appear to be a bite mark, even though the girl stated the incident had happened over a month before his examination. The investigator told the OIG he found the girl's allegations to be inherently unbelievable and believed she had a propensity for lying. The investigator based this opinion on a psychological report of the girl in the possession of a colleague which he had briefly reviewed. The investigator stated he relied on his colleague's summation of the report, however the other worker stated she had not read the report and never discussed it with the Child Protection investigator. The investigator unfounded the report without interviewing the school counselor or the girl's mother, even though the family home was located three blocks from the investigator's office.

Two weeks later, a second report was made by a Department contractual employee alleging the boy was made to sleep in a cage inside the family's home. A second Child Protection investigator was instructed to go to the home within 24 hours and observe the living situation. Upon arriving in the home, the worker observed two metal dog kennels that had been fashioned into a sleeping pen for the boy. The pen had chicken wire covering the top and bottom and a buzzer system attached to alert the parents if the boy attempted to exit the cage during the night. The adoptive mother told the worker the boy was a chronic sleepwalker and that they had consulted with a "sleep specialist" who approved the arrangement. The investigator also observed that the house was cluttered, musty and populated with numerous animals, including 15 to 20 cats. The investigator determined that use of the cage did not constitute confinement as defined by the Department because the door was not locked and the boy seemed comfortable with the situation and referred to the pen as his "room." The Child Protection investigator then turned the case over to a follow-up worker who unfounded the case based solely on the investigator's notes. Neither worker interviewed the Department employee who called the hotline or attempted to verify the identity or advice of the "sleep specialist." The OIG found that while the boy had been evaluated by a physician at a sleep disorder clinic, three years before, there was no record of a diagnosis of sleepwalking or any recommendation for restrictive sleeping quarters. The Child Protection investigator assigned to the first abuse report, who was serving as acting supervisor of the office while the regular supervisor was away, approved the report. In an interview with the OIG, the investigator who approved the finding stated he had not read "every word" of the report and lamented his increased workload and insufficient increase in pay for serving as acting supervisor. A review of the investigator's personnel file found a number of documented concerns regarding his ability to handle his caseloads and complete his work in a timely fashion. The review also found the presence of information the investigator was not afforded an opportunity to respond to which would be more appropriate for inclusion in a supervisory file.

Three after the second report was made, the hotline received a third call after the respite foster parent caring for the girl called police. The adoptive mother was asked to come to the police station for questioning. Prior to arriving at the station, the mother transported the boy and her two biological children to a relatives home in another town. After the mother reached the police station, officers went to the home and made photographic

and video documentation of the cage as well as the general condition of the home. Both adoptive children later told investigators they had been required to sit in the cage on various occasions as a form of punishment and that they were treated much differently than the couple's biological children. The police subsequently took the adopted siblings into protective custody.

OIG RECOMMENDATIONS / RESPONSES

1. The Child Protection investigator assigned to the first abuse report should be disciplined for poor performance, and potential risk of harm to children. A corrective action plan and quarterly review is needed. It should be followed up by close monitoring of not only productivity as an investigator, but also compliance with administrative procedures and rules, the truthfulness of recorded attempts to contact witnesses, and ability and willingness to direct peers to do additional work needed to satisfy rules and procedures when an acting supervisor. If immediate improvement in all areas is not noted, there should be a demotion from the lead worker role, and consideration of whether to reassign him away from child protection work.

The Department agreed discipline was warranted in this case. Due to miscommunication in the implementation of this recommendation, the specific disciplinary action was not completed. This report will be used as a teaching tool with the Child Protection investigator as well as other staff. The report was discussed with the investigator and the deficiencies in case management were addressed.

2. The follow-up investigator assigned to the second abuse report should be disciplined concerning compliance with administrative procedures and rules, including Appendix B – P300 (35), and the necessity of performing a full investigation rather than rely on notes of a 24-hour mandate worker.

The Department agreed discipline was warranted in this case. Due to miscommunication in the implementation of this recommendation, the specific disciplinary action was not completed. This report will be used as a teaching tool with the follow-up investigator as well as other staff. The report was discussed with the investigator and the deficiencies in case management were addressed.

3. The Quality Assurance Supervisor should show the police video and photographs of the home to all local field office staff with responsibility for child protection investigations or 24-hour mandate work. The supervisor should review with staff what constitutes confinement, torture, and environmental neglect; when contact with alleged perpetrators, reporters, and collaterals is necessary or advisable; that contact with a physician or psychologist claimed by a parent to have suggested a course of action must be made for verification; and what course of action to take if an employee believes he or she has been advised by a supervisor to act in a way inconsistent with procedures and performance expectations; since some investigation decisions here are incompatible with the office's accreditation. The children's own account of the use of the cage and their treatment generally should also be discussed.

The Department agreed that this video should be used by Child Protection staff to review new policy regarding tying and close confinement.

4. The Office of Employee Services should review with supervisors at the local field office the types of material it is appropriate to place in personnel files, and what material is best left in supervisory files.

The Department agreed.

5. There should be follow-up by General counsel or OIG staff, as appropriate, of their respective current attempts to obtain a protective order allowing monitoring of the children still in the home, and

other efforts to fully evaluate the mother's expressed interest in reunification with her adoptive son.

The Department agreed. Department Legal staff has been closely involved in monitoring all legal and/or court action in this case.

6. Staff from the Department's Clinical Division should consult with the parenting assessment team regarding the "attachment disorder" diagnosis of the adoptive children, which appears to be provisional. Staff should refer the mother as well as her adoptive and natural children for assessment, with attention to the "attachment disorder" diagnosis.

The Department agreed. Staff from the Department's Clinical Division have been working to address the issues identified in this recommendation.

7. OIG staff have located the children's natural mother. She is divorced from the biological father whose drug involvement was the subject of the recommendation to terminate parental rights. She has remarried and is raising three children in another state, near her own adoptive parents and brother. She asked for her children's new phone number and expressed an interest in contact and in obtaining custody. The Department should follow up to determine whether additional contact and a home study might be in the children's best interest, and request cooperation with any parenting assessment team evaluation.

The Department has spoken with the children's natural mother and determined that she is not a viable option for placement at this time.

GENERAL INVESTIGATION 2

ALLEGATION A private agency received contracts from the Department that doubled in amount each year, even though prior year's contracts had not been fulfilled. In addition, the contract administrator failed to conduct any assessments of the needs of the Department for the services covered by the contracts and personally loaned substantial amounts of funds to the agency when it experienced cash flow problems. During the investigation, the OIG learned that the executive director of the agency, who was also a foster parent, had concealed the fact she was living with a felon.

INVESTIGATION The Department first entered into a contract with the agency in order to ensure Department compliance with a federal law mandating specialized services to members of a minority population. At the time, the agency was a newly incorporated, grassroots organization with no administrative experience or proven ability to provide services. The Department administrator assigned to oversee compliance with the federal law did not actively seek to form partnerships with existing organizations with histories of serving the same population. Despite the inexperience of agency personnel and the absence of critical assessments of what services could be provided, the Department entered into a series of significant contracts with the agency. Between fiscal years (FY) 1997 and 2001, the agency was awarded Department contracts totaling over $1 million. The dollar amount of the contracts continued to increase without objective evaluations of the agency's year-to-year performance. In an interview with the OIG, the Department administrator stated that there was no initial strategy regarding implementation of agency projects funded through the contracts and that the overall goal was to develop an agency "from the ground up" to work with the targeted minority community. A review of agency projects undertaken during the period covered by the contracts found a low level of success in all areas. In addition, the agency entered into a partnership with a university to develop a project that addressed many of the same issues covered by the agency's contract with the Department. Despite this overlap, the Department's monetary contribution to the agency was not adjusted to account for funds the university was granted for the project. Subsequently, the university's success in fulfilling the project's objectives was used to validate the Department's continuing support of the agency's programs, even though the university had discontinued working with the agency because of poor performance issues. The Department's contracts with the agency annually expanded in financial and programmatic terms without an evaluation or completion of previous undertakings.

Although an amendment that increased the contract amount in FY 2000 should have automatically triggered additional scrutiny in accordance with state law, no such review occurred. The amount of agency's FY 2001 contract should have required additional approvals, however the agency received approval as part of a "blanket memo" approving contracts to numerous agencies.

In 1999, when the agency experienced a budget shortfall, the administrator personally loaned the agency $25,000 in order to cover expenses and payroll. The administrator again loaned the agency $10,000 during 2001 when a similar problem arose. The administrator did not consult with his supervisor prior to extending the loans, nor did he discuss with anyone in the department the agency's inability to fulfill it's financial responsibilities or it's apparent reliance on Department funds to remain solvent. The agency's executive director told the OIG she did not receive any guidance regarding how to manage budget shortfalls. The administrator also neglected to provide guidance to the agency regarding conflicts involving board members who also held paid positions with the agency. While board members openly engaged in protracted power struggles over the leadership and direction of the agency, the administrator failed to present an accurate portrayal of the agency's status and ability to perform its functions as they related to the Department contracts.

The agency's executive director was also a licensed foster parent and had three wards living in a pre-adoptive placement in her home at the time the investigation was initiated. The OIG received a complaint that a known

drug dealer was living in the executive director's home and frequently transported the children to and from school. A review of the executive director's licensing record showed that she had been the subject of a similar complaint in 1997, but the allegation was unsubstantiated based on her assurances that was the only adult in the home. The OIG investigation found that staff at the children's school identified the individual and stated he frequently transported the children and telephone and mail records showed the felon lived in the home. A background check of the felon showed that he had previously been convicted for possession of a controlled substance and manufacture and delivery of a controlled substance with intent to deliver. An examination of leases from the executive director's residences for the previous six years showed that she had signed all of them jointly with the man.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should not contract with an agency headed by the executive director because of her apparent lack of integrity, and if her license is revoked, the Department should ensure that the agency's board is made aware of issues of credibility and rule compliance violations that may have been substantiated against the executive director as a foster parent.

The Department agreed. The OIG met with the agency's Board of Directors, as did the Department's Executive Deputy Director, to discuss these issues.

2. The Department should build capacity for services to minority wards in compliance with federal law within the most capable of existing agencies within the community. If feasible, any capacity building run by the agency should include provisions for a fiscal agent, program development, and oversight of the fledgling agency's board of directors to assure their understanding of the fiduciary duties they have to the children and families of the state's child welfare system. If not, the Department should contract with an existing agency that has the capability, with a demonstrated track record. Existing programs that further Department compliance with federal law should be retained.

The Department agreed.

3. The Department should not engage in a FY 2002 contract with the agency without a full assessment of the Department's needs in terms of federal law compliance and a realistic appraisal of the agency's ability to fulfill the contract. No funds should be expended that are not directly related to Department services.

The Department agreed.

4. This report should be shared with the Division of Internal Audits to coordinate their efforts to identify internal controls and to determine amount and method of recouping contract surpluses in FY 2001.

The Department agreed.

5. The Department should reconvene an assembled task force of Department employees to identify Department needs of federal law compliance statewide.

The Department agreed.

6. The Department should fulfill a statutory obligation to conduct a survey of the needs of the specific minority population in Illinois.

The Department agreed with the intent of this recommendation.

7. The Director should terminate the Department administrator from his position with the Department given the poor judgment and lack of administrative skills he demonstrated in monitoring the agency contracts. He failed to develop program plans with measurable outcomes, failed to assess Department needs prior to developing contracts, failed to monitor contract performance or to reassess Department contractual needs in light of prior year's surpluses or federally funded Department training. He also failed to provide technical assistance that may have better prepared the agency to handle cash flow problems, or focus it on the need to develop an objective board. He created a conflict of interest by loaning substantial personal funds to the agency, without alerting supervisors. He did not alert/consult with his supervisors about the agency's cash flow problems. He failed to be forthright in his communications with his supervisor and the Director about the agency.

Disciplinary action has been initiated by the Department.

8. The Division of Support Services/Office of Contract Administration should reduce to writing requirements that must be satisfied before the blanket memo can be used for approval. Suggestions for requirements include the following:

Prior contracting with the Department for same or similar services;

Prior approval by Chief Financial Officer and Chief Legal Counsel; and

Certification from the Department contract monitor or field staff that prior contracts have been complied with, that contract performance was adequate and that the Department has a need for the services contracted.

For those contracts included in the blanket memo, the descriptions in the memo should include the following information about the agency/contract:

- Has the subcontractor provided the contracted work in prior years?
- How has the program plan has changed in the last year?
- What number of children will be served?
- What was the prior contract amount?
- A sufficiently detailed description of the contract that permits evaluation.

The Department agreed.

GENERAL INVESTIGATION 3

ALLEGATION

A licensing investigation determined that a private agency created misleading documents in order to gain certification from the Department as a provider of services for Sexually Aggressive Children and Youth (SACY) and to become accredited by the Joint Committee on Accreditation of Health Organizations (JCAHO).

INVESTIGATION

A licensing investigation was initiated after allegations arose claiming the agency's Vice-President instructed employees to falsify documents. Licensing found that in preparing for accreditation by SACY and JCAHO, missing fire drill reports and shift summaries were created under direct order of the Vice-President. The Vice-President confirmed staff were asked to create the staff summaries and fire drill reports. She stated that although fire drills were not always conducted as required, reports were generated based on "false alarms"; she could not, however, produce any documentation that the false alarms had occurred on those days. She justified ordering the creation of the shift summaries stating they were retroactive projections which were based on recent, documented activities. The failure of the agency to complete timely and accurate staff summaries reduced the quality of care available to wards living at the treatment center.

OIG RECOMMENDATIONS / RESPONSES

1. DCFS Licensing should enforce its investigation, substantiating a licensing violation based on inaccurate daily logs due to shift summaries created far after the fact and false fire alarm reports. A corrective action plan should be initiated that addresses both the documentation failure and the lack of management integrity associated with the actions.

The Department agreed. Agency and Institution Licensing did a licensing investigation and substantiated a violation for falsification of documents. The facility implemented a Quality Assurance plan and took actions to ensure such incidents would not occur again.

2. This report and the DCFS Licensing investigations of the private agency should be shared with DCFS contracting entities, the contract monitor and the SACY Coordinator. Prior to entering into a future contract with the private agency, the Department should ensure that the private agency replaces management that condoned the action.

The Department agreed.

*Private Agency Response: The OIG met with the Licensing Administrator and the Executive Director of the agency and the Board Chair. The agency had prepared a corrective action plan to ensure the accuracy of future shift summaries and fire drill reports. The agency explained that the administrator who initiated the creation of the documents was only in the position temporarily and would be replaced.

3. The Department should implement a communication system between DCFS Licensing and DCFS Contracts to ensure that important information and problems identified in a licensing investigation are shared with DCFS Contracts.

The Department agreed. The Division of Support Services will take the lead on the implementation of a communication system between the Department's Licensing and Contracts divisions.

GENERAL INVESTIGATION 4

ALLEGATION

An agency responsible for managing a residential group home repeatedly demonstrated an inability to provide services and maintain the physical condition of the facility. In addition, the agency's administration was controlled by family members rather than an unrelated board of directors.

INVESTIGATION

The agency had been the subject of a previous OIG investigation into similar issues and had been continuously cited by the Department since its inception in 1989 for licensing violations and serious program, staffing and facility deficiencies. During the course of its current investigation, the OIG found that the agency continued to demonstrate the same organizational problems. Agency management bypassed Department intake protocol which resulted in the inappropriate placement of wards at the facility. Case records were incomplete and poorly maintained which led to poor service planning and treatment. There was also evidence of numerous incidents of violence by residents as well as the use of excessive force by staff and the failure of agency employees to document these occurrences in Unusual Incident Reports (UIR).

During the previous investigation, the OIG outlined the problematic composition of the agency's administration. The agency's founder, President and CEO was also a member of the board of directors. Her husband had served as Chairman of the Board for most of the agency's history. The couple also had a daughter on the board of directors and another that served as Chief Financial Officer. It was determined that the agency president's performance had never been evaluated by the board of directors and that board members who were not part of the governing family were not provided with information regarding the problematic issues cited by the Department. In response to the OIG investigation, the Department conducted a review of the agency. The Department learned that the agency president had earned her degrees from non-accredited institutions which disqualified her from serving as an administrator of a child care institution. The president's daughter, who was a member of the board of directors, assumed her mother's position as head of the agency. The Department neglected to discuss the issues of nepotism or conflict of interest with board members during the review.

In light of the most recent investigation the Department proposed a corrective plan for the agency which was accepted by the Public Guardian's Office. Given the agency's history of poor performance and unwillingness to adhere to the principles of responsible, professional case management, the OIG can find no evidence the current corrective plan will succeed.

OIG RECOMMENDATIONS / RESPONSES

1. Rule 404: Licensing Standards for Child Care Institutions and Maternity Centers should be revised to include all standards that are applicable to child care institutions that were added to Rule 401: Child Welfare Agency Licensing Standards. The Department needs to develop policy that clearly articulates prohibited practices, including nepotism.

The Department agreed. Rule 404 will be revised to include all standards that were added to Rule 401 that are applicable to child welfare agencies.

2. This report should be shared with the Department's Agency and Institution Licensing staff responsible for license renewal and monitoring of the private agency.

The Department agreed. The report was shared with the Department's Agency and Institution Licensing staff.

GENERAL INVESTIGATION 5

ALLEGATION A private agency caseworker placed two brothers, ages 8 and 11, in a relative foster home without conducting background checks on all adult members of the household. Despite learning that a maternal uncle who lived in the home had a record of violent crime and was the subject of a pending Child Protection investigation into physical abuse of one of the boys, the caseworker failed to remove the children.

INVESTIGATION The two boys, who had been removed from their mother's custody because of her persistent drug issues, were placed in a non-relative foster home. During the boys' time in that home, their father, who had been granted visitation, wrote two letters to the agency raising concerns about methods of discipline and corporal punishment in the foster home. The case record also documented a phone call to the boys' caseworker from the social worker at their school reporting that the younger boy had arrived at school wearing inadequate clothing. On another occasion, the caseworker recorded in her notes that the boys told her they had to wait outside of school for three hours before someone came to pick them up. After the boys' therapists raised additional concerns about the children continuing to live in the foster home, the caseworker requested permission to find a new living situation and placed them in the home of their maternal aunt.

One month after the boys were placed, the caseworker called to inquire about the presence of the maternal aunt's daughter and brother in the home. The aunt told the caseworker that her brother did not live with her but frequently visited and helped care for the children. That same day, the older boy's counselor made a visit to the home. He recorded in his notes that while he was there, the caseworker arrived to get the aunt's signature on an addendum to the boys' protective plan. The aunt's brother signed the addendum and listed himself as an alternative caregiver. The caseworker also stated that following the visit, the therapist asked her to conduct a criminal background check on the brother.

Five days later, the caseworker called the brother to obtain information in order to do a background check. During that conversation, the brother informed her he had previous convictions for murder, armed robbery and assault. The caseworker informed the aunt and her brother that he would no longer be able to have contact with the children. Both agreed that the brother would be gone from the home by the time the boys returned from their father's home at the end of the weekend. The caseworker did not visit the home on the day the boys were scheduled to return. Five days later she received a call from the therapist informing her that the aunt's brother was still in the home. The therapist also told her that during a session, the older boy told her that his aunt's brother had hit him in the head and leg with a broomstick. The therapist reported the allegation of abuse to the hotline and the case was assigned to a Child Protection investigator. The caseworker called the brother and asked him if he had any plans to move. The brother referred the caseworker to the aunt who told her that she had spoken to the Child Protection investigator and assured him her brother would not have any contact with the children.

Six days after this conversation, the aunt called the caseworker and told her that her brother was still in the home, but was not involved with the boys. The caseworker then contacted the aunt's licensing agency to request a new placement, 15 days after the brother's criminal history became known and almost two months since the boy's had been placed. After being informed that there was no available placement, the caseworker asked the aunt if her brother could stay with another relative. The aunt replied that he could not. After another week, the child welfare professionals involved with the case determined that the children must be removed as soon as possible and that they could stay with their father until a new foster home was found. The Child Protection investigator indicated the abuse report against the aunt's brother. It was ultimately determined by the court that the boys should remain in their father's custody and their case was subsequently closed.

OIG RECOMMENDATIONS / RESPONSES

1. This report should be shared with the maternal aunt's licensing agency. The caseworker should be disciplined for the following:

- failing to conduct a criminal background check on the aunt's brother and her adult daughter;
- failing to remove the foster children after learning of the aunt's brother's criminal history;
- failing to take action to ensure the safety of the children in the aunt's home after the Hotline report of abuse of one of the boys by her brother;
- failing to follow-up to ensure that the aunt's brother did in fact move out of the home as he promised;
- failing to call the hotline and refer to licensing after the biological father sent a letter to the agency voicing his concerns about excessive corporal punishment in the non-relative foster home, including being hit with objects that left bruises;
-failing to make a referral to licensing after the school's report regarding the younger boy's clothes and their report of waiting three hours to be picked up from school.

The Department agreed. The OIG will share the report with the agency.

*Private Agency Response: The agency informed the OIG that the involved caseworker was allowed to resign from her position.

GENERAL INVESTIGATION 6

ALLEGATION

An 85 year-old adoptive father was unable to care for his two daughters, ages 16 and 11. The 16 year-old had become physically abusive toward the father, however the Department had not responded to requests for intervention.

INVESTIGATION

The adoptive father and his wife, who were licensed as foster parents through a private agency, accepted the older daughter as a foster child when she was two years-old. Though the father was 69 and the mother was 54 at the time, the licensing case file repeatedly reported the father's age as being 10 to 14 years younger. Four years later, the couple adopted the child. Although the private agency caseworker handling their case recommended their foster license be closed at that time because of the couple's stated desire not to care for any more children, the license remained open. One year later the couple requested another child and the second girl, who was 11 months-old, was placed in their home. The couple finalized their adoption of the girl just prior to her ninth birthday. One month prior to the younger girl's adoption, the 14 year-old was hospitalized for psychiatric care. Six months after the adoption was completed, the mother passed away. Members of the church the family attended were heavily involved in the activities of the household. Church members told the OIG that for the final two years of the mother's life, the older daughter, who was 14 years-old when the mother died, had been caring for both parents as well as her sister because of her parent's poor health. None of these issues were reflected in case records compiled by the private agency.

Two years later, the hotline received a report that the younger daughter, age 10, was suffering from an untreated skin condition that had developed into open sores. The report alleged that the adoptive father's declining health prevented him from transporting the child for medical treatment. The report was accepted and a Child Protection investigator was assigned to the case. The investigator found that the father had no family support other than his two adopted daughters, however the church had become executor of his estate and church members continued to assist the family. The father told the investigator that the behavior of the older daughter, then 16, had deteriorated since the mother's death. The father stated that the girl hit him, broke windows in the home, stole money and was generally disobedient. The father requested that the girl be removed from his home. In an interview with the investigator, the older daughter acknowledged her father's accounts were correct and stated she did not wish to live in the home. The investigator indicated the report against the father for medical neglect of his daughter and opened the case for referral to Intact Family Services (IFS), noting that the family required a significant amount of intervention and support. The aftercare plan developed by the investigator and his supervisor did not address the domestic violence issue between the older daughter and her elderly adoptive father.

The IFS worker initially assigned to the case never assessed the father's physical condition or his ability to care for the children. The worker did not address the prevalent domestic violence issues in the home and failed to evaluate the likelihood the father could protect himself and the younger girl from the older daughter's physical attacks. The IFS worker consistently neglected to record interviews, meetings and contacts in the case file. In one instance, the worker documented a home visit with the father on a date he was an inpatient in the hospital. The IFS worker told the OIG she was unaware the father had been in the hospital at any time while she was servicing the case.

Two months after the first report, the hotline received a call alleging that the younger daughter had suffered an injury during a physical altercation with the older girl. The report also stated that the older girl frequently hit both her sister and her father. A second Child Protection investigator was assigned to the case. The investigator learned the older daughter had run away from the home and was staying with her boyfriend's family. The father had obtained an Order of Protection against the girl, though he denied having done so to the investigator. Though the father was unaware of the girl's whereabouts, the investigator did not inform

him where she was staying. The father told the investigator he was in good health and frequently went for walks, contrary to information provided by church members and contained in the previous Child Protection investigation report. The investigator unfounded the report and determined the home to be safe based on the father's assurances about his health and the fact the girl was not currently living in the home.

The IFS worker believed her duty was to keep the family together and return the older daughter to the home, even though the father could no longer adequately care for his children and had an Order of Protection against his daughter because of domestic violence issues that were never addressed. The IFS worker accompanied the older daughter to court and attempted to have the Order of Protection rescinded, however an elder abuse worker assigned to assist the father asked for and was granted a continuance because the father was unable to attend the hearing due to his poor health. Following the hearing, the IFS worker went to the family's home and berated the father for not appearing in court. The next day, the IFS made the hotline call and reported that the father had been physically abusive toward the girls, though she had no evidence or knowledge of any such occurrence.

Despite the fact this was the third hotline call during a six month period involving the father's diminished ability to care for the girls, State Central Register (SCR) workers did not recognize apparent issues regarding the dependency of a minor nor was the case routed to the Department's Child Welfare Services Unit. Instead the call was accepted for inadequate supervision and the second Child Protection investigator was again assigned to the case. The investigator assessed the family home as being safe without interviewing the father. The investigator stated to the OIG there was no risk of harm because the older daughter was still residing with her boyfriend's family, though the boyfriend's mother informed the IFS worker the living arrangement was temporary. The investigator believed it was the responsibility of the IFS worker to formulate a safety plan, if necessary. No contingency care plan was created for the girl's despite the father's poor health.

After contacting the hotline, the worker then went to the family's home and spoke with the father. According to the IFS worker's case entry, the father gave the worker $60 to give to the older daughter. The worker accepted the money in exchange for a handwritten receipt. She then gave the money to the daughter and received another handwritten receipt in return. However, the IFS worker never produced any documentation of the transaction until she was confronted by the father and his elder abuse worker who asked for proof the transfer had taken place. The dates on the receipts offered by the IFS worker and those recorded in the case notes did not match. The worker was removed from the case shortly thereafter.

OIG RECOMMENDATIONS / RESPONSES

1. In the absence of a dependency allegation category, the Department needs to take measures to ensure the proper handling of neglect-dependency cases by Child Protection Services. The OIG recommends: training to SCR staff to discern dependency-related allegations and assign Inadequate Supervision to all hotline calls reporting suspected neglect-dependency issues; the Allegations System is currently under review by DCFS Best Practice, it is therefore timely to develop and expand Caretaker Factors contained in the investigative guidelines of the allegation category of Inadequate Supervision to facilitate more accurate assessments of caregivers; training to supervisors on the dilemma produced by an aging care population; educational material should be shared with all supervisors and caseworkers on aging and available resources; establish an independent relationship with an aging specialist to be available to workers; and evaluation of the Department's Child Welfare Services to determine where it can best serve families in the continuum of child welfare services and how it can be more effective in service delivery.

The Department agreed. This recommendation will be incorporated into the Best Practice initiative. SCR staff have been retrained on identifying dependency issues.

2. The Department should consider terminating the IFS worker's employment for entering false information in a case record; unprofessional conduct; lack of services; disrespectful behavior toward the father; reporting to SCR physical abuse towards the older daughter; and for placing a child at risk of harm by arguing against a protective order in a domestic violence matter. The IFS worker's conduct and work performance suggest she is not well suited to work with families.

The Department agreed. Discipline proceedings were initiated against the IFS worker, however, she resigned from the Department effective 5/15/01. A "Do not rehire" note has been placed in her personnel file.

3. Strict guidelines need to be in place that would prevent a family from being considered for the Intact Family Services program when there are known dependency concerns as well as domestic violence issues, severe mental health problems, addiction, sexual abuse, and criminality issues.

Intact Family Services needs to develop working guidelines for determining a family's appropriateness for IFS after the family is in the program. Training on assessment and re-evaluations of families is needed to assist the worker on an ongoing basis, to determine (1) family issues and how they relate to each other; (2) the family's continued appropriateness for the program; and (3) case planning, services and interventions. Training must dispel the myth that IFS must continue for three months regardless of perceived risks.

The Department agreed. This will be incorporated into the Best Practice initiative.

4. This report should be reviewed and discussed with the Child Protection supervisor, including a discussion of issues pertaining to performance, including her approval of investigations without a review, lack of follow-up with investigators to ensure instructions were followed, and failure to ensure that all allegation issues were investigated and risk factors were properly assessed.

The Department agreed. The report was shared with the Child Protection Supervisor.

5. This report should be reviewed and discussed with the second Child Protection investigator, including a discussion of issues pertaining to performance, including failure to conduct critical collateral interviews, failure to properly assess risk factors, i.e., domestic violence, caretaker's health status, and to conduct an adequate assessment of the caretaker in accordance with the investigative guidelines under Inadequate Supervision.

The Department agreed. The report was shared with the second Child Protection investigator.

6. This report should be reviewed and discussed for learning purposes with other Intact Family Services staff members involved in this case.

The Department agreed. The report was shared with involved IFS staff.

GENERAL INVESTIGATION 7

ALLEGATION

On two separate occasions, a three and a half year-old boy ingested his brother's prescription medication and nearly died. Although Intact Family Services was handling the boy's family case at the time and had noted concerns regarding his caretakers' intellectual functioning, no steps were taken to assess their parenting capability.

INVESTIGATION

The boy and his siblings were cared for by his mother and her brother. The uncle was babysitting. Child care professionals had previously documented their uncertainty about whether either or both adults in the household were developmentally delayed. The mother had previously participated in a parenting class, however a comparison of her pre-class and post-class tests showed no change in her scores. The mother was cooperative towards workers and often participated in required services, but did little to demonstrate retention of any learned parenting skills. There is no indication any services were ever offered to her brother. Despite these questions surrounding the mother and uncle's ability to care for the children, there is no evidence in the record to suggest either adult's level of functioning was ever assessed.

The boy had previously been recommended for physical, occupational and speech therapy. Though he began receiving these services while in foster care after being removed from his mother's care following the second overdose, all therapy ceased after he was returned home and did not resume until 10 months later. While the therapy sessions were finally reinstated, they ended soon afterward when the children were sent to live with their maternal grandmother in another state for an extended period of time. A month after the children left, the mother told her caseworker she intended to leave Illinois and move in with the grandmother permanently. The next time the worker arrived at the home it had been deserted.

OIG RECOMMENDATIONS / RESPONSES

1. If the family's whereabouts can be ascertained, notification to Child Welfare Services in the grandmother's home state would be warranted so continued monitoring might occur to ensure safety of the children.

The Department agreed. The Department sent notification to the state's Department of Child Welfare Services.

2. The Department's expert on developmentally delayed children should review Intact Family's response to developmentally delayed caretakers.

The Department agreed. Clinical Services is creating a special unit, administered by the Department's expert on developmental delays, to focus on issues regarding developmentally delayed children and caretakers in the child welfare system.

GENERAL INVESTIGATION 8

ALLEGATION Five wards living in a foster home were locked in a basement on multiple occasions by their foster parents. Although workers from the private agency that placed the wards in the home were informed by the children of their confinement, immediate action was not taken.

INVESTIGATION The foster father, who was employed by a private agency as a child welfare professional, had emigrated to the United States in 1982. His wife, who had remained in their home country and raised their three daughters, joined him in 1996. Their children remained with relatives overseas. Shortly after the couple was reunited, they sought licensure as foster parents and requested to be approved to house eight children, the maximum number allowed. The initial licensing home study recommended the couple be approved to board eight children based on the amount of space that would be available in the home after renovations were completed. The licensing worker did not take into account the foster father's inexperience raising children, the foster mother's recent arrival or other critical factors. The foster father's child welfare experience was presumed to be a foundation for appropriate child care, despite the fact his wife was to act as the primary care provider. At the licensing worker's supervisor's recommendation, the couple was initially approved for three children but their license capacity was later expanded to five.

The caseworker for the first children placed in the home reported a number of concerns regarding the placement including poor hygiene, inappropriate clothing, declining school performance and the use of corporal punishment by the foster mother. On two occasions the caseworker found the children outside the home after school, unable to enter, because neither parent was present. After those children were removed, a staffing was held to address these concerns and it was determined the foster parents should participate in two trainings. When told of the agency's conclusion, the foster parents were upset they had not been notified of the complaints against them or invited to attend the staffing to discuss the issues raised. The foster parents believed cultural differences contributed to their difficulties with the caseworker and asked that she no longer service their cases. After the foster parents completed the trainings, a new licensing worker was assigned to their home. Since there were no children placed in the home at that time, the new licensing worker did not travel to the residence to conduct an evaluation.

The next two children placed in the home were removed after only three weeks. While the caseworker cited the foster parents' failure to follow up with medical services as the cause for this action, the private agency's intake supervisor contended the children were removed because a relative placement became available and did not believe the matter required inclusion in the couple's licensing file. The foster parents' annual licensing visit was delayed for four months because of scheduling conflicts with the foster father. When the meeting finally occurred, the licensing worker neglected to discuss the foster parents' history of placements in their home.

The next five children placed in the home were four siblings and a fifth child who was an emergency placement. The four siblings' case was the first assigned to a new intake worker at the agency who had no previous child welfare experience. Two months after being placed in the home, the oldest sibling told the worker the foster mother had locked the children in the basement. In an interview with the OIG, the worker stated she returned to the agency after speaking with the boy but her supervisor had left the office. The worker said that by the next time she saw her supervisor, she had forgotten about the allegation.

Over the next two weeks, the children told the worker of two more instances where some or all of them were locked in the basement. The worker raised the issue with the father who told her the basement door was locked so the children could not sneak out of the house after school. The worker also discussed the matter

with her supervisor but neither documented the conversation. The worker told the OIG it was not until she attended a training regarding mandated reporting that she understood the entirety of her obligation to contact the hotline. After consulting with the agency's licensing program director and her supervisor, the worker called the hotline. During the subsequent Child Protection investigation, the foster mother explained she locked the children in the basement, "so they [wouldn't] come into the house and steal." The foster parents were ultimately indicated for tying/close confinement and inadequate supervision.

Although an Unusual Incident Report was completed, a copy was not forwarded to the children's Guardian ad Litem (GAL). The GAL did not learn of the children's change in placement until a court hearing six weeks after the children's removal. The worker sent the Unusual Incident Report to the Assistant State's Attorney but told the OIG she and her supervisor believed responsibility for notifying the GAL belonged to others at the agency. The agency's intake director stated responsibility for informing the GAL belonged to the caseworker.

OIG RECOMMENDATIONS / RESPONSES

1. This report should be shared with the intake worker, her supervisor, the second licensing worker, the intake director and the licensing director for learning purposes.

The Department agreed. The OIG shared this report with the private agency.

As part of its corrective measures, the agency should re-evaluate its foster care program to determine where collaboration between units is necessary. Placements are an important first step in foster care services and improved communication between licensing, intake, and follow-up staff is necessary to ensure the best matches of foster families and children.

*Private Agency Response: The private agency agreed. The private agency will promote collaboration between the intake, follow-up and licensing units.

All new employees with no child welfare experience should be immediately trained on the child abuse and neglect allegations system and mandated reporting. Court orientation should be provided as soon as possible post-hire.

*Private Agency Response: The private agency agreed. New casework staff is required to attend training.

The agency should re-evaluate the licensing policy that excludes foster homes with no current placements from a monitoring visit. Scheduled monitoring visits allow licensing workers a twice-yearly opportunity to become familiar with the family and home, which is especially necessary for newly assigned workers.

*Private Agency Response: When there are not children in the home, the worker reviews the foster parent file, calls the foster parent and confirms there are no children in the home and that no changes that affect licensing status have occurred. Annual visits are still conducted.

New workers with no child welfare background are in apprenticeship and require mentoring. Supervisory staff should initially shadow new employees in the field to ensure their understanding of the role and responsibility of child welfare workers and quality of services.

*Private Agency Response: The private agency agreed. The private agency will assign senior workers to new staff for orientation and shadowing to ensure appropriate support and supervision in the field.

The agency's child welfare staff should review DCFS Rules and Procedures regarding who should be notified of changes in placement, unusual incidents, and other critical events.

*Private Agency Response: The private agency agreed.

2. The Department's procedures pertaining to Licensing of Foster Family Homes (Rule 402) should be immediately updated to correspond with the rule. Procedures should be developed to provide guidance for licensing investigations.

The Department agreed. Revisions to Rule 402 are underway and procedures will be updated to reflect these changes.

GENERAL INVESTIGATION 9

ALLEGATION

Foster parents alleged that a caseworker assigned to the case of a three year-old boy in their care failed to complete required monthly home visits and repeatedly asked them to sign blank forms to verify his visits. In addition, it was alleged the caseworker had offered false testimony in court by stating, under oath, that he had made monthly home visits and seen the boy at his day care center.

INVESTIGATION

The foster parents stated that in the two and-a-half years the investigator had been assigned to service the case, he had visited their home only eight times. In an interview with the OIG , the caseworker stated that he made "regular" visits to the foster home but acknowledged he had missed at least one visit and possibly as many as five during the time he had been handling the case. The caseworker said the foster mother often made it difficult for him to perform his duties by canceling scheduled visits on very short notice. He also explained that although he frequently visited the home, many of the contacts are not documented because he found the practice of recording every home visit "tedious." The caseworker denied ever asking the foster parents to sign blank forms. In response to the question regarding his visit to the day care center, the caseworker told the OIG he had been mistaken about the exact date of the visit, but that he had in fact gone to the center with the foster mother and seen the boy. A form recording this visit was signed by both the caseworker and the foster mother.

The OIG found there was insufficient evidence to substantiate the allegations of perjury against the caseworker. However, the boy's Client Service Plan required the caseworker to visit the foster home twice monthly. The caseworker repeatedly completed and signed service plan evaluations indicating he had satisfactorily achieved this goal. The caseworker acknowledged he had not visited the foster home two times a month.

OIG RECOMMENDATIONS / RESPONSES

1. The caseworker's agency should discipline the caseworker for failure to accurately document all of his foster home visits and for falsifying Administrative Case Review documents.

The Department agreed. The OIG will share the report with the private agency.

2. The caseworker should be immediately transferred from the family's cases.

The Department agreed.

*Private Agency Response: The private agency agreed. The caseworker was disciplined and removed from the case.

GENERAL INVESTIGATION 10

ALLEGATION

A 17 year-old boy who was a ward of the Department was incarcerated in another state. The Department caseworker assigned to his case failed to identify a post-release placement for him, causing him to remain in jail for six months after his term expired.

INVESTIGATION

The boy, who entered foster care when he was 15, had been on runaway status for 10 months when it was learned he had been convicted of burglary in a neighboring state and sentenced to six months in a juvenile detention facility. Testing conducted both prior to his arrest and after he was in jail showed he was developmentally disabled and in need of special educational services. Recommendations for services related to his disability were never put in place. Moreover, the Department used assessment tools previously identified as inappropriate for developmentally delayed individuals. The boy had already served two months of his term when his whereabouts became known, however no one from the Department established contact with him. Two months later the boy had still not been contacted by any representative of the Department when his case was transferred to the caseworker. Information concerning the facility where he was being held, including the detention center's phone number, was contained in summary materials provided to her when she accepted the case. Although the caseworker claimed to have reviewed the files and acknowledged to the OIG she was aware of the boy's location from the time she was assigned the case, she made no attempt to speak with him or anyone from the facility regarding his impending release. At a permanency hearing held one month after the boy's sentence had ended, the caseworker testified in court she had no knowledge of his whereabouts.

The caseworker's first recorded contact with anyone from the detention center occurred when she called the boy's detention center counselor in response to a message from the boy, four months after his jail term expired. The caseworker stated to the OIG she believed her responsibility was to find a placement for the boy based on the date of his release. In an interview with the OIG, the boy's inmate counselor explained that juvenile prisoners could not be released unless a placement was established for them ahead of time. The Department of Corrections had been unable to identify a placement and, without the caseworker's assistance, the boy remained incarcerated far longer than required.

The caseworker told the OIG that following notification that she had been moved to another office she was instructed to prepare her cases for transfer and did little work on the boy's case prior to another permanency hearing held three weeks after the clerk's phone call. At the hearing, the caseworker testified she was aware of the boy's location but could not satisfactorily explain why he was still in jail. The presiding judge entered a finding of no reasonable efforts against the caseworker and ordered her to find a placement for the boy within 14 days. After a month had passed without the caseworker complying with the order, the parties returned to court and the judge entered an order in which the caseworker agreed to serve a week of community service during her vacation time. The boy was ultimately released to the custody of an older sister and then went to live with friends of his family who had previously cared for him.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be disciplined for her failure to respond with appropriate immediacy to the boy's need for a placement and other services upon discharge, for her failure to have contact with him, and for her failure to conduct a diligent search for the boy.

The Department agreed. Appropriate disciplinary action is being pursued.

2. In light of the caseworker's prior evaluation which noted the need for supervision, her current supervisor should ensure that she receives the appropriate supervision.

The Department agreed. A strong and competent supervisor is being identified to address these supervision issues.

3. The caseworker's supervisor should be disciplined for her failure to supervise the caseworker's efforts in this case and ensure timely response to his discharge.

The Department agreed. Appropriate disciplinary action is being pursued.

4. The Department must be more proactive in discharging its fiduciary duty to wards who are developmentally disabled. The Department should develop a systematic response to identify these wards and ensure that child welfare staff receives the appropriate support and training in serving wards with developmental disabilities so that only appropriate education plans and tests normed for the developmentally disabled population are administered to developmentally disabled wards.

The Department agreed. Clinical Services is creating a special unit to focus on issues regarding developmentally delayed children in the child welfare system.

5. The Department's Developmental Disability Specialist should assess the boy in light of his current Job Corps plan to ensure that this is the best option for him and that his educational entitlements are not ignored.

The Department agreed. The Department's expert on developmental disabilities is working on the case.

GENERAL INVESTIGATION 11

ALLEGATION A three year-old girl was removed from her paternal grandmother's custody after the grandmother's mental condition was called into question. The OIG received a complaint suggesting the girl's removal and the subsequent indicated finding against the grandmother were improper. It was further alleged that the Department inappropriately sought an adoptive placement for the girl while her grandmother's appeal of the child's removal was still pending and scheduled a party to "celebrate" the girl's potential adoptive placement in the new home. In addition, concerns were raised regarding the Department caseworker handling the case accepting a personal check from the grandmother.

INVESTIGATION The Child Protection investigation into the grandmother's mental fitness was initiated after she called the State Central Registry (SCR) to report that an unknown intruder had entered her apartment and installed surveillance cameras. The grandmother also told the hotline that one of the cameras had somehow injured the girl's eye. The Child Protection investigator assigned to the case went to the home and met with the grandmother. She showed the Child Protection investigator a television she believed concealed a camera and showed him broken toys and scribbling on a wall she claimed the child was not responsible for. The Child Protection investigator contacted his supervisor and, acting on her recommendation, took the child into protective custody.

The case was then transferred to a follow-up investigator for completion. The investigator interviewed the girl's father, who stated his mother was not sufficiently mentally stable to care for a child, and the family's caseworker, who told her she could not advocate the girl being returned to the grandmother. After reviewing the report taken by the hotline and the information gathered by the initial Child Protection investigator, the follow-up investigator indicated the grandmother for risk of harm. The grandmother appealed both the girl's removal from her home as well as the indicated finding and the Department combined the two appeals. The Department's Advocacy office recommended the grandmother submit to a physical examination and a psychological evaluation.

The grandmother participated in three psychiatric evaluations, none of which identified any evidence of mental instability. A doctor who conducted two of the evaluations noted the grandmother provided a "rational explanation" for her statements, but did not record the substance of her account. The doctor suggested additional psychological testing could be used to identify undetected psychopathology, however none was ever conducted. The grandmother was never referred for a complete physical or gerontology examination as recommended by the Department's Advocacy Office.

While the grandmother's appeal was pending, the caseworker sought a pre-adoptive placement for the girl because her behavior was deteriorating in her foster placement. In an interview with the OIG, the caseworker stated that, at her supervisor's instruction, she sought a long-term placement in order to prevent the girl from being moved through several temporary homes. The girl was placed in a pre-adoptive placement two weeks after being taken into custody, however she was removed after two months when the foster parents became overburdened by the medical needs of their biological child. One month later, another pre-adoptive placement was identified and the involved workers began constructing a transition plan. Visits between the girl and the prospective parents began but were discontinued after the Department's Advocacy Office intervened because it was inappropriate to work towards permanency while the grandmother's appeal was pending. The adoption supervisor stated she did arrange for a meeting between the pre-adoptive parents and the grandmother because the couple had agreed to allow continued visitation after the placement. She said references made to a "celebration" in honor of the girl's transfer to the pre-adoptive home stemmed from miscommunication between the involved parties.

During her interview with the OIG, the caseworker recalled an occasion when she and the grandmother

stopped at a mall while bringing the girl home from a doctor's appointment. The caseworker gave the grandmother $60 in order to purchase groceries and diapers because the grandmother had no money with her at the time. Four months later, the grandmother gave the caseworker a personal check for $60 without being asked to repay the money. The grandmother gave a similar account of the events surrounding the transaction. The caseworker acknowledged to the OIG that extending the loan and accepting a personal check in return may have been inappropriate and that she would refrain from engaging in monetary exchanges with clients in the future.

OIG RECOMMENDATIONS / RESPONSES

1. The OIG recommended expediting the appeal process.

The grandmother succeeded in having the indicated finding expunged and her granddaughter was returned.

GENERAL INVESTIGATION 12

ALLEGATION

A Child Protection investigator received discounted airline tickets from a woman who was the alleged perpetrator of a child neglect report he investigated.

INVESTIGATION

The woman's husband called the hotline to report that she had left their four youngest children, ages six to eleven, at home alone. A report was taken for inadequate supervision and the Child Protection investigator was assigned to the case. The Child Protection investigator contacted the mother who stated she had left the four children at home briefly while she drove her 18 year old daughter to school nearby. She told the Child Protection investigator that she gave the children phone numbers of neighbors to call in case of an emergency during the short time she was gone. She also informed the investigator that she and her husband had been going through divorce proceedings for three years and that the hotline report was a byproduct of their acrimonious separation.

The Child Protection investigator unfounded the allegation and called the mother to inform her of his decision. At that time he asked the mother, who was employed by a major airline, about the cost of plane tickets for a vacation the investigator and his wife were planning. The mother told him she could acquire his tickets for him at a discounted rate because of her position with the company. The mother later purchased the tickets for the Child Protection investigator, who paid her with a personal check.

Since the Child Protection investigator's records were expunged after the report was unfounded, the OIG was unable to review the quality of his investigation. The Child Protection investigator's supervisor signed off on the investigator's recommendation, but stated to the OIG he was never aware of the airline ticket transaction. In an interview with the OIG, the Child Protection investigator stated he had no relationship with the mother prior to his assignment to the family's case. He did not believe his actions constituted a conflict of interest because he had already decided to unfound the report and was calling the mother to inform her the case was being closed, thus ending his interaction with her as a child welfare professional. Their subsequent conversation and agreement regarding the tickets was conducted as private individuals.

The Department rule regarding conflicts of interest states that Department employees may not derive any benefit from their position beyond their salary. It also states that employees may not, "solicit or accept any payment, gift, favor, service, loan or entertainment or other consideration for themselves or others under circumstances that might reasonably be construed to influence the performance of his or her official duties." The Child Protection investigator minimized his financial benefit from the arrangement by explaining he paid for "passes" rather than actual "tickets" and had to fly as a non-guaranteed "standby" passenger. The Child Protection investigator told the OIG he was unfamiliar with the Department rule specifically addressing conflicts of interest. When informed by the OIG he had signed a form certifying he had received notice of the rule, the Child Protection investigator responded that he and other employees routinely signed Department documents without reading them.

