OFFICE OF THE INSPECTOR GENERAL
Illinois Department of Children and Family Services

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

Pursuant to 20 ILCS 505/35.5

JANUARY 2003

Denise Kane
Inspector General

Office Of The Inspector General
Illinois Department of Children and Family Services

January 1, 2003

To Governor Ryan, Governor-Elect Blagojevich, and Members of the General Assembly:

In the 1970's many mothers fell prey to a powerfully popular clinical perspective that held them responsible for their children's schizophrenia. Untold damage was done to families until parents formed alliances that fought questionable non-evidence-based practices. Funding streams stopped and the previously untouchable structure of clinical elitism toppled.

Clinical decision-making with children and families is an area where the Child Welfare System exercises untold power over the children and families we serve. When this decision-making is permitted to stray from careful, evidence-based consideration of the issues, the results for our families can be devastating.

In the past several years, numerous Inspector General investigations found that a dangerous practice existed within the DCFS system where clinical staff made decisions without basic scientific or evidentiary inquiry. In a recent case, the negligent and biased thinking of a clinical coordinator and a nurse labeled a dedicated foster mother as a classic case of Munchausen by Proxy Syndrome (a syndrome in which a caretaker intentionally creates or prolongs a dependent's illness for the caretaker's own distorted needs) and called for the institutionalization of the foster family's six and four-year-old foster children born with cerebral palsy and major medical problems.

In another recent case, a clinical coordinator judged that a private child welfare agency should not have moved a three-year-old to her grandmother's home. The agency discovered that a relative foster parent, who had the child almost since birth, had a troubled past which included six failed marriages, her own children being removed by the juvenile court because of the mistreatment they suffered, and current legal problems because of her abuse of prescription controlled substances at her workplace. The mistreatment her biological children suffered, as described in the juvenile court records, included her fourth husband forcing her son to lick urine off the floor as punishment in her presence, shoving a child down the stairs, and tying a child outside on a hot summer day without food or water for seven hours. The mother condoned these punishments. Like the previous case, the clinical coordinator never reviewed this woman's child welfare and court records before offering her clinical opinion.

Without supervisors and managers demanding factual and evidence-based practice, we create fertile ground for blind errors and abuse of power. Clinical and nursing decisions must incorporate a complete review of case, medical and court records and provide a rigorous review of relevant research and/or evidence to support conclusions. To do less approaches malpractice.

Sincerely,

Denise Kane

Denise Kane, Ph.D
Inspector General

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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 reform the child welfare system and 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. *See* 20 ILCS 505/35.5 and 35.6. 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.

A. INVESTIGATION CATEGORIES

1. Death and Serious Injury Investigations

The Office of the Inspector General (OIG) investigates deaths and serious injuries of all Illinois children and families who were involved in the child welfare system within the preceding twelve months. The OIG is also a member of Child Death Review teams around the state. The Inspector General is an ex officio member of the Child Death Review Team Executive Council. The OIG receives notification from the Illinois State Central Register (SCR) of all child deaths and serious physical injuries 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 or serious injury generates a preliminary investigation in which the death report and other reports are reviewed and computer databases are searched. When further investigation is warranted, records are impounded, subpoenaed or requested and a review is completed. When necessary, a full investigation, including interviews, is conducted. Reports are issued to the Director. The following chart summarizes the death cases reviewed in FY 02:

No. Child Deaths in FY 02 Meeting Criteria for Review	**97**
No. Preliminary Investigations Conducted	**33**
No. Case Records Reviewed	**44**
No. Full Investigative Reports Submitted to DCFS	**6**
No. Investigations Pending	**14**

Summaries of death investigations that resulted in major recommendations are included in the Investigations section of this Report. See page 139 of this Report for a summary of all child deaths reviewed by the OIG in FY 02.

2. General Investigations

The OIG responds to and investigates complaints filed by the state and local judiciary, foster parents, biological parents and the general public. 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.

3. 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 Department (Office of Employee Licensure) administers and issues employee licenses. The Office of the Inspector General of the Department of Children and Family Services investigates and prosecutes Child Welfare Employee Licensure Complaints. The OIG participated in developing Rule 412, implementing the state statute.