OIG RECOMMENDATIONS / RESPONSES

1. The Child Protection investigator should be disciplined for violating the Department's rule regarding conflict of interest.

The Department agreed. The Child Protection investigator received a 20-day suspension.

GENERAL INVESTIGATION 13

ALLEGATION

A Child Protection investigator was arrested for Driving Under the Influence of alcohol following her involvement in an automobile accident while she was transporting a 17 year-old female ward.

INVESTIGATION

The 17 year-old had been taken into protective custody after she reported to police she was raped by an unknown perpetrator and had no knowledge of her mother's whereabouts. The girl was placed in a group home and her case was assigned to the Child Protection investigator. After a diligent search failed to locate the girl's mother, the Child Protection investigator questioned the girl about how else they might locate her mother prior to an upcoming court date. The girl stated that her mother sometimes visited a boyfriend and although she did not know his address, she could recognize the building where he lived. The Child Protection investigator arranged to pick the girl up from the group home that weekend and drive her to the area in search of the boyfriend's building.

After picking the girl up, the Child Protection investigator began driving towards the expressway. En route, she was involved in a two car accident at a four-way intersection where the traffic lights were not operating. An ambulance arrived on the scene but the Child Protection investigator declined medical attention for both herself and the girl. The police officer who responded to the accident spoke with the involved parties. The passengers of the second car stated that the Child Protection investigator had driven directly through the intersection rather than stopping before proceeding as other cars had. The Child Protection investigator contended she had driven through a green light, a statement the officer deemed improbable since the traffic lights were inoperable.

Following the accident, the Child Protection investigator called the group home and requested that someone come to the accident site to transport the girl back to the home. When a worker from the home arrived on the scene she spoke with the girl who told her that while they were driving, the Child Protection investigator had been drinking something that smelled of alcohol. The worker related this information to the officer who then asked the Child Protection investigator if she had been drinking. The Child Protection investigator denied consuming alcohol but would not allow the officer to search her car and also refused to submit to a breathalyzer test, which resulted in the immediate suspension of her driver's license.

The officer did subsequently search the vehicle and found a plastic water bottle under the driver's seat that smelled of liquor. Though the bottle had her name on it, the Child Protection investigator told the officer the bottle belonged to her sister. The Child Protection investigator was then arrested and charged with driving under the influence and possession of an open container of alcohol. After being taken to the police station, the Child Protection investigator asked to be seen by a physician. A laboratory analysis of the bottle's contents conducted by the police found the liquid to be four percent alcohol. When asked why she did not seek medical attention for the girl, the Child Protection investigator replied that she knew there was a clinic at the girl's group home.

An OIG review of the Child Protection investigator's personnel file showed that at the time she was hired by the Department she did not possess a valid driver's license, though it was a requirement of her position. On her original application for employment, she stated she was in possession of a valid driver's license and signed a statement on the application certifying the information she had submitted was accurate.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should initiate charges for termination of the Child Protection investigator's employment for being unfit for duty and transporting a minor while under the influence of alcohol; falsification of records; maintaining employment while a child protection investigator

without a valid driver's license during 1994 and subsequent periods; and for gross negligence and putting a minor at risk of harm, when she did not accept medical evaluation for a minor in protective custody when available immediately following a traffic accident;

The Department agreed. The employee resigned with no reinstatement rights.

2. Revise current handbook policies to include:

- at a minimum, a requirement for current employees, if reasonable cause exists to believe they are under the influence, for drug and/or alcohol testing at a private laboratory which is accredited and set up for such testing.

The Department agreed with the intent of this recommendation. A task force has been created to address this issue.

3. Develop a procedure for regular and accurate reviews of an employee's driving record, license status, and insurance in positions which require driving either a personal or state vehicle, whether or not the employee chooses to seek mileage or other travel reimbursement, and without reliance solely on the individual employee's representation or certification.

The Department agreed.

GENERAL INVESTIGATION 14

ALLEGATION

A Child Protection investigator falsified information contained in a report regarding the possible physical abuse of a five year-old boy.

INVESTIGATION

The State Central Registry (SCR) received a report of suspected physical abuse against the boy by a school bus aide. The Child Protection investigator assigned to the case submitted a report in which he recorded that he and a Deputy Sheriff had gone to the family's home and interviewed the boy and his mother regarding the incident. The investigator recommended the case be unfounded and filed his final report with the Department.

When the mother received notice of the unfounded finding, she contacted the Department. She stated she was unaware of any child abuse investigation and that the Child Protection investigator had never spoken to her or her son. The OIG contacted the Deputy Sheriff named in the report who denied ever having been to the family's home in relation to the case. When confronted with these discrepancies, the Child Protection investigator admitted he manufactured the report in an attempt to complete his cases prior to going on vacation. The investigator immediately tendered his resignation which stipulated he had no right to be rehired by the Department in the future.

OIG RECOMMENDATIONS / RESPONSES

1. The Office of the Inspector General should be notified if the Child Protection investigator requests licensure or an Agency Performance Team person learns that he is employed by the private sector.

The Department agreed. The appropriate individuals have been notified.

GENERAL INVESTIGATION 15

ALLEGATION

A foster parent licensed through a private agency severely physically abused a 10 year-old boy placed in her home.

INVESTIGATION

The boy, who had been in Department custody since he was five, had an extensively documented history of extremely disruptive and dangerous behavior. Throughout his placement history, the boy had exhibited physical and sexual aggression towards other children, foster parents and child welfare professionals. At various times he smeared his feces on walls, threatened adults with knives, urinated on himself and repeatedly engaged in banging his head against hard surfaces. In one instance the boy attempted to touch an electrical socket while his other hand was immersed in water. The boy was diagnosed as being mentally retarded and presenting impulse control disorder and oppositional defiant disorder. Numerous child welfare professionals noted his tendency to become enraged easily and frequently, resulting in uncontrollable behavior to the point of requiring police intervention. During the boy's five year placement history, he resided in seven foster homes and nine different hospitals, mental health facilities, residential centers and group homes and was readmitted to many of these facilities on multiple occasions.

The boy's foster mother in his seventh foster home was a 22 year-old single woman who was approved for licensure through a private agency the day before he was placed in her home. Within the first two weeks of his placement, the foster mother requested emergency counseling twice, the police were called once when he had an outburst in public which required hospitalization and he ran away from a therapy session, at which time the foster mother ran him down and sat on him as a method of restraint. The private agency caseworker assigned to the case later learned during a meeting with the foster mother that she had not attended a training on the use of restraints as required by the agency. Throughout the course of the boy's placement, the caseworker documented frequent behavioral problems. Fourteen weeks after the boy was placed in the home, an incident at school precipitated a violent confrontation between the foster mother and the boy. The boy became angry and charged at the foster mother, kicking her in the stomach. In response the foster mother grabbed a belt and began swinging it at the boy as he continued flailing at her. The boy's bruises were noticed the next day by school personnel who called the hotline. The boy was removed from the home and ultimately placed in a residential treatment facility. The foster mother was indicated for abuse following a Child Protection investigation and criminally prosecuted for aggravated battery of a child.

Assessments of the boy's placements consistently noted his need for intense structure. Although long-term residential treatment was repeatedly recommended as the most beneficial situation for him to live in, the Department's family lead worker assigned to the boy's case continually allowed for him to be placed in foster homes despite her own notes in the case file indicating she believed foster home placements were inappropriate. The lead worker consistently failed to record significant developments in her case notes and did not provide the Placement Review Team or either of the private agencies involved with the boy with information vital to making decisions about how best to proceed with his case.

In addition the Department's Clinical Coordinator maintained an insistence on finding foster home placements for the boy, even though his stays in these homes repeatedly proved to be volatile, chaotic episodes that endangered the safety of the boy and the involved foster parents. The Clinical Coordinator stated to the OIG his conviction that the boy would succeed in a foster home if the proper setting could be found. The Clinical Coordinator recognized the extreme nature of the boy's case and said he persisted in seeking a foster home placement because he feared that if the boy was placed in a residential treatment facility he would become institutionalized and "get lost in the system." While the Clinical Coordinator's actions were well intentioned, his insistence upon placing the boy in a foster home was in direct opposition to the evidence provided by the boy's history and the educated judgment of numerous child welfare workers and medical and

mental health professionals. The Clinical Coordinator compounded the boy's problems by moving him through a number of failed placements rather than identifying a suitable, permanent residential facility.

The private agency's licensing study of the foster mother's home lacked sufficient depth and was hastily completed in order to provide the agency with another option for placing children. Documents were incomplete or missing from the file and the agency did not ensure that the foster mother had completed all of the necessary trainings required to function as a capable foster parent. A more critical analysis of the foster mother's appropriateness as a foster parent in general and as a placement for this boy specifically might have prevented him from being placed in a harmful situation.

OIG RECOMMENDATIONS / RESPONSES

Private Agency

1. The private agency should re-evaluate their foster care applicant screening procedures to ensure a comprehensive assessment is conducted on each applicant, and ensure all necessary paperwork/training is completed prior to making a recommendation for licensure. Any significant life changes or events that become evident or are made known concerning an applicant during the screening process should be thoroughly explored. The agency needs to look at the way the applicant was/is impacted by significant events and how this might affect parenting. The assessment should provide as clear a picture as possible of the applicant's background, strengths, personality, health, parenting style and experiences, relationship history, areas of discomfort or where there might be need for further training, etc. Applicants should be rated on various factors, including maturity, ability to respond to different types of challenging behaviors and crises. The assessment of the applicant should be documented in the licensing file, and, if the applicant is recommended for a license, the assessment should be used as part of the tools to determine appropriate matches for placement. The agency's psychosocial and application forms cannot be used in lieu of an assessment.

The Department agreed. The OIG will share the report with the private agency.

*Private Agency Response: The private agency agreed. The private agency has revised their applicant screening procedures. Weekly match meetings are held with the program manger, supervisor, licensing representative, private agency team members, coordinators and intake.

2. The private agency should develop procedures for appropriate matching of foster homes and children, which promote careful evaluation of the child's needs as well as the dynamics and capabilities of the foster homes under consideration for placement, in accordance with Department Rules and Procedures placement selection criteria, section 301.6. The process should include a staffing between licensing personnel and/or intake, and case management personnel so that effective, informative dialogue can occur between individuals familiar with the child's needs and those familiar with the foster parents.

The Department agreed. The OIG will share the report with the private agency.

*Private Agency Response: The private agency agreed. The private agency has revised their applicant screening procedures. Weekly match meetings are held with the program manger, supervisor, licensing representative, private agency team members, coordinators and intake.

3. The private agency should ensure all relevant copies of a child's records are available prior to assessing a foster home for the child's placement. Because the agency accepts only special needs children, the agency must obtain the child's complete case record.

The Department agreed. The Department revised administrative procedure to ensure private agencies receive full records.

*Private Agency Response: If documentation is not received, it is immediately requested. The child is screened by the intake coordinator and often the supervisor.

4. Given the complex nature of the private agency cases, it is crucial that workers receive regular proactive supervision. The agency should implement a means of reviewing cases on a rotating basis to ensure all cases receive supervisory oversight and input at least every month. Documentation of the case reviews should be either in the case files or in a separate supervisory file. Crucial decisions such as placement decisions need to be staffed and closely monitored by the supervisor.

The Department agreed. The OIG will share the report with the private agency.

* Private Agency Response: The private agency agreed. It has improved the degree of support and supervision to the program manager and caseworkers.

The Department

5. This report should be used as a learning tool with the family lead worker concerning the following matters: 1) the importance of documentation; 2) the need to secure complete information; 3) her failure to provide the private agencies with relevant, integrated information regarding the boy; and, 4) the inappropriate placements the boy repeatedly experienced while the family lead worker managed his case.

The Department agreed. A redacted copy of the report will be shared with the family lead worker.

6. The OIG stands by its objection to Administrative Procedure No. 9 under case transfer requirements. The Department has a fiduciary obligation to maintain complete records for the children under its care. The Department needs to create a central record-keeping department for this purpose. When cases are transferred from one agency to another, the Department has a professional obligation to provide a full record to the accepting agency so the agency is equipped with the information necessary to make appropriate decisions. However, this too frequently does not occur, leaving the accepting agency with incomplete information.

The Department agreed. Revisions to Administrative procedure No. 9 are underway. The revisions will require that when a case file is transferred from one agency to another, the full record must be sent to the requesting agency.

7. The Department must develop procedures for ensuring there is a linkage between children who are known to be developmentally delayed and the Department's specialists in the field. A more effective connection and additional training for staff working with these children are necessary.

The Department agreed. Clinical Services is creating a special unit, administered by the Department's expert on developmental disabilities, to focus on issues regarding developmentally delayed children in the child welfare system.

8. The Department should work with family services in the state where the boy's biological mother now lives with her youngest child to verify their living arrangement and assess the safety/risk of the living arrangement.

The Department agreed. The Division of Operations will work with the state to verify and assess the safety of the mother's living arrangement.

9. This report should be shared with the Department's Guardianship Administrator, to enable her to make informed future permanency planning decisions, and to make the Guardianship Administrator aware that the paternal or maternal family members are seeking custody of the children.

The Department agreed. The report was shared with the Guardianship Administrator

10. The Department's expert on developmental disabilities should review the boy's case and work with staff at his current residence to ensure that his placement and treatment program are appropriate.

The Department agreed. The Department's expert on developmental disabilities has been and continues to be involved in the boy's case.

Placement Review Team

1. This report should be used as a learning tool with the Department's Clinical Coordinator regarding his failure to integrate and apply the information and clinical recommendations that he had regarding the boy's needs. As the Clinical Coordinator, it is crucial that all issues involved in determining placements are considered, including historical information, the child's multiple needs, the provider's or placement's capability to meet those needs, and recommendations from other professionals. The Clinical Coordinator must be able to discern between placement in a long-term residential treatment facility equipped to meet the needs of a child like the boy in this case, and placement in short-term group homes, and recognize when it is in a child's best interest to be placed in a residential facility. The Clinical Coordinator relied upon the assurances and assessments of select individuals and his unwavering belief that the boy belonged in a foster home, rather than conducting a comprehensive evaluation of the boy's placement needs based on his documented historical record and the numerous reports, assessments and recommendations that repeatedly said that the boy needed a long-term treatment facility designed to meet his needs. The Clinical Coordinator's assessments and recommendations did not recognize or adequately respond to the needs of an intellectually low-functioning child with severe behaviors. The OIG will share this report, along with other past redacted reports regarding the Department's treatment of developmentally delayed youth, with the Clinical Coordinator involved in this case and the other DCFS Clinical Coordinators.

The Department agreed. The Division of Clinical Services will share and review the report with the Clinical Coordinator.

GENERAL INVESTIGATION 16

ALLEGATION

Based on complaints received from two separate private agencies, the OIG reviewed Department policy on the notification of private agencies when their employees were the subjects of indicated abuse/neglect reports.

INVESTIGATION

In the first case, a private agency complained that a woman who had been indicated for burns, medical neglect, bone fractures, risk of harm and inadequate supervision against her three foster children while licensed as a foster parent through the agency was currently employed in a residential childcare facility. The facility's executive director was unaware of the indicated finding and had never been notified by the Department.

The second case involved a program supervisor for a private agency who was the subject of an investigation for tying/close confinement and inadequate supervision. The agency's executive director had placed the worker on desk duty pending the outcome of the investigation but had never been notified of a resolution. The investigation of the allegations resulted in an indicated finding against the program supervisor. Since Department rules state that a single instance of tying/close confinement does not require termination, the employee was allowed to remain in his position.

The OIG found that Department rules are unclear in assigning responsibility for notifying private agencies of indicated findings against their employees. A provision assuring that agencies are made aware of abuse and neglect reports against their employees would allow the agencies to restrict the employees access to children while the cases are pending and create an additional level of safety for Department wards. The OIG noted that the Abused and Neglected Child Reporting Act does not require employer notification when the act of abuse occurs outside the context of the performance of professional responsibilities.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. SCR or Child Protection should be required to compare indicated perpetrators against databases of licensed child welfare employees or day care providers. If licensed, either SCR or Child Protection should be given the responsibility of notifying both the employer and the Child Welfare Employee Licensure Board.

The Department agreed.

2. The Department should re-examine Rule 385 to allow for more flexibility in considering single occurrences of particular allegations for unsuitability. While the OIG does not believe that the program supervisor's case rises to the level of unsuitability, the Department should have discretion in determining if a single allegation warrants concern about an employee or foster parent's role working with children.

The Department, Child Protection and DCFS Legal are currently studying Rule 385 for possible revision.

3. The Department should support legislation to clarify that child welfare employers can be notified of any indicated abuse and neglect reports against their employees.

The Department agreed and is supporting proposed legislation.

GENERAL INVESTIGATION 17

ALLEGATION

A Child Protection manager entered into purchase of service contracts with family members, thereby using her position for the financial benefit of her relatives.

INVESTIGATION

The Child Protection manager was asked to submit the names of qualified individuals to a consulting firm contracted by the Department for a special project. The consulting firm would then select people from the list for hire on a short-term basis. The Child Protection manager provided a list which included the names of her mother and daughter, both of whom were later selected by the consulting firm to work on the project. A portion of the women's work for the firm involved objectively reviewing the performance of the child protection investigative team the Child Protection manager oversaw.

The Child Protection manager stated to the OIG she informed her supervisors of the presence of her relatives names on the list, she had no influence over the consulting firm's decisions and that she did not supervise either relative while they were employed on the project. The OIG determined that the consulting firm committed an error in judgment by hiring the Child Protection manager's relatives. Contracting individuals to objectively review the job performance of another family member created the appearance of a conflict of interest, creating the potential for public mistrust of the Department.

OIG RECOMMENDATIONS / RESPONSES

1. The Department should send a memo to all employees of the Department reminding them to make use of the Rule 437 Conflict of Interest committee before making any decisions or recommendations that could lead to the relative of a Department employee obtaining a contract with the Department or with an entity contracted to complete work for the Department. In situations where the Department contractors independently hire family members of the Department employees, the Department employees should recuse themselves from any oversight of the contract process. A copy of a sample memo is attached to this report.

The Department agreed. An informal transmittal was sent to all Department employees regarding the use of Rule 437 on August 15, 2001.

2. The Department's Ethics Officer should remind the consulting firm that the practice in which it engaged resulted in a conflict of interest.

The Department agreed. The OIG assumed responsibility for this recommendation.

GENERAL INVESTIGATION 18

ALLEGATION

A Child Protection investigator had a sexual relationship with the 17 year-old daughter of a Department client.

INVESTIGATION

The Child Protection investigator was assigned to find a placement for the girl who was living in a shelter after she ran away from home. During the course of the investigation, the girl returned home to live with her mother. The girl's mother noticed that her daughter continued communicating with the Child Protection investigator after she moved back home. The daughter and the Child Protection investigator denied the existence of any relationship, however the mother expressed her suspicions to the investigator's supervisor. The supervisor then questioned the Child Protection investigator who again denied any impropriety. The daughter stated that after the Child Protection investigator was questioned at work, he arrived at her school and threatened her, stating, "Tell your mommy she almost got me fired." The girl then became frightened and told her mother about the relationship. In an interview with the OIG, the daughter said she had engaged in consensual sex with the Child Protection investigator on three or four occasions at a hotel and once at his friend's apartment. The girl also stated she was introduced to the investigator's ex-wife and two children during one of their meetings.

The Child Protection investigator denied he ever engaged in a physical relationship with the girl. He said he communicated with the girl because she was experiencing a difficult period in her life. The investigator told the OIG it was impossible that the girl had met his children because he had just recently fathered his first child. A review of Department insurance forms showed that the investigator had requested coverage for two children, ages 5 and 14. A neglect report accepted by the hotline while this investigation was underway revealed the existence of another five year-old child fathered by the Child Protection investigator. A review of phone records found a total of 58 calls between the investigator and the girl during a one-month span, six months after the Child Protection investigation was completed. The records also showed that during a five month span, the Child Protection investigator used his Department-issued cell phone to make 195 calls to his girlfriend's home while contacting his office only 23 times.

OIG RECOMMENDATIONS / RESPONSES

1. The Child Protection investigator should be discharged because of his inappropriate conduct in maintaining a relationship with a client after the termination of the professional relationship, his improper use of the cell phone and his untruthfulness in his interview with OIG staff.

The Department agreed. Discharge proceedings were initiated, however, in accordance with personnel procedures, the Child Protection investigator was given a 30-day suspension.

GENERAL INVESTIGATION 19

ALLEGATION

A Department child welfare specialist was arrested for possession of a controlled substance.

INVESTIGATION

The child welfare specialist was observed entering a known drug house by police officers assigned to a stakeout. The house was approximately three miles from her home and was in the region the child welfare specialist served in her capacity as a Department employee. A public grade school was located across the street from the drug house. When she exited the house within minutes of entering and got into her car, officers approached her and asked her to step out. The employee emerged from the car with her fist tightly clenched. When officers requested she open her hand, she displayed two small plastic bags of crack cocaine. The child welfare specialist was arrested for possession of a controlled substance. Because there was no one else with her in the car, the vehicle was impounded. The child welfare specialist reached an agreement with the State's Attorney's Office to enter a diversion program for first time offenders consisting of weekly drug education classes in exchange for dismissal of the felony charges.

In her interview with the OIG, the child welfare specialist denied the facts of the police report. The child welfare specialist told the OIG she could not recall who explained the diversion program to her in court but accepted the agreement because it meant the charges would be dropped.

OIG RECOMMENDATIONS / RESPONSES

1. The child welfare specialist should be terminated as an employee of the Department as she engaged in conduct unbecoming a public official that eroded the public's confidence in the Department.

The Department agreed. DCFS initiated discipline against the employee. However, the employee resigned with no reinstatement rights.

GENERAL INVESTIGATION 20

ALLEGATION A Department attorney verbally abused a Child Protection investigator after the investigator refused to turn over a report to an Assistant States Attorney during a case screening.

INVESTIGATION During a meeting to determine whether to petition the court for temporary custody of two children, the Assistant State's Attorney asked the Child Protection investigator for a copy of a previous indicated abuse report against the father. The investigator declined the request based on her belief that reports had to be subpoenaed through the Child Protection records office. While the Child Protection investigator attempted unsuccessfully to reach her supervisor for consultation, the court liaison contacted the Department's Legal Division for assistance. The Department attorney arrived and told the investigator to hand over the report. The attorney then spoke by phone with the Child Protection manager who, after conferring with the Associate Deputy Director of Child Protection, instructed the Child Protection investigator to share the report. The investigator handed the report to the Department attorney who in turn gave it to the Assistant State's Attorney. The Child Protection investigator told the Department attorney that she felt he had behaved rudely towards her in his handling of the situation, at which time the Department attorney apologized. In interviews with the OIG, the Assistant State's Attorney, his colleague who was present in the room and the court liaison all stated they did not believe the Department attorney behaved inappropriately and that the Child Protection investigator was unnecessarily uncooperative. The OIG determined that the Department attorney's behavior in this instance did not rise to the level of misconduct.

The children had initially been placed in their father's custody following their mother's murder. The hotline received a call expressing concern for the children's safety because the father had two pending domestic violence charges, including one for felony child abuse, and an extensive criminal history. The Child Protection investigator requested a copy of a recent indicated abuse report against the father, interviewed a number of involved parties, including the children, the father and the detectives handling the murder investigation, and conducted a criminal background check on the father. The check disclosed a pending domestic violence charge involving the deceased mother, convictions for manslaughter and aggravated battery, and a history of arrests for domestic battery. In her investigative notes, however, the Child Protection investigator only recorded the father's most recent arrest. Despite this information, the Child Protection investigator determined that the children were not at risk with the father because a number of the mother's relatives were police officers and they had no objection to the children being placed with him. There was no evidence to suggest the relatives were aware of the father's criminal history. The Child Protection investigator's supervisor concurred with her assessment, dismissed the relevance of the father's criminal record as "past history" and maintained that pending felony child abuse charges were not convictions and should not be considered in judging the children's safety. The supervisor also stated his belief the young children were not at risk because the child the father had abused was several years older. The children were finally removed from the father's home at the insistence of the Child Protection manager.

During the course of the investigation, the OIG identified problems concerning inadequate investigative practices and poor assessments by the Child Protection investigators. A review of two prior abuse reports against the father found a failure to adhere to proper procedure and a disturbing lack of critical thinking on the part of the assigned Child Protection investigators. In the first report, a Child Protection investigator was assigned after a school reported injuries to the father's stepson. The investigator was told by the family that the boy had knocked over the dinner table, spilling food all over the floor. This behavior prompted the father to grab the boy who then fell backwards over the couch as a result. The Child Protection investigator observed significant bruising on the boy's back but concluded the injuries could be consistent with the family's story. The boy did not visit a doctor and the investigator did not consult with a physician to determine the plausibility of the account. In addition, the investigator told the OIG the child had provoked the

incident and` "liked to make people angry," a mitigating factor which he believed, combined with insufficient evidence, prevented him from indicating the report, even though the investigator believed the boy had been abused.

The second investigation was flawed in many respects. The father had become enraged after he believed his nephew had purposely walked in on his niece and stepdaughter while they were changing after swimming. The father began beating the nephew with a toilet plunger and struck the girls and his stepson when they attempted to intervene. Police responded and the father was arrested and charged with four counts of aggravated battery against the children in his care. A second Child Protection investigator was assigned the day the abuse report was received. The second Child Protection investigator interviewed the stepson and his mother and completed body charts of the stepson and stepdaughter's injuries. The second Child Protection investigator attempted to visit the home of the niece and nephew but found no one present at the residence. The investigator then handed the case off to the Child Protection investigator who had been assigned to the first abuse report without making an effort to contact the father or the officer who made the report to the hotline. The initial Child Protection investigator could not determine the father's whereabouts and never interviewed him or the niece and nephew prior to closing the case. His narrative of the incident included in the file misconstrues the events of the incident and is not supported by any other available information. The Child Protection investigator also failed to provide documentation of police reports, medical treatment or a background check on the alleged perpetrator. The Child Protection investigator did not develop a protective plan but relied on the mother's assurance she would have no further contact with the father. The poor quality of this investigation caused the subsequent investigator to discount the indicated finding.

OIG RECOMMENDATIONS / RESPONSES

1. The Child Protection investigator's supervisor should be disciplined for a poor assessment of risk of harm, not documenting a conversation with a person with key information and his lack of familiarity with rules regarding confidentiality and other issues pertinent to this case. His office should receive a full set of rules.

The Department agreed. Appropriate disciplinary action is being pursued.

2. The Child Protection investigator should be counseled by the Child Protection Manager on risk assessment, specifically the role of an investigator when examining prior evidence of violence.

The Department agreed. The Child Protection investigator will be counseled.

3. The Child Protection investigator assigned to the child abuse reports should be counseled by his supervisor on his poor investigative practice in both investigations. He should be closely supervised for the next six months with 3 random cases per month pulled by his supervisor to determine whether his investigations conform to Rules and Procedures.

The Department agreed. The investigator will be counseled.

4. The Department should develop law enforcement liaisons in each region. The liaisons should aid workers in procuring underlying documents in cases with a criminal history. The OIG will assist in facilitating the initial coordination with law enforcement.

The Department agreed to identify individuals responsible for providing assistance and troubleshooting specific problems related to gathering necessary underlying documents for criminal history analysis. All Child Protection workers should be trained to work with law enforcement as well.

5. The Department should ensure that copies of indicated Child Protection investigations are available to Child Protection and forwarded to intact family or child welfare workers, including private agencies. Indicated Child Protection investigations assist workers in the process of assessment and noting critical patterns of behavior.

The Department agreed.

6. This case presents another example that confidentiality rules are not used or understood by staff. Portions of this report should be shared with the Confidentiality Task Force.

The Department agreed. The OIG has provided portions of the report to the Confidentiality Task Force.

GENERAL INVESTIGATION 21

ALLEGATION

A woman who provided overnight in-home care for Department wards in a foster home was paid for her services by the foster mother instead of through the Department's direct payment system. The foster mother cashed the checks that came from the Department in the woman's name.

INVESTIGATION

The foster mother, who had four children placed in her home, submitted four applications for in-home care to three different caseworkers. On each form she listed her hours of employment as 8 p.m. to 7 or 8 a.m., seven nights a week. There was no evidence in the case file that her employment was verified. A handwriting analysis of the enrollment forms intended to be filled out by the care provider found that the care provider's signature had been forged. The enrollment forms listed the foster mother's address as the mailing address for the checks. The care provider's signature had also been simulated on the checks, which were cashed by the foster mother. The foster mother told the OIG that she had already paid the care provider for her services and accepted the checks as reimbursement for the costs. The foster mother denied forging the care provider's name and stated she prepared the enrollment forms but gave them to the care provider to sign. The OIG found no evidence that the foster mother underpaid the care provider, however she acted inappropriately by falsifying Department documents.

A review of the Department's process for handling the day care application and payment process found several basic but potentially serious problems. The forms provide no clear instructions to foster parents or care providers regarding who is responsible for completing and submitting the forms or how and when any party could expect to receive payment. Since the forms are not specific to either party, it is possible for one individual to complete the form in its entirety and return it to the Department without the knowledge of the other party. While a space is provided to indicate how much the care provider will charge for services, the form does not explain that the Department does not automatically cover the cost reported, but bases the number against a pre-determined scale and selects the lesser amount. The form also neglects to inform readers that payments received for in-home care could be considered taxable income and would be subject to Internal Revenue Service regulation. In addition, there is no system to verify the accuracy of the foster parent's employment or the care provider's billable hours. The Office of Child Development, which is responsible for overseeing the process, has not been fully integrated into the Department's overall system and operates out of different offices in each region, requiring compliance with differing standards. A lack of familiarity among Department caseworkers with proper policy regarding payments to care providers creates further confusion. The combination of decentralized resources and insufficient training has created gaps in the application and payment process, exposing the Department to an increased potential for fraud.

OIG RECOMMENDATIONS / RESPONSES

1. Revision of the Day Care Application that allows for each party to have different forms to fill out and sent in or give to the caseworker. The Application should include a set of consumer friendly instructions for completing the application and an information sheet regarding payment and income reporting. The application should include a statement for the foster parent's and day care provider's signature to the effect that "the information provided in the application is true...." Day care providers should be informed that the state is required to report to the IRS payments to any provider that amounts to more than $600 per year and that such payments could be subject to taxation. The signature of the day care provider should also be notarized. Separate forms ensure that all parties are informed as to procedures and have agreed to the arrangement of payment through The Department.

The Department agreed. The Division of Support Service and the Office of Internal Audits are working on a strategy to implement changes in the functioning and organization of the Office of Child Development.

2. The Department should reconsider funding a central Office of Child Development that places control over day care coordination in a single location.

The Department agreed. The Division of Support Service and the Office of Internal Audits are working on a strategy to implement changes in the functioning and organization of the Office of Child Development.

3. As the Office of Child Development has already recommended, training on day care policies and procedures should be included in the statewide training for caseworkers and supervisors. Additionally, foster home licensing workers should also be trained on day care policies and procedures.

The Department agreed. Upon completion of changes to the functioning and organization of the Office of Child Development, statewide training will be provided.

GENERAL INVESTIGATION 22

ALLEGATION A Foster Parent Support Specialist (FPSS) facilitated a meeting between a foster parent, the eight year-old twin brothers in foster care in her home and a man who wished to adopt them, without the knowledge of the caseworker or other involved child welfare professionals.

INVESTIGATION The foster parent, who had been caring for the twin boys for three years, related to her support specialist (FPSS) that she did not wish to become an adoptive placement. Soon afterwards, the support specialist was contacted by a man who stated he was a foster parent interested in adopting twins. The man told the support specialist he was wealthy, well educated and had ongoing, positive relationships with his former foster children and their biological parents. The support specialist recommended to the man that he volunteer to serve as a respite care provider for the twins' current foster parent. She then contacted the boys' caseworker and told her about her conversations with the current foster parent and the man interested in adoption. The caseworker informed the support specialist that she believed the boys were in an appropriate placement and wanted them to stay with their foster mother. This position was reiterated to the support specialist by the caseworker's supervisor during a chance meeting a short time later.

The man continued to call the support specialist who eventually gave him the caseworker's phone number. The man later contacted her again and told her he had received what he felt were unsatisfactory responses from the caseworker and her supervisor regarding his interest in adopting the boys. The support specialist then gave the man the foster mother's phone number so that he could speak to her directly. In an interview with the OIG, the support specialist stated she received the foster mother's permission before sharing her number and passed it along because she believed the man's motives were genuine and that the Department was not adequately responding to his requests. She did not verify any of the information the man gave her about himself before putting him in contact with the boys' foster mother.

The man had several conversations with the foster parent and the two ultimately agreed to a meeting with the boys. The foster mother reported to the OIG that the man behaved strangely during the meeting and took pictures of the twins. She also stated that in subsequent telephone calls, the man told her he had already picked out their furniture and requested that they spend a weekend at his house. The foster parent told the OIG the man seemed "obsessed" with adopting the twins.

The caseworker and her supervisor had no knowledge the man had contacted the foster mother until the caseworker received an e-mail from the man which included his pictures from the meeting. The caseworker told the OIG that she then arranged a meeting with the man at her office. She stated the man spoke extensively on what he believed were physical similarities between himself and the boys and made other comments that made her feel uncomfortable. She was also unable to determine the author of a home study the man presented to her. In an interview with the OIG, the man stated he had written the home study himself.

The OIG contacted the Placement Clearance Desk and learned that the man's foster care license had been put on hold status, barring children from being placed in his home based on two indicated reports against him for inadequate supervision.

The OIG interviewed the support specialist's supervisor who stated she was unaware of the efforts to affect the twins' placement until the support specialist informed her of the entire situation well after the fact. The supervisor said that if she had been aware of the man's inquiry, she would have contacted the Placement Clearance Desk and encouraged the foster mother to seek a respite care provider closer to the foster mother's home.

OIG RECOMMENDATIONS / RESPONSES

1. The support specialist's administrator should examine all the supervisor's supervisory notes concerning the support specialist and all of the support specialist's case notes to determine whether the incidents described here reflect an isolated problem or a general lack of appreciation of the limited role that a Foster Parent Support Specialist should play. After reviewing the notes, the administrator should counsel both the support specialist and her supervisor to ensure that in the future, they both understand that a Foster Parent Support Specialist (FPSS) should never act independently of the Department.

The Department agreed. The administrator reviewed the supervisory notes concerning the support specialist and determined this was an isolated incident with the support specialist. The administrator discussed this incident with the support specialist and her supervisor.

2. The Director should issue a memorandum to emphasize limits on the role of the FPSS and that an FPSS should never act independently of the Department. Specifically, the FPSS should not be permitted to share confidential information about one foster parent with another; the FPSS should not be permitted to make any clinical decisions or decisions regarding the placement of children, including specific respite services; "advocacy" and "support" by FPSS's should be limited to providing *factual* information to child welfare staff and providing information to foster parents about existing rules, procedures and policy.

The Department agreed and is currently in the process of revising the FPSS structure within the Department.

3. This case supports the OIG's previous recommendation that placement and clinical issues should be removed from the Program Plan of FPSS contracts.

The Department agreed. All placement and clinical issues have been removed from the program plan of FPSS contracts.

GENERAL INVESTIGATION 23

ALLEGATION

An eight year-old girl was sexually abused by a fifteen year-old boy residing in the same foster home. A private agency had placed the girl in the home despite their knowledge of the boy's history of sexual aggression towards younger children.

INVESTIGATION

The 15 year-old had been designated for inclusion in the Department's Sexually Aggressive Children and Youth (SACY) program following an incident in which he fondled a 4 year-old girl when he was 11 years-old. At the time he was placed in the foster home, the boy had an existing SACY protective plan which required that he would be the only child in the home and that he not be in an environment where he would have unsupervised contact with young children. Although the foster mother had a number of young grandchildren who frequently visited the home, the agency's workers believed their frequent warnings to the foster mother provided sufficient protection. Although records note the boy was initially successful in the placement, his behavior began to deteriorate during the period leading up to the eight year-old's placement in the home.

The private agency sought a new placement for the girl because her current foster mother had requested her immediate removal due to uncontrollable, aggressive behavior including kicking and biting. At the time the eight year-old was placed in the foster home, there was no "hold" or placement restriction placed on the home. However, one week after she was placed, a placement restriction was submitted to the Placement Clearance Desk prohibiting children younger than the boy from being placed in the home.
Shortly after the eight year-old was placed in the home the two children began engaging in frequent verbal arguments and the fifteen year-old expressed feelings of hostility and resentment towards the girl. The foster mother reported that the boy was very jealous of the attention given to the other child and attempted to get her in trouble in the home. This behavior continued until the time the foster mother called the hotline to report the girl's allegation of sexual abuse by the boy.

The private agency's clinical director told the OIG that staff and administrators were aware of the boy's SACY designation but were unsure of the current status of the designation and whether the placement restrictions were still in place. The clinical director stated she contacted a SACY administrator who informed her the boy was no longer on the SACY database, however the SACY administrator identified stated the boy's case originated in another region and could not recall speaking with anyone from the agency. A new SACY protective plan was not created after the girl was placed in the home. A review of case notes compiled during the course of the boy's placement show repeated references to the potential risk he posed to younger children and concerns regarding the foster mother's ability to provide proper supervision. The case record also indicated that the foster mother's adult daughter, who lived in the home and was a primary caretaker for the children, moved out of the home before the girl was molested. Agency workers did not assess the impact the absence of another caretaker would have on the foster mother's ability to monitor the children. The clinical director stated to the OIG that they were aware of the potential harm posed to the eight year-old girl by living in the home but decided to take a "calculated risk" in order to secure a placement for her.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This report should be shared with the private agency. The OIG will meet with the Executive Director and members of the Board of Directors to discuss the report.

The Department agreed. The OIG shared the report with the agency.

2. This report should be shared with the statewide SACY coordinator to ensure that proper and timely placement restriction information is forwarded to the Placement Clearance Desk.

The Department agreed. The report was shared with the statewide SACY coordinator.

3. This report should be shared with the administrator of the Placement Clearance Desk to explore the feasibility of developing a system whereby new or revised placement restriction information submitted to the Placement Clearance Desk would trigger a review of the suitability of current placements.

The Department agreed. The Administrator of the Placement Clearance Desk is working to develop a system that will be comprehensive in determining the suitability of placements.

COOPERATION WITH LAW ENFORCEMENT AGENCIES

CASE 1:
During an Intact Family Recovery staffing in February 2000, the OIG learned that a mother new to the program previously had a child who died. The OIG began an investigation into the circumstances of the child's death to ensure that there was no risk to the infant and other children currently in the mother's care. The OIG obtained information from the Cook County Medical Examiner's Office and learned that in August 1989, the nine-month-old infant died from a subdural hematoma due to blunt trauma. His death was classified as a homicide.

The infant had been hospitalized for three months with the injuries that eventually caused his death. The OIG contacted the Chicago Police Department to obtain further information and learned that a full investigation of the infant's death was never conducted.

The Chicago Police expressed interest in investigating the case and OIG staff met with investigators from the "cold case" division. The OIG shared information it obtained regarding the case and provided assistance in locating witnesses from DCFS who had been involved in investigating the alleged perpetrator of the infant's death.

In November 2000, the mother's boyfriend at the time of the infant's injuries confessed to killing the infant. He was charged with first-degree murder.

The infant's mother gave birth to four children following the baby's death. The fourth child was born premature, substance-exposed, and medically complex in January 2000. The mother was indicated for neglect and an intact family case was opened. The mother lost custody of the newborn and his three siblings in April 2000 after two more indicated reports of medical neglect and substantial risk of physical injury. The infant died in October 2000 of hypoxic ischemic encephalopathy (see case # 80 in the Child Deaths section of this annual report). The three surviving siblings remain in Department custody. They are placed together in one foster home. Their permanency goal is to return home.

CASE 2:
The OIG investigated use of purchase vouchers to fraudulently obtain goods from branches of a discount department store chain in the Chicagoland area. After a lengthy investigation, the OIG was able to identify several people who were repeated users of the vouchers. They were able to also establish interrelationships between the parties. Numerous records were obtained and all the identified parties were interviewed. They identified one person who was a Department employee. Once they had put the case together, the OIG referred the case to the Illinois State Police and to the Cook County Office of the State's Attorney.

The Illinois State Police completed their investigation. All six individuals filed confessions and have been indicted.

CASE 3:
An infant was removed from her mother immediately after birth and placed in the home of a relative by the Department. The relative already had private guardianship of two older siblings through Probate Court. The oldest of the children was severely handicapped and wheelchair

bound or bedridden. She was 12 years of age. The relative was also caring for an elderly aunt who was terminally ill. The relative asked a friend to care for the infant during the time of stress. The arrangement lasted for several years, during which time the relative completed a formal adoption of the youngster, never notifying the friend of the adoption. The friend maintains she was given no financial assistance during the time she cared for the child even though the adoptive parent was receiving an adoption subsidy. Once the adoptive mother determined the friend was involved in an abusive marriage and that there was little structure and discipline in their home, the adoptive mother took the child back. The case was referred to the State's Attorney's Office for review to determine if there was any criminal intent on the part of the foster and later adoptive mother in not providing financially for the child while she lived with the friend. The State's Attorney's Office concluded no further investigation was warranted.

CASE 4:
An employee on call for weekend duty for Child Protection Investigations took a state car and picked up his girlfriend. It was alleged that the couple was drinking and doing drugs while the employee was on call. While in the car, the couple became involved in a physical altercation that left bloodstains inside the vehicle. The OIG requested that the State Police investigate the situation. Although the State Police did investigate, the State's Attorney declined to prosecute. The employee's behavior was handled administratively.

CASE 5:
The OIG investigated a case involving an individual who accepted day care payments using a false identity. The OIG turned the matter over to the State's Attorney's Office for further investigation. The State's Attorney's Office requested that the OIG refer the matter to the Illinois State Police.

CASE 6:
An employee of a private agency that administers the distribution of Norman funds for Department clients devised a scheme for having checks made out to family members and friends. After investigating the fraud and compiling evidence, the matter was turned over to the Illinois State Police and State's Attorney's Office. As a result of the subsequent investigation, indictments are pending against several individuals.

The OIG receives notification from the State Central Register (SCR) of all child deaths in Illinois where the child was a ward of DCFS, the family was the subject of an open investigation or service case, or the family was the subject of an investigation or case within the preceding twelve months. The notification of a child death generates a preliminary investigation in which the death report is reviewed and computer data bases are searched. When prepared by the field, a chronology of the child's life is also reviewed. When further investigation appears warranted, records are impounded or requested and a records review is completed. When additional investigation is necessary, a full investigation, including interviews, is conducted. Reports are issued to the Director when recommendations are made. In Fiscal Year 2001, the OIG received notification from SCR of 103 child deaths meeting the criteria for review. In 37 cases preliminary investigations were conducted. In 44 cases records were reviewed. In 11 cases reports were sent to the Director. Investigations are pending in another 8 cases. Three full investigations were conducted that did not result in reports to the Director. Summaries of death investigations that resulted in major recommendations are included in the Investigations section of this report. Following is a statistical summary of the 103 child deaths received by the OIG in FY '01 as well as summaries of the individual cases.

Homicide

There were a total of 20 deaths classified homicide.

* 7 children died from inflicted head trauma
* 5 children died from gun shot wounds
* 3 children died from multiple trauma injuries
* 2 children died from strangulation
* 1 child died from hypothermia
* 1 child died from asphyxia due to a foreign body blocking her airway
* 1 child died from hypovolemic shock, dehydration, & prolonged severe diarrhea & vomiting

Perpetrators[1]
* 7 fathers
* 5 unknown
* 2 boyfriends of mothers
* 1 mother
* 1 foster mother
* 1 related child
* 1 unrelated teenager
* 1 adult "boyfriend"
* 1 mother and boyfriend

Male/Female Breakdown of Perpetrators
* 15 known
* 12 males
* 3 females
* 5 unknown

Ages of Children
* 3 children under 6 months
* 4 children ages 6 months to 12 months
* 2 children ages 13 months to 23 months
* 1 child age 2 years
* 1 child age 6 years
* 1 child ages 8 to 10 years
* 5 children ages 11 to 16 years
* 1 child age 17 years
* 2 children age 18 years

Ages of Perpetrators
* Male perpetrators were from 20 to 64 years[2]
* Female perpetrators were from 19 to 43 years

[1] With the exception of 2 children believed responsible for two of the deaths, perpetrator is classified as the person(s) indicated by DCFS or the person(s) against whom charges were brought. See footnote 2.
[2] This is the range for adult perpetrators age 16 and older. Two children, ages 5 and 13 years, were believed responsible for two homicides.

Number of Perpetrators Charged
* 13 people have been charged in 11 of the deaths

County
* 11 deaths in Cook County
* 1 death in Jackson County
* 1 death in Macon County
* 1 death in Massac County
* 1 death in McLean County
* 1 death in Peoria County
* 1 death in Richland County
* 1 death in Saline County
* 1 death in Sangamon County
* 1 death in St. Clair County

Substance Exposure at Birth
* No indicated reports of exposure at birth

Substance Abuse in Family of Origin
* 10 families had evidence of substance abuse
    * 2 families had cocaine users
    * 1 family had alcohol users
    * 1 family had marijuana users
    * 1 family had crystal methamphetamine users
    * 5 families had polysubstance users

Suicide

One death was classified a suicide.

* A twelve-year-old girl slit her wrists in the bathtub
* She had also taken a number of antihistamines
* The cause of death was drowning
* The death occurred in Cook County

Undetermined

Note: A death is classified as undetermined when there is insufficient information to classify the death as homicide, accident, or natural. This situation usually arises because of deficiencies in investigation, most of which are impossible to overcome. When a case is classified as undetermined, the decision usually lies between two of the three possible manners of death. In nearly all cases involving infants and children, the decision rests between homicide and one of the other two possible manners: accident or natural. Thus, there is a certain degree of suspicion attached to undetermined causes and manners.

There were a total of 8 deaths classified undetermined manner.

* 4 children also had an undetermined cause of death
* 3 children died from thermal burns and smoke inhalation in a house fire[3]
* 1 child died from asphyxia due to smothering

Ages of Children
* 3 children under 6 months
* 2 children ages 6 months to 12 months
* 1 child age 8 years
* 2 children age 10 years

Substance exposure at Birth
* No indicated reports of exposure at birth

[3] The OIG investigated this case and contracted with electrical and mechanical engineers who determined the cause of the fire was electrical. The OIG recently shared their reports with the Cook County Medical Examiner's Office and Chicago Fire Department. The Cook County Medical Examiner's Office plans to review the case and reconsider the manner of death.

Substance Abuse in the Family of Origin

* 3 families had evidence of substance abuse
    * 2 families had polysubstance users
    * 1 family had alcohol users

County

* 5 deaths in Cook County
* 1 death in Lake County
* 1 death in Saline County
* 1 death in Vermillion County

Stillbirth

There were 2 stillbirth deaths.

* 1 child was a non-viable fetus
* 1 child died of intrauterine asphyxia

Ages of Mothers

* 1 mother was 37 and had an extensive history of drug and alcohol use
* 1 mother was 36 and tested positive for PCP at the time of delivery

County

* Both deaths occurred in Cook County

Accident

There were a total of 31 deaths classified accident.

* 7 children died from injuries in car accidents
* 7 children died from drowning
* 5 children died from asphyxia due to overlay
* 5 children died from asphyxia, not as a result of overlay
* 3 children died from injuries in house fires
* 2 children died from injuries in dog attacks
* 1 child died from injuries in a fall
* 1 child died from suffocation due to seizure disorder

Ages of Children

* 8 children were 3 months or younger
* 3 children were 6 months to 12 months
* 1 child was 15 months
* 6 children were 2 to 5 years
* 1 child was 6-1/2 years
* 5 children were 8 to 10 years
* 3 children were 11 to 14 years
* 1 child was 16 years
* 3 children were 17 years

County

* 2 deaths occurred in Bond County
* 16 deaths occurred in Cook County
* 2 deaths occurred in Fayette County
* 3 deaths occurred in Jackson County
* 1 death occurred in Kane County
  (case management was in Cook County)
* 1 death occurred in Madison County
* 1 death occurred in St. Clair County
* 1 death occurred in Tazewell County
* 1 death occurred in Wabash County
* 1 death occurred in Will County
* 1 death occurred in Williamson County
* 1 death occurred in St. Louis, MO
  (case management was in Madison County)

Substance Exposure at Birth
* 1 child tested positive for cocaine at birth

Substance Abuse in Family of Origin
* 13 families had evidence of substance abuse
    * 4 families had cocaine users
    * 2 families had marijuana users
    * 1 family had alcohol users
    * 4 families had polysubstance users
    * 2 families had users of unspecified substances

Natural

There were a total of 41 deaths classified natural.

* 11 children died from Sudden Infant Death Syndrome (SIDS)
* 9 children died as a result of complications from premature births
* 7 children died from cardiac disease/complications from heart problems
* 6 children died from multiple medical problems
* 3 children died from asthma
* 3 children died from progressive illnesses
* 2 children died from brain disorders/complications from brain diseases

Ages of Children
* 6 children were under 1 month
* 11 children were 1 to 3 months
* 4 children were 4 to 6 months
* 7 children were 7 to 11 months
* 3 children were 1 to 3 years
* 1 child was 6 years
* 8 children were 8 to 12 years
* 1 child was 16 years
* 1 child was 19 years

County
* 4 deaths occurred in Champaign County
* 26 deaths occurred in Cook County
* 2 deaths occurred in Kankakee County
* 1 death occurred in Lake County
* 3 deaths occurred in Macon County
* 2 deaths occurred in McLean County
* 1 death occurred in Peoria County
* 1 death occurred in Will County
* 1 death occurred in St. Louis, Mo
  (case management was in Jackson County)

Substance Exposure at Birth
* 16 children were substance exposed at birth
    * 10 tested positive for cocaine
    * 1 tested positive for heroin
    * 1 had fetal alcohol syndrome
    * 4 tested positive for polysubstances

Substance Abuse in Family of Origin
* 20 families had evidence of substance abuse
    * 12 families had cocaine users
    * 2 families had heroin users
    * 1 family had alcohol users
    * 5 families had polysubstance users

A special thanks to Sharon O'Connor, child death investigator and liaison to DCFS at the Cook County Medical Examiner's Office, for all her help throughout the year and in preparing this report.

Deaths in which the Manner of Death Was Ruled Homicide by the Medical Examiner or Coroner's Office

Case #1 DOB September 1985 DOD July 2000
Age at death: 14 years
Substance exposed: unknown, however, mother has a history of drug abuse
Cause of death: Gunshot wound
Perpetrator: unknown
County: Cook
Narrative: Fourteen-year-old ward left his relative foster home without permission to go visit his biological father. While talking to his father on the street, the teenager was shot in the back of the head, apparently in crossfire. He was pronounced dead the next day. Prior History: The teenager entered foster care in March 1992 with two of his siblings after his mother, now fifty years old, was indicated a third time for inadequate supervision of the children. Two more children entered foster care, one in October 1996 after being born substance-exposed and the other in December 1998 for substantial risk of physical injury. The deceased and his siblings were placed in the same relative foster home. His siblings remain in the home and have a permanency goal of adoption. The OIG reviewed records in this case.

Case #2 DOB October 1985 DOD July 2000
Age at death: 14 years
Substance exposed: unknown, however, mother has a history of drug abuse
Cause of death: Gunshot wound to the head
Perpetrator: unrelated teenager
County: Cook
Narrative: Fourteen-year-old ward died in a vacant lot near his relative foster home as a result of a gunshot wound to the head. It was initially reported that the teenager and his friends were playing with a gun that accidentally fired, however, an autopsy revealed that he was shot at close range, approximately two feet, and the death was ruled a homicide. A teenage friend at the scene later admitted to police that he aimed and shot the gun at the deceased's head, but that they had been playing with the gun all afternoon and it would not fire. The teen did not think the gun worked. A Cook County Assistant State's Attorney spoke with the children present at the scene and the office decided not to prosecute. Prior History: The teenager's mother has five indicated reports involving neglect due to her substance abuse. The first contact with DCFS was in May 1988 when an intact family case was opened. In 1993, the mother gave birth to a substance-exposed infant and the deceased and four of his then six siblings came into custody; the two other siblings were over the age of eighteen. The deceased had lived in his current foster home since December 1995. At present, the two oldest teenagers, ages 19 and 14, have a permanency goal of independence; two other siblings, ages 10 and 8, are in the process of being adopted. The youngest child, born after the others were taken into custody, remains with her mother. The OIG reviewed records in this case.

Case #3 DOB April 1986 DOD July 2000
Age at death: 14 years
Substance exposed: unknown
Cause of death: Strangulation
Perpetrator: the boyfriend was indicated for the death
County: Cook
Narrative: Fourteen-year-old ward, who was on run and pregnant at the time of her death, died after being strangled by her thirty-something-old "boyfriend" who had been her mother's boyfriend. DCFS indicated the boyfriend who left Chicago after the teenager's death. The Chicago Police Department has made no arrests for her death. Prior History: The Department took custody of the deceased in August 1995 after her mother left her alone. The teenager subsequently had a number of placements in traditional

foster homes, a residential group home, and with relatives. She had a history of running from her placements. In February 1999, shortly after having been placed at the Emergency Reception Center, the teenager ran away and remained on run until her death. The OIG conducted a full investigation of the teenager's death. The investigation is being combined with other investigations involving female minors on run who are taken advantage of by older men. A report to the Director is expected.

Case #4 DOB June 1987 DOD August 2000
Age at death: 13 years
Substance exposed: no
Cause of death: Gun shot wound to the head
Perpetrator: unknown
County: Cook
Narrative: Thirteen-year-old ward was out at night with her sister and cousin. She was a rear seat passsenger of a car and was shot by a pedestrian. The perpetrator was not identified. Prior history: The teenager had been a ward of DCFS since October 1996 when she and her five siblings were removed from their mother after the fifth indicated report involving neglect. The deceased lived with her grandmother the entire time she was in care.

Case #5 DOB August 1982 DOD August 2000
Age at death: 17 years
Substance exposed: unknown
Cause of death: Gunshot wound
Perpetrator: unknown
County: Cook
Narrative: Seventeen-year-old ward was found with a gunshot wound in an alley. He had been on run from the Emergency Reception Center since September 1999. A Chicago Police investigation yielded no leads, witnesses, or suspects and his murder remains unsolved. Prior History: The teenager and his five siblings first became involved with DCFS when their then thirty-two-year-old mother was indicated for inadequate shelter in September 1994. An intact family case was opened. In February 1996, the teenager's father was indicated for sexual molestation of his sisters. In March 1998, the mother was indicated for inadequate shelter and environmental neglect and the children were taken into custody. The mother has mental health issues and has been in and out of services. The teenager had a number of placements and a history of running. His siblings remain wards with permanency goals of independence. The OIG reviewed records in this case.

Case #6 DOB October 1999 DOD August 2000
Age at death: 10 months
Substance exposed: no, although mother may have used drugs during her pregnancy
Cause of death: Asphyxia due to a foreign body blocking airway
Perpetrator: Mother's boyfriend
County: Richland
Narrative: Ten-month-old baby, babysat by her mother's twenty-four-year-old boyfriend, choked on a foreign substance stuck in her throat. The boyfriend reported that he tried to dislodge what was choking her and called the paramedics. The paramedics were also unable to dislodge the mass and the baby asphyxiated. An autopsy revealed injuries to the baby's mouth and a paper-like material that appeared to have been shoved down her throat and stuck in her esophagus. The boyfriend was indicated for death by abuse and the mother was indicated for substantial risk of physical injury. The boyfriend was charged with murder. He pleaded guilty to involuntary manslaughter and was sentenced to five years in prison. Prior History: An intact family case was opened in June 2000 after the baby was brought to the hospital with bruises on her buttocks. The twenty-six-year-old mother told a child protection investigator that she spanked the baby after the baby scratched her face. In August 2000, a second report was received that the

baby had bruises on her face and chest and an injury to her lip. The mother told investigators the baby fell in her crib and hit a screw that was sticking out in the corner. The investigation was unfounded. The intact family case remained open at the time of the baby's death. The OIG conducted a full investigation of this child's death. A report was sent to the Director on March 22, 2001.

Case #7 DOB June 1998 DOD September 2000
Age at death: 2 years
Substance exposed: no
Cause of death: Abusive head trauma due to beating
Perpetrator: Father
County: Massac
Narrative: Two-year-old child was beaten to death by his twenty-five-year-old father. His twenty-three-year-old mother witnessed the abuse and did nothing to stop it. Both parents were indicated for death by abuse and substantial risk of physical injury to the mother's two surviving children ages 5 and 6. The father was charged with first-degree murder. He pleaded guilty in September 2001 and received a sentence of 42 years. The mother was charged with aggravated battery of a child. Her case has been continued for a fitness hearing. The mother gave birth to her fourth child in November 2000. All three surviving children are in the custody of DCFS. They are placed in the same pre-adoptive foster home. The state is seeking to terminate parental rights. Prior History: There were two prior contacts with Illinois DCFS. The first was in December 1999 when the mother went into a DCFS Field Office to advise that she had three children in placement in Missouri and needed someone from DCFS to check out her home in Illinois. The mother was advised that the proper procedure was for her worker to go through the Interstate Compact on the Placement of Children to have a home study completed. An attempt was made to contact the mother's worker, but she was not in the office and a message was left. Missouri never requested a home study from the Illinois Interstate Compact Office. In June 2000, DCFS received a request from a Missouri Department of Human Services noting that the children had recently been returned to their mother from foster care in Missouri, and the mother was interested in supportive services DCFS might be able to offer. A DCFS worker met with the family in June and conducted a safety assessment in which she found the home and parents to be appropriate. The family declined supportive services. There was no further involvement with DCFS until the child's death. After the child's death, the administrator of the Illinois Interstate Compact Office met with the administrator of the Missouri Interstate Compact Office to discuss the interstate violation and ensure that it would not occur again. The OIG reviewed records in this case.

Case #8 DOB October 1999 DOD September 2000
Age at death: 11 months
Substance exposed: no, but there is a family history of substance abuse
Cause of death: Brain injuries due to multiple blunt force injuries
Perpetrator: Father (alleged)
County: Sangamon
Narrative: Eleven-month-old boy was home alone with his twenty-seven-year-old father who was his custodian. The father reportedly shook him because he would not keep quiet. The father called 911 and the child was taken by ambulance to the hospital. He died the next day. An autopsy determined that the child had been shaken. The father was charged with murder. His trial is scheduled to begin shortly. Prior History: From October 1996 to May 1998, DCFS had custody of the mother's then two children. The case was reopened in January 1999 after the hotline received a call alleging abuse of the two children. They were again taken into custody as the mother stated she could not control herself and would harm the children. The thirty-one-year-old mother has been diagnosed with Borderline Personality Disorder, and has a guarded prognosis for a favorable adjustment to adult living. The deceased was born nine weeks premature. He was taken into custody after his birth and placed in foster care. The private agency located the father and his paternity was established in March 2000. The father participated in

services and visited regularly with his son. In August 2000, the court allowed placement of the child with the father. One of the surviving siblings lives with her father. The other lives in a preadoptive foster home. Termination of parental rights is being pursued. The OIG reviewed records in this case.

Case #9 DOB March 2000 DOD September 2000
Age at death: 6-1/2 months
Substance exposed: no
Cause of death: Multiple injuries due to blunt trauma
Perpetrator: Father (alleged)
County: Cook
Narrative: On the day before she died, the six-month-old infant was cared for by her twenty-year-old father while her sixteen-year-old mother was in school. At some point, the infant stopped breathing. She was taken to the hospital where she was found to be suffering from head trauma. She also had multiple injuries including a retinal hemorrhage, subdural hemorrhage, liver laceration, kidney contusion, lung contusion, and bruising to her face and arms. She died the next day. Her father was indicated for death by abuse. He also was charged with first degree murder and is awaiting trial. Prior History: The infant's father was a ward of DCFS. He entered foster care in November 1990 because of physical abuse by his mother. Parental rights were subsequently terminated. After several placements, he moved to his maternal aunt and uncle's home, where he remained until shortly before the infant's death. His permanency goal was independence. The OIG conducted a full investigation of this child's death, but the investigation did not result in a report to the Director.

Case #10 DOB May 2000 DOD October 2000
Age at death: 5 months
Substance exposed: no, however, mother is believed to have used drugs while pregnant
Cause of death: closed head injury due to child abuse
Perpetrator: Father (alleged)
County: Saline
Narrative: Five-month-old baby died as a result of a closed head injury inflicted by her father. The baby lived at home with her twenty-one-year-old father and her twenty-six-year-old mother. Both parents were indicated by DCFS for abuse in the baby's death. The mother was charged with endangering the life of a child and was acquitted in a bench trial in March 2001. The father was charged with murder. His trial is scheduled to begin in January 2002. The mother gave birth to a son in July 2001. A DCFS investigation is pending to determine whether he will be allowed to live with his mother. Prior History: When the deceased was four months old, the Department received a call to the hotline alleging medical neglect of her. The baby had severe medical problems. The report was unfounded, but the mother agreed to accept services from DCFS and an intact family case was opened. Twelve days later, the baby entered the emergency room with numerous cuts and bruises. After a weekend spent with the grandmother, DCFS allowed the mother and baby to return home to live with the father. Two days later, the baby entered the emergency room with her fatal injuries. The OIG conducted a full investigation of this child's death. A report was sent to the Director on March 30, 2001.

Case #11 DOB August 1991 DOD October 2000
Age at death: 9 years
Substance exposed: unknown, but mother was drug user
Cause of death: Peritonitis due to blunt abdominal trauma injuries
Perpetrator: Mother and long-time boyfriend were caretaker adults in the home and were indicated for the death by DCFS
County: Cook
Narrative: Nine-year-old child died from peritonitis resulting from a small bowel laceration due to blunt abdominal trauma. DCFS investigated and indicated the twenty-three-year-old mother and her twenty-

three-year-old boyfriend for death by abuse to the child and substantial risk of physical injury to the other six children living in the home. The Department took custody of the surviving children and they remain in foster care. The Chicago police investigated, ruled it an accident, and closed their case without filing any charges against either caretaker. Prior History: The mother has an extensive history with DCFS dating back to 1993. She had been indicated on seven reports involving neglect, including one substance-exposed infant report. The child's death was the sixteenth hotline report on the mother and the eighth indicated report. The Department took custody of the deceased, when she was three years old, in June 1994, after her mother failed to take her to medical appointments. The child had cerebral palsy and was developmentally delayed. She was placed with her paternal grandmother where she remained until she returned home to her mother in December 1999. Three other children who had been in custody returned home in April 1999. Shortly after she returned home, the child suffered burns while taking a bath. The Department indicated the child's mother for burns by neglect. The child's juvenile court case was closed in July 2000. Three days later, the child's mother gave birth to a substance-exposed infant. The Department reopened the case for intact family services. The child died a little over two months later. All of the surviving children are currently in DCFS custody. The OIG conducted a full investigation of this child's death and a report was submitted to the Director on November 20, 2001.

Case #12 DOB February 1982 DOD October 2000
Age at death: 18 years
Substance exposed: unknown, mother has a history of drug usage
Cause of death: Gunshot wound
Perpetrator: unknown
County: St. Clair
Narrative: Eighteen-year-old ward was driven to the hospital by an unidentified driver and left at the emergency room with a gunshot wound to the stomach. She was pronounced dead twelve minutes later. Her foster parent reported seeing her 45 minutes earlier. Prior History: The ward had been in DCFS custody since 1993. Her family's first contact with DCFS was in February 1989 when she was cut during a fight between her mother and her mother's boyfriend. Five more indicated reports followed, one the birth of a substance exposed infant, before the deceased and her two siblings were taken into custody. In December 1994, the thirty-one-year-old mother gave birth to substance-exposed twins. They were taken into custody. The mother made no attempt to participate in services and her whereabouts were unknown. In June 1997, unknown to DCFS, she gave birth to her seventh child. He was beaten to death in September 1997. The mother and her paramour were indicated for death by abuse. The mother was arrested, but was released without filing charges. The boyfriend was never arrested or charged. The six children in placement were adopted in 1998. The mother gave birth to her eighth child, a substance-exposed infant, in April 2000. He is in custody and his permanency goal is adoption.

Case #13 DOB September 2000 DOD October 2000
Age at death: 29 days
Substance exposed: no
Cause of death: Blunt force injury to the head
Perpetrator: cousins (alleged)
County: Peoria
Narrative: Twenty-nine-day-old baby, who was born prematurely, was laying on a bed when her two-year-old cousin pulled her down to the floor while playing with the straps of the baby's apnea monitor. A five-year-old cousin then repeatedly hit the baby's head into the metal bed frame. The two-year-old carried the baby to the grandmother who called 911. The grandmother, who was caring for the baby after the mother had been arrested for battery the night before, was preparing food for the children. Earlier in the summer, the five-year-old had witnessed violence when a man in a car he was riding in was shot and killed. DCFS took the five-year-old and the two siblings of the deceased baby into custody. The two-year-old remained in the custody of her parents. The grandmother was indicated by DCFS for death by

neglect. Prior History: The twenty-three-year-old mother was indicated by DCFS in June 1994 for substantial risk of physical injury to her then one-month-old baby. The mother voluntarily gave custody of the baby to her mother. In March 1997, the mother was indicated for medical neglect of her then two-month-old baby who was born prematurely and had medical problems. In April 1997, a second report of medical neglect was made and the baby was taken into custody. The baby was returned to the mother, by the court, in July 1997, and the family case was closed the following month. In May 2000, a report alleging that the mother slapped her then three-year-old child was unfounded. The two siblings and the five-year-old cousin remain in foster care. The OIG reviewed records in this case.

Case #14 DOB September 1987 DOD November 2000
Age at death: 13 years
Substance exposed: no
Cause of death: Massive brain trauma injuries compatible with hammer
Perpetrator: Mother's boyfriend
County: Macon
Narrative: Thirteen-year-old child was killed by a twenty-seven-year-old man his twenty-eight-year-old mother had been dating for a couple of months. The man was upset because the mother went out without him. He broke into the home and killed the child with a hammer. The child's two younger brothers were asleep in the basement and were unharmed. The man was caught in the home and confessed to killing the child. In November 2001, he pleaded guilty to first-degree murder and was sentenced to 45 years in prison. Prior history: There was a prior investigation in September 2000 alleging inadequate supervision of the boys by their parents. The investigation was unfounded. The parents left the deceased in charge of his two younger brothers, ages 7 and 8, while they were out-of-town for the day. The eight-year-old got a cut on his forehead while throwing rocks with another boy. The deceased took his brothers to the tavern across the street. He went to get his aunt and the police were called. The CPI determined that the child was mature enough to watch his brothers, that he had his mother's cell phone, and that he knew he could go to the neighbor's for help. The OIG reviewed records in this case.

Case #15 DOB October 1999 DOD January 2001
Age at death: 15 months
Substance exposed: no
Cause of death: Hypovolemic shock, dehydration, prolonged severe diarrhea and vomiting
Perpetrator: Father (alleged)
County: Jackson
Narrative: Fifteen-month-old child was found not breathing by her sixty-four-year-old father. She was taken to the hospital where she was pronounced dead. The child had been sick for several days and had severe diarrhea in the twenty-four hours prior to her death. She had not eaten for 2-3 days prior to her death. Family members advised the father to take the child to the doctor, but he did not seek medical attention. DCFS indicated the father for death by neglect and medical neglect. He has been charged with murder and is awaiting trial. Prior History: There were two prior DCP investigations involving the family. The first was a report called in by a neighbor who stated that the thirty-five-year-old mother had been told by an unidentified person that the father had molested the child, but the mother did not believe it. The parents were not together, but shared care-taking duties. The investigation found no evidence of sexual abuse and the report was unfounded. The second report, made at the end of November 2000, was pending at the time of the child's death. An anonymous caller stated that the father would pick the child up from the babysitter's after he had been drinking all day and then drive home. The investigator spoke with relatives and neighbors who stated that the father was appropriate, did not have a substance abuse problem, and enlisted their help when he needed assistance with the baby. The report was eventually unfounded. The parents have no other minor children. The OIG reviewed records in this case.

Case #16 DOB July 2000 DOD January 2001
Age at death: 6 months
Substance exposed: no, but several family members were believed to be drug users
Cause of death: Multiple injuries due to blunt trauma due to child abuse
Perpetrator: Father (alleged)
County: Cook
Narrative: Six-month-old infant died from multiple injuries inflicted by her twenty-two-year-old father. The infant lived with her father and her twenty-two-year-old mother. Both parents were indicated by DCFS for abuse in the infant's death. Both parents were charged with first-degree murder and are awaiting trial. Prior history: In December 2000, the Department received a call alleging medical neglect and substantial risk of physical injury to the infant. Her mother had taken her to a clinic for crankiness and diarrhea. The clinic found that the infant had a swollen arm and thought that it might be broken. Staff arranged for the mother to take the baby to the hospital for x-rays and treatment. The mother never showed up at the hospital with the baby. Thirty-eight days later, the infant was dead. The DCFS investigation was pending at the time of the infant's death. The child protection investigator had not located the infant and her mother at their last known address and made few and futile attempts to find them. The OIG conducted a full investigation of this child's death. A report was sent to the Director June 27, 2001.

Case #17 DOB September 1994 DOD February 2001
Age at death: 6 years
Cause of death: Hypothermia
Perpetrator: Foster mother was indicated for the death
County: Cook
Narrative: Six-year-old ward died after being punished by his foster mother by being held down in a bathtub of cold water. The foster mother was indicated by DCFS for death by abuse. She also was charged with murder and is awaiting trial. Prior History: The ward entered DCFS custody in January 1999 after a neighbor found him wandering alone in the street. He was placed in a foster home and remained there until his death. In May 2000, his therapist called the hotline to report that the child had told her that his foster parent had punished him by making him stand in a cold shower. DCP investigated and unfounded the report. In August 2000, the licensing agency issued a fourteen-day notice that they would be removing the deceased and another foster child from the home. The foster parent appealed and after mediation between the parties, an agreement was made that the child would remain in the home. In February 2001, just one day before the child died, a worker from Screening, Assessment, and Support Services (SASS) went to the foster parent's home to evaluate the child in response to concerns by his therapist and the foster parent that he was having a psychotic episode. The SASS worker recommended that the child receive a psychiatric evaluation. He died the following day. The OIG is conducting a full investigation of this child's death. A report to the Director is expected.

Case #18 DOB January 2001 DOD March 2001
Age at death: 2 months
Substance exposed: no
Cause of death: Blunt head trauma, child abuse
Perpetrator: Father (alleged)
County: Cook
Narrative: Two-month-old baby was violently shaken by his twenty-year-old father and thrown on a bed. The baby was found unresponsive by his twenty-one-year-old mother. He was placed in pediatric intensive care on life support with a subdural hematoma, broken ribs, and no brain activity. He was pronounced dead the next morning. At the time of his death, there was a pending DCP investigation. A safety plan was made for the baby and his sibling to stay with their maternal uncle, and neither parent was to have unsupervised visits with the baby. The mother and uncle left the father alone in a room with the

baby during a visit. The father later confessed to shaking the baby for several seconds and throwing him on the bed. Both parents were indicated in the child's death. The father was charged with first-degree murder and is awaiting trial. The two-year-old sibling is in foster care. Prior History: In February 2001, an A sequence report was made to the hotline by a hospital stating the baby was admitted for episodes of apnea and possible seizures. A CT scan revealed subdural and epidural hematomas. DCP began investigating and spoke with the attending physician who was unable or unwilling to state the child's injuries were because of abuse. The investigator developed a safety plan for the children to stay with their uncle until a second opinion from a head injury expert could be obtained. The uncle was warned not to allow the parents to be unsupervised with the children. The infant was reinjured and died while DCFS was waiting for the second opinion, which took over a month to get because of difficulty obtaining medical records from the treating hospital. The OIG reviewed records in this case.

Case #19 DOB April 1983 DOD May 2001
Age at death: 18 years
Substance exposed: no, though mother has history of drug abuse
Cause of death: Strangulation
Perpetrator: unknown
County: Cook
Narrative: Eighteen-year-old ward was found in an alley, strangled to death. He was identified five days later from his fingerprints. No suspects have been found. Prior History: The family has been involved with DCFS since March 1991 when the mother gave birth to a substance-exposed infant. An intact family case was opened. In March 1992, the twenty-eight-year-old mother gave birth to a second substance-exposed infant who died two months later from SIDS. In December 1993, a third substance-exposed infant was born and all three children were taken into custody. The children were placed together with a relative who subsequently became a guardian to one of the children and adoptive parent to the other. The deceased stayed with the relative until June 1998 when he was put in juvenile detention. He spent the next three years incarcerated, in various relatives' homes, and on run. At the time of his death, he was living with an aunt.

Case #20 DOB January 2000 DOD June 2001
Age at death: 17 months
Substance exposed: no
Cause of death: Closed head and cervical injuries due to blunt force trauma
Perpetrator: Mother (alleged)
County: McLean
Narrative: Seventeen-month-old child died as a result of injuries inflicted by his nineteen-year-old mother who is a ward of DCFS and who was living in an independent living program. The mother was indicated for death by abuse. She also was charged with first-degree murder and is awaiting trial. Prior history: A month prior to the child's death, a hotline call was made alleging inadequate food and environmental neglect of the deceased and his seven-month-old sister. The investigation was pending when the child died. It was later indicated. This case is being investigated by the OIG.

Deaths in which the Manner of Death Was Ruled Suicide by the Medical Examiner or Coroner's Office

Case #21 DOB May 1988 DOD January 2001
Age at death: 12 years
Substance exposed: no, however, her mother used drugs as a teenager
Cause of death: Drowning
County: Cook
Narrative: Twelve-year-old former ward was staying at her twenty-nine-year-old biological mother's home when she locked herself in the bathroom. The child's step-father broke down the door four hours later. The child was found in the bathtub with her wrists slit. She was pronounced dead on arrival at the hospital. DCFS indicated the twenty-nine-year-old mother for death by neglect and substantial risk of physical injury to her two other children who were taken into custody. A third child born in May 2001 was also taken into custody. Prior History: The child was a ward from 1991 through 1997 when she was adopted by her maternal grandmother. She was taken into custody in 1991 after her then nineteen-year-old mother was indicated for cuts, welts, and bruises. Following the adoption, DCFS had no contact with the family until January 2000. At that time, the child told a school counselor that her grandmother hit her. The child later recanted, and the case was unfounded. During the DCP investigation, it was learned that the child was spending time with her biological mother who was now married with small children. The grandmother and the mother did not get along and the child complained about her grandmother thinking she would be able to spend more time with her biological mother. The investigator convened a family meeting with the mother and grandmother to address the issue. An agreement was worked out between them about how the child would split her time between the homes. The OIG conducted a full investigation of this child's death, but the investigation did not result in a report to the Director.

Deaths in which the Manner of Death Was Ruled Undetermined by the Medical Examiner or Coroner's Office

Note: A death is classified as undetermined when there is insufficient information to classify the death as homicide, accident, or natural. This situation usually arises because of deficiencies in investigation, most of which are impossible to overcome. When a case is classified as undetermined, the decision usually lies between two of the three possible manners of death. In nearly all cases involving infants and children, the decision rests between homicide and one of the other two possible manners: accident or natural. Thus, there is a certain degree of suspicion attached to undetermined causes and manners.

Case #22 DOB January 2000 DOD July 2000
Age at death: 5 months
Substance exposed: no
Cause of death: Undetermined
County: Cook
Narrative: Eighteen-year-old mother said she found her five-month-old baby unresponsive after seeing him alive five minutes earlier. The baby had a history of asthma and was running a temperature. An autopsy revealed that the baby had alcohol in his system, three fractured ribs, and a subgaleal hemorrhage. The parents were indicated for death by abuse and their surviving children were taken into custody. A fourth child, born in September, was discovered by DCFS in November and taken into custody. Prior History: The mother and nineteen-year-old father had an indicated report in July 1999 for inadequate supervision of another child. Their then four-month-old infant, their second child, had a fractured arm. The parents were unable to explain it. Several relatives had recently cared for the baby, including the grandmother. The grandmother thought the baby may have been injured by younger relatives pulling the baby by the arms and legs. DCFS opened an intact family case and provided intensive services. The case was closed in May 2000. The OIG reviewed records in this case.

Case #23	DOB July 1992	DOD July 2000
Case #24	DOB January 1990	DOD August 2000
Case #25	DOB April 1990	DOD August 2000

Ages at death: 8 years, 10 years, and 10 years
Substance exposed: no
Cause of death: Thermal burns and inhalation injuries due to house fire
County: Cook
Narrative: Three foster children, two of whom were biological siblings, died as a result of a house fire in the home of their foster parent. The cause of the fire was the subject of investigation by the police and fire departments. The OIG assisted in the investigations by contracting with mechanical and electrical engineers. Their reports indicate that an electrically damaged extension cord supplying power to a refrigerator was the cause of the fire. The foster children were sleeping in the bedroom directly above the refrigerator. A copy of the investigative report has been submitted to the Cook County Medical Examiner's Office for review. Prior History: Two of the children were members of a sibling group of six whose family became involved with DCFS in 1990 when their mother was indicated for medical neglect of an older sibling. Intact family services were put in place, but the mother's mental health issues and the risk to the children resulted in the removal of the children in 1994. The boys were placed together in the foster home in June 2000. The boys had a permanency goal of guardianship at the time of their death. There are four surviving siblings. Two are in foster care and have permanency goals of out of home placement and guardianship. One siblings is placed outside the home privately. The youngest sibling is in a preadoptive foster home and parental rights are in the process of being terminated. The third child to die as a result of the fire first became known to DCFS in 1992 when his mother was indicated for inadequate supervision of him and an older sibling. An intact family case was opened after a subsequent report in 1996 for substantial risk of physical injury and inadequate supervision due to drug use. The child and his two siblings were taken into custody after a third report in 1997. The child was placed with his older brother in the foster home in January 2000. The older brother left the foster home a month prior to the fire. He and the youngest sibling are placed in the same group home and have permanency goals of independence. The OIG conducted a full investigation of these children's deaths. Reports were sent to the Director on May 22, 2001 and June 21, 2001.

Case #26	DOB March 2001	DOD April 2001

Age at death: 1-½ months
Substance exposed: no, however, mother has a history of drug use
Cause of death: Undetermined
County: Cook
Narrative: One-and-a-half-month-old baby was residing with his twenty-three-year-old mother in a drug treatment program. Staff checked the mother's room and found the mother asleep with the baby in her arms. Staff checked the baby who was unresponsive. The baby was taken to the hospital where he was pronounced dead. The mother had previously been warned not to sleep with the baby. She was indicated for death by neglect. Prior History: In May 2000, the mother was indicated for medical neglect and substantial risk of physical injury. Her three children, then ages seven, four and one, were taken into custody. In March 2001, the mother gave birth to the deceased and was investigated for substance misuse after the hospital reported the baby was exhibiting withdrawal symptoms. The mother was in a methadone substance abuse treatment program, and the withdrawal was thought to have been from the methadone. The allegation of substance misuse was unfounded after the toxicology screen on the baby was negative. The surviving children remain in custody and have a permanency goal of return home. The OIG reviewed records in this case.

Case #27 DOB August 2000 DOD April 2001
Age at death: 8 months
Substance exposed: no
Cause of death: Undetermined
County: Vermillion
Narrative: Twelve-year-old foster child came home from school and found his eight-month-old foster sibling and sixty-year-old babysitter unresponsive. He called 911 and they were rushed to the hospital where the baby was pronounced dead. The doctors suspected that the baby was smothered as a result of the diabetic babysitter falling on him after losing consciousness due to low blood sugar. Prior History: The baby was the fifth child of his biological mother. The twenty-eight-year-old mother has been involved with DCFS since 1992 because of neglect. Three of her children were taken into custody in 1994. The fourth and fifth children were taken into custody after their births. Three of the surviving children have been adopted and the fourth has a permanency goal of adoption.

Case #28 DOB May 2000 DOD May 2001
Age at death: 11-½ months
Substance exposed: no
Cause of death: Undetermined
County: Lake
Narrative: Eleven-and-a-half-month-old infant was found unresponsive by his babysitter. He was rushed to the hospital where he was pronounced dead. The child had bruises on him at the time of his death, however, the pathologist performing the autopsy stated he did not think the bruises were from abuse. A DCFS investigation was unfounded for death by abuse. Prior History: The eighteen-year-old mother had a prior investigation for cuts, welts and bruises that was unfounded one week prior to the child's death. The child's babysitter stated that since early April, when she began babysitting the child, she noticed the baby often had bruises. In early May, she noticed a bruise on his ear and temple and scratches on his neck and cheek. An investigator noted the marks on the temple and ear, but found no marks on the baby's neck. The investigator found that the marks were consistent with the mother and grandmother's story that the baby got caught below the child/pet gate that was raised so the dog could get under the gate. They explained the scratches were from the child pulling and scratching his ears from ear infections. The babysitter corroborated that the child often scratched and pulled on his ears. The OIG reviewed records in this case.

Case #29 DOB April 2001 DOD June 2001
Age at death: 2 months
Substance exposed: no
Cause of death: Cerebral anoxia due to asphyxia, smothering
County: Saline
Narrative: Twenty-year-old mother reported that she found her two-month-old baby unresponsive on the couch. She had last seen the baby alive seven hours earlier. Prior History: In May 2001, the mother was investigated for inadequate supervision of the baby and substantial risk of physical injury to her one-year-old child. It was reported that the mother left the baby alone while she went shopping with her one-year-old. The investigator interviewed several people, including a person who watched the baby, and found no evidence that the child was ever left alone. The investigation was unfounded. After the baby's death, an intact family case was opened. It was closed in September 2001. The OIG reviewed records in this case.

Deaths in which the Manner of Death Was Ruled Stillbirth by the Medical Examiner or Coroner's Office

Case #30 DOB September 2000 DOD September 2000
Substance exposed: baby not tested; mother tested negative, but has history of drug and alcohol abuse
Cause of death: Intrauterine asphyxia
County: Cook
Narrative: The baby girl was stillborn at 4 months gestation. Her thirty-seven-year-old mother has a history of drug and alcohol abuse, however, she tested negative at the time of delivery. Prior History: The mother has ten surviving children born between 1979 and 1996. She had five indicated reports involving neglect between 1988 and 1996. Several involved inadequate supervision. One involved the substance-exposed birth of a child. The children have all been in DCFS care. Nine of the children have been adopted and the tenth is awaiting termination of parental rights.

Case #31 DOB December 2000 DOD December 2000
Substance exposed: baby not tested; mother tested positive for PCP
Cause of death: Non-viable fetus
County: Cook
Narrative: The baby boy was stillborn at 33 weeks gestation. His thirty-six-year-old mother tested positive for PCP at the time of delivery. The mother has given birth to eleven children between 1983 and 1999. She had six indicated reports involving neglect between 1992 and 1999. Five involved the substance-exposed birth of a child. Ten of the children are living. One died in a car accident. None of the children live with their mother. One child is in a DCFS independent living program. Three children live with their father. Five children have been adopted. One child is with relatives.

Deaths in which the Manner of Death Was Ruled Accident by the Medical Examiner or Coroner's Office

Case #32 DOB October 1988 DOD July 2000
Age at death: 11 years
Substance exposed: no
Cause of death: Asphyxia
County: Death: Kane
Case Management: Cook
Narrative: Eleven-year-old child was asphyxiated during a physical restraint by two residential care facility staff members. The workers performed the restraint when the child's behavior became out of control. The child and workers were off-site when the restraint occurred. Improper restraint techniques were used. One of the workers was terminated and the other resigned. Prior History: The child and her three siblings were removed from their mother's custody in 1993 for physical abuse. The child had been living at the residential care facility since March 1999. Her siblings are still in DCFS custody. There are no plans to return them to their mother's care. The OIG conducted a full investigation of this child's death. A report was sent to the Director on June 27, 2001.

Case #33 DOB May 2000 DOD July 2000
Age at death: 2 months
Substance exposed: no
Cause of death: Asphyxia, trapping
County: Cook
Narrative: Two-month-old infant began crying and woke his eighteen-year-old mother, who was a ward. The mother picked up the baby and placed him on a sofa with her. They both fell back asleep. Four and a

half hours later, she awoke and found the baby unresponsive. The baby was transported to the hospital where he was pronounced dead. Prior History: The mother has been a ward since November 1992 when she and her siblings were taken into custody after her father, who had previously molested her and her sisters, got out of prison and came home. The ward has one indicated report on her as a mother. In August 1998, she was indicated for substantial risk of physical injury to her then three-month-old son for starting a fire by placing some material over a lamp. The mother gave birth to her third child in November 2001. Her case with DCFS remains open.

Case #34 DOB July 2000 DOD July 2000
Age at death: 3 weeks
Substance exposed: no
Cause of death: Asphyxia
County: St. Clair
Narrative: Sixteen-year-old mother awoke to find her three-week-old baby unresponsive in the bed they shared. An ambulance was called and the baby was pronounced dead at the hospital. His mother said he had been sleeping on a receiving blanket on his stomach. Prior history: The baby had two older siblings and lived in a household that included his mother, maternal grandmother, two aunts, and a cousin. At the time of the baby's death, the maternal grandmother had private guardianship of his siblings. His mother had been indicated as a perpetrator in July 1999 for inadequate supervision and January 2000 for substantial risk of physical injury. In September 2000, two months after the baby's death, both the mother and maternal grandmother were indicated for neglect after a two-year-old child in the home was burned by a pot of hot water that fell. An intact family case was opened, and it remains open. The OIG reviewed records in this case.

Case #35 DOB February 1989 DOD August 2000
Case #36 DOB November 1990 DOD August 2000
Ages at death: 11 and 9 years
Substance exposed: no
Cause of death: Internal injuries due to car accident
County: Fayette
Narrative: Eleven and nine-year-old children were traveling in a car with their twenty-nine-year-old mother. The mother hit a bump in the road, and she lost control of the vehicle which ended up in a lane of oncoming traffic and was hit broadside. Both children died from internal injuries sustained in the accident. There is one surviving sibling. She turned six on the day her siblings died. There is no current DCFS involvement with the family. Prior History: There are three prior indicated reports on the family from 1995, 1996, and 1997. An intact family case was open from June 1995 to May 1997 and again from October 1997 to November 1998. There was an unfounded report in May 2000. One of the children had a bruise that was determined to be self-inflicted. This report was reviewed by the OIG and appeared to be appropriately unfounded.

Case #37 DOB June 2000 DOD August 2000
Age at death: 2 months
Substance exposed: no
Cause of death: Asphyxia due to overlay
County: Cook
Narrative: Two-month-old infant was sleeping in bed with her nineteen-year-old mother. The mother found the baby unresponsive when she awoke. She brought the infant to the emergency room where she was pronounced dead. Prior History: The mother was a ward of DCFS at the time of the infant's birth. The infant was her third child. In March 2000, the mother requested that her case be closed (wards 18 years of age and over have the right to case closure upon request). The mother had a case opened on her as a caretaker in June 2000 when she was indicated for inadequate supervision and substantial risk of

physical injury to her 2-1/2-year-old son when she left him with her mother who was under the influence of drugs. An intact family case was open from June 2000 to June 2001.

Case #38 DOB January 1997 DOD September 2000
Case #39 DOB May 1998 DOD September 2000
Ages at death: 3-1/2 and 2 years
Substance exposed: no
Cause of death: Carbon dioxide inhalation due to house fire
County: Cook
Narrative: Three-and-a-half-year-old and two-year-old children died in a house fire. The children were playing with matches and started the fire. An adult male also died in the fire. Following the boys' deaths, a case was opened for preventive services. It remains open. The twenty-seven-year-old mother gave birth to her fifth child in April 2001. Prior history: The family had been involved with DCFS since March 1998 because of indicated allegations of inadequate shelter and inadequate supervision. An intact family case was closed in July 2000. The OIG reviewed records in this case.

Case #40 DOB October 1993 DOD September 2000
Age at death: 6-1/2 years
Substance exposed: no
Cause of death: Subdural hematoma due to fall
County: Jackson
Narrative: Six-and-a-half-year-old child was a resident at a residential care facility. He was taken to the hospital by ambulance the day before his death with a laceration to his head that required stitches. He was taken to the hospital by ambulance a second time the same day, twenty-one hours later, in full cardiac arrest with massive bruising to his head. The child suffered from Sanfilippo's Syndrome, a rare genetic disorder that affects the central nervous system and made the child susceptible to injuries from falls. The child had only been a resident at the residential care facility for a couple of days. His family placed him there because they could no longer care for him at home. Both the Illinois Department of Children and Family Services and the Illinois Department of Public Health investigated the child's death. The facility was indicated by DCFS for cuts, bruises, welts, inadequate supervision, and death by neglect. IDPH fined the facility $10,000 for failing to ensure a resident was provided with the necessary supervision to avoid physical harm. It also placed the facility under a corrective action plan. No criminal charges were filed. Prior History: The child's mother was indicated on an A-sequence report for inadequate supervision of the child in January 1999 when she was twenty-one years old. In September 1999, a C-sequence report was made alleging substantial risk of physical injury to the child and his three-year-old sister. It was unfounded. It had already been expunged at the time of the child's death and was not available for review.

Case #41 DOB February 1983 DOD September 2000
Age at death: 17 years
Substance exposed: no
Cause of death: Multiple injuries due to auto accident
County: Cook
Narrative: Seventeen-year-old teenager died in a car accident. He was a passenger in a car with his nineteen and twenty-nine-year-old cousins. The twenty-nine-year-old cousin was reportedly driving at a high speed under the influence of drugs or alcohol when he lost control of the car. All three were thrown from the vehicle, but only the seventeen-year-old was killed. Prior History: The teenager entered foster care in November 1992. He had lived with his grandmother since that time with his three brothers. All four boys had permanency goals of independence.

Case #42 DOB February 2000 DOD October 2000
Age at death: 8 months
Substance exposed: no
Cause of death: Drowning
County: Cook
Narrative: Eight-month-old child drowned in a fish tank that was 1/3 full and sitting on the floor in her home. The child's thirty-year-old mother had put her on the floor to crawl around and lost sight of her. She found the child in the fish tank. The child was rushed to the hospital where she died the next day. The mother has seven surviving children ages 6 to 16. The oldest lives with his maternal uncle. None of the children were home at the time of the child's accident. The child's death was reported for death by neglect. It was unfounded. Prior History: The family previously had an intact family case open from February 1994 to June 1996. The underlying allegations were no longer on file. There also was a prior A-sequence investigation from September 2000 that was unfounded for environmental neglect. The OIG reviewed this investigation and found it to be appropriately unfounded. The report alleged that the family's basement was filled with raw sewage and that the toilets were overflowing. The CPI visited the home and found it to be neat and clean with working toilets and no raw sewage.

Case #43 DOB December 1999 DOD November 2000
Age at death: 10-1/2 months
Substance exposed: no
Cause of death: Asphyxia due to overlay
County: Cook
Narrative: Ten-and-a-half-month-old child was sleeping on a couch with her two-year-old and seven-year-old siblings and her twelve-year-old cousin. The cousin awoke to find the deceased on her stomach with her face in a couch cushion. The boy told his mother something was wrong with the baby and the aunt found the child unresponsive. She was pronounced dead at the hospital. The forty-two-year-old aunt was indicated for death by neglect due to the number of children sleeping on the couch. An intact family case was opened. Prior History: The deceased's mother stabbed and killed the children's father. When she went to prison, the aunt took responsibility for the children. She called the hotline in April 2000 to request assistance. An extended family support case was opened in June 2000 and closed in October 2000. The OIG reviewed records in this case.

Case #44 DOB December 1999 DOD November 2000
Age at death: 11 months
Substance exposed: no
Cause of death: Suffocation due to seizure disorder
County: Cook
Narrative: Eleven-month-old child was found unresponsive on a sofa. She was transported to the hospital where she was pronounced dead. The child was lying face down on the couch when she had a seizure and suffocated. An investigation for death by neglect was unfounded. The deceased was an only child. Prior History: In September 2000, an A-sequence report was made to the hotline against the child's twenty-year-old mother for medical neglect. The report was indicated as the mother failed to consistently give the child her anti-seizure medication and regularly follow-through on medical appointments. An intact family case was opened in October 2000 to ensure medical care compliance.

Case #45 DOB November 2000 DOD December 2000
Age at death: 1-1/2 months
Substance exposed: no
Cause of death: Asphyxia
County: Tazewell
Narrative: One-and-a-half-month-old baby asphyxiated while sleeping with her twenty-four-year-old mother on a couch. The mother fell asleep with the baby on her chest. When she awoke, the baby wasn't breathing. There was a crib in the home. Prior History: An intact family case was opened a week after the baby's birth when an A-sequence report was indicated against the mother for substantial risk of physical injury to her nine-year-old son. The mother slapped the boy in the face while at the grocery store causing a bloody nose. The mother was arrested for domestic battery, but charges were later dropped. The family, which includes two surviving siblings, ages 3 and 10, and their mother and father, continues to receive intact family services from DCFS. The OIG reviewed records in this case.

Case #46 DOB January 1992 DOD January 2001
Age at death: 9 years
Substance exposed: no
Cause of Death: Drowning
County: Cook
Narrative: Nine-year-old child drowned at the bottom of a motel swimming pool during a birthday party. The child and his brother were brought to the party by a thirty-five-year-old family friend. Several adults were present in the pool area, but none saw the child go under. He was discovered by a twelve-year-old who was also swimming in the pool and who called for help. Prior History: The child was in foster care from October 1998 until May 2000 when he and his three siblings were adopted by a relative.

Case #47 DOB May 1990 DOD February 2001
Age at death: 10 years
Substance exposed: no
Cause of Death: Drowning
County: Cook
Narrative: Ten-year-old child was found face down in the bathtub by her eight-year-old sister. The child had a history of seizures and was supposed to be taking anti-seizure medication. However, a toxicology study at autopsy revealed that she did not have any medication in her system. Her thirty-six-year-old mother and thirty-three-year-old father were indicated in a B-sequence report for death by neglect and medical neglect to the deceased and substantial risk of physical injury to their surviving four children ages 8, 9, 13, and 15. An intact family services case was opened following the child's death. It remains open. Prior History: The parents were indicated for medical neglect in August 2000 on an A-sequence report. The child had a seizure and was taken by ambulance to the hospital. While hospitalized, it was discovered that the child had not been receiving her anti-seizure medication. The mother reported that she could not always afford it. The case was indicated, but DCFS did not open an intact family services case. The OIG is conducting a full investigation of this child's death.

Case #48 DOB November 2000 DOD February 2001
Age at death: 2-1/2 months
Substance exposed: no
Cause of death: Asphyxia due to overlay
County: Cook
Narrative: Two-and-a-half-month-old baby was sleeping in a bed with his thirteen-year-old mother and four-year-old uncle. The mother awoke to find her four-year-old brother laying on top of the baby. The baby was not breathing. He was pronounced dead at the hospital. Prior history: There was a prior unfounded DCP investigation involving the baby. A hotline report was made when the baby was born

alleging that he was born substance-exposed. The OIG reviewed this investigation and found it to be appropriate. The hospital made the report in error. The mother had received Tylenol 3 while in the hospital, and it caused her and the baby to test positive for opiates.