Referrals for Employee Licensure Investigations are 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. 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. When the OIG believes licensure action is appropriate, it provides the licensee with an opportunity for a hearing on the issue. An Administrative Law Judge presides over the hearing and reports findings and recommendations to the Child Welfare Employee Licensure Board. The following chart reports disposition of FY 02 complaints received:

Complaints Received in FY 02	**48**
Investigations in Abeyance*	**2**
Investigations of FY 02 Complaints Closed	**34**
Investigations of FY 01 Complaints Closed	**5**
TOTAL Investigations Closed in FY 02	**39**

* An indicated finding of abuse or neglect is a basis for licensure action, however, no permanent licensure action (other than temporary suspension pending outcome) will ensue if the employee has a pending expungement hearing. Therefore, employees, with indicated findings, will have their Employee Licensure investigations placed on hold, pending the outcome of the administrative Expungement Hearing.

Of the investigations closed in FY 02, the following chart summarizes the recommendations made:

Recommendations for No Licensure Action	**34**
Recommendations for Non-issuance of License	**3**
Recommendations for Hearing on Licensure Action	**2**
Recommendations for Disciplinary Action Only	**8**
Number of Employees Resigning During Investigation	**2**

4. Criminal Background Investigations and Law Enforcement Liaison

The OIG provides technical assistance to the Department and private agencies in performing criminal history checks. In FY 02, the OIG performed 5541 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.

B. ADDITIONAL RESPONSIBILITIES

1. OIG Hotline

Pursuant to statute, the OIG operates a statewide, toll-free telephone number for public access. This past year, the General Assembly clarified through legislation that the OIG Hotline is available to all members of the general public. Foster parents, officers of the Court, Judges and others involved in the child welfare system 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;
- Complaints about private agencies or contractors;
- 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 the OIG.

The OIG Hotline is an effective tool that enables the OIG to: communicate with concerned persons; respond to the needs of Illinois children; and address day-to-day problems of the delivery of child welfare services. The number for the OIG Hotline is (800) 722-9124.

The following chart summarizes the response to calls received in FY 02:

Information and Referral	**776**
Referred to SCR Hotline	**437**
Opened for OIG Investigation	**51**
TOTAL Calls	**1264**

2. 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 possible conflicts of interest of those employees of the Department of Children and Family Services who are required to file Ethics Statements. For FY 02, 469 Statements of Economic Interest were submitted to the Ethics Officer. Of the 469 submitted, 55 indicated potential conflicts of interest. The 55 were further reviewed, and 21 were

determined to pose a conflict of interest (an actual conflict or the appearance of a conflict.) The 21 cases were investigated and 18 letters were sent to the individual employees advising them of the potential conflict and corrective action.

No. Economic Interest Statements Filed	**469**
No. Statements Prompting Further Examination	**55**
No. Requiring Investigation	**21**
No. Advisory Letters Sent to Employees	**18**

3. Consultation

OIG staff provided 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.

4. Best Practice Initiatives

Informed by OIG investigations and practice research, the OIG's Best Practice Project develops best practice training models for caseworkers and supervisors. The model initiatives are interdisciplinary and involve field tests of strategies. The initiatives are evaluated to ensure the use of evidence based practice and determine the effectiveness of the model. See page 177 of this Report for a full discussion of the current initiatives.

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. In FY 02, the OIG received over 1600 Requests for Investigation. Requests for Investigation and notices of deaths or serious injury are screened to determine whether the facts suggest possible misconduct by a DCFS employee, private agency employee or foster parent, or whether there is the need for systemic change. If an allegation is accepted for investigation, the OIG will review records and interview relevant witnesses. The OIG reports to the Director of DCFS and the Governor, with recommendations for discipline, systemic change, or sanctions against private agencies. The OIG monitors the implementation of accepted recommendations. The OIG may work directly with a private agency and its board of directors to ensure implementation, when recommendations are regarding a private agency. In rare circumstances, the Inspector General may request that an agency be put on "hold" or that an employee be placed on "desk duty" if the allegations are serious enough to present a risk to children, pending the outcome of an investigation.The OIG is mandated by statute to be separate from the Department. OIG files are not accessible to the Department.

If a complaint is not appropriate for full investigation by the OIG, the OIG may refer the complaint to law enforcement (if criminal acts appear to have been committed); to the DCFS Advocacy Office for Children and Families; or other state regulatory agencies such as the Department of Professional Regulations.