Case #49 DOB December 20/00 DOD February 2001
Age at death: 2-½ months
Substance exposed: yes, opiates and cocaine
Cause of death: Asphyxia due to overlay
County: Cook
Narrative: Thirty-four-year-old mother found the two-and-a-half-month-old baby unresponsive in the morning. The baby was sleeping with his mother and two-year-old sibling on a futon. 911 was called and the baby was pronounced dead at the hospital. The mother was arrested because she had an outstanding warrant. Prior History: The deceased baby was the second of the mother's children to be born substance-exposed. The two-year-old sibling tested positive for cocaine at birth. The mother was indicated for substance misuse on the first baby, but a case was not opened for services until the second baby was born substance exposed. Following the baby's death, the mother agreed to enter an inpatient substance abuse treatment facility where her surviving child could reside with her. The intact family case remains open, and the mother is engaged in treatment. The OIG reviewed records in this case.

Case #50 DOB January 1987 DOD February 2001
Age at death: 14 years
Substance exposed: no
Cause of death: Head injuries due to car accident
County: Williamson
Narrative: Fourteen-year-old teenager was a passenger in a car driven by a thirty-two-year-old friend of the family who was under the influence of drugs. The car was involved in a serious accident and the driver fled the scene. The teenager was rushed to the hospital where he died several days later. The police apprehended the driver four hours after the accident and charged him with driving under the influence and leaving the scene of an accident. DCFS investigated the death and indicated the driver for death by neglect, as he was in a caretaker role. The thirty-one-year-old mother was indicated for substantial risk of physical injury for allowing her son to go out with the driver. Prior History: The family had an open intact family case at the time of the teen's death. It was opened in August 2000, when the hotline was notified that the mother had beaten her eleven-year-old son, leaving bruises on his back and chest, and she was suicidal. The mother was arrested for domestic battery and her three children, then ages 13, 11 and 8, were taken into protective custody. In jail, a mental health worker assessed the mother and determined she was not actively suicidal. The mother told DCFS that she had not been taking her medication for bipolar disorder and that was why she acted irrationally, beating her son for lying about home work. At the shelter care hearing the children were returned home under a court order that the mother take her medication and cooperate with DCFS services. The mother was indicated for cuts, welts, and bruises and substantial risk of physical injury. The mother was sporadic in her cooperation and her mental health continued to be unstable. After the death of her son, she refused to cooperate with mental health services or DCFS. The two surviving children were taken into custody. The OIG conducted a full investigation of this child's death and a report is being completed for the Director.

Case #51 DOB November 1992 DOD March 2001
Age at death: 8 years
Substance exposed: unknown, but mother has a history of drug use
Cause of death: Asphyxia due to subcutaneous emphysema due to manipulation of tracheotomy tube during a therapeutic procedure
County: Cook
Narrative: Eight-year-old medically complex ward who was diagnosed with cerebral palsy, seizure disorder, hydrocephalus with a shunt, and need for a tracheotomy tube was placed at a long term care facility. The child had a history of sudden onset facial swelling during nebulizer treatments, and recurrent pneumonia secondary to cerebral palsy. During a nebulizer treatment, a nurse noticed facial swelling and that the child had stopped breathing. She began CPR and called 911. The child was transported to the hospital where she was pronounced dead. Prior History: The child had been a ward since October 1996 when she was diagnosed with inorganic failure to thrive and taken into custody. Her four siblings entered foster care a month later when their twenty-five-year-old mother was indicated for cuts, welts, and bruises. The four siblings reside in the same home. One sibling has been adopted and the other three are awaiting adoption. The OIG reviewed records in this case.

Case #52 DOB November 1996 DOD March 2001
Age at death: 4 years
Substance exposed: no
Cause of death: Smoke inhalation, carbon dioxide poisoning due to house fire
County: Cook
Narrative: Four-year-old child died in a fire that broke out in his relative foster parent's home. The foster parent's fiancé awoke her and she called for the child but received no answer. The foster parent and fiancé made it out. The fiancé went back in to get the child, but was unable to locate him and incurred third-degree burns. Firefighters found the child's body on the floor next to the bed. Prior History: The deceased and his sibling had been in DCFS custody since January 1999 after their nineteen-year-old mother took the sibling to the hospital for a fever and wheezing and the hospital found a skull fracture, broken leg, and four old rib fractures. The surviving sibling has a permanency goal of substitute care pending court determination on termination of parental rights. The OIG reviewed records in this case.

Case # 53 DOB October 1983 DOD March 2001
Case # 54 DOB April 1983 DOD March 2001
Ages at death: both 17 years
Substance exposed: unknown
Cause of death: Head injuries due to car accident
County: Bond
Narrative: Two teenagers were killed in a car accident. One of the teens had been driving. The car was traveling at a high rate of speed and came over an incline in the road. The driver apparently lost control of the vehicle and hit a tree. The teens were on their way to the vet to pick up a dog. There was unopened beer in the trunk of the car, but none was inside the vehicle and the boys did not appear to have been drinking. They were wearing their seat belts. Prior history: The passenger in the car was a ward and had been in DCFS custody since July 1999 when he was found dependent. He ran away from his residential facility placement two days before his death. The driver of the car had been in DCFS custody from February 1996 to February 2001 when he was returned to his grandmother's care with support services.

Case # 55 DOB October 1996 DOD April 2001
Age at death: 4-½ years
Substance exposed: no
Cause of death: Lacerated jugular vein due to animal bite
County: Jackson
Narrative: Twenty-four-year-old boyfriend of the twenty-three-year-old mother was babysitting the child. At around 7:00 p.m., the four-and-a-half-year-old child told the boyfriend he was going to his friend's house down the street. At approximately 9:40 p.m., the mother phoned the neighbor's to ask that the child be sent home. The neighbor told the mother the child was not there and everyone began looking for the child. The neighbor found the child's body in her backyard near the family dog who was on a chain. The child had multiple dog bite marks on his body and neck. The neighbor told police the child and dog had often played together, and there was no history of aggressive behavior on the part of the dog which was a Huskie and Malamute mix. Prior History: In May 2000 the boyfriend was indicated for substantial risk of physical injury on his then six-week-old baby, the half-sibling of the deceased. The father and the mother got into an argument and the father tried to hit the mother while she was holding the baby. The father was arrested for domestic battery and DCFS was notified. The mother got an order of protection, the father moved out, and each parent was referred to community services. In March 2001, after an apparent reconciliation, it was reported that the parents left the children alone for 30 minutes during a domestic disturbance. While the investigator found that the parents did not leave the children alone, the investigation was ultimately indicated for substantial risk of physical injury based on the domestic violence. The father again moved out and an intact family case was opened six days prior to the child's death. The OIG reviewed records in this case.

Case # 56 DOB February 2001 DOD April 2001
Age at death: 2-½ months
Substance exposed: no
Cause of death: Asphyxia due to overlay
County: Cook
Narrative: Thirty-year-old mother put her two-and-a-half-month-old baby to sleep in her bed with her in the early morning. Four and a half hours later, she found the baby unresponsive. The baby was transported to the hospital where she was pronounced dead on arrival. The baby was born prematurely and required weekly check-ups to ensure that she was gaining weight. At the time of the baby's death, an investigation of medical neglect was in the process of being indicated because home health nurses had not gained access to see the baby in three weeks to check her weight. Prior History: The mother has seven indicated reports dating back to 1990 for neglect. All six of her surviving children were removed from her care prior to the birth of her seventh child. Two have been adopted, one lives with her father, and three are in foster care. The report of medical neglect on the deceased infant was received twenty-two days prior to the death of the baby. The investigator initially took protective custody of the baby, however, it lapsed after the State's Attorney's Office decided not to take the case into court and advised the investigator to open an intact family case to closely monitor the mother for compliance with medical plans instead of immediately taking the child into custody. The OIG is conducting a full investigation of this child's death.

Case # 57 DOB March 2001 DOD April 2001
Age at death: 1 month
Substance exposed: no
Cause of Death: Multiple injuries due to dog attack
County: Cook
Narrative: One-month-old baby died after being mauled to death by the family dog, a Rottweiler. The infant lived at home with her sixteen-year-old mother, a twenty-seven-year-old unidentified male, and her maternal grandmother. Prior history: Prior to her birth, the baby's forty-year-old maternal grandmother

was indicated for inadequate supervision and inadequate shelter of the baby's mother. A case was opened for intact family services in March 2000 and closed in January 2001, three months before the infant's death. The OIG is conducting a full investigation of this child's death.

Case # 58 DOB November 1984 DOD May 2001
Age at death: 16 years
Substance exposed: no
Cause of death: Drowning
County: Jackson
Narrative: Sixteen-year-old ward drowned while attempting to swim across a strip mine pit with two friends. One friend turned back before going too far. The teen called for help halfway across. The remaining swimmer tried to help him, but he could not keep the teen afloat without endangering himself, and he swam back to shore. Complicating factors were the low water temperature which led to hypothermia and crosswinds which made it difficult to swim across the pit. Prior History: The teen entered foster care as a dependent minor in March 1991. He lived with his maternal grandmother for most of his life. In June 2000, he was placed with his maternal aunt and was reportedly doing well in her home.

Case # 59 DOB January 2000 DOD May 2001
Age at death: 15 months
Substance exposed: no
Cause of death: Drowning
County: Will
Narrative: Fifteen-month-old child was outside with his twenty-seven-year-old mother when he wandered off and disappeared. The family lived 20 feet from a retention pond. The child was found floating face down in the pond by a neighbor. The neighbor began CPR. The child was taken by ambulance to the hospital and transferred to a second hospital where he died three days later. The child was the youngest in the family. There are four surviving siblings. The mother was indicated by DCFS for inadequate supervision of the deceased child, leading to his death. An intact family case was opened in June 2001. Prior history: The family first became involved with the Department in January 1998 when the mother's third child was born substance-exposed. The case was open for intact family services from February 1998 to August 2000. There was a second indicated report in September 2000 for medical neglect of two of the children. One needed immunizations and the other needed special eye glasses. The intact family case was reopened in October 2000. In December 2000 there was an unfounded medical neglect report involving the child who required special glasses. The intact family case was closed in January 2001.

Case # 60 DOB November 1996 DOD June 2001
Age at death: 4-½ years
Substance exposed: no
Cause of death: Drowning
County: Wabash
Narrative: Four-and-a-half-year-old child was with his mother and sister at a swimming party held at a public pool. The child wandered into the deep end of the pool. One of the two lifeguards on duty noticed the child floating face down and pulled him out. He was pronounced dead about an hour later at the local hospital. Prior History: An intact family case was opened in September 2000 when the twenty-seven-year-old mother was indicated for substantial risk of physical injury to the deceased after a preschool teacher witnessed the mother hit the child approximately fifteen times on the legs, arms, and buttocks. The family was referred for services through the community. The deceased was diagnosed with attention deficit disorder, developmental delays, and visual impairment. He was prescribed the psychotropic

medications clonidine and thorazine. There are two surviving siblings, ages seven and ten. Their intact family case was closed in August 2001. The OIG is conducting a full investigation of this child's death.

Case # 61 DOB October 1998 DOD June 2001
Age at death: 2-½ years
Substance exposed: no
Cause of death: Head injury due to auto accident
County: Case Management: Madison
Death: St. Louis, Missouri
Narrative: Two-and-a-half-year-old ward was killed in a car accident in St. Louis, Missouri. She was a passenger in a van driven by her foster mother. The van was involved in a multiple car accident caused by a drunk driver who was driving on the wrong side of the road at a high speed. The foster mother survived. Prior History: The child came into care in May 1999 after her biological mother was indicated for substantial risk of physical injury and inadequate supervision. The child had been with her foster parents since September 1999. They were interested in adopting her.

Case # 62 DOB May 1993 DOD June 2001
Age at death: 8 years
Substance exposed: no
Cause of death: Drowning
County: Madison
Narrative: Eight-year-old ward was psychiatrically hospitalized after experiencing uncontrollable behavior problems in his foster home. He was in a bathtub at the hospital when he had a seizure and drowned. The nurse attending to him had left the room to get his clothes. Upon her return, she found him laying face down in the bathtub. The child had a history of seizures and was supposed to be taking anti-seizure medication. However, a toxicology study at autopsy revealed that he did not have any medication in his system. The facility nurse was indicated by DCFS for death by neglect. The OIG referred this case to the Illinois Department of Public Health which is conducting an investigation into the medication issue and the child's death at the facility. Prior History: From May 1998 to March 1999, the mother was indicated on four reports involving neglect. The final report was also indicated for substantial risk of physical injury to the deceased, and he was taken into custody. His four siblings remained at home. An intact family case on them remains open.

Deaths in which the Manner of Death Was Ruled Natural by the Medical Examiner or Coroner's Office

Case # 63 DOB October 1990 DOD July 2000
Age at death: 9 years
Substance exposed: no
Cause of death: Asthma
County: Cook
Narrative: Nine-year-old child was attending a wedding with his relative foster family. He began to have an asthma attack while playing. The foster parent administered his asthma medication, but was not successful in stopping the attack. He was taken to the hospital by ambulance. The hospital was unable to stabilize him, so he was transferred to another hospital where he was pronounced dead. Prior History: In December 1992, the mother took her youngest son to the hospital with a head injury. He was diagnosed with a skull fracture. The mother's explanation was inconsistent with the injury. The deceased and his sibling were taken into custody. The mother later gave birth to two more children who entered foster care in December 1997. They were returned to their father's care in February 1998. The oldest sibling has a permanency goal of substitute care pending court determination on termination of parental rights.

Investigation of this child and another child's death from asthma resulted in a report to the Director on November 17, 2000 regarding asthma management for wards of DCFS.

Case # 64 DOB July 1991 DOD July 2000
Age at death: 8-1/2 years
Substance exposed: no
Cause of death: Sanfilippo's Syndrome
County: McLean
Narrative: Eight-and-a-half-year-old child died in a foster home where he had resided since November 1994. The ward had multiple medical problems including Sanfilippo's Syndrome, mental retardation, cerebral palsy, epilepsy, hydrocephalus, hearing impairment, and severe developmental delays. In March 1999, the DCFS guardianship administrator signed a Do Not Resuscitate (DNR) Order for the child. Prior History: The child entered DCFS custody in November 1994 when the father, who was the custodial parent, left the child in a motel room with the mother who attempted suicide by overdosing on tranquilizers. Parental rights were terminated and the child's permanency goal was subsidized guardianship with the foster family. The OIG conducted a full investigation of this child's death, but the investigation did not result in a report to the Director.

Case # 65 DOB January 1981 DOD July 2000
Age at death: 19 years
Substance exposed: no
Cause of death: Brain aneurysm
County: Cook
Narrative: Nineteen-year-old ward died from a brain aneurysm. She resided in an independent living program with her one-year-old child. Prior History: The teenager had been a DCFS ward since 1987, when the father was indicated for sexually abusing her. The teen had done very well in the independent living program; she was working, attending college classes, and providing good care for her son. The OIG reviewed records in this case.

Case # 66 DOB May 1989 DOD July 2000
Age at death: 11 years
Substance exposed: no, but mother has a history of substance abuse
Cause of death: Myocarditis
County: Cook
Narrative: Eleven-year-old ward was not feeling well for a couple of days. When she became worse, her foster mother took her to the clinic where she showed signs of a stomachache and excessive vomiting. The child had several psychiatric diagnoses and the clinic felt her symptoms were indicative of an anxiety attack likely related to her impending change in schools. The clinic prescribed some medication and administered an EKG before they released her. At a follow-up appointment the next day, she began acting out and attacked a physician. She was transported to the hospital where she died the following day. Myocarditis is difficult to diagnose and often is not discovered until autopsy. Prior History: The family became involved with DCFS in February 1991 when the nineteen-year-old mother gave birth to a substance-exposed infant. An intact family case was opened. The deceased and her four siblings entered foster care in 1992 after three more indicated reports for inadequate supervision, birth of a second substance-exposed infant, and sexual abuse of the deceased child by her mother's paramour. The mother has given birth to a total of ten children between 1986 and 1999. Four of the children were born substance-exposed. The deceased had several placements in foster homes and group homes. In her last group home placement, an employee took an interest in her and wanted her placed in her home. The employee and her husband became licensed foster parents and the child was placed with them in April 2000. They were in the process of adopting her. The OIG reviewed records in this case.

Case # 67 DOB May 1984 DOD July 2000
Age at death: 16 years
Substance exposed: unknown
Cause of death: Bronchial Asthma
County: Cook
Narrative: Sixteen-year-old had a severe asthma attack. She was taken to the hospital by ambulance and was placed in the ICU. She died three hours later. The teen had a history of asthma and had been hospitalized at least three times for asthma problems. Prior History: The family has a history of DCFS involvement dating back to 1995 for neglect. The thirty-five-year-old mother has given birth to six children, two of whom were born substance-exposed. All of the children eventually entered foster care. At the time of her death, the teen was living with a paternal cousin. The five surviving children have been returned to their mother's care. Investigation of this child and another child's death from asthma resulted in a report to the Director on November 17, 2000 regarding asthma management for wards of DCFS.

Case # 68 DOB July 2000 DOD August 2000
Age at death: 14 days
Substance exposed: yes, cocaine
Cause of death: Sepsis, pneumonia due to prematurity
County: Cook
Narrative: Twenty-six-year-old mother gave birth prematurely to twins who were born substance-exposed. One twin died in the hospital. The second twin survived and was taken into custody and placed in specialized foster care. Prior History: The mother had two prior indicated reports from 1995 and 1996. In 1995, her two children, ages three months and two years, were taken into custody after she was indicated for inadequate supervision, environmental neglect, and substantial risk of physical injury. In 1996, her third child was taken into custody after the baby was born substance-exposed. The mother's rights on the three children were terminated in 1998 and there was no further contact with her until the birth of the twins. During the ensuing investigation, it was learned that the mother had two children, ages 1 and 2, in her care. They were taken into custody and placed with a relative. The three older children were adopted in June 2000. The three younger siblings have permanency goals of return home.

Case # 69 DOB July 2000 DOD August 2000
Age at death: 1 month
Substance exposed: yes, cocaine and marijuana
Cause of death: SIDS
County: Cook
Narrative: One-month-old infant was found unresponsive by his mother. The twenty-three-year-old mother had been sleeping with the baby in her bed and was reported by a relative to be under the influence of drugs. There was a bassinet in the home. Prior History: The mother had two prior indicated reports. In 1997, the mother left her then four-month-old son with her seven-year-old and did not return until the next morning. The grandmother obtained guardianship of the children and the case was closed in September 1998. In July 2000, the mother was indicated for giving birth to a substance-exposed infant, the deceased, and an intact family case was opened. It was closed following the child's death. In July 2001, the mother gave birth to her fourth child who was also born substance-exposed. The baby was taken into custody in October 2001 and is placed with his maternal grandmother. The OIG reviewed records in this case.

Case # 70 DOB July 2000 DOD September 2000
Age at death: 2 months
Substance exposed: no
Cause of death: Myocarditis
County: Kankakee
Narrative: Two-month-old infant was dropped off by his twenty-four-year-old parents at his paternal aunt's house to be babysat. When they went to pick him up, he was found unresponsive. The baby was supposed to be on an apnea monitor, but he was not because his parents left it at home. The parents were indicated for medical neglect to the baby for failure to have the apnea monitor on and substantial risk of physical injury to the surviving child, a four-year-old. The four-year-old was placed with his paternal grandfather. He returned home two months later in November 2000. Prior history: The baby was the second child in this family to die. On July 20, 1999, a ten-month-old infant died. His death was investigated by DCFS and unfounded as the coroner determined his death was due to SIDS. The OIG reviewed records in this case.

Case # 71 DOB June 2000 DOD September 2000
Age at death: 3 months
Substance exposed: yes, alcohol
Cause of death: Sepsis due to peritonitis
County: Champaign
Narrative: Three-month-old infant was brought to the hospital with breathing difficulties. She went into septic shock and required surgery for a bowel obstruction, but died before the surgery could be done. The baby had been born prematurely with numerous complications including Fetal Alcohol Syndrome, respiratory problems, and cardiac complications. Prior History: DCFS first became involved with the family two months prior to the baby's birth when DCFS received a request to provide services to the mother because she had shown up at a hospital intoxicated. The mother refused services and continued to drink during her pregnancy, believing she would abort the baby. Upon the baby's birth, in June 2000, the thirty-two-year-old mother was indicated for substance misuse because the baby was born with Fetal Alcohol Syndrome. The baby was taken into custody and placed in specialized foster care. The two older siblings, ages six and eight, were left at home under a safety plan that the husband or grandmother would be present with the mother and children. The family's case was closed a month after the baby's death as workers did not feel the surviving children were at risk. The OIG reviewed records in this case.

Case # 72 DOB September 2000 DOD September 2000
Case # 73 DOB September 2000 DOD September 2000
Ages at death: 1 and 3 days
Substance exposed: no
Cause of death: Extreme prematurity
County: Champaign
Narrative: Fraternal twins were born at 27 weeks gestation and were unable to survive their extreme prematurity. The infants' premature birth may have been prevented if their twenty-nine-year-old mother had not left the hospital against medical advice. Prior History: The mother has four surviving children, ages one to five. She has been the indicated perpetrator on three reports. One of her children was in custody from June 1998 to August 1999. An intact family case is open on the family.

Case # 74 DOB June 2000 DOD September 2000
Age at death: 2 months
Substance exposed: no
Cause of death: SIDS
County: Kankakee
Narrative: Two-month-old baby's day care provider noticed that the baby's breathing was shallow. She called 911 and the baby was transported to the hospital where he was pronounced dead. Prior History: The baby was born to a twelve-year-old ward of DCFS who was sexually abused while living in foster care with her maternal aunt. The baby became a ward in August 2000 when it was determined that his mother could not adequately care for him. Both children lived in the same foster home and were receiving services. The OIG reviewed records in this case.

Case # 75 DOB March 1992 DOD September 2000
Age at death: 8-1/2 years
Substance exposed: yes, cocaine
Cause of death: Intestinal ischemia
County: Cook
Narrative: Eight-and-a-half-year-old child died while in surgery for a possible bowel obstruction. The child had a history of extensive health problems and prior surgeries. He had a medical history of cerebral palsy, seizures, and asthma, and he was fed with a G-tube. Prior History: The child had been in foster care since February 1993 because of neglect by his mother. He had been living with the same foster parent in specialized foster care since November 1999. The child has ten surviving siblings. Three of the siblings have been adopted, three are in subsidized guardianship, and four live with relatives.

Case # 76 DOB February 2000 DOD September 2000
Age at death: 7 months
Substance exposed: yes, cocaine
Cause of death: Liver failure due to premature birth
County: Cook
Narrative: Seven-month-old baby was born premature and substance-exposed. She never left the hospital and was removed from life support. Prior History: An intact family case was opened following this child's substance-exposed birth. The mother, who had a one-year-old child at home, was offered substance-abuse treatment services. In January 2001, the surviving child was taken into custody because of the mother's continued chaotic lifestyle and failure to participate in substance-abuse treatment. The child is placed with a relative and has a permanency goal of return home. The OIG reviewed records in this case.

Case # 77 DOB July 2000 DOD September 2000
Age at death: 2 months
Substance exposed: no
Cause of death: SIDS
County: Cook
Narrative: Two-month-old baby was found unresponsive by her foster mother. The baby had been placed for a nap on her side on a couch with pillows surrounding her. A foster home licensing investigation following the child's death revealed some concerns. The agency amended the age range of children the woman could care for to eight years and above and recommended that she receive additional first aid training. Prior History: The family came to the attention of DCFS in February 2000 when an older sibling of the deceased baby was removed from his parents' care because of domestic violence that placed him at substantial risk of physical injury. At the time of the deceased's birth, the mother had left the father and was living with her father. The mother was allowed to keep the baby at home with her with monitoring by her worker. A month after the child's birth, the baby was taken into custody after the

mother moved from her father's home and failed to take the baby to medical appointments. The surviving sibling remains in foster care and has a permanency goal of adoption. The OIG reviewed records in this case.

Case # 78 DOB October 1990 DOD October 2000
Age at death: 9-1/2 years
Substance exposed: yes, cocaine and alcohol
Cause of death: Craniofacial anomalies due to hydrocephalus due to obstructive airway
County: Cook
Narrative: Nine-and-a-half-year-old child had multiple medical problems including multiple congenital anomalies, hydrocephalus, spastic cerebral palsy, and seizure disorder. She had a tracheostomy and a gastrostomy feeding tube. Prior History: The child entered DCFS custody in September 1991 due to her family's inability to care for her. The ward had been a resident at a residential care facility since June 1994.

Case # 79 DOB February 2000 DOD October 2000
Age at death: 8 months
Substance exposed: no
Cause of death: Acute bilateral bronchopneumonia, generalized hypoxic injury
County: Macon
Narrative: Eight-month-old premature twin, who suffered from bronchopulmonary dysplasia, was at the babysitter's when he began to have extreme breathing problems and seizures. The babysitter's twelve-year-old daughter, who often helped care for this baby, gave the child a nebulizer treatment which seemed to initially help. The baby was taken to the local hospital and immediately flown to another hospital where he died the next day. Prior History: The twenty-one-year-old mother of the deceased child had no prior contact with DCFS. The thirty-six-year-old babysitter had a recently closed case at the time of the death. The babysitter first came into contact with DCFS in September 1996 when she gave birth to a substance-exposed infant. An intact family case was opened and closed one year later. In July 1998, DCFS indicated the babysitter for substantial risk of physical injury to her own children. The children were placed in foster care for a year. The mother completed services and the children were returned home in August 1999. The family was monitored and their case was closed in August 2000. The family has had no further contact with DCFS. The OIG reviewed records in this case.

Case # 80 DOB January 2000 DOD October 2000
Age at death: 9-1/2 months
Substance-exposed: yes, cocaine
Cause of death: Hypoxic ischemic encephalopathy
County: Cook
Narrative: Nine-and-a-half-month-old baby was born premature and substance exposed at 24 weeks. He was a medically complex infant; he had bronchial pulmonary disorder and tachycardia; he was oxygen dependent, and he had a tracheostomy. Two days before his death, the baby was rushed to the hospital after his heart monitor went off and his foster parent found him unresponsive. Once at the hospital he was placed on a respirator. The following day he was declared brain dead. The next day he was taken off the respirator with the consent of his biological mother. Prior History: An intact family case was opened in January 2000 after the baby's thirty-one-year-old mother was indicated for neglect because the child was born substance-exposed. The mother lost custody of him and his three siblings in April 2000 after two more indicated reports of medical neglect and substantial risk of physical injury. The child lived in a specialized foster home. He had been living with his foster parent for two months after he spent four months in hospital and residential care. The mother has a history with DCFS dating back to 1988. This baby was her second child to die. The first child died from a subdural hematoma due to blunt trauma. His death was ruled a homicide. When the OIG began investigating the initial death for the intact family

team in February 2000, it was discovered that the death was never fully investigated by the local Police Department. The OIG met with the police and information was shared with them. In November 2000, the mother's boyfriend at the time of the death, confessed to killing the baby and was charged with first-degree murder. All three surviving siblings remain in DCFS custody. They are placed together in one foster home. Their permanency goal is to return home.

Case # 81 DOB April 1999 DOD October 2000
Age at death: 18 months
Substance exposed: yes, cocaine
Cause of death: Congenital heart disease
County: Cook
Narrative: Eighteen-month-old child's heart monitor alarm sounded and his foster mother attempted CPR. He was brought to the hospital where he was pronounced dead. The deceased child and his twin brother, who died in May 1999, were born premature at 30 weeks gestation positive for cocaine and heroin. The baby was a medically complex child; he had developmental delays and was diagnosed with failure to thrive and a complex congenital heart defect which required many surgeries. He was scheduled for surgery on the day of his death. Prior History: The child entered the temporary custody of DCFS in July 1999. He was in specialized foster care. He had been in the same foster home since being released from the hospital in August 1999. His permanency goal was substitute care pending court determination on termination of parental rights. There are two surviving siblings, ages 4-1/2 and 9, who have never been in DCFS custody. They were subjects of an open case from July 1999 to April 2001.

Case # 82 DOB November 2000 DOD November 2000
Age at death: 1 day
Substance exposed: not tested, but mother admitted to using heroin the day before giving birth
Cause of death: Prematurity
County: Cook
Narrative: The baby's twenty-seven-year-old mother showed up at a hospital clinic to get a Deprovera shot and was told that she was pregnant. She went into labor that same day. The baby was born premature at 23-24 weeks gestation. A toxicology screen was not completed on the baby, but the mother admitted to using heroin the day before. The baby went into respiratory distress and died the day after his birth. A death by neglect report was unfounded by DCFS. Prior History: The mother has six surviving children ranging in age from 22 months to 13 years. She has a history of neglect dating back to 1996 when she delivered a substance-exposed infant. Four of the children were adopted by their maternal grandmother in February 2000; one was adopted by a non-relative in November 2000. The remaining child is in a preadoptive home and termination of parental rights is expected.

Case # 83 DOB January 1992 DOD November 2000
Age at death: 8-½ years
Substance exposed: no
Cause of death: Bronchopneumonia, Rett's syndrome
County: Cook
Narrative: Eight-and-a-half-year-old ward was found unresponsive by her foster mother who had gone to wake the child for school. The child was rushed to the hospital, arrived in full cardiac arrest, and died shortly thereafter. The child was previously diagnosed with seizure disorder, developmental delays, and Rett's Syndrome, a progressive brain disorder characterized by autism, dementia, ataxia, and purposeless hand movements. Children with the disorder usually remain at cognitive and social level equivalents of one year. Prior History: The family came to the attention of DCFS in 1996 when the then twenty-three-year-old mother was indicated for medical neglect of the deceased and inadequate shelter for the deceased and her two siblings, then ages four and six. An intact family case was opened. Four more indicated

reports involving medical neglect or substantial risk of physical injury followed over the next two years. The children were taken into custody in May 1998. The deceased lived at a residential care facility until March 2000 when she was placed in a specialized foster home. Her two siblings live together in a relative foster home placement and their permanency goal is guardianship.

Case # 84 DOB October 2000 DOD December 2000
Age at death: 2 months
Substance exposed: no
Cause of Death: SIDS
County: Lake
Narrative: Two-month-old baby was found by his foster sibling in his crib not breathing and blue. CPR was administered and 911 was called. The baby was transported to the hospital where he was pronounced dead. Prior History: DCFS took custody of the baby after the investigation of an A-sequence report that the newborn was abandoned at the hospital by his mother. The baby was born premature and remained in the hospital for three weeks after his birth. His twenty-five-year-old mother had no contact with him. While the DCP investigation was pending, in November 2000, the mother dropped off the infant's three siblings at a DCFS office stating she could no longer care for them. The State is in the process of terminating her parental rights to these children. The children are placed together in the same foster home in which the deceased child was placed.

Case # 85 DOB January 2000 DOD December 2000
Age at death: 10-1/2 months
Substance exposed: yes, cocaine
Cause of death: Complex congenital heart disease, severe hypoxia, pulmonary disease
County: Cook
Narrative: Ten-and-a-half-month-old infant died while undergoing a medical procedure at the hospital. The infant was born substance-exposed and had multiple medical problems including congenital heart disease and convulsive disorder. The infant had lived at a residential care facility since April 2000 when she was released from the hospital where she was born. Prior History: An A-sequence report made in February 2000 was indicated for substance exposure as the infant tested positive for cocaine at birth. Her thirty-seven-year-old mother was referred to intact family services. The B-sequence report, made in March 2000, was unfounded for medical neglect. The mother participated in drug treatment and visited her daughter regularly until August 2000 when she quit both. The C-sequence report made in October 2000 was indicated for medical neglect and abandonment because of the mother's failure to visit her daughter and participate in her care. The child entered custody in November 2000. The mother has one other child who has been in DCFS custody since 1989. The child has lived with his maternal grandmother since that time. He is 20 years old and has a permanency goal of independence. The OIG reviewed records in this case.

Case # 86 DOB July 1988 DOD December 2000
Age at death: 12 years
Substance exposed: yes, cocaine
Cause of death: Multiple medical problems, complications of cerebral palsy
County: Cook
Narrative: Twelve-year-old ward was born four months premature and substance exposed. He had numerous medical problems including cerebral palsy, profound mental retardation, spastic quadriplegia, compensated hydrocephaly, seizure disorder, gastrointestinal problems, respiratory problems, bowel and bladder incontinence, scoliosis, hip dislocation and bronchopulmonary dysplasia. In the last months of his life, his respiratory problems worsened. Prior History: DCFS opened an intact family case shortly after the child's birth. He was taken into custody in June 1989. The child spent his life in hospitals and a

residential care facility. His mother is deceased and other family members, including his father and grandmother, never visited him. The OIG reviewed records in this case.

Case # 87 DOB April 1999 DOD December 2000
Age at death: 1-1/2 years
Substance exposed: yes, cocaine
Cause of death: Bronchial asthma
County: Cook
Narrative: One-and-a-half-year-old toddler was found unresponsive in his crib by his foster mother. He died during an asthma attack. Prior History: The child entered foster care in March 2000 with his four siblings after his three-year-old sister was sexually abused by their father. The child lived with his current foster parents since the beginning of November 2000. His foster mother was an ex-emergency room nurse and his foster father was a paramedic. They had a son who also had asthma. The child's biological mother participated in drug treatment and other services. Two of her children were returned to her care in September 2001 and the other two are expected to return home in March 2002. The thirty-three-year-old mother has no contact with the forty-five-year-old father. He was never charged with a crime related to the sexual abuse. The OIG reviewed records in this case.

Case # 88 DOB August 2000 DOD January 2001
Age at death: 4-1/2 months
Substance exposed: yes, cocaine
Cause of death: SIDS
County: Cook
Narrative: Twenty-nine-year-old mother found her four-month-old infant unresponsive following a nap. The mother reported that she and the infant both took a late afternoon nap. The infant was placed for his nap in the mother's bed. He was placed on his side with pillows to keep him in place while he slept. The mother and a cousin found the child not breathing following the nap. The child was pronounced dead at the scene. Prior History: The family's first involvement with the Department was in August 2000. An A- sequence report was indicated because the child was born substance-exposed. The B-sequence investigation following this child's death was indicated for substantial risk of physical injury and medical neglect to the child's two siblings. They were placed in foster care in February 2001 and have permanency goals of return home.

Case # 89 DOB December 2000 DOD January 2001
Age at death: 2 weeks
Substance exposed: no
Cause of Death: SIDS
County: McLean
Narrative: Two-week-old baby was found unresponsive in the morning by her nineteen-year-old mother. The infant was pronounced dead at the hospital. Prior History: The family's first involvement with DCFS was three days prior to the infant's death when the Department received a report alleging inadequate supervision. The mother called the doctor's office and made the comment she had to get off the phone because she left her baby alone. DCP investigated. The mother stated that her friend was with the baby when she used the phone next door and that she told the nurse she had to get back to her baby, not that she left the baby alone. The report was unfounded as the DCP investigator did not find evidence of inadequate supervision rising to the level of neglect. The OIG reviewed records in this case.

Case # 90 DOB November 2000 DOD January 2001
Age at death: 1-½ months
Substance exposed: no
Cause of death: SIDS
County: Champaign
Narrative: One-and-a-half-month-old baby was fed in the early morning by his fourteen-year-old mother and put back to bed. The mother found the child unresponsive three hours later. The baby was transported to the hospital where he was pronounced dead. The day after the baby's death, a report was made to the hotline alleging environmental neglect because of the home's dirty conditions and roach infestation. The report was indicated. Prior History: The thirty-four and thirty-six-year-old grandparents have a history of neglect dating back to 1987. From 1987 to 1994, the two oldest of the six children, ranging in age from five to seventeen, were in foster care. In 1995, the family's case was closed. It was reopened in May 2000 and closed in September 2000 when the family moved. An intact family case was reopened in January 2001 when the grandparents were indicated for environmental neglect. The case remains open. The OIG reviewed records in this case.

Case # 91 DOB November 1994 DOD February 2001
Age at death: 6 years
Substance Exposed: no
Cause of death: Metastatic Wilm's tumor
County: Cook
Narrative: Six-year-old ward died from a recurrence of a Wilm's Tumor that had first been diagnosed when he was fifteen–months-old. At that time, he had surgery to remove one of his kidneys and underwent radiation and chemotherapy. Subsequently, and during the course of chemotherapy, the child suffered multiple bone fractures due to demineralization of his bones. In September 1999, the child underwent surgery to remove a cancerous tumor in his brain. In September 2000, he was diagnosed with inoperable cancer to his jaw and was treated with radiation and chemotherapy. The child succumbed to his illness five months later. Prior History: The child's twenty-three-year-old mother had been a ward of the state since August 1994. The first indicated report on the mother as a caretaker was in October 1996 when her three-month-old baby was diagnosed with inorganic failure to thrive. In May 1997, she was indicated for medical neglect of the deceased and he and his sibling were taken into custody. The mother was indicated on one more report for substantial risk of physical injury on a subsequent child born in October 1998. That child came into custody in February 2000 and was returned home in October 2001. The younger child, born in June 2000, was never removed from the mother and remains with her. The child who entered foster care with the deceased was adopted in September 2001. The OIG conducted a full investigation of this child's death and a report was submitted to the Director on February 9, 2001.

Case # 92 DOB October 1999 DOD February 2001
Age at death: 16 months
Substance exposed: no
Cause of death: Complications of cerebral palsy
County: Death: St. Louis, Missouri
Case Management: Jackson
Narrative: Sixteen-month-old baby was hospitalized in St. Louis, Missouri where he died from complications of cerebral palsy. Prior History: In January 2001, DCFS received a report alleging that the baby's nineteen-year-old mother had medically neglected the baby to the point that he was failure to thrive. An intact family case was immediately opened to assure that the mother was taking the child for all of his appointments and providing proper care at home. The investigation was unfounded shortly after the baby's death. The intact family case was closed in May 2001. A four-year-old sibling remains with the mother. There has been no further involvement with DCFS.

Case # 93 DOB October 2000 DOD March 2001
Age at death: 5 months
Substance exposed: no
Cause of death: Congenital heart disease
County: Cook
Narrative: Five-month-old baby was found unresponsive on a couch where she had been sleeping with her eighteen-year-old mother. The baby was rushed to the hospital where she was pronounced dead. The baby had been seen at a clinic the day before for a cold. Prior History: An intact family case was opened in February 2001 after the baby was diagnosed with non-organic failure to thrive. The mother was indicated for inadequate shelter for the baby and her two siblings, ages one and two. The child was initially taken into protective custody, but released to her mother the following day when the baby was diagnosed with a heart condition. An intact family case remains open.

Case # 94 DOB January 2001 DOD March 2001
Age at death: 2 months
Substance exposed: yes, cocaine
Cause of death: SIDS
County: Cook
Narrative: Two-month-old baby was found unresponsive by his twenty-eight-year old mother. He was transported to the hospital where he was pronounced dead. Prior History: This family's history with DCFS began in 1994 when the mother gave birth to her first substance-exposed infant. A second substance-exposed infant was born in 1996. The mother's five children entered foster care in August 1997. One child lives with his father and the other four were adopted by their paternal grandmother. After the birth of the deceased child, the mother moved in with her father and stepmother and entered substance abuse treatment. She was allowed to retain custody of her son under these circumstances. At the time of the baby's death, she was progressing in treatment. The OIG reviewed records in this case.

Case # 95 DOB December 2000 DOD April 2001
Age at death: 4 months
Substance exposed: no
Cause of death: SIDS
County: Peoria
Narrative: Four-month-old infant was found unresponsive by her foster parents who called 911. CPR was administered and the infant was transported to the hospital where she was pronounced dead. Prior History: The infant was taken into DCFS custody following her birth. Her mother was indicated for substantial risk of physical injury to the infant based on her prior history. The child's five siblings are in DCFS custody with no plans to return to their mother's care.

Case # 96 DOB March 2001 DOD May 2001
Age at death: 2 months
Substance exposed: no
Cause of death: Sepsis due to prematurity
County: Cook
Narrative: Two-month-old baby was found unresponsive in the morning by his twenty-eight-year-old mother. He was transported to the hospital where he was later pronounced dead. The baby was born prematurely at 6-½ months gestation and remained in the hospital for some time after his birth. His mother visited him regularly. Prior history: In November 1996, the mother and father were indicated for substantial risk of physical injury to their two children, then ages 3 months and four years, following an incident of domestic violence. In April 2001, the mother was indicated for inadequate supervision of her eight-year-old son, as she had not made an adequate care plan for him while she was visiting the baby in

the hospital. An intact family case was opened. It was closed in July 2001. The OIG reviewed records in this case.

Case # 97 DOB November 2000 DOD May 2001
Age at death: 6 months
Substance exposed: no
Cause of death: Hypertrophic cardiomyopathy
County: Cook
Narrative: Seventeen-year-old mother brought her six-month-old baby to the medical clinic in sudden distress. The baby was transferred to the hospital where he died fourteen days later. Prior History: At the time of the baby's death, there was a pending DCP investigation for inadequate food. The investigation was ultimately unfounded.

Case # 98 DOB February 2001 DOD May 2001
Age at death: 3 months
Substance exposed: yes, cocaine
Cause of death: Complications of a heart valve disorder
County: Will
Narrative: Three-month-old baby died in the hospital. She had spent only two days outside of the hospital since birth. The mother was indicated for death by neglect based on doctors' statements that the baby's heart valves were destroyed by the mother's drug use. Prior History: The baby's twenty-four-year-old mother has five indicated reports dating back to 1994. She was twice indicated for inadequate supervision and her two children entered foster care in April 1995. They were returned home in April 1996. In August 1999, an intact family case was opened after the mother gave birth to a substance-exposed infant. After the deceased was born substance-exposed in February 2001, the five children, ages newborn to nine years, were taken into custody. The surviving children remain in custody and have permanency goals of return home.

Case # 99 DOB July 2000 DOD June 2001
Age at death: 10 months
Substance exposed: no
Cause of death: Brain tumor, cerebral edema
County: Macon
Narrative: Ten-month-old infant died in the hospital. She had a brain tumor. Prior history: The family first came to the attention of DCFS prior to this child's birth. The nineteen-year-old parents were indicated for environmental neglect and an intact family case was open for three months. In April 2001, a hotline report was made alleging medical neglect and environmental neglect. The report was indicated. The baby was taken into DCFS custody as her doctors did not believe her parents could meet her medical needs. There are two surviving children, ages 2 and 5, in the family. They are currently receiving intact family services.

Case # 100 DOB June 2001 DOD June 2001
Age at death: 2 days
Substance exposed: yes, cocaine
Cause of death: Pulmonary hemorrhage
County: Cook
Narrative: The baby girl and her twin brother were born prematurely and substance-exposed at 25 weeks gestation. Their twenty-four-year-old mother admitted using heroin. The baby girl died two days after birth. The baby boy later died as well. Prior History: This mother has given birth to nine children between 1988 and 2001. The six youngest children all tested positive for drugs at birth. The three oldest children may not have been tested. Six of the surviving seven children have been adopted. The youngest

is in a home of relative foster placement. The state is in the process of terminating parental rights so that he can also be adopted.

Case # 101 DOB January 2001 DOD June 2001
Age at death: 5-1/2 months
Substance exposed: no
Cause of death: SIDS
County: Macon
Narrative: Five-and-a-half-month-old baby died from SIDS. Prior history: The baby's family had a preventive services case open at the time of his death to assist the family with housing. The case was opened in March 2001 and closed in September 2001. There were also two unfounded reports during this time involving this baby and his one-and-a-half-year-old brother. The first report was made in April 2001 on the child's maternal great-aunt who lived with the family. The report alleged inadequate supervision and cuts/bruises/welts. It was unfounded. The second report was made in May 2001 on the child's twenty-one-year-old mother for inadequate supervision and medical neglect. It was also unfounded. The OIG reviewed both investigations and found them to be appropriately unfounded. They appeared to have been made for harassment.

Case # 102 DOB May 2001 DOD June 2001
Age at death: 1 month
Substance exposed: no
Cause of death: SIDS
County: Cook
Narrative: One-month-old infant was found unresponsive by a sibling. His twenty-eight-year-old mother left for work early in the morning while the father, age unknown, was left with the infant and seventeen and fourteen-year-old siblings. The father checked on the child who was sleeping in the bassinet. A couple of hours later, the infant was found unresponsive and 911 was called. The child was transported to the hospital where he was pronounced dead. Prior History: The family's first involvement with the Department was in April 2001 when there was an unfounded report of substantial risk of physical injury to one of the infant's siblings. This report was reviewed by the OIG and appeared to be appropriately unfounded.

Case # 103 DOB May 1991 DOD June 2001
Age at death: 10 years
Substance exposed: no
Cause of death: Anoxic encephalopathy
County: Cook
Narrative: Ten-year-old child was hospitalized four days prior to her death for respiratory distress. She never regained consciousness at the hospital and was taken off life support the day before she died. The child had Werdnig Hoffmann disease, a hereditary disorder characterized by progressive weakness and wasting of skeletal muscles caused by degeneration of anterior horn cells. The disease rendered the child totally disabled and eventual death was expected. The minor's sister also died from the disease. Prior History: The Department obtained custody of the deceased child in January 1997 after her parents failed to visit her during a long hospital stay. The child lived in a residential care facility. She had been there since leaving the hospital in October 1998. She had no contact with her parents.

INTACT FAMILY RECOVERY

The Intact Family Recovery Project (IFR) integrates child welfare and substance abuse disciplines to maximize child safety and effective participation in substance abuse treatment for families receiving intact services who have delivered a first or second substance-exposed infant. Basic tenets of the model include:

- immediate and increased communication and collaboration between child welfare and substance abuse treatment workers
- comprehensive services offered to the entire family
- intensive home visits by both child welfare and substance abuse providers
- cross training in both disciplines
- cases are followed for 18 to 24 months in recognition of the difficult process of addressing drug dependency

The model imposes graduated sanctions to increase effective participation in substance abuse treatment. Graduated sanctions are imposed pursuant to a Memorandum of Agreement, or contract, between the workers and the parent(s) listing conditions and consequences for noncompliance. Graduated sanctions include prescreening or reviewing the case with the Cook County State's Attorneys Office; and obtaining court orders mandating treatment compliance. Data suggests that the use of graduated sanctions have been effective in compelling parents to complete significant courses of substance abuse treatment. Currently, the child welfare and substance abuse providers selected to implement the model in Cook County are Lutheran Social Services of Illinois (LSSI) and Recovery Point serving the North and South Cook regions; and Lutheran Children and Family Services of Illinois (LCFS) and Haymarket House, serving the Central Cook region.

Child Care for Older Siblings

Although some treatment providers offer residential services for mothers and children five years and younger, none accept older, school age children. To remedy this, the DCFS Division of Health Policy, Haymarket Center, and Columbus-Maryville agreed to develop a program which allows mothers to enter residential treatment at the Haymarket Treatment Facility while her older children are placed at Columbus-Maryville (an emergency reception area for children that is located near Haymarket).

Family Literacy

Research shows that children who are read to at home and who are introduced to literature early in their lives show stronger academic skills in the primary grades. When families transmit the important value of reading to their children, children approach reading with excitement and enthusiasm, laying the groundwork for academic success. The Intact Family Recovery Literacy Initiative was launched in January, 2001 to address the need to encourage reading at home.