A. INVESTIGATIVE PROCEDURES

1. Administrative Rules for the Office of the Inspector General

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

2. Confidentiality

A complainant to the OIG, or anyone providing information, may request that their identity be kept confidential until the investigation is concluded. If possible, the OIG will attempt to procure information from another source. 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 accused employee needs to have sufficient information to enable them to present a reasonable defense. Recommendations for discipline are subject to due process requirements.

OIG Reports contain various types of information that are 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.

3. 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 have to impound files to ensure the integrity of records. Impounding involves the immediate securing and retrieval of original records by the OIG. When files are impounded, a receipt for impounded files is left with the office or agency from which the files are retrieved. Critical information necessary for ongoing service provision may be copied during the impound in the presence of the OIG investigator.

4. 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

B. OIG REPORTS

OIG Reports are submitted to the Director of DCFS. The OIG also reports to the Governor's Office. An OIG report contains a summary of the complaint, a 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 concern a private agency, appropriate sections of the Report are 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 are given an opportunity to meet with the Inspector General to discuss the Report and recommendations.

The OIG uses some reports as teaching/training tools. The reports are redacted to ensure confidentiality and then distributed to private agencies, 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 practice of child welfare. Redacted OIG reports are available from the OIG by calling (312) 433-3000.

III. RECOMMENDATIONS

In its reports, the OIG makes recommendations for systemic reform and case specific responses. Systemic recommendations are designed to strengthen the child welfare system to better serve children and families.

Ideally, discipline should be constructive in that it serves to educate an employee on matters related to his/her misconduct. However, it must function also to hold employees responsible for their conduct. 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 and/or to the Director and Board of the private agency. The OIG monitors implementation of recommendations for disciplinary action. 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 this 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.

The OIG monitors implementation of OIG recommendations. Monitoring may take several forms. The OIG may monitor to ensure that Department or private agency staff implements the recommendations. Or the OIG may work directly with the Department or private agency to implement recommendations that call for systemic reform. The OIG may "incubate" accepted reform initiatives 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 AND SERIOUS INJURY INVESTIGATION 1

ALLEGATION

A three and a half year-old boy required surgery for a perforated bowel. At the time the boy was admitted to the hospital, three pending investigations of his mother and her boyfriend were assigned to the same Child Protection Investigator. The complaint was that the investigator had falsified notes pertaining to one of the pending investigations.

INVESTIGATION

The initial hotline report for abuse was made after the boy's mother went to a shelter and requested assistance. The mother told shelter workers that the previous evening, her boyfriend had punched her three and a half year-old son in the stomach. The mother stated that she was working at the time of the incident and when she returned home her boyfriend admitted hitting the boy. The shelter worker reported the allegation to the State Central Register (SCR) and a Child Protection Investigator was assigned to the case the following morning.

The Investigator recorded speaking with two shelter employees who reported that the mother had come in around 6:00 p.m. with her *three* children and had made no mention of domestic violence issues. (SCR records document the hotline call was made at 2:00 p.m., not 6:00 p.m.) However, in an interview with the OIG, administrators of the shelter stated that only one of the two names listed by the Investigator as contacts belonged to someone who worked at the shelter. The worker who could be identified told the OIG she had spoken to the Investigator, however it was regarding a different case involving another child. In addition, the mother told the OIG she had only taken her *two* youngest children with her as her five year-old daughter was in school that afternoon. The Investigator could not explain the inconsistencies between his notes and the statements made by the mother and shelter staff other than to say he wrote down what the employees he spoke with had told him.

In the two weeks following assignment of the case, the Investigator documented numerous unsuccessful attempts to visit the family home. During this time, the investigator's supervisor instructed him to utilize other methods of reaching the family such as having an on-call worker to visit the home, requesting local police to conduct a child welfare check or sending a certified letter to the residence. The investigator failed to initiate any of these options before arriving at the home on an evening when the boyfriend and the three children were at the home, 14 days after the initial report was made. The boyfriend denied punching the boy and said he had been arguing with the boy's mother and that she had called in an intentionally false report out of anger. The boyfriend also stated that he had been married to the children's mother for two years but she had kept her name in order to receive public aid benefits. The investigator observed no bruises on the children and the two oldest denied being abused by the boyfriend. The Investigator also documented a conversation with a neighbor (recording his first name only) who stated the couple had a good relationship and that he had never witnessed any signs of abuse. The OIG was unable to find any evidence of the neighbor named by the investigator residing at that address. Neither the people who lived at that address nor the apartment manager knew of anyone by that name in the building. Following the visit, the investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) indicating no areas of concern. The next day, the investigator's supervisor signed off on the CERAP and included a note stating the mother had recanted her allegation.

The following day, SCR received a hotline call from a social worker at the five year-old's school alleging the girl had arrived that day with a bloody nose and told her teacher her mother hit her. The case was assigned to the same Child Protection Investigator who was investigating the allegation that the boyfriend punched the three and a half year-old in the stomach. The Investigator contacted the social worker who stated the five year-old said her mother struck her in the face and instructed her not to tell anyone. That evening the Investigator went to the home and met with the boyfriend and the three children. The mother, who worked evenings, was not present. The boyfriend stated the injury occurred after the mother accidentally bumped into

the girl while carrying dirty clothes. The investigator made several more unsuccessful attempts to speak with the mother, all of which were in the evening. When asked by OIG investigators why he continued to go to the home during the evening when that was when the mother was at work, the investigator responded that evenings were a more convenient time for him.

The investigator documented his first contact with the mother 10 weeks after shelter personnel made the initial report. The investigator's notes document that the mother supported the boyfriend's statements that they had been married for two years and that her initial allegation of abuse was false and stemmed from her anger following an argument between the couple. The investigator recorded that he observed the children and found no signs of abuse. The investigator then met with his supervisor and recommended unfounding the abuse report against the boyfriend. The supervisor agreed and the boyfriend was informed of the preliminary decision to unfound the initial report.

Ten days later, SCR received a third call on this family. This report alleged the couple had left their six month-old son in a car while they went into a store at 1:00 a.m. on a night the temperature was 10 degrees. The report was assigned to the same Child Protection Investigator. After beginning work on the third report, the Investigator learned the three and a half year-old had been admitted to the hospital three days before with a stomach infection and internal injury. The mother told physicians the boy had fallen down stairs, however after further examination revealed the boy had a distended stomach that required surgery to repair his perforated bowel, the boyfriend admitted abusing the child. The boyfriend stated that on the evening before the mother first went to the shelter, he had been involved in a car accident and punched the boy in the stomach in anger after returning home.

In an interview with the OIG, the mother stated the first time she spoke with the investigator was when he came to her home the day after her son had surgery. She denied ever having been interviewed by him before or telling him she made a false report against her boyfriend. She also stated that the couple was not married as she was in the process of finalizing a divorce from another man. The OIG obtained the mother's timecards which showed she was at work at the time when her first interview with the investigator allegedly took place. When presented with this information, the investigator admitted the interview had never taken place and that he had falsified the case record. When OIG investigators arrived at the Investigator's field office to impound his itineraries they could not be located. The investigator stated he kept his itineraries at home and produced them the following day, however the integrity of the documents could not be positively confirmed.

The investigator's supervisor was unaware the Investigator had failed to submit travel vouchers or that his itineraries were not being maintained in the field office. During the handling of the case, the supervisor never instructed the investigator to seek out collateral contacts such as family physicians to establish any previous concerns of abuse. Furthermore, the supervisor accepted the Investigator's initial report which was based almost entirely on the boyfriend's statements and neglected to instruct the Investigator to complete a more comprehensive overview of the case.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue the discharge of the Child Protection Investigator. According to the Employee Handbook disciplinary action for falsification of records can include immediate discharge.

The Department agrees. Discipline was initiated, however, the employee resigned without reinstatement rights on 6/12/02.

2. The Department should pursue the revocation of the Investigator's child welfare license. Rule 412.50 "Grounds for Suspension, Revocation or Refusal to reinstate License" states that the Board may

recommend revocation for acts of misfeasance including: an egregious act that demonstrates incompetence, unfitness or blatant disregard for one's duties in providing direct child welfare services; falsification of case records, court reports or testimony.

The Department agrees. Upon the employee's resignation, the employee also surrendered his child welfare license.

3. The Department should pursue disciplinary action against the investigator's supervisor for his lack of substantive supervision.

The Department agrees. The investigator's supervisor received a written reprimand for his lack of substantive supervision. The supervisor grieved this discipline. The grievance is pending

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

A two and a half year-old boy died after being pulled from a bathtub and shaken violently by his mother's live-in boyfriend. The boyfriend had been investigated for abusing the boy in public seven months prior to the child's death. The previous investigation was unfounded.