IFR child welfare and substance abuse workers participated in six trainings, which provide a "tool box" of knowledge which included: an overview of child development, observation skills,

cultural issues and their influence on literacy, family expectations and behaviors around literacy and how to form collaborations with agencies (e.g., libraries, museums, early childhood programs and child care centers) to support literacy. The trainings stressed positive effects of parents, especially fathers, reading to their children.

The IFR literacy specialist is now doing hands-on training with workers and parents' in the homes of families, modeling techniques for reading aloud, observing children, and helping families select books. Each family receives a book bag with three to five specially selected books to match the age and developmental levels of their children. Parents receive two books. The majority of books have been donated by libraries, book publishers, and individual donors.

Worker Training

The IFR Project requires a well-trained team of child welfare and substance abuse treatment workers and supervisors. To ensure continued quality of services, we are designing a multi-media, leader led training curriculum which will allow existing teams to thoroughly train new workers as well as enable the Department to establish additional IFR programs in the state.

Mental Health

A recent study[4] shows that 53% percent of Illinois substance abuse clients reported experiencing serious depression; 48 % reported experiencing serious anxiety and more than a quarter reported experiencing suicidal thoughts. Twenty one percent (21%) reported receiving some type of outpatient mental health treatment; nineteen percent (19%) reported inpatient or hospitalized care for an emotional problem.

Nationally, seventy five percent (75%) of substance abuse treatment programs perform some type of mental status evaluation, but less than a quarter (under 25%) provide mental health treatment at the same time. Mental health issues may affect parenting ability even after a parent has successfully completed drug treatment. Therefore, teaching caseworkers to recognize and address mental health issues, is critical to ensuring child safety and family stability.

The IFR Project also developed a mental health screening tool to enable workers to better identify mental health issues and more quickly connect families with appropriate mental health services. In six percent of cases, concerns about the parent's ability to safely care for their children prompted IFR workers to refer the family to the Parenting Assessment Team.

[4] Bruni, M., Jacob, B. and Robb, S., The Effectiveness of Substance Abuse Treatment in Illinois: Results of the Illinois Statewide Treatment Outcomes Project. Illinois Department of Human Services Office of Alcoholism and Substance Abuse, September, 2001.

OLDER CAREGIVERS

Three years ago a series of OIG investigations and Department reviews of foster homes caring for five or more children revealed implications of an aging care giving population on children's permanency and safety, and culminated in the development of a problem-solving model constructed from blended child welfare and geriatric perspectives.

After initial development and field test of the program model by the Office of the Inspector General (OIG) and the Department of Children and Family Services (DCFS) in FY '00, Metropolitan Family Services in Chicago assumed implementation of the Older Caregiver pilot program. The program was designed to address both child welfare and aging issues that arise in foster care, kinship care and adoptive/guardianship families, involving caregivers 65 years old or older. The program assists families with older caregivers to sustain the care taking arrangement or to assist the extended family in making an alternative arrangement. The overall goal of the program is to ensure the child's safety and permanency of placement.

The program employs a developing problem-solving model comprised of three components: information gathering and assessment, service provision, and family conferences. Three assessment areas help to determine a family's needs: personal, social and parenting history; physical and cognitive status; and financial and housing concerns. The caregiver's relationship with the children in care is assessed across these areas and in terms of the children's developmental needs and challenges, and the children's relationship with extended family. At the family conference, child welfare and geriatric specialists provide comprehensive and integrated feedback to the family regarding the caregiver's capabilities. With the assistance of an independent mediator, the family develops care and protection plans, back up care plans, and commit to tasks related to child safety and permanency.

In FY '01, the program served 26 urban families headed by elderly caregivers that came to the program's attention because child neglect allegations, placement disruption, or a suspended adoption/guardianship jeopardized the child's placement. As expected, the program participants have been long-term caregivers. Many raised their own children to adulthood and are now caring for their grandchildren, great nieces or nephews. A typical family receiving services has 4.57 members in the home and a monthly median income of $1,310. All of the older caregivers are female and all but one is African American. The average age of the older caregiver is 73.19 years and she has cared for her grandchild for an average of 5.2 years. She is widowed and typically has an adult child living in her home in addition to grandchildren. On average the children living with the older caregiver are 8.29 years old and African-American. A slight majority of the children in her care are male.

Problems with physical and cognitive difficulties were a primary issue for the vast majority of the adult program participants. Arthritis, hypertension, kidney disease, diabetes, heart disease, vision loss, weakness and fatigue were the most common physical problems presented by caregivers. Cognitive-related difficulties reported by caregivers included early stage Alzheimer's, depression and generalized anxiety. The status of the caregiver's physical and cognitive functioning impacted, to varying degrees, on their ability to care for their children and to manage their daily activities. Caregivers reported problems with mobility, including walking

and climbing stairs and carrying out household chores, including cooking, cleaning and doing laundry.

Financial and housing needs constituted significant issues for the families. Many of the caregivers reported inadequate income to meet basic needs of dependents in their home and nearly all of the households were at or below the federal poverty line. Housing for the families was often inadequate to meet the families' needs. Some homes were too small for the number of residents; other homes had structural problems and were not reasonably accessible by the caregivers with physical limitations.

Many caregivers reported an inability to adequately care for their children because of health issues and fatigue. They could no longer provide the structure and discipline needed and remarked on the difficulty in caring for today's generation of children. Older caregivers of adolescents often characterized their relationship with the child as conflictual.

The children of family participants presented an array of concerns, including developmental delays, learning disabilities, academic failure, truancy, failure to thrive, drug exposure at birth, and problematic behaviors.

The majority of family participants cooperated with the program toward achieving a compassionate, long-term solution to a difficult problem.

ETHICS

Since its formation, one of the primary goals of the Ethics Office at the OIG has been to facilitate the operation of the Child Welfare Ethics Advisory Board, which considers issues brought to it by the Inspector General and other child welfare professionals.[5] The Board met five times during this fiscal year, and focused most of its attention on a cluster of cases in which DCFS wards were accused of serious crimes. These children had been advised by their attorneys not to discuss the circumstances of the crime with anyone and were thus precluded from psychological counseling or other therapeutic interventions. The Board considered the following questions: (1) can or should the emotional and psychological needs of such a ward be taken into account and balanced against his or her legal interests, (2) who should have the responsibility for making such decisions, and (3) what are the proper criteria to be used in making such decisions? The Board analyzed these issues in depth, recommending that the Inspector General consult with the Cook County Public Guardian, the State's Attorney, and the DCFS Guardian. At the Board's suggestion, the ethics staff researched the law in several other states and found that these questions have not been resolved elsewhere. A task force was assembled involving representatives from the above offices as well as the Public Defender's Office and DCFS Legal. This group continues to meet to consider possible changes in policy, rules, or statute to protect the interests of such wards as well as other wards that might have been victims or witnesses.

The Ethics Office contributed to the analysis in several OIG investigative reports, and traced recurring issues that could be presented to the Ethics Board or the Director. These recurring issues included: (1) abuses of power and negligence within private agencies where nepotism is practiced, and (2) the problematic consequences of blurring professional boundaries between caseworkers and Foster Parent Support Specialists (FPSS), who are both DCFS licensed foster parents and contractual employees of DCFS. The Director recognized the ethical problems with respect to the second issue, and is reviewing the FPSS contracts both to clarify their role and to make sure they are licensed and supervised as foster parents in a different DCFS region than the one in which they work. As of the end of the fiscal year, the Ethics Board was considering the implications of recommending an anti-nepotism policy for contracting agencies.

The Director requested and was given clarification from the Ethics Office about the circumstances when it would be appropriate for a supervisee to question a decision by his or her supervisor on ethical grounds. The Office also advised the Director with respect to his memoranda to DCFS staff on the subject of personal relationships between supervisors and supervisees and DCFS employees recommending or hiring their relatives within the agency.

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[5] As of July 1, 2001, the members of the Child Welfare Ethics Advisory Board were:
Roberta Bartik, J.D., Commander, Youth Investigations Division, Chicago Police department
Michael Bennett, Ph.D., Director, Msgr. John J. Egan Urban Center, DePaul University
Michael Davis, Ph.D., Illinois Institute of Technology's Center for the Study of Ethics in the Professions
Esther Jenkins, Ph.D., Department of Psychology, Chicago State University
Jimmy Lago, MSW, Chancellor, Archdiocese of Chicago
Martin Leever, Ph.D., University of Detroit Mercy
David Ozar, Ph.D., Director, Center for Ethics, Loyola University Chicago
Ada Skyles, Ph.D., J.D., Chapin Hall Center for Children, University of Chicago (Chair)
Eugene Svebakken, MSW, Executive Director & CEO, Lutheran Child & Family Services

Informal inquiries from DCFS employees and employees of private agencies were fielded by the Ethics Office. Most of these concerned secondary employment issues or questions about professional boundaries between workers and clients. The ethics staff also continued to join representatives from DCFS' Internal Audits and Child and Family Policy divisions in weekly meetings of the DCFS Conflict of Interest Panel.

As Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General has the responsibility to collect and review the Statements of Economic Interest of senior DCFS employees. The ethics staff supervised this effort and checked the statements for problematic gifts or conflicts of interest.

The OIG Ethics Office was involved in several special projects this year. A contract was signed with the Child Welfare League of America (CWLA) to publish Volume I of the Ethics Handbook written by the ethics staff in conjunction with Professor Elsie Pinkston of the University of Chicago and Professor Eileen Gambrill of the University of California at Berkeley. The CWLA will market and distribute the handbook to a national audience. The ethics staff continued to work on Volume II of the handbook, which will address ethical issues in child welfare supervision and administration.

In April, 2001 members of the ethics staff collaborated with the ABA Center on Children and the Law to present a workshop at the 13th National Conference on Child Abuse & Neglect in Albuquerque, New Mexico. The workshop explored the intersection of legal ethics and child welfare ethics, looking at practice situations where the professional responsibilities of attorneys and child welfare professionals may not mesh well or may conflict. The issue of how to best serve the interests of wards accused of serious crimes was a main focus of the workshop.

The ethics staff conducted two trainings with regional DCFS Administrative Case Reviewers in the winter of 2001. The trainings reviewed the core professional values of child welfare and presented several practice situations involving the work of an Administrative Case Reviewer where ethical decision-making skills could apply.

A major initiative this year was the production of an ethics video, with accompanying trainer's and participant's manuals, in cooperation with Governor's State University and the Park Ridge Center for the Study of Health, Faith & Ethics. This project, to be completed in Fall 2001, involved constructing scripts for four filmed case scenarios, and for a mock ethics committee discussion following each vignette, as well as working on drafts of the accompanying manuals. The training can be used by both private and public agencies who wish to set up ethics committees and promote critical thinking skills among their staff. The Ethics Office also prepared a grant proposal which was submitted by the Director and the Inspector General to the Annie E. Casey Foundation. The proposal requests funding for a child welfare ethics education initiative which would be jointly managed by the Ethics Office and the Park Ridge Center.

BEST PRACTICE

Asthma Initiative

In fiscal year 1999, the OIG completed two full investigations related to the asthma management of wards of the State of Illinois. The first investigation reviewed the circumstances that lead to the asthmatic deaths of three wards. The second investigation reviewed the case of a child who was diagnosed as a fatally prone asthmatic. Both investigations revealed that the lack of appropriate medical care, management and follow-up were implications in all three deaths and severely affected the health of the child who was fatally prone. Asthma is a controllable disease that can be fatal, if poorly controlled.

In fiscal year 2000, the OIG completed a full investigation of another two wards who died of asthma. A third ward died of asthma, and a review of his records was performed, but a full investigation was not conducted. Similar to the asthma deaths in 1999, a lack of appropriate medical care, management and follow–up were also implicated in these latest deaths.

In all six deaths, a review of their medical records showed that their asthma was poorly controlled and in each case the deaths should have been preventable. In response to these six deaths, and at the request of the Director of DCFS, an Asthma Training was developed and piloted on three occasions during FY 2000. One hundred and seventy-five POS caseworkers in Cook County attended the pilot trainings. Their response to the initial trainings was overwhelmingly positive, and an "Asthma within DCFS" training that discussed the implications of caseworkers role in preventing further asthma deaths was designed. POS workers in Cook County are currently receiving this training and POS workers in Illinois will be receiving this training during FY 2001/2002.

The Department's Division of Health Policy was selected to participate in a Casey Foundation study of Asthma. Two Healthworks of Illinois sites in North Chicago have been identified. The study involves screening all wards for asthma during the Initial Health Screening at both these locations. Those identified with asthma or possible asthma will be enrolled in a comprehensive asthma program. The study began on October 1, 2001 and will run for nine months.

CHILD ABUSE AND NEGLECT INVESTIGATIONS

- The Abused and Neglected Child Reporting Act, and the corresponding DCFS Rules, should be amended to clarify that a child with no caretaking responsibilities is not an eligible perpetrator of abuse.

- The Department should ensure that copies of prior indicated Child Protection investigations are available to current Child Protection investigators and forwarded to intact family or child welfare workers, including private agencies who are assessing the family or offering services.

- The Department should assure that indicated Child Protection investigations are shared with therapists when parents are referred for therapy. Any intact family service records for the family should also be forwarded to the follow-up team and therapists.

- DCFS procedures should be clarified to require that when a case is already open with the Department and a new Child Protection investigation is initiated, the Child Protection investigator must be responsible for developing the safety plan until the investigation is completed. The follow-up caseworker should receive a copy of the plan to assist DCP in monitoring the safety plan while the investigation is pending.

- The body chart and training used in Child Protection investigations should be adapted to incorporate pediatric studies that discount the ability to "date" children's bruises solely by color.

- Strategies to decrease bias and increase the reliability and validity of Child Protection decisions, as described more fully in the OIG Report, should be included in Child Protection training.

- During an investigation, a Child Protection Investigator should ask alleged perpetrators for the names, dates of birth, and living arrangements of any of their children who are not members of their household. The Investigator should investigate the reason such children are not living with their parent(s).

- Available extended family members should be included in safety planning and needs assessments.

- A local DCFS Office needs to retrain its investigators and supervisors on what constitutes confinement, torture, environmental neglect and general investigation procedures (following a flawed investigation that failed to identify a problem in a foster home, which used a cage to confine a 13 year-old foster child).

- The Department needs to take measures to ensure the proper handling of dependency-like allegations. The Department should:

  1) Train Hotline staff to discern dependency-related allegations and assign a category of "Inadequate Supervision" to hotline calls reporting suspected neglect-dependency issues;
  2) Expand Caretaker Factors contained in the investigative guidelines of the allegation category of "Inadequate Supervision" to facilitate more accurate assessments of caregivers.

3) Train supervisors on the dilemma produced by an aging care population; educational material should be shared with all supervisors and caseworkers on aging and available resources;
4) Establish an independent relationship with an aging specialist to be available to workers (previously recommended by OIG).
5) Evaluate the Department's Child Welfare Services to determine where it can best serve families in the continuum of child welfare services and how it can be more effective in service delivery.

- When a mother with previous indicated child abuse and neglect reports who is currently involved with DCFS is pregnant but cannot be located, the assigned caseworker and/or supervisor should make efforts to contact hospitals where (1) the mother has previously given birth (if known); and (2) hospitals within the mother's geographical vicinity to request that they contact DCFS should the mother give birth at the hospital.

- The Department must report re-abuse data in a way that promotes useful analysis. Currently, the re-abuse data is folded into data reports that do not separate the categories of abuse and neglect, making it difficult to isolate, review, and analyze cases in which children have been re-abused.

- The Hotline or Child Protection should be required to compare indicated perpetrators against databases of licensed child welfare employees or day care providers. If a perpetrator is found to be licensed, the Hotline or Child Protection should be given the responsibility of notifying either the employer or the Child Welfare Employee Licensure Board.

SAFETY

- Rule 385 (Background Check) limits acts that warrant license revocation or discharge for a single act by categories of allegations. The Rule should be amended to allow more flexibility in considering the seriousness of a single act (such as tying a child) in considering licensure or employment action.

- Procedures should require that the Office of Child Development be required to review criminal history checks on alternate childcare providers, in addition to abuse/neglect checks, before any payment to the childcare provider is issued.

- Procedures should reflect effective fire protection/evacuation plans. Such plans should incorporate suggestions of the State Fire Marshal and the fire department of a major municipality, such as identifying two escape routes from each bedroom, and should include floor plans of the home that clearly delineate those escape routes.

- Procedures should require at least two fire drills by foster parents each year.

- Procedures should require that licensing workers review evacuation plans and conduct fire drills whenever the Placement Clearance Desk authorizes the placement of a child in a foster home.

SERVICES

Enhanced Services for Southern Illinois

- DCFS should review whether the expansion of the initiative that coordinated Child Welfare and Substance Abuse Treatment responses within a family is sufficient to meet the demands of the growing substance abuse problem of the Southern Region.

- The OIG Best Practice Unit will work with the Department in developing specialized substance abuse treatment/child welfare services in Southern Illinois.

- DCFS should develop, with a leading State University, a mobile forensic Parenting Assessment Team for the far south and southeast areas of the DCFS Southern Region.

Intact Family Services

- Strict guidelines need to be in place to prevent a family from being accepted for Intact Family Services when multiple concerns, as well as domestic violence issues, severe mental health problems, addiction, sexual abuse, and criminality issues would suggest a poor prognosis for success.

- Intact Family Services need to develop working guidelines for determining a family's appropriateness for Intact Family Services after the family is in the program. Training on assessment and re-evaluations of families is needed to assist the worker on an ongoing basis, to determine (1) family issues and how they relate to each other; (2) the family's continued appropriateness for the program; and (3) case planning, services and interventions. Training must dispel the myth that Intact Family Services must continue for three months regardless of perceived risks.

- The Department should develop guidelines regarding developmentally delayed caretakers.

- Caseworkers should determine dates of birth and living arrangements of all biological children not living with client families.

- DCFS should work to include extended family, when possible, in working with an intact family.

- When extended family is available to provide family support, family meetings should be held to create a plan for the children using family members' assistance. DCFS should work to include families during follow-up.

- Homemakers should be trained on how to do task-centered activities. They should receive more detailed instructions about the expectations for services in a particular case and closer supervision of their activities.

Confidentiality

- When a conflict arises between the Clinical Division and DCFS Regional Legal Counsel concerning the sharing of information and confidentiality issues, the matter must be referred to the General Counsel for a final determination. If the legal decision is that the information that Clinical needed to share cannot be shared, the basis for the determination should be noted and reflected in the case file.

Medical

ASTHMA AND OTHER CRITICAL MEDICAL CONDITIONS

- Child Protection investigators and case management staff need to be educated regarding the risk signs and red flags of the child's asthma condition.

- Child welfare workers and foster parents should be educated to ensure that physicians who care for their children follow the National Heart, Lung and Blood Institute's guidelines for the diagnosis and treatment of asthma.

- In managing the medical needs of asthmatic children, mental health needs are often overlooked. Service provision should include mental health services that address the child's quality of life.

- While DCFS is developing a database to identify and track wards with serious and chronic illnesses, the Department should, in the interim, identify and track wards with acute or chronic complex diagnoses through existing databases.

MEDICAL CRISES

- DCFS Procedure 327.5, which details current protocol for obtaining medical/surgical consents, is complicated and confusing. The procedure should be reviewed and simplified, if possible, to maximize access and minimize multiple authorizing agents. Complex cases should be tracked to ensure continuity of service.

- For medically related crises, the Guardianship Administrator's Office should consider having a fact sheet available that outlines the protocol for obtaining consents and the limitations of consents. In extraordinary medically related crises, the Guardianship Administrator's Office should consider providing on-site crisis management.

- In order for the Guardianship Administrator to make informed decisions pertaining to removal of life support measures, every aspect of a physician's recommended Do Not Resuscitate directive must be subject to a medical/ethical debate by the medical providers' ethics committees and an independent ethics consultation before granting or denying consent.

- With Do Not Resuscitate directives, physicians must be permitted access to the child's medical records if necessary in order to provide a statement of support. Guidelines may be needed to address those instances where the medical opinion of a specialist is most appropriate.

- A separate form should be created for the request of consent to a Do Not Resuscitate Order. This form should call for information that verifies a conference was attempted with the biological and foster family, that consultation was obtained from attending physicians, the DCFS Medical Director, a medical specialist, if appropriate, and that consultation on the medical issues was obtained from an ethicist.

- When a Do Not Resuscitate directive has been obtained, the Guardian should assess information on the biological parents regardless of status of parental rights. The information should be reviewed to assess the appropriateness of the relationship between the biological parents and the child to determine the best interest of the child.

- The Department needs to develop guidelines to implement Rule 325: Administration of Psychotropic Medications to Children for whom DCFS is Legally Responsible. (Previously recommended by OIG.)

NURSING AND MEDICAL MANAGEMENT OF CHILDREN ON PSYCHOTROPIC MEDICATIONS

- The Department should require the use of developmentally appropriate behavioral monitoring and tracking for any child on psychotropic medication by using reporting forms similar to those used by the Illinois State Board of Education. In addition, the Guardianship Administrator's Authorizing Agents should gather vital information prior to authorizing the approval of psychotropic medications. This information would include, but is not limited to: baseline weight, weight gain/loss, blood pressure, cardiac measures, and dyskinesia. Baseline information pertaining to the targeted behaviors and programming used to target the behaviors should also be obtained.

- In addition, the Department should require that children on psychotropic medication be taught how to keep a daily Mood Diary to encourage self-monitoring of their own behaviors. The tool must be adapted for the developmental level of the child.

- Staff should be trained on how to use the tool and on how to assist children to keep the diary and reinforce their self-monitoring.

- Nursing and clinical staff in residential programs should be required to attend annual seminars regarding psychotropic medications in pediatrics for Continuing Education credit. The material covered should include use, administration, side effects, monitoring, and polypharmacy (the effects of multiple drugs being taken at one time).

- Nursing and clinical staff should be evaluated at least twice per year to assess their critical thinking skills pertaining to pediatric psychotropic medication use. These evaluations should be kept in their personnel files, and require at least an 80% accuracy to pass. If they score below 80% they should then be required to review appropriate articles or text related to the topic and be reevaluated.

- Nursing staff in residential programs should be required to attend at least annual seminars for CEU credit pertaining to pediatric nursing assessment skills. Follow-up evaluation using a critical thinking tool should be completed at an agency in which a child died while in restraint.

- In all instances of physical restraint, a nurse or other medical personnel should physically examine the child for physical injuries immediately or no more than one hour following the incident.

- Regarding significant weight gain, the Department needs to enforce strict dietary guidelines for children in residential facilities who are recommended or ordered to be on special diets, including but not limited to general diets with portion control and Healthy Choice Diets. These guidelines need to include clear specifications of foods that can and cannot be eaten by the child with a diet recommendation.

- Staff who work in the residences need to be provided appropriate instruction regarding dietary guidelines and weight management programs that are recommended or ordered for a participant.

- Nursing staff for the residential programs should be directly involved in staff education and monitoring of dietary guidelines.

- When a child is to be on a special diet and exercise regimen for weight loss or control, the residential facility needs to provide a structured exercise program for the child.

- Weight monitoring needs to be done at least every other week and recorded on a flow sheet for children with specific weight loss goals as determined by a dietician. This flow sheet should be kept in the same place as the vital sign flow sheet and medication administration forms.

- A private residential facility should provide exercise equipment that could be used by the participants and the staff alike.

- Exercise goals should be established between the appropriate staff (dietician) and the child and written on a care plan or other form that house staff would have access to. An appropriate reward system should be established for reaching goals.

- Regarding vital sign monitoring, the Department should consider requiring blood pressure monitoring prior to every dose of Clonidine. Residential staff responsible for administering medications such as Clonidine need to be instructed regarding not only the low blood pressure parameters of when to hold the medicine, but also need to be provided education pertaining to blood pressure and heart rate values that are higher than what is normal for a child according to age. Tables containing this information could be placed in the logbook of each child requiring routine blood pressure and heart rate monitoring. Reporting of high or low values needs to be not only written but also verbal to the appropriate persons, in a prompt manner. The private agency needs to develop guidelines for the prompt reporting of vital health information between house and nursing staff, and subsequently with other medical staff.

Foster Care

- The Placement Clearance Desk (PCD) system should be revised to ensure that when a new or revised placement restriction is submitted, the PCD would review the suitability of existing placements.

- Adoption Specialists should be part of the team that monitors an interstate placement. The Adoption Specialist should be involved in all out-of-state pre-placement visits. In the event that the caseworker familiar with the children cannot attend a pre-placement visit, the Adoption Specialist should make the pre-placement visits. The Department should amend Rules and Procedures to reflect this change.

- Comprehensive Home Assessments, prepared for foster home licensing applicants, should be used for matching.

- A private agency that handles special needs children must ensure it has the child's complete records prior to determining a foster home for the child's placement.

Developmentally Delayed Wards

- The Department must be more proactive in discharging its fiduciary duty to wards who are developmentally disabled. The Department should develop a systematic response to identify these wards and ensure that child welfare staff receives the appropriate support and training in

serving wards with developmental disabilities so that only appropriate education plans and normed developmentally disabled tests are administered to developmentally disabled wards.

- DCFS must develop procedures for ensuring there is a linkage between children who are developmentally delayed and the Department's specialists in the field. A more effective connection and additional training for staff working with these children are necessary.

Developmentally Delayed Parents

- The Department's specialist in developmental disabilities should develop a proactive plan for identifying developmentally disabled parents who could benefit from programs specifically directed to parents with developmental disabilities.

- Current contracts and resources should be reviewed to ensure that parenting enhancement programs specifically designed for developmentally disabled parents are available and the Department should ensure that the new DCFS database system track developmental deficits of parents.

Teen Services

- Prior to case closure, family conference/mediation should be a requirement for parenting teen's families, including the parents, extended family members of both parents (foster and biological), where there are concerns regarding the safety and welfare of the children of the teen.

Ward Charged With A Crime

- When it appears that a ward will be charged with a crime that would subject the ward to automatic or discretionary transfer to adult court, The Guardian Administrator (Guardian) should review the record, identify persons who are sources of emotional support for the ward, determine the limits of the child's ability to make important decisions; become acquainted with the child's mental health history and issues; determine the child's ability to withstand a long wait for trial; and determine the child's needs for therapy and spiritual or moral guidance. The Guardian should ensure appropriate communication with and direction of any attorney representing a ward in such cases. Specifically:

    1) Contracts with outside defense attorneys for wards should be entered into and managed by the Guardian of DCFS.
    2) Attorneys should understand that wards should be allowed to make difficult decisions only to the extent they are able, and that otherwise the Guardian should direct the attorney's actions. The Guardian and the attorney should work together to determine to what extent the child is capable cable of directing the attorney.
    3) The Guardian should meet with the child's attorney to ensure that the attorney has full knowledge of the child's history and developmental needs (non-legal best interests).
    4) The Guardian must intervene whenever the Guardian believes that there is a genuine possibility that the child will harm him or herself or others, or that the child will suffer irreversible emotional harm without Guardian intervention.
    5) Attorneys should be advised to take the ward's developmental, therapeutic, and spiritual/moral needs into account when determining the ward's legal needs, and should work cooperatively with the Guardian to lessen the traumatic impact of the legal process.

6) DCFS should develop a list of steps that private defense attorneys and public defenders representing wards should take to ensure that the above goals are met.
7) The Guardian should have a team of knowledgeable clinical caseworkers who can proactively direct and/or provide needed services. In such cases, the field should receive a directive from the Director informing them to take clinical direction from the Guardian's office.
8) The Guardian may seek outside consultation of experts in mental health, child development and ethics to advise the Guardian on difficult decisions.
9) The Guardian should determine whether there is any conflict of interest in her role in each case: e.g., did any action of the Guardian or of DCFS (such as a bad placement decision) possibly contribute to the child's dilemma?
10) The Guardian should, in the appropriate cases, ensure the child's right to spiritual counseling from a legitimate representative of the child's faith and protect the child's religious rights including the right to know about the clergy exception to confidentiality provisions.

Restraints

- Management in Child Care Facilities should, at a minimum, prohibit any weight being placed on the child's upper torso, neck, chest or back during a restraint and any positioning that restricts a child's breathing.

- The Department should certify Crisis Management Training Programs. In order to establish consistent and accurate criteria for training facility personnel in using crisis management procedures, the Department should develop a set of criteria that contractors with such training programs must follow to deliver a program to a contracted facility and Department personnel. The program should include but not be limited to:

  1) Classroom and supervised applications of at least a specific range of crisis management procedures recommended by the Department that do not require physical restraints.
  2) Classroom demonstrations and thorough discussions for no less than a specified number of hours on the dangers of physical restraints, a how to ameliorate these situations with physical restraints and practice of a range of prone, single person and two-person procedures, and communication and reporting procedures.
  3) Development of a management and supervisory training or seminar series for the purpose of developing facility-based accountability and a tracking system for physical restraints.
  4) Documentation of a facility-specific plan to reduce the incidence of physical restraints to a target number over no more than 90-day intervals and evidence of implementing plans to reach these goals.

- A policy that defines how much about the residential crisis management program should be shared with external treatment and other facilities that work with the residential facilities.

- The Department must enforce the development of behavioral intervention committees and seek the assistance of qualified experts in overseeing the development of effective behavioral management committees and monitoring restraints for contracted facilities. The committees should adapt the Illinois State Board of Education's recommended guidelines of behavioral interventions for their facilities and adopt the use of the Illinois State Board of Education's sample Functional Analysis Summary, Behavior Management Plan Summary, Emergency Report,

Restrictive Behavioral Interventions Parent and Guardian Notification, and Time-out Reports Forms. The Department should require every facility to have on staff competent behavior analysts with training that reflects appropriate academic and ethical preparation, and can report to the behavioral intervention committees.

Crisis Management

- Crisis Response Services Procedure 302.387 should be amended as follows:
  1) The Department should exercise fiduciary oversight of a crisis response regardless of whether the Department has primary case management responsibility for the child. The protocol should be amended in each of the major areas of Planning, Communication and Implementation, to reflect the level of authority and role that a team leader must have in order to carry out crisis response services in an effective and expeditious manner. Guidelines should be developed to address a crisis that occurs out of state.
  2) In order for a child's worker to be an integral part of a crisis response team, the DCFS or private agency must commit to relieving the worker from his/her caseload, at least during the initial and intensive period of the crisis. The protocol should also delineate who will assume the responsibilities of the child's worker and/or supervisor who are significantly affected by the crisis and would not be expected to provide crisis response intervention.
  3) The child's guardian ad litem is notified at the outset of a crisis requiring team intervention. When a child is not represented by a GAL, DCFS Legal Services should notify the juvenile court parties.
  4) The protocol should expand the pool of specialists to be available to a crisis response team to include ethicists, education specialists, and other experts as required by the crisis.
  5) Pastoral support should be made available to the child and family, and should be utilized within the hospital or community in which the crisis occurs. The child and/or family should be provided linkage to any needed support services after the crisis. Brothers and sisters should be given every consideration and opportunity to visit a sibling in a life-threatening crisis.

Adoptions

- The Department must establish guidelines for facilitating out-of-state adoptions of DCFS children with families unknown to the children. Included in these guidelines should be a requirement that the caseworker meet with pre-adoptive parents in their home before sending a child to them. Pre-placement visits and evaluation should never be waived. Visits must occur in both Illinois and the pre-adoptive family's home state. The worker and/or the adoption specialist must accompany the child at all times.

- The Department should amend Rule 357 or draft a new rule that would require that out-of-state agencies meet specific standards so that the Department has adequate information about the out-of-state provider. At a minimum, this would include ensuring that contracts for out-of-state placement cannot be considered individualized foster care contracts exempt from some of the requirements of Rule 357. The Department should ensure that program plans reflect that the agency has provided and maintains a list of the qualifications of staff members, the length of each staff member's employment with the agency, etc. In light of the anticipated increase in out-of-state placements because of tools such as the Internet, the Department should convene a work group to further assess that sufficient protections are built into Rule 357.

- When a case changes teams, a staffing should be required to include the former worker and supervisor, the new worker and supervisor, and the Adoption Specialist, where applicable.

INTERSTATE COMPACT

- DCFS should determine the scope of the Compact Administrator's role in interstate placements, and should communicate this determination to all DCFS employees. DCFS should consider whether it is necessary to amend Rules and Procedures to reflect the parameters of the role of the Compact Administrator.

- When DCFS arranges for the interstate adoptive placement of a child from Cook County, it should send a letter to the receiving agency, explaining that this child has legal representation through the Office of the Public Guardian. The letter should provide the name of the Cook County Public Guardian, and the telephone number of the office. It should be explained that if the receiving agency has any questions about this representation, it should forward questions to the Public Guardian.

FOSTER HOME LICENSING

- To avoid possible bias, where there is death or serious injury, workers who licensed a foster home should not be assigned to investigate the home.

- DCFS should revise its Licensing Compliance Record Form to require that workers note whether foster homes have working smoke detectors, and to show the dates on which the licensing worker checked the smoke detector. DCFS should notify all DCFS and private agency licensing workers to immediately check for the presence of smoke detectors and to check whether the smoke detectors are in working condition.

- When a foster parent successfully overturns a finding of abuse or neglect, Department Licensing should review the home to determine whether any facts raise a licensing concern.

- Foster homes with no current placements should not be excluded from bi-annual monitoring visits.

- Foster Home Licensing Procedures should be updated to correspond with the Rule and to give guidance on how to conduct licensing investigations.

- Foster home licensing should note dates of birth and living arrangement of all biological children not living with the foster parents or other adults in the foster home.

- Private Agency's licensing process was found inadequate in that comprehensive assessments were not performed prior to recommending foster care licenses. The OIG recommended more explanation into significant life changes or events. Applicants should be rated on various factors, including maturity, ability to respond to different types of challenging behaviors and crises. The OIG noted that a comprehensive assessment can be used as a tool to determine appropriate matches for placement.

AGENCY AND INSTITUTION LICENSING

- The Department needs to develop policy that clearly articulates prohibited practices, including nepotism.

- The Department should implement a communication system between DCFS Licensing and DCFS Contracts to ensure that important information and problems identified in a licensing investigation are shared with DCFS Contracts and inform decisions on future contracting.

- DCFS should work with the Illinois Youth Fire Safety Association to develop a training program for licensing supervisors to increase their knowledge of fire safety. At a minimum, licensing workers should know about identifying fire hazards and testing smoke detectors. DCFS should choose twelve licensing supervisors, from both DCFS and private agencies, to participate in a pilot training program.

- All licensing workers should be trained on how to test whether smoke detectors are in working condition.

- DCFS Rules should be amended to reflect that foster homes should comply with all state and municipal codes regarding fire safety.

- The private agency prepared a Corrective Action Plan in response to the OIG Report. Plan highlights include emphasis on licensing's role in investigating licensing complaints, follow-up staffings to promote compliance with requirements for continued licensing, clearer delineation between licensing and direct service roles, and retraining on importance of pattern analysis to identify problem trends. The OIG supports this plan and the agency's ongoing effort to reduce incidents of abuse or neglect in foster care.

- As part of the agency's corrective measures, the agency should re-evaluate its foster care program to determine where collaboration between units is necessary. Placements are an important first step in foster care services and improved communication between licensing, intake, and follow-up staff is necessary to ensure the best match of foster family and child(ren).

DAY CARE

- The Day Care Application should include a set of consumer friendly instructions for completing the application and an information sheet regarding payment and income reporting. The application should include a statement for the foster parent's and day care provider's signature to the effect that "the information provided in the application is true...." Day care providers should be informed that the state is required to report to the IRS payments to any provider that amounts to more than $600 per year and that such payments could be subject to taxation. The signature of the day care provider should also be notarized. Separate forms ensure that all parties are informed as to procedures and have agreed to the arrangement of payment through DCFS.

- For better daycare coordination, the Department should recreate a central Office of Child Development .

ADVOCACY OFFICE

- All upper management personnel should be notified that any complaint received should be referred to or coordinated with the Advocacy Office. Advocacy Office personnel should inquire into the complaint and report to the Director or the referring party.

COLLABORATION WITH OTHER AGENCIES/DEPARTMENTS

- Clarify existing policy and procedure to ensure that workers will notify law enforcement for help in locating an alleged child victim.

- Procedures for coordinating investigations with law enforcement should be redrafted to ensure a mutual understanding of the different roles and joint agreement regarding specific evidence available.

- The Department should develop law enforcement liaisons in each region. The liaisons should aid workers in procuring underlying criminal documents to assess criminal history.

ADMINISTRATIVE

- The Department needs to create a central record-keeping department to maintain complete files for each child. When cases are transferred from one agency to another, the Department has a professional obligation to provide a full record to the accepting agency so the agency is equipped with the information necessary to make appropriate decisions.

- The Division of Support Services/Office of Contract Administration should reduce to writing requirements that must be satisfied before the blanket memo can be used for approval of contracts. Suggestions for requirements include the following:

  1) Prior contracting with the Department for same or similar services.
  2) Prior approval by Chief Financial Officer and Chief Legal Counsel.
  3) Certification from the DCFS contract monitor or field staff that prior contracts have been complied with, that contract performance was adequate and that the Department has a need for the services contracted.

- For those contracts included in the blanket memo, the descriptions in the memo should include the following information about the agency/contract:

  1) Has the subcontractor provided the contracted work in prior years?
  2) How has the program plan has changed in the last year?
  3) What number of children will be served?
  4) What was the prior contract amount?
  5) A sufficiently detailed description of the contract that permits evaluation.

- The Department should prepare a standard contract for out-of-state adoptive placements that could be used as a template for future out-of-state placement contracts. The Department should ensure that the contract properly delineates the responsibilities of the out-of-state agency.

- The Department should examine all contracts and contract templates to ensure that no language excluding the placement of any racial or ethnic group exists.

- DCFS should conduct training for Loss Prevention personnel of the major department stores that are used for purchases with vouchers. The Department should meet with such personnel on a quarterly basis to work with Loss Prevention on how to identify fraudulent vouchers and explain why it is necessary to have store personnel secure IDs from customers using vouchers to purchase merchandise. The OIG met with the Loss Prevention personnel of a major store chain and will meet with Loss Prevention personnel of others.

- The Department should create an internal control database to track purchase vouchers that are distributed to office managers and subsequently show to whom the money is paid and the name of the purchaser. A separate list of fraudulent vouchers should be maintained.

- Form 932, the voucher form with a tracking number should be the only one used for Department clients. A C-13 voucher should only be used for state employees and never for clients and the state employee should have to show employment ID.

- The Department should consider recommending to Central Management Services that it use a numbering system for the C-13s (which are used statewide by the code agencies) and include with the numbering system a letter designation for each different code agency. (For example, A123456 for DCFS, B123456 for DHS, C123456 for DOT, etc.)

- The Director should consider issuing a bulletin to all personnel regarding the necessity of maintaining tight controls on the issuance of vouchers to clients to minimize the possibility of fraudulent use. Employees should be informed that the Department will use all means to see that employees that misuse Department money for fraudulent purposes will be criminally prosecuted.

- The Department should fulfill its obligation under Illinois House Resolution 204 (passed May 25, 1999) to conduct "a survey of the needs of the Native American/Alaskan Native population in Illinois."

- The Director should issue a memorandum to emphasize limits on the role of the Foster Parent Support Specialist and that the Foster Parent Support Specialist should never act independently of the Department. Specifically, the Foster Parent Support Specialist should not be permitted to share confidential information about one foster parent with another; the Foster Parent Support Specialist should not be permitted to make any clinical decisions or decisions regarding the placement of children, including specific respite services; "advocacy" and "support" by Foster Parent Support Specialist's should be limited to providing factual information to child welfare staff and providing information to foster parents about existing rules, procedures and policy.

- Placement and Clinical decision-making should be removed from the Program Plan of Foster Parent Support Specialists.

- Foster Parent Support Specialists should be licensed as foster parents in a different DCFS region than the one in which they are employed.

PERSONNEL

Conflict Of Interest

- The contracts of private agencies should reflect the anti-nepotism rule that relatives may not work within the same hierarchy of supervision in an agency.

- DCFS should notify, in writing, all DCFS field offices and private agencies that Department and Agency employees must not be licensed for foster care by their employer or an entity with which they have a working relationship. All employees currently licensed for foster care by their employer or an agency with which they have a working relationship must transfer their license immediately. The Department should conduct a random audit to verify implementation of this recommendation. (Previously recommended by OIG.)

- The Director should send a memo to all employees of DCFS reminding them to make use of the Rule 437 Conflict of Interest committee before making any decisions or recommendations that could lead to the relative of a DCFS employee obtaining a contract with DCFS or with an entity contracted to complete work for DCFS. In situations where DCFS contractors independently hire family members of DCFS employees, the DCFS employees should recuse themselves from any oversight of the contract process.

General Personnel

- All personnel who work directly with children must be certified and regularly re-tested in CPR. Mouth shields must be provided for staff on supervised off-site visits and field trips.

- DCFS field workers and supervisors, including licensing workers and supervisors, should be cross-trained on day care policies and procedures.

- The Department should require drug and/or alcohol testing at a private laboratory for employees when reasonable cause exists to believe they are under the influence of drugs or alcohol. (Reissuance of prior OIG recommendation)

- The Department should regularly review, through independent verification, employees' driving records, license status, and insurance for positions that require driving.

- The Department should update the DCFS policy on sexual harassment.

- All new employees with no child welfare experience should be immediately trained on the child abuse and neglect allegations system and mandated reporting. Court orientation should be provided as soon as possible post-hire.

- New workers with no child welfare background are in apprenticeship and require mentoring. Supervisory staff should initially shadow new employees in the field to ensure their understanding of the role and responsibility of child welfare workers and quality of services.

- Particular local Department field offices are short-staffed of Child Protection investigators. The Department should explore the feasibility of hiring permanent overlapping four-day shifts.

- Child Protection investigators and follow-up workers who experience a child's death should be offered assistance with their caseload.
- The Department and all private agencies should offer post-crisis support to affected employees following a child's death, i.e., time off, post-crisis support counseling of the worker's choice, or other employee assistance considerations.

COURT INVOLVEMENT

- DCFS Legal should collaborate with the State's Attorney's Offices to conduct trainings for DCFS and private agency staff on how to screen cases. These joint trainings should focus on the pertinent information that a caseworker should provide to the State's Attorney at court screenings.

- Supervisors should be required to sign off on all screening packets prior to a worker's presenting the information to the State's Attorney. In a case where the State's Attorney does not accept the

case for screening or where the worker does not present sufficient information, the supervisor should be required to attend subsequent screenings on that case with the worker.

- DCFS Legal should inform all caseworkers (DCFS and private agencies) that when an oral motion is made by any attorney representing a party that takes the caseworker by surprise and the DCFS attorney is not present in the courtroom, the caseworker must ask for a short recess to consult with DCFS Legal Services staff.

RECOMMENDATIONS FOR DISCIPLINE

Two Child Protection investigators should be disciplined for failing to assess risk of harm in a foster home where a 13 year-old foster child was kept in a cage.

A caseworker should be terminated for purchasing drugs in the neighborhood she serves as a Department employee.

The Department should terminate a caseworker's employment for entering false information in a case record; unprofessional conduct; lack of services; disrespectful behavior toward a client; reporting physical abuse to the hotline without a reasonable basis; and for placing a child at risk of harm by arguing against a protective order in a domestic violence matter.

A hold should be placed on professional licensing status for a former Department employee who unfounded an abuse report without conducting a Child Protection investigation.

A worker should be terminated for transporting a minor while under the influence of alcohol; falsification of records; maintaining employment while a child protection investigator without a valid driver's license during 1994 and subsequent periods; and for gross negligence and putting a minor at risk of harm when she did not accept medical evaluation for a minor in protective custody following a traffic accident.

An investigator should be disciplined for interviewing the victims in the presence of the perpetrator, failing to note "Others Present" on the interview notes, failing to evaluate the disclosures of two children, failing to interview a reporter and two sources for in an abuse investigation.

A supervisor should be counseled for failing to supervise the investigator in ensuring that the disclosures of the children were evaluated by the investigator and failing to ensure that the investigator interviewed both reporters of the hotline calls and sources, failing to ensure a complete investigation and allowing a judicial finding of temporary custody to serve as a sole basis for indicating a case.

An administrator should be counseled for failing to supervise the investigator in ensuring that the disclosures of two children were evaluated by the investigator and failing to ensure that the investigator interviewed both reporters of the hotline calls and sources, failing to ensure a complete investigation and allowing a judicial finding of temporary custody to serve as a sole basis for indicating a case.

A follow-up worker should be disciplined for preparing an inadequate home assessment that failed to note the existence of pending Child Protection and criminal investigations, for placing children at the suggestion of the alleged perpetrator without adequately assuring that the perpetrator would not have access to the children and for placing the children in a non-relative, unlicensed home.

A private agency therapist must be counseled regarding the necessity of exploring critical events in client's lives.

A private agency administrator must be counseled regarding the importance of ensuring that children's therapeutic needs are not ignored.

A Child Protection investigator should be discharged for maintaining an inappropriate relationship with a client after the termination of the professional relationship; his improper use of a Department cell phone and his untruthfulness in his interview with OIG staff.

A private agency caseworker should be disciplined for her failure to provide services to a client and for misrepresenting case information to the court and the OIG.

A supervisor should be counseled for failing to use sound clinical judgment when he made the decision to leave a child in a foster home pending completion of a bonding assessment.

A caseworker should be counseled for failing to notify the GAL that a child's out of state placement had disrupted, not requesting ICPC approval after the placement disrupted, and failing to follow up on the recommendations for therapy made by another worker.

A supervisor should be counseled for failing to schedule any staffings or reviews of a complicated case involving several workers and an out of state foster placement.

A Department administrator should be counseled for exerting her authority in an adoption without conducting a thoughtful investigation into the facts of the case.

A Department employee should be disciplined for failing to transfer her foster care license from the Department to a private agency, agreeing to accept a child into her home after her foster care license had lapsed, failing to notify the Department when she married and her husband moved into the home and allowing her husband to use corporal punishment on the child in her home.

A caseworker should be disciplined for not documenting and discussing with her supervisor advice she gave to a client during a home visit

A caseworker and her supervisor should be counseled on ethics violations for failing to identify the conflict of interest presented by the caseworker's previously relationship with a client as their therapist..

A license resource manager and foster parent support specialist should be counseled after an investigation revealed that the foster parent support specialist had independently facilitated a meeting between an existing foster parent and a prospective foster parent without alerting the caseworker.

A Child Protection investigator should be counseled and retrained regarding how to conduct comprehensive, well-reasoned, well-documented child protection investigations after he ignored significant information in completing substance abuse screens and safety assessments.

A Child Protection investigator should be disciplined for accepting discounted airline tickets from a woman who was the subject of a child abuse report he was investigating .

A Child Protection supervisor should be disciplined for a poor assessment of risk of harm, not documenting conversation with a key person with information and his lack of familiarity with Rules 431 and Administrative Procedure No. 6. His office should receive a full set of rules.

A Child Protection investigator should be counseled on the role of an investigator when examining prior evidence of violence.

A Child Protection investigator should be counseled for poor investigative practice.

A supervisor should be disciplined for failing to impart relevant information and direction to a caseworker, not making necessary and critical decisions required of her, failing to ensure Department rules and procedures were followed pertaining to unusual incident reporting, runaway status of a ward whose whereabouts are known, and referral of an eligible ward to the Teen Parent Services Network for specialized intervention.

A private agency licensing worker should be disciplined for failing to check for fire hazards during a home inspection and failing to familiarize herself with procedures and rules necessary to perform the fundamental functions of her job.

A Child Protection investigator should be counseled for failing to make a proper inquiry into whether children were adequately supervised on the evening the foster home caught on fire.

A Child Protection supervisor should be disciplined for his failure to determine any facts pertaining to a reported incident of child abuse.