INVESTIGATION

The initial abuse report was made after members of a bowling league observed the boy's mother's boyfriend periodically hitting and kicking the child at the bowling alley during the course of the evening. The boy was huddled against a wall with a coat over his head throughout the couple's time at the bowling alley. The patrons reported this behavior to the manager who subsequently contacted police. The boyfriend was arrested and charged with Battery of a Child and the boy was taken to a hospital for examination where physicians found no signs of injury.

The investigator spoke to the arresting officer who related the initial information gathered by police. The mother denied to the investigator that her boyfriend had ever hit either of her children and stated she did not allow corporal punishment. When the Investigator interviewed the five year-old in the presence of her mother and grandmother, she stated she had witnessed the boyfriend strike her brother. The investigator noted that he observed the boy while he was sleeping and that the mother stated there were no signs of abuse. The notes do not indicate whether the investigator attempted his own visual examination of the boy.

In a subsequent interview by telephone with a follow-up investigator, the mother stated her opinion that the entire situation had been a misunderstanding and that her son was underneath the coat because he was playing peek-a-boo. She further contended that the police did not give equal weight to her version of events and that she was told by others present at the bowling alley that some of the witnesses were motivated by their racial bias against her boyfriend. The investigator did not ask the mother to provide the names of any individuals who could support this contention. The investigator's supervisor instructed the investigator to initially unfound the case just one day after the case was assigned to this Investigator and six days after the case was opened. The investigator documented that she unfounded the allegation because the witnesses' statements to the police were "inconsistent" with the reporter's initial allegation and the fact the attending physician had found no signs of abuse.

During the course of her investigation, the investigator failed to conduct interviews with the reporter or any of the witnesses from the bowling alley and did not complete a scene investigation. The investigator also neglected to contact the arresting officer or make any attempt to speak with the boyfriend, verify the criminal charges against him or ascertain whether he was still in custody. Although an initial criminal history background check was conducted, the investigator did not request underlying documents which would have shown that while the boyfriend had no convictions, he had been arrested multiple times on numerous charges including simple battery, aggravated assault and domestic battery against family members and other cohabitants.

In addition, the boy's medical records were never requested from the hospital and no attempt was made to speak with the treating physician. Although available medical evidence has shown that physical evidence of trauma may not be detected for more than 48 hours after initial injury, no follow-up examination of the boy was ever conducted. The investigator gave undue weight to the mother's denial of abuse and allegation of racial bias without making a concerted effort to obtain available contradictory information.

In his interview with the OIG, the investigator's supervisor stated he supported the investigator's conclusions. In addition the supervisor, a 26-year employee of the Department with 4 years experience as a supervisor, stated it was his belief child protection investigators were prohibited from crossing state lines in the course of

conducting investigations (the bowling alley was located just across the state line, but the family lived in Illinois). A review of the supervisor's evaluations showed his team completed 95 percent of investigations within 30 days (1/2 the time required by law), a level the evaluator noted greatly exceeded the Department's objective of 75 percent completion. Given the supervisor's approval of the minimal amount of investigation undertaken in this case, concerns were raised regarding the excessively high completion rate and it's correlation to the quality of work produced by the supervisor's team.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Child Protection Investigator received a five-day actual suspension on April 2, 2002 for failure to contact the reporter, contact informed officer and contact all collaterals. The OIG concurs with the discipline imposed and further recommends that the report be shared with the Investigator as a teaching tool and that her Supervisor's Supervisor discuss with her actions she can take if she is directed to close out an investigation that is incomplete.

The Department agrees. The report was shared with the Investigator.

2. The investigator's supervisor received a five-day paper suspension on April 30, 2002 for his failure to perform supervisory duties in this investigation. The OIG further recommends that the report be shared with the supervisor as a teaching tool. The supervisor's supervisor should review the report with him and discuss the importance of conducting comprehensive child protection investigations.

The Department agrees. The report was reviewed with the investigator's supervisor.

3. The supervisor's poor supervision and inability to direct and/or conduct a full child protection investigation placed the child in this case at risk of harm. Therefore the supervisor's supervisor should review unfounded investigations completed by this team within the past 12 months and the next 3 months.

The Department agrees. The Director agreed to review all of the supervisor's unfounded cases for the past 12 months.

4. The Department should revise procedures to require a scene investigation in all child protection investigations of abuse, provide guidance on how to conduct a scene investigation and ensure that scene investigations and mock demonstrations are required components of an investigation.

The Department agrees and procedures will be revised. In addition, a notice will be sent to all DCP staff of the requirement that in all investigations the investigator must review the scene where an alleged incident took place.

5. In this case, had further contact been made with law enforcement in the neighboring state, the Child Protection Investigator would have learned that the alleged perpetrator was still being held in the county jail, that the State's Attorney was pursuing the case for Criminal Battery of a Child, and could have received a fourth witness statement from another employee of the bowling alley. The Department should advise Child Protection Investigators and Supervisors to work closely with law enforcement when criminal charges for child abuse or neglect related to the current case are pending against an alleged perpetrator.

The Department agrees that child protection workers need to work closely with law enforcement. Department procedures 300 are replete with requirements for working with law enforcement.

6. The OIG reaffirms it's recommendation made on June 17, 1998 that in all Cook County cases in which domestic violence is an issue, not just those in which domestic violence is the primary issue, the supervisor should consult with the Department's consultant on domestic violence as to the appropriate services that should be incorporated into the case plan. In addition, the domestic violence consultant should be available as a consultant for the duration of the case and should be included in the joint staffing discussing the return home of children. The Department should track the number of referrals made to the consultant and should reassess the referral process three months after implementation of the domestic violence consultation referral process.

The Department agrees that it is important to have experts in domestic violence available to consult with Department staff when domestic violence is identified as an issue. The Department is in the process of identifying these resources in all areas of the state. In addition, there is currently a domestic violence protocol in development that will provide clear guidance and instruction for servicing cases in which domestic violence is an issue.

7. Closure rates for abuse cases should be calculated separately from closure rates for neglect cases within each Child Protection Investigative team. In teams where 30-day closure rates are high, there should be a review of unfounded abuse cases by the Field Service Manager.

The Department currently examines all statistical outliers. Managers use this information to conduct reviews and do corrective action when necessary.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

An OIG investigator contacted a Department Public Service Administrator in order to secure case files required for an investigation. The Public Service Administrator instructed caseworkers under her supervision to alter documents contained in the case record prior to turning them over to the OIG.

INVESTIGATION

The OIG investigation was initiated when a father killed his 14 year-old son and injured two of his other children. The family had a case open with the Department for Intact Family Services (IFS). An OIG death team investigator contacted the Public Service Administrator in the field office that had been providing services to the family for the prior three years. It is the regular practice of the OIG to request that case files are secured prior to being picked up by OIG personnel in order to ensure the integrity of the information contained within and to prevent attempts to add or alter vital documents. The OIG relies on the professionalism of the office administrator to ensure compliance with these requests. The death team investigator spoke with the local field office's Public Service Administrator and asked her to secure the case record. A second OIG death team member who was present during the phone call confirmed the request to have the file secured. The administrator informed the death team investigator that she had anticipated the OIG's involvement and had instructed workers to begin making a copy of the case record so one would be available in the office while the OIG reviewed the original documents. The death team investigator then asked two OIG field investigators to travel to the office and retrieve the case file.

The field investigators were kept waiting for 30 minutes before the administrator appeared and asked them to continue waiting. The field investigators informed the administrator they had to take possession of the file immediately and entered the main office. The field investigators stated the administrator attempted to obstruct their entry into the main office where the file was being kept. Upon entering the main office, the field investigators observed a caseworker applying white-out onto a document. When one of the field investigators questioned the administrator about the activities taking place, the administrator responded that the caseworker was completing an evaluation of a service plan and assured him the case had not been tampered with. The field investigator tabbed the page in question and, after workers completed copying the file, the field investigators left the office with the original case record.

The OIG informed, the Regional Administrator, who stated the Public Service Administrator had called him earlier in the day and told him, "We screwed up."

The Public Service Administrator stated that after she instructed her staff to begin copying the case file in anticipation of the OIG's request, she took the original record and the corresponding photocopies home in order to compare them. During this comparison, the administrator found that two service plans had not been evaluated. In response, the administrator instructed two of the involved caseworkers to complete the service plan evaluations. Later that morning, the OIG death team investigator called to request the case file. The caseworkers were still in the process of completing the evaluations when the OIG field investigators arrived at the office to impound the file. The administrator stated that it was her belief that the request to secure the case record did not preclude her from adding or altering documents if it was done to "enhance the file." When asked what she meant by "enhancing", the administrator stated, "If anything is needed to be filed, any events that have not been added yet." Death team investigators compared the contents of the original file to the copies made by workers in the field office and found that all of the service plans contained in the primary case file were originals except for the one the field investigator tabbed, which was a photocopy. The tabbed case plan was dated two years prior to the date of the impound.