A Child Protection investigator should be disciplined for improperly preparing a family assessment document without ever having seen the parent and children.

A Child Protection supervisor should be disciplined for failing to provide adequate supervision and to ensure completion of a Child Protection investigation prior to giving his approval to unfound and close the report.

A caseworker should be disciplined for her failure to secure a placement for a ward by his scheduled release from jail, causing him to remain incarcerated for four additional months beyond the end of his sentence.

A supervisor should be disciplined for her failure to supervise a caseworker who failed to secure a placement for a ward by his scheduled release from jail, causing him to remain incarcerated for four additional months beyond the end of his sentence.

A private agency should discipline a caseworker for failing to accurately document all of his foster home visits and for falsifying Administrative Case Review documents.

A Child Protection investigator should be disciplined for failing to add an abuse allegation to a report after the mother gave an obviously inconsistent statement regarding her daughter's injuries.

A Department administrator should be discharged for failing to develop program plans with measurable outcomes while overseeing private agency contracts, failing to assess Department needs prior to developing contracts, failing to monitor contract performance or to reassess Department contractual needs in light of prior year's surpluses or federally funded Department training, failing to provide technical assistance that may have better prepared the agency to handle cash flow problems, or focus the agency on the need to develop an objective board, creating a conflict of interest by loaning substantial personal funds to the agency without alerting supervisors of his intention or the agency's cash flow problems and failing to be forthright in his communications with his supervisor and the Director about the agency.

A private agency caseworker should be disciplined for failing to conduct a criminal background check on two adults who frequented a foster home; failing to remove the foster children after learning of one of the adult's criminal history; failing to take action to ensure the safety of the children in the home after the hotline report of abuse of a child by that adult; failing to ensure the adult moved out of the home; failing to relay concerns regarding corporal punishment to the hotline; failing to make a referral to licensing after the foster children's school reported inadequate supervision of Department wards.

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, the names have been changed. All names, except for those of the professional references, are fictitious.

File No: **010128**
Minor: **Carolina Yardley**
Subject: **Child Death**
Date: **March 30, 2001**

Persons Involved

Family and Others Living in the Home
Carolina Yardley, deceased child, DOB 5/5/00, DOD 10/5/00
Tina Yardley, mother, DOB 11/4/73
Eric Yardley, father, DOB 11/6/78
Beth Smith, maternal aunt, DOB 10/13/76
Tyler Smith, Beth Smith's son, DOB 3/11/99
Wendy Peters, roommate, DOB 6/24/81
Brian Peters, Wendy Peters' son, DOB 1/6/97

DCFS and Service Providers
Clay Parker, child protection investigator
Olivia Brown, child protection investigator
Brett Walters, child protection supervisor
John Garrett, child protection (on-call) supervisor
Rich Fischer, child welfare specialist
Connie Pacini, child welfare specialist
Anna Breslin, child welfare supervisor
Jan Keller, Family Services family support specialist (homemaker)

Summary of Complaint

In October 2000, five-month-old Carolina Yardley died as a result of injuries inflicted by her twenty-one-year-old father, Eric Yardley. At the time of Carolina's death, her family was receiving intact family services through the Genesee Field Office. The office also was investigating a report of child abuse to Carolina at the time of her death.

Investigation

First Report Involving the Yardleys - Sequence A, February 2000[1]

On February 28, 2000, the Yardleys' neighbor contacted the hotline complaining that Tina Yardley continually asked for food and diapers and that her home was filthy. A report was taken for investigation of allegations of inadequate food, inadequate clothing, and environmental neglect to Tina's nephew, Tyler Smith, age 11 months. Tina had guardianship of Tyler pursuant to an agreement with her sister, Beth Smith, reportedly because of Beth's chaotic lifestyle and irresponsibility.[2] Beth, and Tina's husband, Eric Yardley, also lived in the home. The report was unfounded after investigation by Child Protection Investigator (CPI) Olivia Brown. Ms. Brown found adequate food, clothing, and diapers in the home. While she found the home to be in disarray, she did not find that the condition of the home rose to the level of environmental neglect. Ms. Brown came to believe that the neighbor made the report to retaliate against the Yardley family, as she was arrested earlier that day on the complaint of Beth Smith, Tina Yardley's sister. The neighbor and Tina had argued over a babysitting fee and the neighbor broke into the Yardleys' apartment and broke things.

During the investigation, Ms. Brown conducted Adult Substance Abuse Screens on Tina, Eric, Beth, and Beth's boyfriend. Only Eric reported a history of using drugs or alcohol. Tina reported that she did not have a problem with drugs or alcohol and that she did not smoke or drink.[3] Eric reported that he had previously received treatment for alcohol abuse and that he currently drank beer. He stated that he had been hospitalized as a teenager for alcohol and behavioral issues and that he received services and saw a counselor at the local Health Department. Eric reported that he regularly used marijuana in place of his medication for bipolar disorder, particularly when he couldn't afford his medication. Eric admitted that he had multiple arrests and served time for violation of probation due to his behavioral and substance use issues. Eric agreed to undergo a substance abuse assessment and signed a consent for DCFS and the local Health Department to exchange information.

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[1] This investigation was unfounded and, therefore, expunged. Because a service assessment was requested, the Family Assessment Factor Worksheet (CFS 1440) was available, as were the Child Endangerment Risk Assessment Protocol (CERAP), substance abuse screens, doctors' notes, referrals, and consents for release and exchange of information. This section is based on the available documents.

[2] Beth had three older daughters residing in another state with their father.

[3] The neighbor, when interviewed by the CPI, reported that Tina smoked crack.

Ms. Brown made the referral for a substance abuse assessment on March 15, 2000.

Tina reported that she had guardianship of Tyler because of Beth's chaotic lifestyle and irresponsibility. Ms. Brown noted on a Family Assessment Factor Worksheet that Tina herself had not been consistent with Tyler's care in terms of getting him WIC, putting him on a schedule, and getting him immunized (Tyler was behind one set of immunizations at the time of the investigation). On March 1, 2000, Tina brought Tyler to a doctor's appointment made by Ms. Brown who was concerned about Tyler's small size. The doctor found that Tyler was below the fifth percentile for weight and below the tenth percentile for height. Tyler was referred to a pediatrician who was not overly concerned about his size.

Although she unfounded the investigation on March 15, 2000, Ms. Brown referred the case to follow-up for a service assessment based on concerns raised during the investigation: Tina was pregnant; Eric was diagnosed with bipolar disorder and had a history of alcohol and marijuana use; Eric had a problem controlling his temper according to both Tina and Eric; and Tina and Eric had minimal family support.[4]

Ms. Brown found Eric to be more cooperative during the investigation than Tina. She indicated that she thought both parents could benefit from learning parenting skills for new parents.

Service Assessment, March 2000

Child Welfare Specialist Connie Pacini received the Yardley case for assessment on March 16, 2000. She completed her assessment of the family on April 3, 2000. Ms. Pacini completed a Child Endangerment Risk Assessment Protocol (CERAP) and Family Assessment Factor Worksheet on the family. She noted that Eric had bipolar disorder and a history of marijuana use; that Tina was pregnant; and that Tyler appeared active and age appropriate, and he seemed well-cared for by the three adults in the home. Ms. Pacini did not find that the family needed services through DCFS. She referred the family to a child center for Tyler to receive a 0-3 evaluation and she noted that Eric had been referred to the local Health Department for a substance abuse assessment.[5] DCFS did not have further contact with the Yardley family until September 2000.

Child Protection Administrative Issues - August, September, October 2000

In September 2000, Brett Walters, the child protection supervisor for the Genesee and Brighton Field Offices, noted in his administrative report that the Genesee unit was down in staff. Child protection investigator Olivia Brown was on medical leave for six weeks.

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[4] Eric reported that his family had had nothing to do with him since he married Tina. They had some contact with Tina's mom, but she reportedly provided minimal support.

[5] It is unknown whether the family ever completed the 0-3 evaluation. A letter was sent to Tina on March 28, 2000 informing her of an appointment on March 31, 2000. A second letter was sent to Beth on May 10, 2000 stating that the agency had been trying to schedule an appointment with her to complete Tyler's evaluation, but had been unable to contact her. Copies of both letters were sent to Connie Pacini.

Between the Genesee and Brighton offices, there was a shortage of 2.5 workers. In the Brighton office there was one vacancy and one worker working ½ time because of graduate school. Because the offices were geographically split between the northern and southern sections of the region, Mr. Walters told OIG staff, he was unable to secure full-time floaters. The floaters were assigned to either the northern or southern sections and his offices had one foot in each area making them bottom priority to either. In addition, the Genesee unit was preparing for the Council on Accreditation. His team was responsible for peer review (18) reports in addition to the high worker caseload because of vacancies.

Clay Parker

Clay Parker was the investigator assigned to the next investigation involving the Yardley family. Mr. Parker is a seasoned eleven-year career child protection investigator. His personnel file contains numerous positive letters from law enforcement and community supporters. In addition, he has consistent positive comments from his supervisor for his dependability, pitching in and helping out his unit in times of staff shortages, overloads or emergencies, and having the best statistics in the region. In 1999, Mr. Parker received a State Police Award for his work on a child sexual abuse investigation and a letter of praise from a Genesee school principal. In that same year, Mr. Parker's supervisor noted improvement in Mr. Parker's interview documentation. She described him as becoming thorough, descriptive and complete once he had access to a dictating machine.[6] Mr. Parker, she added, often worked in pain.

Reasonable Accommodation Request

In April 2000, Mr. Parker requested reasonable accommodation "due to the increased pain in my right wrist from the massive amount of paperwork generated from investigations." He requested a voice-activated computer program or a contractual typist to type his reports. Mr. Parker included a half page progress note written by his doctor, stating it would be in Mr. Parker's "best interest" to award him the voice activated system to assist in preventing further injury. A 4th level administrative decision did not approve Mr. Parker's request as a protected disability under the Americans with Disability Act; however, on a practical basis the option was left open for management on an informal basis to make arrangements for the equipment. On August 3, 2000, the Chief of the Office of Affirmative Action sent the notice for the decision on the Reasonable Accommodation Request to Mr. Parker with copies to local area manager and labor relations staff. The OIG checked with the Information Systems Division and found that a computer program that cost under $200 has been made available in other cases when requested by administration. Middle management never pursued the matter further leaving the situation status quo. Upper management was unaware of the request or decision memo. While the regional administrator, had no line authority over child protection, as the Regional Manger he supervises the field offices and secures equipment for the offices.

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[6] At some point Mr. Parker stopped using the dictating machine because the Department ceased contracting with the typist who transcribed the tapes.

Performance Evaluation

Mr. Parker's 1999 performance evaluation noted he completes 94% of his reports within 30 days, a rate that is higher than the team (78%) and state average. DCP worker performance data on Mr. Parker (7/1/99-5/31/00) shows of the 103 reports completed, 80.6% were completed by the 1-14th day mark. Of these, 30% were indicated. DCP performance data shows that throughout the years Mr. Parker completes the majority of his investigations within the 10th day time frame.[7] A review of Mr. Parker's investigation completion dates for the years 1997-2000 shows Mr. Parker consistently had an unusually high percentage for completion of investigations by the 10th day compared to the statewide or the Region's averages. *See Table 1.* The statutory limit on the completion of investigations is 60 calendar days. The Department encourages its staff to complete investigations within 30 days of the report. The Division of Quality Assurance Analysis provides monthly and annual reports of key information and performance objectives of Investigative Team Performance. Data on the percent of investigations completed within 30 days is tied to a performance objective of 75%; data on the percent of investigations completed within 10 working days is distributed for information purposes only. There is no performance score or objective tied to the 10th day performance category.

Table 1: Four-year comparison data on percentages of cases completed within 10th day

Year	This Region % of cases completed by 10th Day (December to December)	Statewide % of cases completed by 10th Day (December to December)	Parker % of cases completed by 10th Day (July to May) *
2000	35.2%	33.1%	83%
1999	43.7%	34.8%	81.6%
1998	46.7%	37.8%	81.5%
1997	50.5%	42.1%	85.3%

* Mr. Parker's percentage of cases completed by 10th day is based on his performance evaluations which are from July to May.

Child Protection performance data on Mr. Parker (7/1/98 to 5/31/99) shows of the 119 completed cases, 81.5% were completed at the 10th day mark. Of these, 30% were indicated and 68% were unfounded. Performance data for the preceding period (7/1/97 to 5/31/98) shows of the 143 cases completed by Mr. Parker, 85.3% were completed by 10th day mark; 17.5% were indicated and 81.8% were unfounded.

In an earlier evaluation period ending 7/17/97, Mr. Parker's supervisor questioned his low 15.4% indication rate "which is almost 20 points below the average for the team and state. This has been a consistent difference . . . and efforts to evaluate the difference have produced no definite explanation . . . ." Mr. Parker commented, "I would like to respond to

[7] The 10th day measurement is actually ten working days, effectively 14 calendar days.

the 15.8% (sic) indicated rate which is 20% below team and state average. I believe a CPI must assess what is overall best for the child-children involved as it relates to DCFS follow-up in the home of cooperative or non cooperative (sic) parents. Do we cause harm by arousing the anger of parents that are habitually, year after year, generations back borderline neglectful. My belief is work from the heart - do no harm. I will always strive for the best interest of children in the long haul". It appears that Mr. Parker was saying it is better to get DCFS follow-up involved on an unfounded report than it is to indicate the report and risk the family being angry and non-cooperative with DCFS services. The statement reflects the attitude that intact family services are the answer with the investigator paving an emotionally supportive entry-way.

Weekend Work and Overtime

During the months of September, October, and November 2000, Mr. Parker worked 77% of the weekends (over 400 hours) earning more than $12,000 for his weekend work. *See Table 2.* In addition, several times a month (3-4 times) he worked 10- 12 hour days during his regular work week.

Table 2: Weekend Work August 2000 to November 2000

Month	Callback Time*	Standby Time+	Overtime	Other	Total	Travel
August 2000	59.7 hrs $2062	40 hrs $919	2 hrs $69	Temp Assign 17.6 hrs	119 hrs $3068	$770.68
September 2000	75 hrs $2507	50 hrs $1151	2 hrs $69		127 hrs $3728	$919
October 2000	79 hrs $2,527	44 hrs $1013.	1 hr $34		124 hrs $3575	Oct and Nov $1240
November 2000	71.5 hrs $2,469	58 hrs $1335	1 hr $34		130.5 hrs $3840	

* callback time is time spent working on calls received.
+ standby time is time spent on-call, but not actually working.

Second Report Involving the Yardleys - Sequence A, September 8, 2000

On September 8, 2000, five months after the first report on the Yardleys involving Tina's nephew, Tyler, Unity Medical Clinic called to report medical neglect of the Yardleys' four-month-old daughter, Carolina. According to the CANTS 1 report:

> [Carolina] was born with bronchial dysplasia and meconium aspiration. [Carolina] has severe medical problems and is now on oxygen. [Tina] has failed to bring [Carolina] to the last several appointments. [The visiting nurse] has not seen [Carolina] because [Tina] is not home for scheduled

appointments. [Tina] has attempted suicide once since the birth of [Carolina]. [Dr. Shaw] believes [Carolina] is at risk due to lack of medical care.

Child Protection Investigator Clay Parker was assigned to the investigation. On the evening of September 8, 2000, Mr. Parker interviewed Tina Yardley who reported that she would take Carolina to Dr. Shaw at Unity Medical Clinic on Monday morning, September 11, 2000. She said the CPI could call the office on Monday to verify that they were there. Tina signed a consent for release of information allowing Unity Clinic to release Carolina's recent medical records.[8] Tina stated that she takes good care of Carolina and the reason she was not home for the visiting nurse was because she doesn't stay home for anyone because she has things to do. On this same evening, Mr. Parker observed Carolina who was hooked up to oxygen.

Mr. Parker completed a substance abuse screen on Tina Yardley on September 8, 2000. Every question on the screen was answered "no". In the area for additional screener comments, Mr. Parker noted that Tina said she overdosed in August on Prozac and Risperdal because she was angry at her husband and depressed, but that she had no intention of harming herself. Tina stated that two days before she overdosed, she took two puffs on a cigarette made of crack and that was the only time she tried cocaine. Tina stated she did not need counseling.

Mr. Parker completed a CERAP on September 8, 2000. All safety factors were checked "no" and Carolina was found to be safe in the care of her mother. A LEADS check by Mr. Parker on Tina on September 9, 2000 was negative.

On the morning of September 11, 2000, Mr. Parker contacted Unity Medical Clinic and spoke with the nurse who made the hotline report. She said that Tina called for an appointment that morning and was coming in at 11:00 a.m. The nurse told Mr. Parker that if Tina did not show up with Carolina, the office would contact him. At 11:05 a.m., Mr. Parker verified that Tina had shown up at the clinic with Carolina for her appointment.

Mr. Parker also contacted the visiting nurse who was listed on the hotline report. The nurse said the main concern was that Carolina should be off oxygen, but there was also concern that Tina was not always home for health visits. The nurse stated that Carolina had gained weight, and she appeared to be getting proper care from Tina. The nurse said

[8] Mr. Parker faxed the consent to Unity Medical Center on September 13, 2000. It is worth noting that Mr. Parker did not need Tina's consent to obtain Carolina's medical records, nor should he have relied upon it. The Children and Family Services Act, 20 ILCS 505/21, grants the Department subpoena power in child abuse and neglect investigations. Thus, child protection investigators should encourage third parties to hand over records voluntarily during an investigation or issue a subpoena for the records. Child protection investigators should not depend on obtaining an alleged perpetrator's permission to acquire information. This could lead to the absurd result of a perpetrator not being held responsible for abuse or neglect because of his/her refusal to release information.

that Tina needed to find better friends.

Mr. Parker contacted WIC on September 13, 2000 and learned that Carolina was on WIC. The WIC worker reported that Tina had missed the last appointment and it was rescheduled.

Mr. Parker spoke with Carolina's doctor, Dr. Shaw, the source of the hotline report, on September 15, 2000. Dr. Shaw stated that Carolina was born with a terrible bronchial problem and Tina tested positive for cocaine. Dr. Shaw did not feel that Tina was medically neglecting Carolina, but did feel strongly that Tina and Carolina needed monitoring. He indicated that Tina's lifestyle and her attempt at suicide were real concerns, and he would feel more comfortable if someone was monitoring the family.[9]

On September 15, 2000, Mr. Parker staffed the investigation with his supervisor, Brett Walters. It was agreed that Mr. Parker would unfound the report, but that he would offer services to Tina and Carolina. On that same day, Tina agreed to accept DCFS services.

On a Family Assessment Factor Worksheet Summary completed September 18, 2000, Mr. Parker indicated an overall risk rating of low. Specific risk factors rated intermediate risk included strength of family support system, environmental conditions of home, caretaker's emotional health, and caretaker's parenting skills/knowledge. Risk factors rated high risk included caretaker's substance misuse and child's age/physical/mental abilities.

Eric Yardley was not interviewed. He was reportedly not living in the home at the time the report was made.

Intact Family Services Case, September 2000

On the afternoon of September 18, 2000, the Yardley case was transferred from DCP to Follow-up. A face-to-face handoff took place in the Yardley home. CPI Parker, Follow-up supervisor Anna Breslin, and homemaker Jan Keller met with Tina and Carolina Yardley in their home. Tina's sister, Beth, was present. Also present were Wendy Peters and her son, Brian Peters, who lived in the home. Beth, Wendy, and Brian left the living room so the workers could speak with Tina in private. Eric had recently moved back in with Tina and Carolina, but he was not present. Tina explained that he was at the County Court House paying a fine.

Mr. Parker went over the reason for DCFS's involvement and explained that Dr. Shaw requested that DCFS monitor Carolina's medical care and address Tina's mental health and substance use. Ms. Breslin explained the benefits and risks of participating in services and

[9] Dr. Shaw told Illinois State Police investigators and OIG staff after Carolina's death that he told Mr. Parker that Tina tested positive for cocaine at the time of her suicide attempt and that she admitted to smoking crack cocaine at that time and while she was pregnant with Carolina. Dr. Shaw said he informed Mr. Parker that Tina was smoking crack cocaine at her residence and he was concerned about Carolina.

Tina agreed to accept services. Ms. Breslin explained to Tina that Rich Fischer would be her worker, but that he was off work sick. She also explained that Jan Keller was a homemaker who would be coming to the home several times a week to check on Carolina. Ms. Breslin began a CERAP and found Carolina to be safe at present, but stated that she needed to see Eric to complete the CERAP. Ms. Breslin obtained consents from Tina allowing DCFS to exchange information with Agency A (early intervention services); Visiting Nurse Association Home Health Care; Department of Health and Human Services; Dr. Shaw and Unity Medical Clinic; Family Services (the homemaker agency); and Women, Infants, and Children (WIC).

The group discussed Tina's substance use, her overdose, and Eric's mental health. Tina reported that her substance use was a "one time" occurrence. She explained that someone brought a crack pipe into her home and she took several hits. This was right around the time she overdosed. Tina said that she abused substances in the past, but that she currently did not. Tina stated that when she overdosed, she did not intend to harm herself. She took Eric's medication because she was angry with him for leaving her. She called 911 and was taken to the emergency room where her stomach was pumped. She talked to her doctor and agreed not to do it again (*See section entitled Tina Yardley's Drug Overdose on page 22*). Tina said that Eric had bipolar disorder and took Risperdal, Prozac, lithium, and Avalide for high blood pressure. His doctor was at Unity Medical Clinic (*See section entitled Eric Yardley's Mental Health History on page 22*).

Ms. Breslin began a social history of the family. Tina and Eric were married on August 6, 1999. Tina gave birth to Carolina nine months later on May 5, 2000. Tina and Eric were recently separated. Eric left the home on August 5, 2000 and returned September 12, 2000. According to Tina, Eric left because he could not take the stress of being unemployed and of having a sick child on oxygen. He also was frustrated because the apnea monitor did not work. Tina described Eric as young and wanting to play with his friends; she said he had to realize he had responsibilities.

Tina's marriage to Eric was her second. She was previously married from March 14, 1992 to October 12, 1994. Tina stated they divorced because her ex-husband was in the service and stepped out on her. They had one child together, a daughter born September 30, 1992. Tina said that this daughter lived with her father in another state. According to Tina, her ex-husband got custody of their daughter in 1996 in a hearing without Tina.[10]

Eric and Tina were unemployed. Eric had been a farm hand, but had to quit because of a lack of transportation. Tina and Carolina had been on TANF (Temporary Aid for Needy Families), but since Eric moved back in, they were no longer eligible. DHS was going to help Eric get a job.

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[10] Tina's ex-husband did not initiate a court case in 1996. Rather, he did not return his daughter to her mother in Illinois in 1996 after his daughter complained of being sexually abused by Tina's then-boyfriend. Department of Social Services in the state he was living was contacted. A medical exam revealed no evidence of sexual abuse, but in counseling the daughter made statements of being touched by Tina's boyfriend, and she engaged in sexualized play. The investigation was indicated for sexual abuse of the daughter by an unknown perpetrator.

Ms. Breslin discussed potential services with Tina. She suggested marital counseling, assistance with parenting by the homemaker, and, possibly, more intensive in-home services. Tina appeared receptive to services and said she felt marital counseling would be beneficial.

Ms. Breslin observed Carolina at the visit. The homemaker, Jan Keller, held and played with Carolina. Ms. Breslin described Carolina as an active baby who cooed and smiled and appeared happy. Ms. Breslin noticed that Carolina's eyes were crossed and she had a cough that Ms. Breslin attributed to her lung problems. Ms. Breslin noted that Agency A was opening a case on Carolina and a nurse came to the home to discuss 0 to age 3 services with Tina while the workers were at the home. Tina appeared receptive to the services offered by the nurse. She stated she wanted to provide good care for Carolina (*See section entitled Agency A Early Intervention Services on page 19*).

Ms. Breslin noted that during the visit several friends and neighbors came to the house and Tina asked them to come back later. It appeared to Ms. Breslin that there might be too much traffic in the home, interrupting a schedule for Carolina.

The following day, September 19, 2000, the homemaker, Jan Keller, took Tina to fill a cough medicine prescription for Carolina. Public Aid would not pay for the prescription, so they stopped at Dr. Shaw's office and picked up some sample bottles of the cough syrup. Ms. Keller dropped Tina off at home and did not see Carolina that day.

A few hours later, Ms. Breslin arrived for an appointment she made earlier that day by telephone. Ms. Breslin met Eric for the first time. Tina was also present. Carolina was in her room taking a nap. The apartment was clean and orderly. Eric was cordial and listened attentively while Ms. Breslin explained the reason for DCFS's involvement and the services available to the family. Eric appeared distressed that DCFS was getting involved with his family over a missed medical appointment. Ms. Breslin explained that there was concern about Tina's drug overdose, her use of crack cocaine, Carolina's medical condition, and the number of people in and out of the home. Eric agreed to give DCFS a chance and stated that he loved Carolina and was trying to make his marriage work. Ms. Breslin spoke to Tina and Eric about the need for Carolina to be on a schedule and they agreed with her. It was apparent to Ms. Breslin that Eric was not happy about the others living in the home and that this was a point of contention between him and Tina. Ms. Breslin told the couple about relationship counseling and both agreed it would be beneficial. Ms. Breslin completed the CERAP she had begun the day before. All safety factors were checked "no" and Carolina was found to be safe.

On September 19, 2000, Ms. Breslin completed the referral for homemaker services and faxed it to Family Services. Ms. Breslin selected the following from the referral form: "monitor and report [on] child care patterns and incidents . . . teach infant care . . . directly assist with infant care . . . provide transportation as needed to address other task[s] and goals . . . and provide emotional support." Ms. Breslin added "monitor and report on medical care/appointments and teach child medical follow-up, WIC, etc." Ms. Breslin recommended 3-5 contacts per week for a minimum of six service hours per week. Attached to the referral was a service plan task sheet that included the

following tasks.

1. Tina and Eric agree to meet Carolina's medical needs and agree to comply with all medical appointments for Carolina.
2. Tina and Eric agree to keep WIC appointments for Carolina.
3. DCFS agrees to provide a homemaker to assist family as needed to make sure Carolina's medical needs are met and her condition is being monitored. Will visit in home 3-5 times/weekly; total 6 hrs. Will provide transportation, emotional support, guidance re: parenting a medically involved infant.
4. DCFS caseworker agrees to meet with family twice monthly to monitor family progress and provide support as needed.

Ms. Keller picked up Tina on Wednesday, September 20, 2000 for an appointment at the local Health Department where Tina needed to pick up WIC coupons and take a nutrition class. Tina told Ms. Keller that Carolina was going to stay home with Eric. Ms. Keller offered to take care of Carolina, but Tina said Carolina was asleep and she didn't want to disturb her. Following Tina's WIC appointment, Ms. Keller and Tina stopped at the market where Tina purchased formula and some groceries. Ms. Keller then dropped Tina off at home. Ms. Keller did not see Carolina on this date as she picked up and dropped off Tina outside.

Ms. Keller attempted her next contact with the family at 9:30 a.m. on Wednesday, September 27, 2000. Wendy Peters came to the door of the apartment and said that Tina and the baby were still asleep. Ms. Keller asked the friend to tell Tina that she would be back tomorrow after 3:00 p.m.

On Thursday, September 28, 2000, Ms. Keller arrived at the apartment at 3:30 p.m. and was told by Wendy that Tina, Eric, Carolina, and Eric's grandfather had gone shopping for diapers and formula. Ms. Keller asked Wendy to tell the family she would be back in the morning.

Ms. Keller returned to the home Friday morning to learn that the electricity had been turned off due to nonpayment. Ms. Keller spoke to a representative of the electric company and learned that the company had contacted the Yardleys numerous times about the bill and had sent a certified letter advising that the power would be turned off. Tina recalled that she had a paper in her purse advising her to pick up a certified letter. Ms. Keller drove Tina to the post office to pick up the letter. She also took Tina to Unity Medical Clinic to pick up a letter that the baby needed to have oxygen at any time and, therefore, needed electricity.[11] Ms. Keller advised the electric company that DCFS would try to rectify the problem. Ms. Keller called the DCFS caseworker, Rich Fischer, to advise him of the situation and inquire whether Norman funds could be used to pay the bill. Mr. Fischer inquired about the need for electricity for oxygen and Ms. Keller told him that Carolina was not presently on oxygen. Mr. Fischer stated that he would explore the possibility of

[11] Apparently, the electric company had already been notified about the necessity for electric service for medical reasons. In its letter dated September 11, 2000, the electric company advised that the power would be disconnected on September 28, 2000 unless the unpaid balance of $1,075.21 was paid in full. The letter advised that alternative living arrangements should be made for the "individual needing electric service for medical reasons".

accessing Norman funds. Ms. Keller told the family she would see them on Monday, October 2, 2000 with Mr. Fischer. In an interview with OIG staff, Ms. Keller recalled that she saw Carolina on September 29, 2000, but she did not hold her. She did not see any marks or bruises on Carolina that day and she felt it was light enough in the apartment to see.

Later that day, Rich Fischer contacted Agency A's Early Intervention Program and spoke with Ms. Fischer, a nurse.[12] Mr. Fischer had not yet met the Yardley family and was calling to verify that Carolina's health would not be in danger if she was without electricity for the weekend. The nurse offered to go see the family to ensure that Carolina would be okay in the apartment. The nurse called Mr. Fischer back after seeing the family. She told him that she saw Tina, Eric, and Carolina at the next door neighbor's.[13] Carolina did not need oxygen, however, the family was going to spend the weekend at the neighbor's apartment due to the electricity being turned off. Tina and Eric did not appear to be upset about having the electricity turned off and stated they thought it could be turned back on the following week.

Third Report Involving the Yardleys - Sequence B, SCR #880478, September 30, 2000 and Intact Family Services Following Carolina's Injuries

On Saturday, September 30, 2000 at 6:27 p.m., Genesee Medical Center called the hotline to report allegations of cuts, bruises, and welts (allegation #11) and wounds (allegation #7). According to the CANTS 1 report,

> [Tina], [Tina's roommate, Wendy Peters] and [Carolina] are currently at [Genesee Medical Center]. [Carolina] was brought in with the following injuries: a small puncture wound (the size of the tip of a pen) on the bottom left foot, a "rug burn" to the nose and a tear to the underside of the tongue as if the "tongue was ripped from the bottom of the mouth". [Tina stated that] the tongue injury was caused by a "pacifier". [Tina] had no explanation for the other injuries, but [stated that Carolina] has been with [her] all day. [Reporter stated that] local police are currently at hospital. [Carolina] will need surgery to repair the tongue injury.

At the top of the report was the statement, "reporter states that when looking at [Carolina], [Carolina's] eyes look up and to the left. Reporter states that this is a possible symptom of Shaken Baby Syndrome."[14]

SCR conducted a LEADS (Law Enforcement Agency Data System) check on Tina that was found to be negative. SCR did not conduct a LEADS check on Eric as he was listed on the report as "unk[nown], unk[nown]".
Clay Parker was the on-call worker who was paged by the hotline to respond to the report. Mr.

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[12] Rich Fischer and the nurse are husband and wife.
[13] The nurse, Ms. Fischer, told an OIG investigator that she did not see any marks or bruises on Carolina during the visit.
[14] Looking up and to the left is not believed to be a symptom of Shaken Baby Syndrome. Carolina was cross-eyed; this may have accounted for the way Carolina looked.

Parker telephoned the treating physician at Genesee Medical Center, Alice Ritter. According to his case entries, Dr. Ritter told Mr. Parker that Carolina's tongue was severed at the base; she had two small cuts to the ball of her foot; and she had three bruises like finger tip marks to her back below her shoulder on her right side. Tina said she did not know how Carolina got the cuts. Dr. Ritter stated that she wanted Carolina seen by Dr. Turner, a specialist at Park Hospital, and she was sending Carolina by ambulance. Mr. Parker said he would go to Park Hospital.

Mr. Parker saw Carolina Yardley at Park Hospital at 8:26 p.m. Mr. Parker observed the infant's injuries and recorded them on a suspected abuse injury note sheet (body chart). According to his notes and the body chart, Carolina had rug type burns on the tip of her nose and on both sides of her nose; two minor contusions (also described by him as scratches) on the bottom of her left foot; a reddish purple, fresh looking bruise to the outside area of her left ear; three finger tip bruises to the right side of her mid-back faint brown in color 10-14 days old; a crack on the upper lip that appeared almost healed; and a cut under her tongue.

Mr. Parker interviewed Tina Yardley at Park Hospital at 8:58 p.m. Mr. Parker asked Tina what happened. Tina stated that she had laid Carolina down for a nap and after 30 to 45 minutes, she heard Carolina crying and she and Eric went in to get her. Eric picked-up Carolina and said she had blood on her and that he did not do anything to cause it. Tina said the orange part of Carolina's pacifier was in Carolina's mouth and Eric took it out of her mouth. Tina took Carolina from Eric and told him to get a cold wash cloth. Tina tried to wipe the inside of Carolina's mouth to see where she was bleeding from. They got a flashlight out and Tina noticed that the skin under her tongue looked like it was cut. Tina told Eric she was taking Carolina to the emergency room, but he could not go with her because he had drank four to five beers and she did not want the hospital to smell him and think he was drunk. Tina stated her sister, roommate, and a few neighbors were at the home during this time. Tina admitted that she had never heard of a pacifier cutting an infant's tongue, but stated that was the only way the injury could have occurred. Tina explained Carolina's other injuries to Mr. Parker. According to his notes, Tina stated that Carolina got the rug type burn on her nose from pulling and rubbing her face on the sheet and pillow; the cut on her lip was from hitting Eric's shoulder while he played with her by throwing her in the air and catching her; the scratches on Carolina's foot were from her toe nail as she rubs her feet together (Mr. Parker observed that Carolina had long toenails); the bruises on her back were from the tips of Eric's fingers because he pats her too hard. Tina said she did not know how Carolina got the bruise on her ear. She agreed that it looked fresh and said they might have caused it while they were holding her head to look in her mouth. Tina said no one hit or shook her baby. She told Mr. Parker that she had wanted to go home to get diapers and clothes for Carolina, but the doctor would not let her leave. Tina said she told Ms. Keller about the cut lip and that Eric caused it by throwing her in the air. She also said she thought she told Ms. Keller about the bruises on Carolina's back from Eric patting her too hard. Mr. Parker had Tina sign a consent for the release of Carolina's emergency room report.[15]

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[15] Again, Mr. Parker did not need Tina's consent to obtain Carolina's emergency room report. See footnote 8.

At 9:45 p.m., Mr. Parker consulted with the on-call supervisor, John Garrett. According to Mr. Parker's notes, Mr. Garrett stated that it would be best to find a relative who Tina and Carolina could stay with until Monday, October 2, and who could monitor Carolina's safety. In an interview with OIG staff, Mr. Garrett recalled that he was aware that Carolina had physical injuries to different parts of her body. There were explanations for some of the injuries, but some of them were unexplained. Mr. Garrett did not remember why Mr. Parker felt Carolina was safe in Tina's care, but he did recall that Mr. Parker believed the perpetrator was the male in the home and he felt confident in Mr. Parker's assessment of the case and the plan for Tina and Carolina to stay with a relative as the weekend safety plan. Mr. Garrett and Mr. Parker did not discuss what would occur with the family on Monday. Mr. Garrett explained that the focus was on getting through the weekend. He was not aware that the safety plan, as written, lapsed on Monday morning until he signed on Monday the copy faxed to his office.

Mr. Parker completed a CERAP (Child Endangerment Risk Assessment Protocol). In Part A, Safety Factor Identification, all safety factors were checked "no" with the exception of "other" which was checked "yes" as "child has unexplained bruises, scrapes, scratches, laceration to tongue area." Mr. Parker made a safety decision of unsafe and implemented the following safety protection plan:

> I, Tina Yardley, agree to stay at my mother's residence in [town redacted] with my child, Carolina, until Monday, October 2nd, 2000. I will then return to my residence in [town redacted] and DCFS worker and homemaker will be in contact and advise me on further goal plans if changes are made. My mother, [name redacted], will monitor me and Carolina until I return to my home. I, EricYardley, will stay at our residence in [town redacted] and will cooperate fully.

At 9:50 p.m., Mr. Parker spoke with Dr. Turner at Park Hospital. According to Mr. Parker's notes, Dr. Turner carefully checked Carolina and after the exam and trying to place the pacifier into Carolina's mouth past her lips, stated that she "could possibly get pacifier into mouth and cause cut to the tongue." Dr. Turner prescribed medication for an ear infection and requested a follow-up visit at his office on October 3, 2000.[16] Mr. Parker took a copy of the doctor's notes from the

[16] Following the injuries that led to Carolina's death, the Child Protection Manager asked Mr. Parker to recall and record in detail his contact with Dr. Turner. Mr. Parker recorded the following additional details: Dr. Turner and a nurse examined Carolina. Dr. Turner looked at Carolina's ears first and the nurse had a difficult time holding Carolina's head still for the exam. Mr. Parker asked Tina to tell Dr. Turner what caused the rug type burns to Carolina's nose, the bruises on her back, the bruise on her ear, and the cracked upper lip. Tina repeated the explanations she gave Mr. Parker earlier. Mr. Parker gave Dr. Turner Carolina's pacifier, which had blood on it, to see if he could get it into Carolina's mouth where it could have caused the cut under the tongue. After awhile, Dr. Turner said it was possible that the pacifier could cause the injury under the tongue. Mr. Parker asked Dr. Turner to give him his notes from the visit and to include anything in them that seemed "out of the way". Dr. Turner was rather quiet throughout the exam. At one point, Dr. Turner stated "to Tina that this child has more bruises than his girls had in 13 or 14 years." Dr. Turner gave Tina a prescription, an ointment, and a note to call for a follow-up appointment. The nurse gave Mr. Parker a copy of Dr. Turner's

exam *(See section entitled Carolina Yardley's September 30, 2000 Injuries on page 24).*

Upon leaving the hospital, Mr. Parker took Tina and Carolina to their home to pick up clothing and personal items to take with them to Tina's mother's home. Eric came up to Mr. Parker's car while he waited with Carolina for Tina. Eric asked if he could hug Carolina and tell her goodbye. Mr. Parker told him he could and advised Eric that someone would be by, possibly as early as Monday, to talk to him and the others who were present when it was discovered that Carolina was injured. Tina and Eric signed the CERAP safety plan.

Mr. Parker transported Tina and Carolina to Tina's mother's home. They arrived at 1:00 a.m. on Sunday. Tina's mother said she would be with Tina and Carolina, and she signed the CERAP safety plan.

A substance abuse screen on Tina, dated October 1, 2000, indicated that Tina did not need to be referred for an assessment by a qualified substance abuse counselor. Mr. Parker wrote "no" for every question on the screen, contrary to his prior knowledge about Tina's substance use. Mr. Parker did not complete a substance abuse screen on Eric. He did not conduct a LEADS check on Eric.

At 3:05 a.m. on Sunday, October 1, 2000, Mr. Parker contacted the homemaker, Jan Keller, at home and advised her that she needed to pick up Tina and Carolina at Tina's mother's home instead of Tina's home to have Tina at the Public Aid office at 9:00 a.m. on Monday, October 2, 2000. Mr. Parker said that he needed information regarding her contacts with the family and any notes of any marks, cuts, burns, etc. He told Ms. Keller that a child protection investigator would speak with her on Monday.

On Monday morning, Ms. Keller picked up Tina and Carolina at Tina's mother's home. After Tina told Ms. Keller about Carolina's nose looking raw, Tina's mother stated that Tina's older daughter rubbed her nose a lot when she was a baby. Ms. Keller dropped Tina and Carolina off at the Public Aid office and told Tina to walk over to the DCFS office when she was finished with her appointment.

Also that morning, at 8:15 a.m., Clay Parker staffed the case with the Yardleys' caseworker, Rich Fischer,[17] and Mr. Fischer's supervisor, Anna Breslin. According to their notes, Mr. Parker advised Ms. Breslin and Mr. Fischer of the new report on the Yardleys and that Tina and Carolina spent the weekend at Tina's mother's home. Mr. Parker stated that Dr. Alice Ritter saw Carolina at the Genesee Medical Center emergency room and was concerned that Carolina had a cut on her tongue, possibly caused by a pacifier. Dr. Ritter referred Carolina to Dr. Turner because she was concerned that Carolina might need surgery to repair her tongue. Mr. Parker told the pair that Dr. Turner said it was possible that the baby could get the pacifier behind the lips and cause the cut

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notes.

[17] Although he was assigned to the case, Mr. Fischer had not yet met the family as he had been out of the office on sick leave.

and that the cut would heal. Mr. Parker informed Ms. Breslin and Mr. Fischer about the old finger-tip bruises that Tina said were from Eric patting Carolina on the back too hard and the cut lip from hitting Eric's shoulder while he was throwing Carolina up in the air and catching her. According to Ms. Breslin's notes, Shaken Baby Syndrome was mentioned in the report and according to Mr. Fischer's notes, Mr. Parker discussed concern about possible Shaken Baby Syndrome if Eric continued to be rough with Carolina. Mr. Fischer said he would meet with the family in the afternoon to devise a new CERAP safety plan addressing the issues. Ms. Breslin and Mr. Fischer also discussed increasing homemaker services for the family and possibly referring the family to a provider for services.

In interviews with OIG staff, both Ms. Breslin and Mr. Fischer stated that they were under the impression following the staffing that Tina and Carolina had been staying with Tina's mother under a safety plan because the electricity had been turned off in the Yardley apartment. Neither thought the safety plan was implemented to keep Eric away from the baby as Mr. Parker had told them the doctor said Carolina's injuries could have occurred the way Tina said they did.

Mr. Parker staffed the case Monday morning at 8:47 a.m. with his supervisor, Brett Walters. The staffing took place over the telephone as Mr. Walters was in his office at the Brighton Field Office. In an interview with the OIG, Mr. Walters said that when he read a copy of the CANTS report that he received at the Brighton Field Office, he wondered whether DCFS had taken protective custody of Carolina. When he talked with Mr. Parker, he learned that a safety plan had been developed for Tina and Carolina to stay with Tina's mother. Mr. Walters thought this was a good plan. Mr. Parker told Mr. Walters that he had spoken with the reporting doctor who had concerns about the injuries and with a specialist the child had been referred to who believed the injuries could have happened the way Tina said they did. Mr. Walters asked whether Mr. Parker had spoken to Eric Yardley or the roommate, Wendy Peters. Mr. Parker said he had not. Mr. Walters directed Mr. Parker to interview Eric Yardley and Wendy Peters as soon as possible to get their versions of events. At this time, Mr. Walters believed that Tina and Carolina were still staying at Tina's mother's home pursuant to the safety plan.

When Tina arrived at DCFS that morning, Ms. Keller introduced her to her caseworker, Rich Fischer. Ms. Keller held Carolina while Tina and Mr. Fischer talked. After Tina told Mr. Fischer that Carolina got the cut lip from Eric throwing her up in the air, Mr. Fischer discussed Shaken Baby Syndrome with Tina who said she had never heard of it. Mr. Fischer explained that babies cannot handle such rough treatment and their brains could be damaged. Mr. Fischer said he was concerned about the rough treatment Carolina was getting from Eric and he needed to see them at their apartment in the afternoon to discuss with her and Eric the changes that must be implemented immediately to ensure Carolina's safety in the home.

Ms. Keller and Mr. Fischer visited with Tina, Eric, Carolina, and Wendy and Brian Peters in their home on the afternoon of October 2, 2000. Tina reported that the electricity was being turned back on the following day in Wendy's name. Mr. Fischer educated Tina and Eric about Shaken Baby Syndrome and Sudden Infant Death Syndrome; he advised them not to throw Carolina in the air and to place her on her back or side to sleep. Mr. Fischer advised Eric to take his medication for

his bipolar disorder and not to drink alcohol. He also discussed a CERAP safety plan with the parents. On the CERAP, in Part A, Safety Factor Identification, all safety factors were checked "no" with the exception of "Caretaker's alleged or observed drug or alcohol use may seriously affect his/her ability to supervise, protect, or care for the child" (emphasis in original by worker). Mr. Fischer found Carolina unsafe and implemented the following safety plan:

> I, Eric Yardley, agree not to drink alcohol of any kind while presently taking medications. I, Eric Yardley, also agree not to throw the baby in the air because of the risk of shaken baby syndrome. I, Tina Yardley, agree not to let the baby Carolina sleep in my bed, but I will agree to move the baby bed into my bedroom so I will be with her at night. I, Tina Yardley, will also ensure that the baby sleeps on her side and not on her stomach.

Eric and Tina signed the plan, as did Mr. Fischer and his supervisor. Mr. Fischer noted that Carolina "is safe in the home with this safety plan in her present home with her parents Tina and Eric Yardley. This worker will monitor the safety plan along with DCFS homemaker Jan Keller on a weekly basis."

Mr. Walters staffed the case with Mr. Parker again on Tuesday, October 3, 2000 during Mr. Parker's regular in-person supervision. Mr. Parker said he had not yet interviewed Eric or Wendy and Mr. Walters directed him to go see them. At this time, Mr. Walters still thought Tina and Carolina were out of the home.

At approximately 2:30 p.m. on October 3, 2000, Ms. Keller picked-up Tina, Eric, and Carolina to take them to Carolina's follow-up appointment with Dr. Turner. During the car ride, Ms. Keller talked to Eric again about Shaken Baby Syndrome and not being rough with the baby. According to Ms. Keller's case entry, "Dr. Turner said the baby was doing fine and . . . the bruise on the ear was from Carolina pulling on her ear because of the fluid that was there." Ms. Keller told OIG staff in an interview that she waited for the family in the waiting room and never spoke with Dr. Turner. The information she recorded came from Tina. Ms. Keller noted that Carolina had another appointment on Wednesday, October 4, but Eric's grandfather was going to take the family and Ms. Keller would see them again on Thursday.

On October 3, 2000 at 3:56 p.m., Mr. Parker went to the Yardleys' home to conduct interviews with Eric and Wendy. He received no response at the door (Eric was apparently with Tina, Carolina, and Ms. Keller at Dr. Turner's office).

On October 4, 2000 at 3:14 p.m., Mr. Parker called the telephone number Tina had given Genesee Medical Center. Eric's grandfather answered the phone and gave Mr. Parker a new telephone number for Tina. Mr. Parker tried that number and got no response.

That evening, at 11:09 p.m., Mr. Parker was contacted by the County Sheriff's Office and

advised that Carolina Yardley was at Genesee Medical Center and was not expected to live. Mr. Parker contacted his supervisor, Brett Walters, at home and was directed to go to the hospital and, after learning more, call him back. It was during this phone call that Mr. Walters learned that Tina and Carolina were back at home.

While at the hospital, Mr. Parker interviewed Tina, the paramedic who first responded, and the attending physician. He also saw Carolina and noted that she did not appear to have any fresh marks or bruises on her face or ears since seeing her on September 30, 2000. He was not able to observe the rest of Carolina as she was under a sheet.

At 12:31 a.m. on October 5, 2000, Mr. Walters directed Mr. Parker to interview Wendy Peters and Beth Smith and to ask the police for assistance. That early morning at the police station, Mr. Parker interviewed Wendy and Beth. At 6:00 a.m. Mr. Parker learned from the police that Eric admitted he shook Carolina because she was crying and she fell out of his hands and hit her head on the floor. At 9:40 a.m. Mr. Parker contacted the hotline to report Carolina's new injuries. A different child protection investigator was assigned to investigate.

Carolina Yardley's Early Health History (compiled from Park Hospital and Strong Hospital records)

Carolina was born one week late on May 5, 2000 at Park Hospital. She weighed 7 pounds, 8 ounces and measured 21 inches in length. Carolina aspirated meconium during delivery and was not breathing on her own. As soon as she was resuscitated, she was sent to Strong Hospital's Neonatal Intensive Care Unit. Later that same day, she was transferred to a children's hospital where she remained until May 27, 2000. Carolina was diagnosed at the hospital with Meconium Aspiration Syndrome, Persistent Pulmonary Hypertension, Bronchial Pulmonary Dysplasia, and Sepsis. Treatment included oxygen and antibiotics. Carolina was transferred back to Strong Hospital on May 27, 2000 where she remained until June 8, 2000. She was discharged home on oxygen and with an apnea monitor for sleeping. Home nursing visits by Home Health Services were ordered three times a week for saturation checks of Carolina's oxygen.

Agency A Early Intervention Services

On July 17, 2000, Carolina was referred by her home health nurse for early intervention services. Due to Carolina's medical conditions, she was automatically eligible for early intervention services. From July 27 to August 7, 2000, Tina was non-responsive to calls and letters to engage Carolina in services. On August 10, 2000, Tina's permission to coordinate evaluations for Carolina was received and a referral was made on August 11, 2000 to Agency A for global functioning and nursing evaluations of Carolina.

On August 24, 2000, a nursing evaluation and a Battelle Developmental Inventory Assessment were conducted. At the time of assessment, Carolina weighed 13 pounds, 2 ounces, measured 25-1/2 inches tall, and had a head circumference of 41.5 centimeters. On a standard growth chart her weight was at the 75th percentile, her length at the 90th percentile, and head circumference at the 95th percentile. Carolina appeared to have very low muscle tone (she looked floppy). She was described as pleasant and very vocal. Tina said that Carolina slept well, usually waking only once during the night. She ate well (formula, cereal, and first foods) and was not on any medication. Tina reported that Carolina's doctor was Dr. Shaw at Unity Medical Clinic, that Carolina had an appointment last week, and that her next appointment was September 6, 2000 when she would receive her first set of immunizations.

The Battelle Developmental Inventory Assessment showed a 30% or more delay in the personal/social, adaptive, and fine motor domains. Carolina demonstrated upper body weakness. Ms. Fischer, in her Early Intervention Service Report, recommended weekly developmental therapy to address personal/social, adaptive, and fine motor skills; and physical and occupational therapy evaluations to assess gross and fine motor skills.

An Individualized Family Service Plan staffing was held on September 20, 2000. Tina declined to complete Section 1 of the IFSP (Family Considerations for the IFSP), indicating, "I do not agree to provide this information". Tina agreed to weekly developmental therapy for Carolina with Ms. Fischer, but she declined the physical and occupational therapy evaluations that were recommended.

Ms. Fischer saw Tina and Carolina once following the IFSP, on September 29, 2000. Ms. Fischer had a therapy session with Carolina and checked on Carolina for DCFS to make sure that Carolina was not on any equipment that required electricity. The therapy session took place at the next door neighbor's apartment where the family was staying while the electricity was off. Ms. Fischer's next visit with Carolina was scheduled for 2:15 p.m. October 5, 2000, the day Carolina died. In a telephone interview, Ms. Fischer told an OIG investigator that, while the neighbor's apartment was not that well-lit, she did not see any marks or bruises on Carolina during her visit on September 29, 2000. She and Carolina sat on the floor together. Tina mentioned to her that Carolina had bumped her Dad's shoulder with her pacifier, but Ms. Fischer did not see any marks. Ms. Fischer said that Carolina could turn her head side to side, but she was not very strong; she was not strong enough to lift herself up and cause abrasions to her nose.

Pediatric Care, Dr. Shaw, D.O., Unity Medical Clinic

Dr. Shaw, D.O. is board certified in emergency medicine and family practice. He was Carolina's family practice doctor at Unity Medical Clinic from July 28, 2000 until her death on October 5, 2000. Dr. Shaw first met Carolina when she was almost three months old. Dr. Shaw obtained information from Tina about Carolina's first month in the hospital, her medical diagnoses and medications, and her feeding schedule. Carolina weighed 11 pounds, 12 ounces and measured 25 inches at the first visit. Dr. Shaw conducted a physical exam and blood tests. He diagnosed Carolina with bronchial pulmonary dysplasia and post persistent pulmonary hypertension. He noted that Carolina appeared to be a well baby given her history. Dr. Shaw asked to see Carolina again in two weeks.

Dr. Shaw next saw Carolina on Friday, August 11, 2000. Carolina had gained weight since her last visit. She was up to 12 pounds, 6 ounces. Tina reported noticing increasing congestion in Carolina. Dr. Shaw diagnosed Carolina with sinusitis, acute bronchitis, and bronchial dysplasia. He prescribed pediatric Amoxil for 10 days and Albuterol every 4 hours. He said to place Carolina upright to sleep. Carolina was to remain on the oxygen and Dr. Shaw asked to see her again on August 16, or sooner if she experienced problems. He noted that Carolina was improving well.

On August 16, 2000, Tina called to reschedule Carolina's appointment for August 18, 2000. The home health nurse also called that day to report that Carolina's oxygen was on 100% saturation and when the oxygen was off for 15 minutes, it was at 95-98% saturation. She reported that the home was clean, but that people were in and out and there were flies in the home.

Dr. Shaw saw Carolina for the third time on Friday, August 18, 2000. Carolina weighed 13 pounds, 2 ounces. She was doing well and her bronchial dysplasia was improving. The doctor noted a rash on Carolina's face caused by the tape from the oxygen; he prescribed an ointment to be applied two to three times daily. Dr. Shaw asked to see Carolina on September 6, 2000 for her four-month-old immunizations.

On the evening of Tuesday, August 29, 2000, Tina brought Carolina to the Genesee Medical Center emergency room with a 102 degree fever, runny nose, cough, and congestion. She was released with a prescription for medication and told to follow-up with Dr. Shaw the next day.

Tina brought Carolina into Dr. Shaw's office three days later, on Friday, September 1, 2000, for follow-up on the emergency room visit. Tina was concerned about congestion and rattling, but Dr. Shaw noted that Carolina's emergency room x-ray showed minimal early infiltrate. When he sat Carolina up and extended her chin, her lungs were clear. He noted it was only head and neck congestion and that Carolina's sinuses were irritated from the oxygen. Tina said Carolina had improved much since being treated at the emergency

room with medication. Carolina was receiving nebulizer treatments every four hours. Dr. Shaw noted in his record that Tina "doesn't seem to tend to the baby very well in the office. We talked about more cuddling, holding, keeping the baby upright to help with congestion." Dr. Shaw's plan was to see Carolina again on Tuesday and Friday of the next week. He increased the Albuterol treatments to every three hours and told Tina to use nasal drops and saline and to suction frequently. He prescribed Rondec-DM pediatric orally only as needed for congestion or cough.

Carolina's Tuesday, September 5, 2000 appointment was rescheduled by Tina to Friday, September 8, 2000. Tina did not show up for the appointment on Friday and Dr. Shaw made a report to the DCFS State Central Register.

On Monday, September 11, 2000, Mr. Parker contacted Unity Medical Clinic to confirm an appointment for Carolina that day. Carolina was seen in the office that day for a four-month-old check-up and a recheck of her pneumonia. Carolina was doing well. She weighed 13 pounds, 14 ounces and measured 25 inches long. Her pneumonia was gone. She was still on oxygen. She had not been seen by the home health nurse for a week. The doctor contacted the nurse to discuss weaning Carolina from her oxygen. The plan was to try her off the oxygen for 2 hours and if she stayed above 95% saturation, to discontinue the oxygen. The home health nurse was to check back two days later and call the office with the results of both visits. Dr. Shaw administered Carolina's first set of immunizations. He asked to see her again in two weeks.

On Monday, September 18, 2000, Tina called the doctor's office to say Carolina had a cough and runny nose. A prescription for cough syrup was called into the pharmacy. Tina tried to fill it the following day with Ms. Keller, but couldn't pay for it, so they picked up samples from Dr. Shaw's office.

Carolina's next appointment was Monday, October 2, 2000. She did not show up for her appointment and Tina called to say she "had some trouble over the weekend, dealing with DCFS now." The appointment was rescheduled for October 6, 2000.

Dr. Shaw was very upset about Carolina's death. He cooperated with the OIG investigation and arranged for an in-person interview at his office. In the interview, Dr. Shaw stated that he called Clay Parker the day Carolina died. Dr. Shaw said he had hoped to start a dialogue about what had happened and what they could do in the future, but Mr. Parker thanked Dr. Shaw for calling, said he already knew about Carolina's death and was doing the paperwork.[18] Dr. Shaw obtained information from Dr. Turner and Genesee Medical Center about what had happened to Carolina.

[18] A case entry by Mr. Parker confirmed this conversation.

Dr. Shaw related to OIG staff that he contacted DCFS because he was concerned about Carolina and felt that she needed close observation on a daily basis. He had told Mr. Parker that Tina was engaged in a drug lifestyle, that she tested positive for cocaine when her stomach was pumped of Eric's medication, and she admitted to using crack cocaine while she was pregnant with Carolina. Dr. Shaw found it hard to believe that Carolina remained in her parents' care after her physical injuries came to light on September 30, 2000. Dr. Shaw, who has been trained to recognize child abuse and neglect, said Carolina did not have enough head weight to cause the injury under her tongue on her own. He also said that babies do not bruise their ears from pulling on them due to ear infections.

Tina Yardley's Drug Overdose

On August 14, 2000, Tina arrived at the Genesee Medical Center by ambulance. Dr. Shaw was Tina's treating physician. Tina reported that she got into an argument with her husband and took his medication. She took approximately 6 Risperdal 1 mg. and 4-5 Prozac 20 mg. She denied taking anything else. Tina admitted to smoking crack cocaine (3 hits) two to three days prior. She indicated she was frustrated with life events lately, such as having a sick child, not getting along with her husband, and financial difficulties. Tina's stomach was pumped and she was discharged the following day. Dr. Shaw's final diagnoses were: intentional drug overdose; depression; attention getting spell; and illicit drug use by history of cocaine. A drug screen came back positive for cocaine. Tina received a mental health consult. The consulting doctor's diagnoses were Dysthymia and Borderline Personality Disorder. He and Dr. Shaw recommended mental health outpatient follow-up treatment. Tina said she would go to the local Mental Health office for outpatient treatment.

Eric Yardley's Mental Health History

Eric was seen at Unity Medical Clinic since childhood. In the last few years, he had been seen primarily for accidental injuries sustained at work and medication and monitoring for his high blood pressure. It was not until April 2000 that Eric disclosed he had been previously diagnosed with Bipolar Disorder. On April 20, 2000, a few weeks before Carolina's birth, Eric was at the doctor's office complaining of anxiety. Eric stated that his wife was pregnant and he was not sure if that was what was contributing to his anxiety. Eric said that he had become somewhat violent at home, punching holes in the walls. He advised that from 1996 to 1998 he had been treated for bipolar disorder with Lithium, Prozac, and Risperdal. Eric was noted to appear very anxious in the office and was given a one-month starter pack of Paxil and a fifteen-day supply of Xanax. The office requested Eric's prior psychiatric records.

Eric was seen twice in June for rechecks and refill of his medications. He reported feeling sluggish from the medication and adjustments were made. The Paxil was changed to Prozac. At an appointment on July 7, 2000, Eric reported that his medications were not working. Eric was observed to be very nervous and agitated in the office. He denied having any paranoid delusions at the time, but had some fears that he might attempt to hurt someone. He did not have any suicidal ideations. He reported having an appointment with a psychiatrist at the local Health Department on July 10, 2000. The doctor noted that Eric had generalized anxiety with bipolar disorder. He adjusted Eric's medications and told him to follow-up in two weeks.

Eric called the office for refills of his medications in August 2000. On September 15, 2000, Eric went to the office complaining of a low grade fever and a swollen tongue. He said that he had been biting at his tongue on and off for the past week or so. He reported that he had stopped taking his Prozac approximately two weeks earlier because his wife got mad at him and threw it away. He said he still took his Risperdal and that it helped a little with his anger issues. Eric was given some samples of Prozac and encouraged to use Chloraseptic for management of the ulcer on his tongue.

Eric's prior psychiatric history included a hospital stay from May 8, 1996 to May 10, 1996. On the day of admission, Eric got three traffic tickets for reckless driving and speeding. In a history taken by the hospital, Eric reported high anxiety, poor appetite, insomnia, irritability, and problems controlling his temper. He reported hitting walls and throwing things when angry. Eric related having problems with mood swings and being hyperverbal, highly impulsive, and paranoid. He reported fighting, truancy, stealing, lying, running away, and being destructive. He reported seeing a doctor three to four years prior for behavioral problems. He denied suicidal ideations. He admitted having homicidal thoughts, but he did not have an immediate plan to hurt anyone.

Eric also told hospital staff that his family had a history of violence and mental illness. He said his brother, maternal uncle, paternal uncle, and paternal aunt were all highly violent and highly labile people. His paternal grandfather was an alcoholic and physically abused Eric's father. Eric's father had a nervous breakdown and was previously hospitalized. Eric had an aunt who was schizophrenic. His step-father reportedly physically abused Eric with severe whippings for many years. Eric said the whippings would leave bruises.

Eric reported a history of substance abuse. He was in the hospital for ten days in December 1995 for substance abuse treatment. Eric used marijuana within the last month. He said he used to abuse alcohol and marijuana extensively. He reported drinking alcohol since the age of nine and stated he would drink every day to every other day, up to a bottle a day. He said he had used marijuana since age fourteen.

Eric's diagnoses included Axis I: Major Depressive Disorder with Psychotic Features versus Bipolar Disorder with Depression or Mixed State, Rule out Post-Traumatic Stress Disorder, Conduct Disorder, and Polysubstance Dependence; Axis II: Deferred; Axis III: Bronchitis; Axis IV: Educational problems, problems with primary support group, and legal problems; Axis V: Global assessment of functioning of 50-60.

Eric was started on a course of Lithium Carbonate, Prozac, and Risperdal. He did well on the unit. His support system was his biological father whom he met three years earlier and with whom he lived. Eric was discharged to the partial hospitalization program in stable condition on May 10, 1996. Eric attended the partial hospitalization program twice weekly for two weeks. While he attended and was cooperative in the program, Eric was somewhat eager to be discharged from the program. He continued to smoke marijuana, but was compliant taking his medication. He reported having one visual hallucination and one auditory hallucination and his Risperdal was increased. Eric's discharge plan was medication management and outpatient therapy.

Carolina Yardley's September 30, 2000 Injuries (compiled from Genesee Medical Center and Park Hospital records)

Tina arrived at Genesee Medical Center with Carolina at 5:14 p.m. She told a nurse that Carolina was lying down for a nap and she awoke crying. Carolina had the pacifier in her mouth and when Tina pulled it out it had blood on it and Carolina had blood in her mouth.

Carolina had a complete physical exam. A genital exam was conducted. There was no evidence of sexual abuse. A CT scan without contrast was taken of Carolina's head and was found to be normal. Carolina was found to have the following injuries which were photographed: laceration under tongue; purple bruising to left ear; abrasions to nose; abrasions above upper lip; bruises to right cheek and forehead; 3 small bruises to back right side of head; and puncture wound with scratch above it on bottom of left foot. Carolina also had three bruises like finger tip marks to her back below her right shoulder. Tina said that the abrasions on Carolina's nose were from Carolina rubbing her nose on the bed. She said the abrasion above Carolina's lip had been there for two days. The bruise on Carolina's left ear and right cheek were described by hospital personnel as "old". Carolina was referred to in the notes as a "crack baby".

A developmental assessment completed by the hospital on September 30, found Carolina to be age appropriate in gross motor, sensory, language, and social domains, but lagging in fine motor skills in that she was not able to grasp objects voluntarily.

Dr. Ritter arranged for Carolina to be transferred by ambulance to Park Hospital to see Dr. Turner, an eyes, ears, nose, and throat specialist, for her tongue injury. Ambulance staff were advised by Dr. Ritter that Carolina was a possible child abuse case and that DCFS was notified. They were told that they would be escorted by the Police Chief. Park Hospital emergency room staff were advised that Carolina was not to leave with her parents, and that DCFS, Mr. Parker, would be there as soon as possible.

Mr. Parker arrived at Park Hospital at approximately 8:15 p.m. and Carolina arrived at approximately 8:30 p.m. She was seen by Dr. Turner shortly thereafter. In his notes of his examination of Carolina, Dr. Turner documented the facial injuries to Carolina: lacerated tongue, abrasions to nose, bruised ear, and abrasion/contusion to upper lip. He also documented the explanations given by Tina: unsure of mechanism causing tongue laceration, rubbing nose on sheets causing abrasion of nose, unknown cause of contusion, and lip injury due to accident hitting father's shoulder. Dr. Turner did not find that Carolina needed surgery. He indicated that the laceration would heal spontaneously. Carolina had ear infections in both of her ears. She had a chest x-ray taken due to congestion. No abnormalities were noted. Discharge instructions were given to Tina to follow-up with Carolina's regular doctor, call Monday for an appointment with Dr. Turner on Tuesday, and administer Augmentin twice a day for 10 days for ear infections.

As a courtesy, Dr. Turner sent Dr. Shaw, Carolina's primary physician, a letter dated October 5, 2000 detailing his treatment of Carolina. He stated Carolina "sustained a laceration to the floor of mouth region. The details are uncertain. Her pacifier may have jammed up under her tongue causing the laceration." In the letter, Dr. Turner mentioned the abrasion to Carolina's nose, but none of the other injuries.

Carolina Yardley's Fatal Injuries

Medical Examiner Report

Carolina's death was ruled a homicide due to a closed head injury. An autopsy revealed the following injuries: subdural and subarachnoid hemorrhage; abrasions and contusions of her face, scalp, and mouth; bilateral retinal hemorrhages and acute hemorrhage around the optic nerve; contusions on her back, abdomen, left buttock, and extremities; six fractures of the left posterior rib cage; old fracture of the right clavicle; and a healing laceration under her tongue.

Illinois State Police and DCFS Investigations of Carolina's Fatal Injuries

Illinois State Police (ISP) and DCFS cooperated in their investigations. The following is a summary of what was learned after Carolina's death.[19]

At 10:04 p.m. on October 4, 2000, the County Sheriff's Office received a 911 call from Wendy Peters stating that Carolina Yardley was not breathing. Upon arriving at the residence, paramedics initiated CPR and transported Carolina to Genesee Medical Center where she was placed on life support. Carolina was transferred to another hospital where she died at 2:10 p.m. on October 5, 2000 from inflicted head injuries.

The ISP investigation revealed that Eric inflicted the injuries that resulted in Carolina's death. Eric stated that he became angry when Carolina would not stop crying. Carolina fell while he was shaking her; she hit her head on the frame of the bed and fell onto the floor. Eric was charged with three counts of murder. His trial has not yet begun. Tina was charged with endangering the life of a child for allowing Carolina to be alone with Eric given his history of harming her in the past. She was acquitted in a bench trial on March 1, 2001. Eric was indicated by DCFS for death by abuse, brain damage/skull fracture, subdural hematoma, and bone fractures. Tina was indicated by DCFS for brain damage/skull fracture, subdural hematoma, and bone fractures. Tina is pregnant with her third child. Eric is believed to be the father.

A criminal history check by the ISP revealed that Tina did not have a criminal record. Eric had charges dating back to 1997 (when he turned 18 years old). 1997 charges included theft, burglary, knowingly damaging property, and attempted theft. He was found guilty of some of the charges and sentenced to probation. In June 1999 Eric was charged with possession of liquor by a minor, DUI, and illegal possession and transportation of liquor by a passenger. He was found guilty of one count and sentenced to imprisonment. In October 1999, Eric violated his probation and was sentenced to periodic imprisonment. A June 2000 charge of deceptive practices was disposed of nolle pros. In August 2000 and September 2000, Eric was charged with escape felony for failing to show up for weekend imprisonment at the County Jail.

Wendy Peters was interviewed. Wendy said that Tina and Eric went into their bedroom to put Carolina to bed. They were in the bedroom for approximately 20 minutes and Carolina had been crying for the last ten minutes when she stopped. Shortly afterward, Tina ran into the living room asking Wendy to call 911 because her baby wasn't breathing. Wendy called 911 and went into the bedroom. Eric was improperly trying to perform CPR and Wendy tried to intervene, but Eric wouldn't let her so she ran next door to get Tina's sister, Beth. When she returned to the apartment with Beth and the neighbor, Eric ran out of the

[19] OIG staff, in their analysis of the case, recognized that "hindsight is 20/20" and considered that information obtained after Carolina's death may not be the same information that was provided (or would have been provided) prior to her death.

apartment. Wendy said that shortly after Eric began living in the apartment, she noticed that Carolina started getting bruises. She said they were "all over" Carolina. Since Eric returned, he very rarely let anyone including Tina change or feed Carolina. Wendy said that Eric would get angry with Carolina for crying or not eating enough. Eric would pat Carolina on the back so hard that he would cause bruises. A week ago, Carolina had a split lip. Eric said he was tossing Carolina in the air and she bounced off the bed onto the floor. Wendy said she believed Tina loved Eric so much that she would lie for him about his actions even though he may have killed Carolina.

Beth Smith, Tina's sister, was interviewed. Her account of the night of October 4, 2000 was similar to Wendy's account, except that Beth said Tina told her she was in the living room with Wendy when she heard Carolina cry. Tina said she went into the bedroom two minutes later and found Carolina on the floor and Eric "freaking out". Like Wendy, Beth reported that Eric had been possessive of Carolina since returning to the home. He would not let anyone other than himself care for Carolina. He would often prevent Carolina from sleeping just so he could play with her. On one occasion, Beth observed that Carolina's lip was "busted". Eric said it happened when he was throwing Carolina in the air and catching her. She fell and hit the mattress on the bed. Beth said that she had never observed Eric hurt Carolina in any manner or become frustrated with the baby, but she did not remember Carolina being hurt until Eric returned to the Yardley home after his separation from Tina. Beth had witnessed Eric force Carolina's milk bottle into her mouth harder if she would cry. She said Eric and Tina had fights that were usually about Carolina. Tina wanted Eric to leave Carolina alone. Beth said she had seen Eric push Tina up against the wall and Eric would choke Tina, but he never hit Tina because he knew better. Beth said Tina was afraid of Eric.

The next-door neighbor related the same information as Beth, except she said that Tina told her that Eric had been in the bedroom feeding Carolina while Tina, who was also in the bedroom, was doing something else. The neighbor said Tina told her this while the paramedics were at the apartment. The neighbor said she had previously seen Eric and Tina argue. Eric had tried to choke Tina in the past, but somebody usually got in between them and broke it up. Eric usually left so he could "go cool off". The neighbor said she had never seen Eric get mad at Carolina or harm Carolina in any way. However, she had witnessed Eric squeeze Carolina's neck in an attempt to get Carolina to take her bottle. She had heard from various individuals, including Tina, that Eric would not allow Carolina to sleep because he wanted to spend time with her. The neighbor knew about Carolina's earlier trip to the hospital. Tina told the neighbor, Beth, and the neighbor's live-in boyfriend that Carolina got the cut in her mouth from sucking her pacifier too hard. The neighbor saw marks on Carolina a few times. When Carolina was approximately two months old, she saw some bruises on her hands and wrists. A couple of weeks ago, Carolina had a "busted-up" nose and a bump on her head that was reportedly caused when Eric threw Carolina in the air and she fell onto the bed with the pacifier in her mouth. The neighbor said that Eric had a very "bad" temper and she believed he would hurt Carolina if he believed it would keep the baby quiet. In the past, Tina frequently slept all day,

especially when she and Eric were separated, and the neighbor and Wendy would feed and take care of Carolina.

In her interview, Tina said she had given Carolina a bath and dressed her and told Eric to come in from outside to help put Carolina to sleep. Eric laid down with Carolina on a mattress on the floor. Carolina was crying. Tina left the room saying she would be back in a minute. Tina went back to the bathroom to clean up and returned to the bedroom about five minutes later. She laid down on the bed and looked at Eric and Carolina on the floor on the mattress. Carolina went limp, or she was already limp, and Tina knew something was wrong.[20] Eric tried to administer CPR, but Tina knew he was doing it wrong, so she tried to get Carolina from him, but Eric yelled at her to get away from him. Tina ran up the hallway and yelled for Wendy to call 911. Beth came over and got the baby away from Eric. Eric disappeared and the paramedics arrived. Tina maintained the explanations she gave to Mr. Parker for Carolina's prior injuries. She added, however, that Eric had once caused a bruise to Carolina's jaw line by clamping her mouth shut to stop her from crying. Eric admitted to Tina that he did this.[21] She threw a fit and he stormed out of the house.

In his interview, Eric said he had been drinking the evening of October 4, 2000. He drank about a twelve-pack of beer with the next-door neighbor. He had not been taking any of his medication for about a month to a month-and-a-half because he could not afford it. Eric explained that he had stopped drinking about 20 minutes before Tina yelled for him to come home. She was trying to put Carolina to sleep and Carolina was fussing. Eric offered to help. Carolina kept fussing and crying and Eric wanted her to stop crying so he started to shake her a little and she slipped out of his hands. She hit the bed frame and fell onto the floor. Eric denied throwing Carolina onto the floor.

Other neighbors were interviewed. They all reported seeing marks and bruises on Carolina in the past. Tina and Eric gave them the same explanations for the injuries that they gave to Clay Parker. Most neighbors had seen Eric get frustrated with Carolina's crying and had observed him shove her bottle into her mouth to quiet her. The neighbors reported alcohol and drug use by Tina and Eric and visitors to the home.[22] One neighbor said that Tina used drugs and drank alcohol during her pregnancy with Carolina. The neighbors reported that others would often care for Carolina because Tina would just let her cry and not pick her up. Eric frequently told people how much he loved Carolina and that he would never hurt her. When he came home after his separation from Tina, Eric was very possessive of Carolina and said he was trying to make up for lost time. Some of the neighbors reported

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[20] There are some discrepancies in what Tina told people Carolina was doing when she stopped breathing. According to one of the ambulance crew members, Tina initially told emergency medical personnel that Carolina stopped breathing while being fed. She then said that Carolina was in the bathtub when she stopped breathing. Before arriving at Genesee Medical Center, Tina said that Carolina stopped breathing while she was in one of the bedrooms of the apartment.

[21] Eric also told the Illinois State Police that he did this. He said Carolina would not stop crying.

[22] In his interview with the ISP, Eric said that the police had been watching his house because of suspicion that his sister-in-law, Beth Smith, was dealing drugs.

that Tina knew Eric was hurting Carolina, but she protected him because she loved him so much. Neighbors confirmed that Eric had a temper. They witnessed some physical fighting between Eric and Tina.

Information was obtained about the events of September 30, 2000. Dr. Alice Ritter was interviewed. She stated that she was concerned about the baby after finding the injuries noted elsewhere in this report. Dr. Ritter said that Tina brought Carolina into the emergency room saying that she woke up with blood in her mouth. Tina said that Carolina had the pacifier in her mouth at nap time and upon waking up, she had a significant laceration to the base of her tongue. Dr. Ritter questioned Tina about the bruises and she could not give Dr. Ritter explanations for the marks. Tina became upset and said that Dr. Ritter was implying that she was responsible for the injuries. Tina argued about going to see the ear, nose and throat specialist until Dr. Ritter felt it was necessary to send the child by ambulance. Tina just wanted to take the baby home. Carolina had an elevated white blood count that was consistent with trauma. A CAT scan was negative. A genital exam did not reveal any signs of sexual abuse. Dr. Ritter called Dr. Turner and advised him about Carolina's suspicious injuries. Dr. Turner agreed to see Carolina. Dr. Ritter took photographs of Carolina's injuries and sent her by ambulance to Park Hospital.

Dr. Turner was interviewed. He said that he was contacted by Dr. Ritter during the late evening. Dr. Ritter asked him to examine Carolina who was suffering from a laceration under her tongue. Dr. Ritter had already examined Carolina at Genesee Medical Center and advised Dr. Turner that she suspected child abuse because Carolina had other injuries including abrasions on her nose and bruises on her ear, back, and head. Dr. Turner asked Dr. Ritter if she was handling the notification to DCFS and Dr. Ritter advised that DCFS had already been contacted and an investigator was enroute to Park Hospital. Dr. Turner said that he agreed to examine Carolina, but for the limited purpose of evaluating whether the laceration under her tongue needed to be repaired.

Dr. Turner arrived at Park Hospital at approximately 9:20 p.m. Upon his arrival, he observed five or six uniformed police officers and hospital security in the emergency room. Dr. Turner stated that emergency room staff had been alerted by Genesee Medical Center that there might be trouble from the parents if the child was taken into protective custody.

Dr. Turner examined Carolina and observed that she was bleeding from the mouth. She also had mild abrasions on the tip and sides of her nose, a small bruise on the outer part of her left ear which he estimated to be one to two days old, a small abrasion on her mid-upper lip, and small bruises on the back of her head. Explanations for the injuries were given to Dr. Turner by Tina Yardley. Tina explained that she found Carolina in her bed crying with a pacifier in her mouth. Dr. Turner stated he could not determine what kind of mechanism caused Carolina's laceration. He told Mr. Parker the pacifier could have been jammed in her mouth, she could have been hit in the mouth while the pacifier was inside her mouth, or she could have fallen on her face on the pacifier.

Tina explained the scrapes on Carolina's nose by stating that Carolina had a history of rubbing her nose on her sheets. Dr. Turner said the explanation was "theoretically possible". He said the minimal scrapes could have easily happened by rubbing her nose on her sheets. Tina explained that the abrasion to Carolina's upper lip was caused by an accidental fall onto her father's shoulder. Tina said she witnessed the fall. Carolina had bruises on the back of her head. Dr. Turner told Mr. Parker that the bruises could have been caused by abuse or by an innocent injury as they were quite minor. Dr. Turner said he could remember thinking that Carolina had more injuries than his two daughters had in their whole lives, but he could not recall if he verbalized this thought. Dr. Turner said the examination of Carolina was difficult because Carolina was upset and crying. He noticed that when held by her mother, Carolina was not consolable, which Dr. Turner thought was unusual. Dr. Turner overheard Mr. Parker talking to Tina and telling her that Carolina and she would have to stay with a relative for a few days. Tina did not resist. Dr. Turner said that he had been happy DCFS was taking action and removing Carolina from her current living situation. He said he thought DCFS would subsequently review the history of the child's situation and make appropriate decisions about her well-being.

Dr. Turner said that he prescribed Augmentin for Carolina's ears, both of which were infected. He said the laceration would heal on its own. He noted that Carolina had an elevated white blood cell count that could be attributed to infection and/or stress. Dr. Turner reviewed a CT scan of Carolina's head sent from Genesee Medical Center. It showed no damage. Dr. Turner ordered a chest x-ray with instructions to release Carolina if it was normal. He told Tina to bring Carolina back for an appointment on October 3, 2000. Dr. Turner saw Carolina on October 3, 2000 with both her parents. Eric appeared to appreciate the care Carolina received. Dr. Turner said that Carolina had improved since he saw her on the 30th.

A woman who was at the Park Hospital emergency room on September 30, 2000 seeking treatment for her mother was interviewed by ISP investigators. The woman said that she observed and overheard interactions between Tina Yardley and Clay Parker. She overheard Mr. Parker tell Tina he was going to take her and Carolina to Tina's mother's house. After Tina heard this, she telephoned an individual the woman believed was Carolina's father. She overheard Tina tell Eric to meet them at her mother's home at which time Mr. Parker interrupted Tina and said Eric could not be around the baby. Tina asked why and Mr. Parker said, "you know why." Tina then told the father, "you need to cut this out or they're going to jerk the baby away from us."

Three of the four law enforcement officers present at Park Hospital the night of September 30, 2000 were interviewed. The officers were present at the hospital at the request of the Acting Chief of Police. The Chief was worried that Eric might come to the hospital to get Carolina. He was anticipating trouble from Eric and requested assistance. The officers had been told by an unidentified nurse and the Chief that Carolina had been sexually and physically abused and had injuries including a laceration to the underside of her tongue. After the Chief spoke with Mr. Parker, he approached the officers and told them that he was leaving. He said Mr. Parker was going to accompany Tina and the baby to her home to pick up some things and take them to another place to stay for a few days. The officers were upset that Carolina was going to remain in her mother's care and felt that Carolina should have been taken into protective custody and placed in foster care.

Analysis

Intact Family Services Prior to Carolina's Injuries on September 30, 2000

Follow-up was involved with the Yardley family for only twelve days when Carolina entered the emergency room with injuries on September 30, 2000. The intact family case was opened for "preventive services" because of Dr. Shaw's concerns about Carolina's medical care, not because of an indicated child abuse/neglect investigation. Thus, it was not considered a high priority case, particularly given the staffing issues at the Genesee Field Office during September 2000.

Only three out of four Child Welfare Specialist IIs were working in the Genesee Field Office. The fourth CWS II had vacated the position on September 1, 2000 and his replacement was scheduled to begin October 16, 2000. Two of the three CWS IIs were out of the office the week of September 18, 2000, when Carolina's case was opened. Connie Pacini had a scheduled out-of-state vacation the week of September 18, 2000 and Rich Fischer was on sick leave because of a serious event that took place over the weekend. Mr. Fischer's absence left one CWS II and the supervisor to cover the caseload of 23 placement cases and 46 intact family cases.[23]

Complicating matters further, the supervisor, Anna Breslin, splits her time between the Genesee Field Office and the Fairport Field Office. She supervises seven child welfare specialists. On September 14, 2000, the Fairport Field Office was notified about a child beaten by his mother's paramour who was not expected to live and who died on September 20, 2000. The Fairport Field Office had previously been asked to complete a service assessment on the family. Ms. Breslin spent a considerable amount of time assuring the safety and care of the surviving children who entered DCFS custody and preparing a chronology of the case for the Office of the Director and the Office of Communications. Thus, the supervisor and her workers were primarily handling crises during the time

[23] Among these cases were reunification and "paramour" cases which require more frequent contact than other cases.

Carolina's case was open for services.

Despite the context in which Carolina's case was opened, Ms. Breslin acted quickly to provide services to the Yardley family. She initiated homemaker services requesting that a homemaker from Family Services be present at the case hand-off from the child protection investigator. At the handoff, Ms. Breslin executed consents for the release and exchange of information between DCFS and other service providers, and she began to gather social history information from Tina.

A more expedient approach could have been taken, however, to address the presenting problem, Carolina's medical care. The primary reason for the case being opened was Dr. Shaw's concern about Carolina's medical needs being met. Dr. Shaw requested assistance from DCFS to monitor Carolina and to ensure she was being taken care of properly, including receiving appropriate medical care. Yet, no one from follow-up spoke with Dr. Shaw. They allowed Tina to advise them of appointments and report her follow-through on Carolina's medical care. In essence, nothing changed after DCFS got involved.

A parent's self-report that a child with medical problems is receiving medical care is an unacceptable mode of verification. The former Family Preservation Program Plan required that parents' assurance that medical care for children with medical problems is occurring be verified from an independent source. "'Verified by an independent source' means the least intrusive of the following: calling the office of the physician involved in treatment, [or] visiting the physician's office with the parent and the involved child" (DCFS Family Preservation Program Plan attached to the Director's April 1, 1997 Memorandum to all DCFS Staff regarding the Transfer of Cook County Intact Family Teams to the Division of Child Protection).

When an infant or vulnerable child's medical condition is high risk, the child welfare specialist should not only verify the child's medical care through an independent source, but should plan for the child's care. At the beginning of the case, the child welfare specialist should contact the treating physician to introduce himself, inquire about upcoming appointments, and ask for a meeting with the doctor, the family, and the homemaker (if one is assigned) to discuss how DCFS, the family, the homemaker, and the doctor can work together to ensure the child receives appropriate medical care.

There appeared to be an assumption in this case by DCFS follow-up and the homemaker agency that Carolina missed her doctor's appointments because of a lack of transportation and if transportation were provided, the problem would be solved. Operating under that assumption, DCFS and the homemaker agency relied on Tina to self-report the dates and times for Carolina's doctor's appointments so the homemaker, Jan Keller, could drive them. However, there was no evidence in the case record that lack of transportation was the issue preventing Carolina from making her doctor's appointments. It was too early in the case history to know why Tina was not keeping the appointments. Several hypotheses could be made including drug use, depression, indifference, and forgetfulness.

Having known the family for such a short time, there was no basis to believe the Yardleys would accurately or honestly inform Ms. Keller about Carolina's appointments. In fact, Carolina had an appointment scheduled at Dr. Shaw's office on Monday, October 2, 2000. Although Tina had told Ms. Keller that she had an appointment on Monday at Public Aid and requested transportation, she had not told Ms. Keller about Carolina's appointment at Dr. Shaw's office that same day and the appointment was not kept. Sadly, had Carolina been seen by Dr. Shaw that Monday (two days after her entry into the emergency room), she might be alive today.

While Tina and Eric's mental health were issues that were discussed at the case hand-off on September 18, 2000,[24] because of staff illnesses and the short duration between referral of the case and the second report, minimal intervention was implemented. Timely intervention in cases presenting mental health issues should include initiating contact with clients' doctors and therapists to obtain information relevant to child safety.[25] Eric sought help for his illness and was honest with his doctor. Like many with Bipolar Disorder, Eric was inconsistent in taking his medication. Still, Eric appeared to be reaching out for help during his doctor visits. In April 2000, Eric made an appointment because he was feeling highly anxious. He told his doctor he was becoming violent at home punching holes in the walls. In June and July 2000, Eric returned to the doctor's office for refills of his medication. In July, he was concerned that the medication was not working. He said he was afraid he might attempt to hurt someone. On September 15, 2000, Eric told the doctor he had stopped taking his medication because Tina got mad at him and threw it away. The doctor gave him samples, but, at the time of Carolina's death, he was not taking the medication. He said he had not been taking it for over a month because he could not afford it.

Currently, there are no available resources or sound procedures for a collaboration and understanding of risks and protective factors of child welfare families with mental health problems in certain rural areas of DCFS Southern region. A series of OIG investigations in these areas has demonstrated that the absence of an expert forensic mental health team capable of a methodologically sound assessment has jeopardized and continues to jeopardize the safety of children who have been indicated for abuse or neglect while being cared for by parents with mental health problems or dual diagnosis. Preliminary discussions with the chairs of the child death review teams for the Southern Region

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[24] However, the extent of Tina's substance use may not have been apparent. Tina denied current drug use and said her use was a one-time occurrence near the time of her drug overdose. Mr. Parker did not refute Tina's account with Dr. Shaw's report that Tina also used cocaine while she was pregnant with Carolina. Follow-up did not have access to Mr. Parker's investigative interview notes as the medical neglect investigation was unfounded and the Abused and Neglected Child Reporting Act (ANCRA) does not allow the sharing of unfounded reports.

[25] The OIG is currently working with the Best Practice Work Group to develop best practice in cases involving mental illness. One of the goals is to design questions appropriate to ask professionals treating clients with mental illness.

indicate that the development of a forensic team with the assistance of Dr. Felthous, [name unchanged] Southern Illinois School of Medicine Department of Psychiatry in Springfield, and Southern Illinois Department of Psychology is possible. Through the pooling of resources, creation of supportive forensic fellowships, and partnering between the University and DCFS, similar to the 1996 partnerships forged with the University of Illinois Chicago Campus Department of Psychiatry, the replication of an empirically based model adapted to the local conditions and needs of the target population of families in Southern Illinois can be accomplished.

Homemaker Services

The homemaker agency, Family Services, was not under the same staffing constraints as DCFS and could have been more effective in this case. The homemaker agency's interventions should have been scheduled in an organized way using DCFS's service request as a guide. In this case, the homemaker, Jan Keller, was assigned to help the family manage their infant's health care as Carolina was born medically compromised and was in need of remedial medical care. The homemaker should have secured needed information such as the name of the primary physician, the address and phone number of the practice, the name of the person who scheduled appointments, a schedule of preventive well-baby exams and immunizations, and details about the necessary remedial medical care.

The family's organizational abilities were questionable. They had missed several medical appointments following emergency room care for Carolina. The family had also missed several nurses' visits while the baby was on oxygen. Tina had refused physical and occupational therapy evaluations recommended for Carolina. She had not responded to numerous contacts from the electric company that her power was being turned off. She had a history of drug problems: cocaine use and an overdose of her husband's psychotropic medication. Eric had a history of psychiatric problems.[26] The household appeared chaotic with numerous people coming and going. Tina and Carolina slept late into the morning. All these observations suggested a problematic, perhaps partying lifestyle.

Ms. Keller was authorized to provide six hours of service per week. A master calendar with critical appointments or tasks was not designed. In addition to medical appointments, there were other routine events to coordinate: daily infant care; WIC appointments; 0-3 services; mother and father's mental health services; and shopping, housekeeping, and laundering.

The homemaker's approach to the family paralleled the family's laissez-faire style. She set no expectations, elicited no clear or concrete understanding of the baby's or family's routine, accepted the mother as the sole informant for the infant's medical appointments,

[26] He also had a history of alcohol abuse and marijuana use, but the homemaker may not have had this information until later in the case. Eric had revealed the history in the first A sequence investigation (involving Tina's care of Tyler), but because the investigation was unfounded, the information was not available.

and haphazardly intervened. She appeared to operate on the assumption that the only obstacle to Carolina's medical care was transportation. As a result, she did not see Carolina on a regular basis. She had not seen Carolina for the ten days between September 18, 2000 and September 29, 2000. *See Table 3.*

DCFS has long used homemakers to assist parents and teach them how to perform tasks that are a part of daily living. Typically, a homemaker has more frequent contact with a family than the caseworker or others working with the family. As a result, homemakers also act as a protective resource for a child by being "eyes and ears" in the child's home. Homemakers tend to be viewed as helpers to families rather than as partners in the provision of services. In this case, Jan Keller's role as a helper was reinforced by Mr. Parker who, after Carolina was injured, asked Ms. Keller to transport Tina and Carolina, but did not ask her about her observations of the Yardley family. Despite being present in the Genesee Field Office, neither child protection nor follow-up asked Ms. Keller to take part in the sharing of information at the staffing following Carolina's injuries.

Table 3: Homemaker's Contacts with Yardley Family from Case Opening to Child's Death

Date / Time	Purpose of Contact	Those Present	Activity	Saw Carolina Yes/No
Monday 9/18/00 2:30 p.m.	Case Hand-off from Child Protection Investigator	Jan Keller, Anna Breslin, Clay Parker, Tina and Carolina Yardley	Ms. Keller held and played with Carolina while facts of case and history were exchanged and services were explained.	Yes
Tuesday 9/19/00 12:45 p.m.	Transportation	Jan Keller, Tina Yardley *Infant not seen*	Ms. Keller took Tina to fill a cough medicine prescription for Carolina. Went to doctor's office for samples; Ms. Keller waited in car.	No
Wednesday 9/20/00 12:15 p.m.	Transportation	Jan Keller, Tina Yardley *Infant not seen*	Ms. Keller took Tina to WIC to take class & pick up coupons, stopped at grocery store.	No
Wednesday 9/27/00 9:30 a.m.	Attempted home visit	Jan Keller, Wendy Peters (roommate) *Infant not seen*	Wendy told Ms. Keller Tina and Carolina were still asleep. Ms. Keller said she would return the following day.	No
Thursday 9/28/00 3:30 p.m.	Attempted home visit	Jan Keller, Wendy Peters (roommate) *Infant not seen*	Wendy told Ms. Keller Tina, Carolina, and Eric went shopping with Eric's grandfather. Ms. Keller said she would return the following day.	No
Friday 9/29/00 8:45 a.m.	Home visit Transportation	Jan Keller, Tina and Carolina Yardley, Wendy Peters, and possibly Eric Yardley *Infant seen by Ms. Keller in A.M. and nurse, Ms. Fischer in P.M. Baby had no visible bruises.*	Ms. Keller arrived at home to find electricity had been turned off. Took Tina to post office to get registered letter from electric company and to doctor's office for note that needed electricity for Carolina's oxygen.	Yes
Monday 10/2/00 8:00 a.m.	Transportation	Jan Keller, Tina and Carolina Yardley, Tina's mother	Ms. Keller picked-up Tina and Carolina from Tina's mother's home to transport them to Public Aid Office.	Yes
Tuesday 10/3/00 2:30 p.m.	Transportation	Jan Keller, Tina, Eric, and Carolina Yardley	Ms. Keller picked-up Tina, Eric, and Carolina to take them to follow-up appointment at Dr. Turner's office.	Yes

B Sequence Child Protection Investigation of Carolina's September 30, 2000 Injuries
Twelve days after Mr. Parker completed the A sequence investigation of medical neglect, Carolina, just four months old and weighing 13 pounds, entered the hospital with injuries on nine sites of her body: her nose, upper lip, under her tongue, her left ear, upper mid-to-right side of back, left foot, right cheek, right forehead, and back of head. Cuts and bruises on such a young infant are highly suspicious for abuse because children of that age are non-ambulatory and cannot cause such injuries to themselves (Carpenter, 1999; Sugar, Taylor, Feldman, & Puget Sound Pediatric Research Network, 1999). (*See Section entitled Research on Bruises on page 48*).

The treating physician, Alice Ritter, was suspicious of Carolina's injuries. She had strong concerns for Carolina's safety. Reasons for her concern included: the extent of Carolina's injuries; Tina's inability to explain the injuries despite having said she was with Carolina for the entire 48 hours before bringing her to the hospital; Tina's desire to take Carolina home instead of seeing Dr. Turner; and Tina's hostility toward staff.

Perhaps Clay Parker's greatest error in the B sequence investigation, was not conducting a complete interview with Dr. Ritter prior to making his decision to not take protective custody of Carolina. Mr. Parker spoke briefly with Dr. Ritter when he learned of the report, and he took brief notes. The focus of the conversation was on Carolina's transfer to Park Hospital for a consultation by Dr. Turner for possible surgery. Mr. Parker did not contact Dr. Ritter again that night, despite having the opportunity to call her when he arrived at Park Hospital while he waited for Tina and Carolina to arrive *and* after Carolina was seen by Dr. Turner while he was waiting for Carolina's release. Mr. Parker told OIG staff that he would have contacted Dr. Ritter prior to the completion of the investigation, but Carolina's next entry into the emergency room happened so quickly. Mr. Parker said he would have asked Dr. Ritter why she did not take protective custody of Carolina if she thought the injuries warranted it. Mr. Parker appeared to rationalize his own failure to take protective custody of Carolina by saying that Dr. Ritter did not take protective custody.

Dr. Ritter did what was required of her as a mandated reporter. She contacted the DCFS hotline to report suspected abuse. Dr. Ritter also acted appropriately as a doctor. She took a CT scan of Carolina's head and ruled out head injuries (Shaken Baby Syndrome).[27] She documented Carolina's injuries with photographs. She requested that Carolina be seen by an ear, nose, and throat specialist at Park Hospital because of her concern about Carolina's tongue injury. She contacted the police because Tina was upset that the doctor implied that Tina caused Carolina's injuries and because Tina resisted taking Carolina to see Dr. Turner. Dr. Ritter arranged for Carolina to be transported to Park by ambulance because she was worried that Tina would not take her there. She called ahead to advise hospital personnel not to allow the parents to leave with Carolina prior to DCFS getting there. It would not have made sense for Dr. Ritter to take protective custody of Carolina when she was sending her to another hospital. Dr. Ritter knew that DCFS was acting quickly on the

[27] Dr. Ritter did not request a skeletal survey (bone scan) of Carolina.

report; Mr. Parker immediately contacted her after receiving notification of the report and told her he would meet Carolina and Tina at Park Hospital.