Two caseworkers had been enlisted by the Public Service Administrator to assist in "enhancing" the file. One of the caseworkers stated that after changing the evaluation, she had initially dated it as being completed two

years earlier but was in the process of changing it to one year earlier when the OIG field investigators entered. The second caseworker retained the original service plan with the date whited-out and provided it to the OIG.

The Public Service Administrator's actions in failing to properly secure a case record following a request from the OIG, adding and altering documents after the fact and failing to provide assistance to a caseworker whose position was compromised by adhering to the administrator's own instructions constitute a failure of professional responsibility. As an individual entrusted with supervising Department employees, the administrator is expected to demonstrate appropriate and trustworthy behavior. Whether or not the administrator intended to purposefully mislead OIG investigators, her interference could be construed by a reasonable person as self-serving and was unquestionably misguided in light of the tragedy faced by a family receiving services through her office.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Public Service Administrator should be disciplined for disregarding her administrative responsibilities to ensure the integrity of a file after a catastrophic event, for failing to give full disclosure to the Office of the Inspector General, for contributing to an appearance of impropriety and conflict of interest and for failing to ensure that the original document was provided to the Inspector General.

The Department has addressed this issue with the Public Service Administrator. This incident highlighted the need for clarification of the expectations around OIG involvement with field office staff. The Department, in cooperation with the OIG, is currently drafting procedures to Rule 430, which explains the internal review process for the Department's Office of Inspector General investigations. These procedures will provide better guidance to staff when a case is identified as having OIG involvement.

The Public Service Administrator has taken early retirement.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION

A six week-old boy died as a result of injuries suffered from being violently shaken by his father. The father had been indicated for abusing his four year-old daughter one month prior to the infant's death.

INVESTIGATION

The first hotline report was made after relatives of the four year-old's mother contacted police and stated that the four year-old girl had bruises on her face and legs. Officers responded to the relative's home where the mother lived with the four year-old and her then two-week-old son. The officers observed the injuries and found the mother to be uncooperative. The mother stated the father had spanked the girl with a belt several times during the preceding weeks for wetting her bed. Officers contacted the State Central Register (SCR) and a Child Protection Investigator was assigned to the case.

The Child Protection Investigator went to the mother's family home to conduct interviews. The mother repeated her statement that the father had spanked the girl with a belt for wetting the bed but that he ceased when the mother asked him to stop. The mother told the investigator the bruise on the girl's face was the result of a fall. The four-year old told the investigator she bruised her face when she fell but would not say what caused the marks on her legs. The mother's relatives told the investigator the father had been in jail during the previous week but were unaware of the reason. The mother stated that both she and the father were homeless. The mother and children were residing with her relatives while the father was living with friends.

The investigator located the father and interviewed him at his mother's home. The father acknowledged striking the four year-old with a belt but stated the mother's relatives may have caused the injury because they also hit the girl. The father also told the investigator he had recently been in jail, however the investigator did not ask him the circumstances of his incarceration. Court documents obtained by the OIG found the father had been jailed for failure to pay a fine leveled previously for a finding of domestic battery. The investigator conducted child abuse and criminal background checks on both parents. The mother had one previous arrest for obscenity while the father was named in a 1997 child abuse investigation as an "allowed perpetrator" who failed to prevent abuse of his then three-year old son. The criminal background check of the father used the birth date incorrectly recorded in the child abuse registry, which yielded a false "clean" report. The OIG conducted another criminal background check using the father's correct birth date and found he had two previous convictions for drug possession and domestic battery as well as arrests for disorderly conduct, resisting arrest and obstruction of justice.

The investigator indicated the allegation and developed a safety plan that required the children to reside with their grandmother and prohibited the mother and father from having unsupervised visits. The investigator informed the family that the plan was to end after the parents successfully cooperated with services and the father learned to employ alternative methods of discipline. One week later the investigator returned to hand the case off to an intact family worker for services.

Soon after the case transfer, the mother informed the worker that she and the children had left the grandmother's home after their grandfather hit the mother during an argument. The mother also told the investigator she had obtained an order of protection against the grandfather but was not concerned for the safety of her nine year-old son from of a previous relationship who lived in the home. The worker referred the mother to a shelter while the children were placed in the home of a friend. In an interview with the OIG, the worker stated she was not concerned about the children's safety or the disruption of the service plan because the father was the abuser and the mother was not residing with him. The worker told OIG investigators she believed the mother could protect her children based on the mother's previous statement that the father stopped hitting the girl when she asked him to.