Mr. Parker decided not to take protective custody of Carolina and to implement a weekend safety plan after he interviewed Tina. Although Tina was not able to give explanations for Carolina's injuries to hospital personnel, she did have explanations for Mr. Parker. Tina explained the injuries by blaming some on Carolina for causing them to herself and blaming herself and Eric for causing some of them accidentally. According to Tina, Carolina cut her tongue on her pacifier, cut her foot with her own toenails, and got "rug burns" on her nose from rubbing her face on the sheets. Eric cut Carolina's lip by throwing her in the air and accidentally letting her hit his shoulder and caused bruises to her back by patting her too hard.[28] She or Eric may have caused the bruise to Carolina's ear when they held her head to look in her mouth at her tongue. Instead of critically examining the likelihood of the injuries occurring in the manner described, questioning the likelihood of a four-month-old, thirteen pound infant injuring herself, or inquiring why Tina had not been able to explain Carolina's injuries to hospital personnel, Mr. Parker jumped to the conclusion that the explanations given by Tina were true and decided Carolina would be safe in her care. Mr. Parker told OIG staff that, although Carolina's injuries seemed to be extensive – he had never had an investigation involving a child with so many bruises - the explanations made sense.

Following his conversation with Tina, all of Mr. Parker's behaviors were driven by his operating assumption that Carolina's injuries were the result of self-injury and accidents. Mr. Parker believed that if he removed Tina and Carolina from Eric for the weekend, on Monday, follow-up staff could begin working to correct Eric's rough behavior toward Carolina.

Mr. Parker used Dr. Turner's examination of Carolina to support his conclusion that Carolina's injuries were the result of self-injury and unintentional injuries by Eric. Mr. Parker ignored Dr. Turner's cryptic statement that Carolina had more injuries on her than his daughters had in thirteen or fourteen years. He did not ask Dr. Turner to elaborate and he did not include the statement in his initial notes of his conversation with Dr. Turner. He did, however, record that Dr. Turner said Carolina "could possibly get pacifier into mouth and cause cut to the tongue".[29] That Carolina injured herself was a *possible* explanation for the injury did not make it the true explanation or even a *probable* or *plausible*

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[28]Tina told Mr. Parker that she had told Ms. Keller that Carolina had a cut lip from hitting Eric's shoulder and that she thought she told Ms. Keller about the bruises on Carolina's back from Eric patting her too hard, but while talking with Ms. Keller, Mr. Parker did not attempt to verify the statements.

[29] After Carolina's death, Dr. Turner acknowledged that he told Mr. Parker that it was possible the pacifier caused the injury. Dr. Turner told Illinois State Police investigators that he told Mr. Parker that the pacifier could have been jammed in her mouth, or she could have been hit in the mouth while the pacifier was inside her mouth, or she could have fallen on her face on the pacifier. None of these possibilities were mentioned in Mr. Parker's or Dr. Turner's notes and a credibility determination was not made by OIG staff.

explanation. The *possible* explanations for Carolina's tongue injury were countless. Whether a particular explanation was possible was not the correct question. However, it was a question that would support Mr. Parker's determination that the tongue injury was self-inflicted. The correct question was whether the explanation was the probable or most likely explanation for Carolina's injury. The answer to that question would have been, or should have been, no.

The more probable explanation for Carolina's tongue laceration was that another person jammed something into the baby's mouth and caused the injury. According to the American Association for Protecting Children (1989), the mouth is an easy target for physical abuse due to its physical significance in feeding and communication. Crying is the most common precipitant of serious physical abuse (Schmitt, 1987). Injuries to the frenula (the small folds of skin which connect the lips to the gums and connect the tongue to the floor of the mouth) are very frequent in abuse and should arouse suspicion (American Association for Protecting Children, 1989). A lacerated frenulum can occur from a direct blow to the face or from the jamming of an object such as a spoon, bottle, or pacifier into a resistant child's mouth (American Association for Protecting Children, 1989; Schmitt, 1987; DCFS Specialized Curriculum Indicators of Abuse/Neglect: Trainer's Notes; Illinois Child Protective Services Handbook, 1990). This type of injury cannot be accidental until the baby is old enough to sit up and fall forward (DCFS Specialized Curriculum Indicators of Abuse/Neglect: Trainer's Notes). Infants less than six months old will not incur such accidental injuries (Illinois Child Protective Services Handbook, 1990). Carolina did not have the fine motor skills necessary to grasp the pacifier and put it into her own mouth. She also was not able to sit up alone so she would not have been able to fall over onto the pacifier and get it jammed into her mouth. Research on pacifier injuries does not support Mr. Parker's supposition that the pacifier cut Carolina's tongue on its own *without force*.[31]

Dr. Turner's primary focus as an ear, nose, and throat specialist was the consultation

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[30] A developmental assessment conducted September 30, 2000 at Genesee Medical Center found that Carolina did not have the fine motor skills to grasp objects voluntarily.

[31] Pacifiers generally do not injure babies on their own. A review of pacifiers recalled by the U.S. Consumer Product Safety Commission (CPSC) since 1990 found that the vast majority of pacifier recalls stemmed from concerns regarding the tendency of various pacifiers to separate into their smaller component parts. These smaller pieces presented potential choking hazards for babies. Of the 19 pacifier recalls issued since 1990, 14 occurred solely because the pacifiers in question were prone to separating into smaller pieces. In two other cases, the same problems contributed to CPSC decisions to issue recalls. Other reasons cited included the lack of ventilation holes in pacifier shields and the absence of printed messages on packages warning parents not to tie pacifiers around their babies' necks. In one case, a pacifier was recalled because the shield was able to penetrate too far into babies' mouths, however this was viewed as a danger because the shield also lacked ventilation holes, presenting a suffocation hazard. Carolina's pacifier, which was kept by Mr. Parker, was a Nuk brand pacifier with ventilation holes. Although one CPSC recall in 1994 involved Nuk brand pacifiers produced by the Gerber company, it was issued because of the pacifiers' tendency to separate into smaller pieces. There is no record of any pacifier being recalled as the result of concern over it's potential to cause lacerations inside babies' mouths.

requested by Dr. Ritter to determine whether Carolina needed surgery to repair her tongue. While Dr. Turner did discuss Carolina's other injuries with Tina and Mr. Parker, he was not aware that his statements or non-statements about them would be used by Mr. Parker to corroborate his decision to leave Carolina in her parents' custody. In fact, Dr. Turner told an Illinois State Police investigator that he overheard Mr. Parker talking to Tina and knew the plan was for Tina and the baby to stay at Tina's mother's home for a couple of days. Dr. Turner thought the plan to remove Carolina from her current living arrangement was appropriate until DCFS could obtain further information.

Dr. Turner was never given the opportunity to refute Mr. Parker's conclusions about Carolina's injuries or clarify that he was not an expert in child abuse and neglect. Mr. Parker should have had a private discussion with Dr. Turner, outside Tina's presence, to explain his role as a child abuse and neglect investigator; to give Dr. Turner some history about the Yardley family; and to advise him that he was planning to make a decision about Carolina's custody based on Dr. Turner's assessment of her safety and whether or not he thought she was abused. Instead of being direct with the doctor, Mr. Parker "interviewed" Dr. Turner through the mother by telling her to tell the doctor about each of Carolina's injuries. He requested a copy of Dr. Turner's notes asking him to include in them anything that seemed "out of the way".

In his interview with OIG staff, Mr. Parker described himself as a "layman" hoping to make the best calls with the information provided to him by medical professionals. However, Mr. Parker is not a layman. As a CPI with 11 years of experience, Mr. Parker should have been able to recognize that the sheer number of injuries on this four-month-old baby made her unsafe in her environment. The number of injuries in conjunction with known risk factors made her that much more unsafe. While Mr. Parker did not actively attempt to gather information about social stressors, he was aware of numerous risk factors: Eric and Tina were young; Eric had problems with alcohol and had been drinking the afternoon Carolina entered the emergency room; Tina was a drug user who had tested positive for cocaine in the past; Dr. Shaw was concerned about Tina's drug lifestyle and the number of people in and out of her home; Eric had Bipolar Disorder; Tina had recently overdosed on Eric's medication; and Carolina had a medical condition for which she needed increased care and attention. When interviewing medical personnel, a child protection investigator should not "check his own knowledge at the door," but should use it to formulate the questions asked, decide upon the facts shared, and assist the doctor in formulating an opinion about whether injuries were inflicted, caused unintentionally, or were the result of a disease process mimicking injury.

Carolina had three fingertip-like bruises near her right shoulder. Tina explained that Eric caused the bruises by patting Carolina too hard on the back. Mr. Parker said he could see this happening due to Eric's lack of knowledge about how to care for a baby. He was not suspicious of the explanation, although grab marks or fingertip bruises are indicators of shaking, not patting. Normally, people pat babies with an open hand. Fingertip bruises from shaking are usually found on the upper arm, shoulder, or extremities, most commonly

on children who cannot yet walk (DCFS Specialized Curriculum Indicators of Abuse/Neglect: Trainer's Notes). The original report by the hospital stated that Carolina may have been shaken, yet Mr. Parker dismissed this possibility. Mr. Parker did not ask Dr. Ritter whether Carolina may have been shaken. He did not ask her whether Tina had given her the same explanation for the bruises, or whether the explanation was reasonable. Mr. Parker did not ask Tina questions such as who witnessed Eric patting Carolina too hard, what Carolina was doing at the time, how many times it had happened, what she did to stop it, and when the marks appeared. Mr. Parker also did not ask the father, the roommate, and the homemaker these same questions to collaborate or cast doubt on Tina's explanation.

Two of the primary tasks in a child abuse and neglect investigation are to assess a child's safety in his environment and to determine whether there is credible evidence of abuse or neglect. A child protection investigator must be able to support his conclusions and there are a variety of strategies to increase the credibility of a conclusion. Social scientists, anticipating researcher bias and the effect the researcher has on the subject being interviewed, attempt to put in place "controls that deal with both anticipated and unanticipated threats to validity" (Bickman & Rog, 1998, p. 91). The following, taken from Bickman and Rog (1998), are a few of the techniques that can be used by investigators to prevent inadequately supported conclusions.

Informant interviewing emphasizes using multiple sources and making efforts not to over rely on a single source (who may be answering questions based on what they believe the investigator wants to hear). In this case, Mr. Parker over relied on Dr. Turner who was the medical professional least qualified to make an assessment of the family and the presenting circumstances. *See Table 4.*

Since investigators also have a tendency to notice supporting evidence and overlook contradictory information, it is important to systematically look for discrepant evidence and determine if the conclusion is more plausible than the alternatives. In this case, Mr. Parker looked for supporting evidence of Tina's explanation that the bruise on Carolina's ear was from she or Eric holding Carolina's head to look in her mouth by observing and noting that the nurse had a difficult time holding Carolina's head still for Dr. Turner's examination. However, Mr. Parker disregarded Dr. Turner's comment about Carolina having more bruises than his daughters had in thirteen or fourteen years.

A third technique, triangulation, involves "testing one source of information against another to strip away alternative explanations and prove a hypothesis," by comparing differing sources of information to test both the quality of information and the source (Bickman & Rog, 1998, p. 495). Here, Mr. Parker could have compared the information provided to him by Tina with the information she gave to Dr. Ritter. He also could have tested the information provided to him by Dr. Turner by interviewing Dr. Ritter.

Researchers also systematically solicit feedback from a variety of people, including the

participants in a study, to test bias, assumptions, or flaws in a method of logic. In the present case, Mr. Parker could have restated for Dr. Turner what he believed the doctor was saying, told the doctor how he planned to use the information, and given Dr. Turner the opportunity to refute Mr. Parker's conclusions or clarify his level of expertise in child abuse and neglect. While none of these techniques guarantee that an investigator will arrive at the most accurate conclusion, incorporating these methods aids an investigator in fighting potential bias and "ultimately to put the whole situation in perspective" (Bickman & Rog, 1998, p. 495).

Table 4: Medical Sources of Information

Source	What Parker knew about doctor	What Parker did not know, but could have obtained by interview
Dr. Ritter	• Observed infant in emergency room • Contacted hotline because of suspicion of abuse • Saw mother in emergency room and witnessed mother's behavior • Given history by mother that she was with child for 48 hours prior, but no explanations for injuries • Requested police escort	• Tina's explanations to Mr. Parker were inconsistent with Carolina's injuries • Infant was sent to hospital by ambulance because of her fear Tina would not take her • Dr. Ritter had documented infant's injuries with photographs
Dr. Turner	• Was an ear, nose, and throat specialist • Purpose of exam was consultation for need for surgery on tongue • Never met family before • Did not know family's risk factors • Did not know Carolina's primary physician had previously expressed concern about infant's care • Did not observe mother's behavior in ER	• Was not expert in child abuse and/or neglect
Dr. Shaw	• Had history with Tina and Carolina; was Carolina's primary physician and was Tina's doctor in emergency room when she overdosed on husband's medication • Was concerned about Tina's ability to care for medically compromised infant based on mother's drug use (cocaine), erratic behavior (overdose on husband's psychotropic medication), inconsistent availability for home health care, and missed two medical appointments • Made hotline report and requested monitoring of family by DCFS	• Dr. Shaw was trained to recognize child abuse and neglect • Tina's explanations for Carolina's injuries were improbable causes

Mr. Parker acknowledged in his interview with OIG staff that he could have taken protective custody of Carolina that night based on her injuries. He explained that he did not feel it was appropriate to take the baby from her mother at that time because Tina was willing to comply with a safety plan for her and Carolina to stay at her mother's home for the weekend. He did not feel that Tina was a threat to the baby, and Tina's mother would monitor the two until they returned home. Mr. Parker said he wanted to maintain family harmony and take the least intrusive measures possible. There were at least three things wrong with this rationale. First, compliance does not equal safety. *Compliant parents can be abusive parents*. Mr. Parker had been investigating Carolina's injuries for less than five hours. He did not have adequate information that night on which to base his decision that Tina was not a threat to Carolina. If anything, Mr. Parker had information from the A sequence investigation that Carolina was at risk with Tina. Second, the safety plan automatically ended on Monday providing no protection to Carolina. Even if Mr. Parker accepted the explanations given by Tina for the injuries and believed that they were the result of ignorant caretaking by Eric, Eric was not likely to change his behavior by Monday and Tina was not likely to prevent the behavior as she had failed to prevent it in the past. DCFS Intact Family Services had also been unable to prevent Carolina's injuries by their presence in the family's life. Third, Mr. Parker did not conduct a background check (CANTS and LEADS) on Tina's mother to determine whether she was an appropriate safety monitor for Tina and Carolina.[32]

A more prudent course of action for Mr. Parker to take would have been to take protective custody of Carolina and place her with a relative on whom appropriate background checks were completed. After further investigation, Mr. Parker could have let protective custody lapse if facts warranted it. Alternatively, Mr. Parker could have implemented a safety plan with the Yardleys whereby the relative would care for Carolina pending further investigation. The critical point is that such a young infant with such numerous injuries required a more intrusive, not less intrusive, safety measure pending further investigation.

Although Mr. Parker was at the very beginning of the investigation, he had decided to accept Tina's explanations that Carolina's injuries were accidental instead of remaining open to the competing hypothesis that they were inflicted injuries. As a result, Mr. Parker never *investigated* the explanations given by Tina. He did not use investigative skills such as observation and knowledge about human behavior and child development. He did not obtain a thorough history. DCFS training materials instruct that obtaining a history of injuries is critical to a child abuse/neglect investigation. A history includes how the incident leading to an injury occurred: the informant, date, time, place, sequence of events, height of pertinent objects, surface of impact, other people present, length of time between injury and medical attention, and any other relevant facts. While the materials suggest that the physician should obtain this information from parents in separate interviews

[32] The LEADS Protocol (Administrative Procedure #6) requires a LEADS check on all adults in the home when a safety plan involves placement with an unlicensed relative (AP #6, Section 6.5(b)).

immediately before the parents have time to think of explanations, the material is relevant to child protection investigators as well (DCFS Specialized Curriculum Indicators of Abuse/Neglect: Trainer's Notes). In fact, comparing information given to hospital personnel with that given to DCFS is one way to assess parents' credibility. In this case, Tina gave different histories to Dr. Ritter and Mr. Parker.

Mr. Parker ignored opportunities to investigate this case. Instead of actively seeking out information from people, Mr. Parker engaged in form over substance by acting as a "statement-taker" who felt no urgency to gather information. This approach is exemplified by the following examples:

1. Mr. Parker was aware that police officers were present at Park Hospital. Yet, he never interviewed the police officers to find out what they might know. Mr. Parker told OIG staff that one officer said the doctor was afraid Tina would not go to the hospital, but he was not really sure why the police were there.
2. Mr. Parker called Jan Keller at 3:05 a.m. to tell her to pick up Tina and Carolina at Tina's mother's home the next day. Instead of asking Ms. Keller on the telephone about injuries or concerns about the parents' caretaking, he told Ms. Keller to make notes about any marks she had seen on the baby and when she saw them and that someone would be in touch. Earlier, Tina had informed Mr. Parker that she had previously told Ms. Keller that Carolina had a cut lip from hitting Eric's shoulder, but Mr. Parker did not attempt to verify this with Ms. Keller.[33]
3. Mr. Parker waited in the car with Carolina outside the Yardleys' apartment while Tina went in to gather some things to take to her mother's house. Eric came out to see Carolina and, instead of interviewing him about Carolina's injuries, Mr. Parker told Eric someone would be by to talk to him on Monday.

Mr. Parker further engaged in form over substance when completing a substance abuse screen and CERAP on Tina. In the adult substance abuse screen dated October 1, 2000 and signed by Clay Parker, Mr. Parker answered "no" to every question on the screen so that it was not a reflection of reality. Mr. Parker knew that Tina had admitted to using drugs on at least one occasion, she tested positive for cocaine on at least one occasion, she admitted to using cocaine while pregnant with Carolina, and she had been identified by Dr. Shaw as having a drug lifestyle. Yet, Mr. Parker did not indicate this history anywhere on the substance abuse screen. Despite this history of drug use, Mr. Parker also did not indicate it as a safety factor on the CERAP he completed the night of September 30, 2000. Both of these forms were incongruent with the Family Assessment Factor Worksheet Summary Mr. Parker completed on September 18, 2000 in the prior investigation which rated Tina's substance misuse as a high risk factor.

CERAP Safety Plan

[33] If the only purpose of calling Ms. Keller was to tell her to pick up Tina and Carolina at Tina's mother's home, he could have waited until the next day and not woken her up in the middle of the night.

The safety plan was poorly designed to expire automatically on Monday, October 2, 2000 with no change in the conditions of the family or the home. The safety net of a supervisor approving Mr. Parker's CERAP safety plan failed in this case. When he approved the safety plan, the on-call supervisor, John Garrett, was not aware that Mr. Parker had written it to automatically expire on Monday. When he saw and signed the safety plan on Monday, he may reasonably have assumed that a new safety plan would be implemented that day. However, Mr. Parker never wrote another safety plan, and he did not tell his supervisor, Brett Walters, that the safety plan ended on Monday. Mr. Walters never saw the safety plan.[34]

As the child *protection* investigator, Mr. Parker should have taken the lead in assuring Carolina's safety. He, not follow-up, should have been responsible for implementing any CERAP safety plans until the investigation was completed. The most effective assessment of safety involves the continuous process of weighing each new piece of information against what the investigator already knows (Intact Family Services Handbook, May 1, 2000). Thus, the CERAP safety plan could change at any time based on new information, including the necessity of taking protective custody which follow-up staff cannot do.

Mr. Parker's failure to tell Mr. Walters that the safety plan had expired was probably not intentional. In his mind, the injuries were not abusive, so there was no reason for an extended safety plan. He had told follow-up about the new report and expected them to address the problem. Mr. Parker was operating under the belief that advising follow-up about the new issues in the home was equivalent to taking away the safety risks to the infant. Yet, there was no service follow-up could implement in the home on an immediate and continual basis that could ensure Carolina's safety. The safety plan developed by follow-up was that Eric "agree[d] not to drink alcohol" and "agree[d] not to throw the baby in the air". Safety tasks of this type, while well-meaning, are worthless. They control nothing and are dangerous because they give workers a false sense of security. There is no guarantee that the clients will follow the safety plan, and experience tells us that families frequently do not follow the safety plan. To be effective, safety tasks must control the *cause* of the potential abuse (Intact Family Services Handbook, May 1, 2000). The presumed cause of Carolina's injuries was Eric's rough treatment. Operating under this presumption, DCFS should have controlled Eric's access to Carolina. Practically, this would have required placing Carolina with another caretaker because there could be no guarantee that Tina would prohibit Eric's access to the infant.

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[34] The weekend of Carolina's injuries was the first weekend of a new on-call system. Under the old system, every supervisor was on-call every weekend for his worker who may have been on-call. Under the new system, the supervisors rotate weekends with one supervisor on-call for the worker on-call in the subregion. During this first weekend, the on-call supervisor was responsible for verbally approving the Yardley CERAP Safety Plan and signing it on Monday morning. Since Carolina's death, the system has been refined so that the on-call supervisor *and* the regular supervisor sign the Safety Plan. If the regular supervisor is uncomfortable with the Safety Plan, he can design a new one, but he must obtain the on-call supervisor's approval of the new plan.

Mr. Parker and his supervisor staffed the investigation by telephone on Monday, October, 2, 2000. Believing that Carolina and Tina were staying with Tina's mother, Mr. Walters instructed Mr. Parker to interview Eric Yardley and Wendy Peters as soon as possible to obtain their versions of events. Mr. Parker did not interview either of them and spent the majority of the day in the office. On Tuesday, October 3, 2001, Mr. Walters again directed Mr. Parker to interview Eric and Wendy. Mr. Parker attempted a visit to the home on Tuesday afternoon, but Ms. Keller had taken the family to Carolina's follow-up appointment with Dr. Turner. Mr. Parker tried phoning the apartment on October 4, 2000, but got no response. During this time, he did not conduct any other investigative activities. He did not follow up with Dr. Ritter or the reporter, the nurse. He did not conduct a LEADS check on Eric. He did not check on the safety of Brian Peters, another child in the Yardley home, despite having knowledge that Brian lived in the home.[35]

Monday, October 2, 2000 Staffing Between Child Protection and Follow-up

On Monday morning, October 2, 2000, Mr. Parker staffed the case with child welfare supervisor Anna Breslin and child welfare specialist Rich Fischer. At that time, Mr. Fischer had never met the family and Ms. Breslin had met the family once on September 18, 2000 at the face-to-face handoff in the Yardley home. At the time of the staffing, Mr. Parker, through his two investigations involving the Yardleys, possessed the most knowledge about the family and Ms. Breslin and Mr. Fischer deferred to his lead. Mr. Parker told Ms. Breslin and Mr. Fischer about the new report. He told them that the doctor said Carolina's injuries could have occurred the way Tina said they did. Mr. Parker also said he felt the injuries could have happened due to the parents' ignorance about how to care for a small child. Ms. Breslin and Mr. Fischer were left with the understanding that the doctor had opined that Carolina's injuries were not because of abuse, but were the results of accidents and rough treatment that could be rectified through education. They were aware that a safety plan had been implemented over the weekend and that Tina and Carolina were going back home. Both were left with the impression that the safety plan had been implemented because the electricity had been turned off in the Yardley apartment, and Tina and Carolina were being allowed to return because the electricity was being turned back on.

Intact Family Services Following Carolina's Injuries

Ms. Breslin and Mr. Fischer, believing that ignorant caretaking was the problem, discussed educating the family, increasing homemaker hours, and possibly referring the family to more intensive services. Mr. Fischer visited the family at home that afternoon. He implemented a safety plan that addressed three issues he believed were risks to Carolina's safety: Eric's drinking while taking medication for bipolar disorder, Shaken Baby Syndrome, and Sudden Infant Death Syndrome (SIDS). His case entries reflect good

[35] Mr. Parker informed OIG staff he did not think he was going to keep the Yardley investigation because he believed he had reached his monthly total of reports. Mr. Walters, however, instructed Mr. Parker to perform interviews on the case which should have caused Mr. Parker to reconsider his belief that the Yardley investigation would not be assigned to him.

attempts on his part to educate the family about Shaken Baby Syndrome and SIDS.[36]

Self-Report

Everyone in this case relied on self-report to the detriment of the primary client, Carolina. Mr. Parker relied on Tina's self-report about the causation of Carolina's injuries. Ms. Keller relied on Tina's self-report about Carolina's medical care. Reliance on self-report is an on-going problem. Clients have multiple reasons to lie to DCFS: fear that their children will be taken away, not wanting to feel judged, to protect a loved one, to appear socially acceptable, etc. As pointed out in the Jessica Brown [redacted name] investigation, workers may rely on clients' self-report because they feel restricted by confidentiality or time constraints. Some workers may never have been taught the importance of verifying clients' accounts. Whatever the reason, reliance on self-report has to end. We do our families, and especially our children, a disservice by not verifying the accuracy of the information they provide us.

Clay Parker

Estimates based on Mr. Parker's time sheets for field hours during the months of August, September, and October 2000 show the DCP investigator consistently spent the majority (80%) of his regular work time in the office. He spent limited time in the field. During October, Mr. Parker had an all time high of 22 reports to investigate, as he was covering for a co-worker on medical leave. Because of the increased demand of investigations, one could expect increased time in the field with the concomitant overtime in the field. This was not the case. Mr. Parker spent less time in the field during Ms. Brown's absence in October. In October, Mr. Parker requested 22½ hours overtime for "paper overload 22 pending cases . . . paper chase overload . . . writing reports" and four hours for covering the Genesee office as the only CPI in the office and staffing time with his supervisor. His supervisor approved 18 hours of overtime for the increased paperwork. By comparison, his requested and approved field overtime was 9½ hours. By November 2000, Mr. Parker had accumulated over 70 hours in compensation time, the majority of which was for "paperwork".[37]

Actual time on investigative interviews in the field during Mr. Parker's regularly scheduled

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[36] It should be noted, however, that Mr. Fischer and later, Ms. Keller were misguided in their attempts to educate the Yardleys about Shaken Baby Syndrome. Contrary to popular belief and an Illinois advertising campaign, babies are not fragile. Although defense attorneys argue it, babies do not get Shaken Baby Syndrome from being tossed into the air, or bounced on a knee, or from resuscitation efforts. Violent shaking causes Shaken Baby Syndrome. The shaking must be of such force that a lay observer would recognize it as likely to be harmful to the child. Certainly, families should be educated not to shake babies. And, of course, babies should not be handled roughly. It is frightening for them, and rough treatment may result in other types of injuries. Workers should always provide SIDS and "Back to Sleep" education when an infant is in the home.

[37] Despite the amount of time spent on paperwork, Mr. Parker's case entries are not comprehensive. They are "bottom line" accounts of his interviews in which details are omitted. This is demonstrated by a comparison of Mr. Parker's interviews with Dr. Ritter and Dr. Turner prior to Carolina's death and the more comprehensive entries he was asked to complete after her death.

hours is less because the field hours charted included travel time and attempts at contacts. Of his unfounded September cases (A - cuts welts and bruises, B - risk of harm, C – expunged, D - expunged, D - cuts welts and bruises, A - cuts welts and bruises, A - expunged), Mr. Parker spent less than an hour conducting field interviews in two cases, less than 2 hours on three cases, and 2 hours and 10 minutes on the remaining case. His regular work time sheets show a low rate (less than 17-21%) of investigative field activities. For example, on October 11, Mr. Parker reported he spent 7½ hours in the field including 3 hours of overtime. In his overtime request, he stated he had to find involved children, do CERAPS on existing cases, and assess safety on others. The Genesee Field Office covers a large geographic area stretching a circumference of 80 to 100 miles. Mr. Parker's activity report documented that he traveled over 140 miles on October 11. Travel time would have absorbed close to 40% of the 7½ hours of field time (based on an estimate of 50 miles per hour) leaving Mr. Parker an estimated 4½ hours to conduct all the critical child protection tasks he noted.

Mr. Parker's pattern on regular week-day investigative assignments include short durations for investigations and low intensity, low frequency field interviews. This may be the result of the extraordinary amount of weekend and holiday work and paperwork. Thorough and thoughtful investigations require in depth field interviews. An exhausted, overburdened investigator is more likely to superficially skim through investigations and quickly pass the case to follow-up. Management should determine what hours need to be expended for weekend child protection investigations and hire staff accordingly. Mr. Parker's personnel file contains numerous mentions by his supervisor of the demanding duties of weekend child protection work. Overtime should be reserved for emergencies and unpredictable circumstances. Other public services such as police, paramedics, and fire departments arrange for seven day availability without depending routinely on taxing overtime work.

Paired Team Approach

Carolina's death was a painful experience for everyone in the Genesee Field Office. It was apparent in interviews with staff that they are feeling overwhelmed by the numbers and types of cases being opened for services. Substance abuse has increased in the subregion and staff are trying to learn how to deal with it. Many of the workers have had serious illnesses in the past year that may be stress-related. Staff discussed wanting to practice good social work, but being unable to because of the distances they travel, the number of cases, and the amount of paperwork.

Ms. Breslin felt that the lack of a supervisor in the office full-time may have contributed to the failures in Carolina's case. She commented that the office is going to a paired team approach where investigative staff and follow-up staff will be under one supervisor who is in the office full-time. She stated her hope that the paired team approach would prevent another tragedy from happening.

In 1999, Hornby Zeller Associates produced an evaluation of Child Protection's Front End Redesign pilots. The intent of the Redesign, according to the evaluators, was to create an

environment at the time of the investigation that permitted and encouraged workers to offer services to the families while an investigation was still underway. The evaluators noted several findings that related directly to the Downstate region. First, there was a shortage of investigators in the Downstate region - not enough people to get the work done. Second, while the Downstate paired team pilots ensured early delivery of services and a larger share of case openings prior to the investigation being closed, there was a safety concern. The Downstate paired team models experienced the largest increase in reabuse in the statewide pilot project. The evaluators understood there was no simple explanation for the phenomenon. Nevertheless, they issued a caution since the basic purpose of child protection is child safety: "The last recommendation, therefore, is that **prior to implementing the Paired Team model on a wider basis, DCFS should examine the reasons behind the increase in subsequent indicated reports among Paired Team pilots**. There is no basis for deciding in favor of a model which is ineffective in preventing subsequent abuse and neglect, when that is the primary mission of the agency" (Hornby Zeller Associates Executive Summary, p. vii-viii, emphasis in original).

Research on Bruises

Mr. Parker appeared unaware throughout the investigation of the significance of bruises in infants. The number of bruises on a perambulatory infant raised concerns in this case and the Mathew London [redacted name] case. Misunderstandings about color patterns and aging of bruises in children created errors in both this case and the Jessica Brown [redacted name] case. In the present investigation, bruising on Carolina's ear was aged differently by three different people: Dr. Ritter described it as old; Mr. Parker described it as fresh; and Dr. Turner described it as 1-2 days old. Because of these discrepancies, the OIG conducted a literature review on children's bruises. A summary of the review follows.

Prevalence of Bruises in Infants and Toddlers

Sugar and colleagues, in a 1999 study to establish normal baseline data on the prevalence of bruises in infants and toddlers younger than 3 years, found that bruises are extremely rare in normal infants who are younger than 6 months and are very uncommon in perambulatory infants who are younger than 9 months. In a sample consisting of 973 infants and toddlers aged one day to 35 months and for whom abuse and medical conditions were not suspected, bruises were noted on 203 (20.9%) of the total sample of children. Infants between 6 and 9 months of age may develop bruises as they begin to "cruise". The age of 9 months is a reasonable guideline for judging whether bruises are likely to be developmentally appropriate, accidental injuries (Sugar, Taylor, Feldman, & Puget Sound Pediatric Research Network, 1999).

The presence of bruises was associated with child age and developmental stage. With regard to age, bruises were rare in infants younger than 6 months. Only 2 infants out of 366 (0.6%) had bruises; these children each had a bruise on the scalp. In the group of children aged 6 through 8 months, 6 out of 107 (5.6%) had bruises. The presence of bruises was also correlated with developmental stage. Only 2.2% of precruisers (those not walking) had any bruises; 17.8% of cruisers (those walking with support) had bruises; and

51.9% of walkers (those walking independently) had bruises. Within every chronological age group, infants who were walking had bruises more frequently than those who were crawling. *See Table 5.*

Table 5: Bruises by Age and Developmental Stage of Child*

Age, month	Precruiser	Cruiser	Walker
0-2	1/225 (0.4)	. . .	. . .
3-5	1/141 (0.7)	. . .	. . .
6-8	4/99 (4.0)	2/8 (25)	. . .
9-11	4/38 (10.5)	12/63 (19.0)	7/18 (38.9)
12-14	1/8 (12.5)	3/24 (12.5)	23/49 (46.9)
15-17	. . .	1/6 (16.7)	26/57 (45.9)
18-23	. . .	. . .	39/79 (49.4)
24-35	. . .	. . .	70/115 (60.9)
Total[+]	**11/511** (2.2)	**18/101** (17.8)	**165/318** (51.9)

*Data are presented as the number of children with bruises/total number of children (percentage). Precruiser indicates a child who is not walking; cruiser, one who walks with support; walker, one who walks independently; ellipses, not applicable.

[+]P<.001.

In the study, 973 children had a total of 466 bruises. Considering only those infants and toddlers who had bruises, the mean number of bruises ranged from 1.3 per child in precruisers (perambulatory) to 2.4 per child in walkers (with a range of 1-2 in precruisers, 1-5 in cruisers (ambulatory), and 1-11 in walkers). The most common site of bruises for all developmental groups was the anterior tibia (shinbone) or knee. The second most common site was the forehead. In cruisers, the third most common site was the scalp. In walkers, the third most common site was the upper leg. *See Table 6 below.* Bruises on the back, chest, forearm, and face (excluding the forehead) were extremely rare in precruisers or cruisers and were noted in less than 2% of walkers. *See Table 7 below.* No children in the sample exhibited bruises on the hands or buttocks and only one child had a bruise on the foot.

Table 6: More Common Sites of Bruises by Location and Developmental Stage*

	Number (%) of Children		
	Precruiser	Cruiser	Walker
Location	**(n = 511)**	**(n = 101)**	**(n = 318)**
Anterior tibia or knee	3 (0.6)	12 (11.9)	142 (44.7)
Forehead	3 (0.6)	3 (3.0)	18 (5.7)
Scalp	3 (0.6)	5 (5.0)	2 (0.6)
Upper leg	1 (0.2)	1 (1.0)	13 (4.4)

* Precruiser indicates a child who is not walking; cruiser, one who walks with support; and walker, one who walks independently.

Table 7: Less Common Sites of Bruises by Location and Developmental Stage*

	Number (%) of Children		
Location	**Precruiser (n = 511)**	**Cruiser (n = 101)**	**Walker (n = 318)**
Back	0 (0)	1 (1.0)	6 (1.9)
Chest	0 (0)	0 (0)	4 (1.3)
Forearm	0 (0)	0 (0)	5 (1.6)
Face (cheek or nose)	1 (0.2)	1 (1.0)	5 (1.6)

* Precruiser indicates a child who is not walking; cruiser, one who walks with support; and walker, one who walks independently.

The authors concluded prudent physicians should seriously consider the possibility of inflicted injury or medical illness when (1) evaluating a young infant who has any bruises and (2) when bruises in infants or toddlers are on atypical sites.

A similar study conducted in England in 1998 examined 177 babies ages 6 to 12 months. Twenty-two babies had bruises for a point prevalence of 12.4%.[38] There were a total of 32 bruises seen in 22 babies. Fifteen babies had one bruise and seven babies had more than one bruise (five had two, one had three, and one had four bruises). *See Figure 1 which shows the sites of the bruises.*

Twenty-five bruises were on the face and head; sixteen of those were on the forehead; and four on the skull were seen on the same girl, who at 10 months was pulling to stand and repeatedly banged her head on the underside of the dining room table. Seven bruises were on the shins. In all cases, the bruises were located over bony prominences and on the front of the body. The bruises were of different colors and could not be matched with the age of the bruises, except yellow which only appeared in bruises over 48 hours old. There was a significant increase in bruises seen in babies with increase in mobility. Four bruises were seen in 101 children able to sit. Nine bruises were seen in 52 children who crawled. Nine bruises were seen in 24 children who walked. All the babies with bruises on shins were mobile.

Generally, inflicted bruises may be distinguished from accidental bruises by a number of characteristics. One is location. Accidental bruises are frequently seen over bony areas such as the shins, the forehead, and other exposed bony surfaces. Bruises located on padded areas, such as the buttocks, cheeks, or genitalia, or on relatively protected areas like the ear lobes, neck, or upper lip are highly suspicious (Richardson, 1994).

Another clue to the inflicted etiology of bruises is their number and relative ages. Toddlers and active children may have numerous bruises on their lower extremities from minor

[31] 22 out of 177 babies had at least one bruise at a point in time between the ages of 6 and 12 months.

accidental trauma. Children with multiple bruises of different ages in less accessible locations may have been victims of abuse. The pattern of bruises must be interpreted in

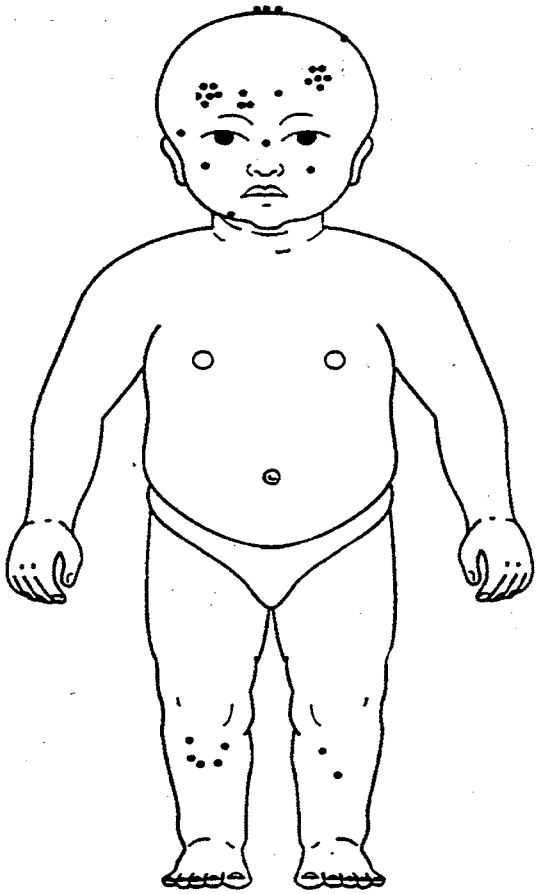

Figure 1 Illustration of the approximate sites of all the observed bruises.

light of the child's developmental capabilities and the history given (Richardson, 1994). The explanation should be compatible with the injury seen (Carpenter, 1998). In his study, Carpenter, in determining that the babies' bruises were accidental took into consideration the injury observed, the explanation given, the developmental level, growth and general care of the baby, the demeanor or behavior of the baby and the parent, and the available knowledge about the whole family (Carpenter, 1998).

Other authors have noted frequent injuries of the head and face in children who are victims of abuse. In one large retrospective case review (de Fonseca, Feigal, ten Bensel, 1992, in Sugar), 385 (75.5%) of 511 physically abused children had injuries of the head, face, neck, or mouth. In a 1995 study which included 105 abused infants and toddlers, 49% of the soft tissue injuries in infants and 38% of the soft tissue injuries in toddlers involved the head or face (McMahon, Grossman, Gaffney, & Stanitski, 1995, in Sugar).

The Aging of Bruises

Determining the age of a bruise from its appearance is useful to child protection for several reasons. First, if the apparent age of the injury is different from when the parents say the injury occurred, doubt is cast on the parents' story. Second, if the bruise can be aged, it may allow exoneration of adults who cared for the child before or after the time of injury. Third, whether multiple bruises are the same age or different ages can help determine whether there was one or more episodes of injury. Unfortunately, these questions can be very difficult to answer (Stephenson, 1997).

Generally, it has been thought that bruises progress through a series of colors prior to resolution. In Robert M. Reece's *Child Abuse: Medical Diagnosis and Management* (1994), the chapter on Cutaneous Manifestations of Abuse states, "the bruise goes through a characteristic progression of color changes. Fresh bruises vary from deep purple to red, depending on the depth of the bruise and amount of blood. As the heme molecules are metabolized, the appearance of the bruise changes from green to yellow to brown." (Richardson, 1994, p. 169). The following table appears, listing the average time for the evolution of the changes:

Table 8: Estimating the Age of Bruises

Approximate Age	Skin Appearance
0 to 2 days	Tender and swollen
0 to 5 days	Blue, purple, red
5 to 7 days	Green
7 to 10 days	Yellow
10 or more days	Brown
2 to 4 weeks	Cleared

Note: Bruises progress through the phases of resolution in the above order; rate of resolution may be affected by variables such as the depth of the bruise and the amount of bleeding into the bruise.

The DCFS body chart uses a similar progression chart to age bruises and there are at least five other published aging schemes. All of these schemes are inconsistent with each other (See Stephenson, 1997). None of the charts distinguish the aging of bruises in infants and children from the aging of bruises in adults.

In recent years, the belief that bruises go through a set progression of color changes has been challenged. The exact appearance and color change with time for any particular bruise may be influenced by (1) the amount of blood extravasated; (2) distance below the surface of the skin; (3) severity of the blunt force; (4) vascularity of the underlying tissue; (5) connective tissue support at the site of injury; (6) age of the person; (7) sex of the person; (8) color of the skin; and (9) drugs, such as steroids, that can alter the rate of bruise dispersion (Stephenson, 1997; Langlois & Gresham, 1991). Few of these factors have been researched. Therefore, even if it is accepted that bruises start out red/blue/purple, and some

time later turn brown/green/yellow, it is unlikely that any one particular bruise can be precisely aged, and bruises of the same age could be different colors because of the first five factors listed above (Stephenson, 1997).

There have been two major photographic studies of the ages of bruises. Both studies were conducted on white subjects because it is very difficult to discern the colors in a bruise in a dark-skinned subject (Langlois and Gresham, 1997). The first study (Langlois and Gresham, 1991) involved 369 photographs of 89 white individuals between the ages of 10 and 100 years. Only bruises of known cause and age were photographed. Some subjects had more than one bruise and some subjects were photographed on more than one occasion. The photographs were assessed and analyzed for the colors blue, red, yellow, and purple/black. The color green was observed, but was thought too difficult to tell from a mixture of blue and yellow. For the same reason, orange and brown, which were also observed, were not counted (Langlois & Gresham, 1991).

Yellow was never seen in any photograph up to 18 hours from the time of injury and was then seen with increasing frequency until, by ten days from the time of injury, virtually 100% of photographs showed yellow color. Of those bruises photographed up to twenty days from injury, 100% still showed yellow color. The study concluded that if a bruise has a yellow color, it is very likely to be more than 18 hours old, but the converse - that a bruise without a yellow color is less than 18 hours old - is not necessarily true. A bruise may not develop a visible yellow color until much later than after 18 hours. Red was seen in about 70% of all bruises photographed up to twenty days from injury. Purple/black was seen in about 40% of all photographs up to twenty days. Blue was seen in 30% of bruises in the first 24 hours and gradually decreased so that blue was not seen in any photograph taken more than twelve days after the injury (Langlois & Gresham, 1991).

Langlois and Gresham also noted that (1) colors present on one day could disappear the next, only to reappear at a later date; (2) even in the same subject where two bruises occurred on the same part of the anatomy at the same time in the same way, they need not display the same color or develop changes in color at the same rate; and (3) not all bruises develop a yellow color before they resolve (Langlois & Gresham, 1991).

The other major photographic study of the ages of bruises was undertaken by Stephenson and Bialas (1996). Fifty photographs of bruises in 23 children ages 8 months to 13 years (median 8 years) were taken. Only bruises of known cause and age were photographed. Some subjects had more than one bruise and some subjects were photographed on more than one occasion. Yellow was not seen in any of the eight photographs taken of bruises less than 24 hours old and was seen in 10 of 42 bruises over 24 hours old. Red was not seen in any of the 13 photographs of bruises over 7 days old but was seen in 15 of the 37 bruises less than 7 days old. Only 24 of 44 (55%) bruises were aged correctly by an experienced pediatrician using a scale of less than 48 hours old, 48 hours to 7 days old, and more than 7 days old (Stephenson & Bialas, 1996).

Aside from color, other features of the injury may suggest it is relatively new. A fresh cut or abrasion may overlie the bruise, suggesting newness. A scab takes time to form and ultimately will fall off. Initially, bruised tissue shows some swelling, partly due to the volume of extravasated blood and partly due to the inflammatory reaction. Later, as the blood separates into serum and clot and as the serum is absorbed, the swelling lessens. A fresh injury will be painful or tender while an older injury may not be (Stephenson, 1997).

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Recommendations

1. Mr. Parker should be counseled and retrained on how to conduct comprehensive, well-reasoned, well-documented child protection investigations.

2. Mr. Parker's supervisor should review with Mr. Parker the fact that only 20% of his time investigating is spent in the field. The supervisor should advise and plan with Mr. Parker to increase his time spent in the field on investigative activities and decrease the time spent in the office on paperwork. A time management study on Mr. Parker should be considered to provide specific information about Mr. Parker's activities.

3. During a three-month period (August, September, October 2000) Mr. Parker worked 77% of the weekends. Mr. Parker should be restricted from accepting after-hours and weekend on-call responsibility beyond that made mandatory under the union contract. He should be restricted from volunteering for additional after-hours and weekend on-call responsibility.

4. Management should consider, on an informal, practical basis, whether getting Mr. Parker a voice-activated computer program would reasonably improve his documentation in his child protection investigations.

5. DCFS should develop with Southern Illinois University a mobile forensic Parenting Assessment Team for the far south and southeast areas of the DCFS Southern Region.

6. DCFS procedures should be clarified to require that when a case is already open with the Department and a new child protection investigation is begun, the child protection investigator must be responsible for any CERAP safety plan until the investigation is completed. Follow-up should receive a copy of the plan to assist DCP in monitoring the safety plan. The continuous process of weighing new information against what is already known may require a change in the safety plan at any time, including taking protective custody which caseworkers cannot do.

7. This Region's field offices often seem short-staffed of child protection investigators. The Department should explore the feasibility of hiring permanent overlapping four day shifts as is done in other areas to ensure weekend coverage. These added shifts could assist with the increased demand for child protection visits required by the new paramour policy during a pending investigation and making necessary contacts to assure safety when the regular shift has been unable to make contact.

8. Homemakers should be trained on how to do task-centered activities. They should receive more detailed instructions about the expectations for services in a particular case

and closer supervision of their activities.

9. Child protection investigators and follow-up workers who experience a child's death should be offered assistance with their caseload.

10. The body chart used in the DCP investigations should be changed to incorporate the new information on children's bruising. The information should be incorporated into DCP trainings.

11. When Tina Yardley gives birth to the child with which she is pregnant, the Department should do an investigation to consider if the baby should be taken into temporary custody for risk of harm because of the dangerous situation in which she placed Carolina and her demonstration of her failure to protect Carolina, and her older daughter.

12. Strategies to decrease bias and increase the reliability and validity of child protection decisions, as described on page 40 of the report, should be included in child protection training.

13. During the course of an investigation, a CPI should ask alleged perpetrators for the names, dates of birth, and living arrangements of any of their children who are not members of their household. The CPI should investigate the reason such children are not living with their parent(s). In this investigation, and others (e.g., Jessica Brown [redacted name]), the reason the children are not living with their parent(s) has been relevant to the safety and well-being of the children currently living with the alleged perpetrators. This recommendation should also be followed when follow-up or foster home licensing becomes aware of the existence of additional children not living with their parent(s).