The worker did not interview the mother's relatives regarding the incident that led to her departure from the home. In an interview with the OIG, the grandfather stated he did not hit his daughter but grabbed her by the arm during an argument regarding the mother's lifestyle and learned that the father had picked the mother up from the grandparents' home. An OIG check of police records found the mother did not obtain an order of protection against the grandfather. Although the safety plan was disrupted, the worker did not construct a new plan or contact shelter staff to request their assistance in monitoring the mother's behavior and possible interactions with the father. In her interview with the OIG, the worker stated she did not believe a new safety plan was warranted because the mother was capable of protecting the children. She based this belief on the mother's self-serving statement that when she told the father to stop hitting the child, he stopped.

The mother resided in the shelter for three weeks, during which time the worker focused with her on addressing housing issues. The mother told the worker she had returned to her job and that two friends babysat for her children while she was at work. At the end of the three-week period the mother was required to leave the shelter. Upon leaving the shelter the mother, father and the two children checked into a motel. Five days later, the six week-old was brought to a hospital with massive injuries that proved to be fatal. The father subsequently admitted to police taking the baby into the bathroom and shaking him because he would not stop crying.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue disciplinary action against the worker for her failure to properly assess risk and for her failure to provide a safety plan for the children in a physical abuse case.

The Department agrees to counsel the worker. *(The OIG recommendation was for discipline. The Department did not agree to discipline for this worker. The Department instead counseled the worker. According to personnel rules, the counseling session will not be included in the employee's personnel file)*

2. The Child Protection Investigator should be counseled on investigative techniques and her failure to follow up on information she obtained during her investigation.

The Department agrees. The Child Protection investigator was counseled.

3. When a safety plan has been disrupted, the worker should contact all parties to the plan to verify the reasons for the disruption and to determine whether a substitute plan should be put in place. Workers must document their contacts and explain why the safety plan is no longer needed.

The Department agrees. Recent changes have been made to Rule 300; Reports of Child Abuse and Neglect and Rule 315; Permanency Planning. These changes require weekly reassessments for children that have been determined to be unsafe.

4. This report should be shared with the administrators in the regional field office. The OIG will meet with the administrators of both Child Protection and Intact Families to discuss the issues raised in this report.

The Department agrees.

5. The Department should require that anyone completing a CANTS or LEADS check on a potential caretaker obtain a copy of that person's driver's license or state identification to ensure the correct birth date and spelling of their name.

Although not all individuals have a driver's license or state ID, the Department agrees that efforts should be made to ensure the correct spelling of a potential caretaker's name during a CANTS or LEADS check.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION

A two month-old boy died of cocaine asphyxiation after being kept in a confined area with his mother while she smoked crack cocaine. At the time of the boy's death, the family had an open child welfare case with the Department.

INVESTIGATION

The family became involved with the Department when the second of the mother's three children tested positive for cocaine at birth. Hospital staff contacted the hotline and the subsequent Child Protection Investigation resulted in an indicated report against the mother. The case was opened for Intact Family Services (IFS), and the investigator, who was part of a project testing the viability of integrating investigation and service workers, became the family's caseworker. The caseworker identified the mother's substance abuse issues as the primary focus for services and referred her for drug treatment through a private agency. The mother's attendance in treatment was sporadic and insufficient to effectively address her substance abuse problem.

Following the mother's dismissal from the program, the caseworker downgraded the mother's requirements from active participation in treatment to random drug tests. The caseworker's supervisor agreed with the revised approach. The mother accepted the proposal and informed the worker that she was due to give birth to her third child in three months. The caseworker did not confirm whether the mother was receiving pre-natal care. The caseworker always scheduled the "random" drug drops, because she believed the client needed time to arrange for transportation. The worker did not understand that the advance notice she gave rendered the tests useless.

The mother never arrived for the drug test. She told the worker she missed the appointment because she could not afford to travel to the center. The caseworker re-scheduled a test for three days later and agreed to transport the mother. When the caseworker arrived at the family's home, the mother was not present. The mother finally took and passed a drug test five days later, but her unavailability to the caseworker and unwillingness to comply with services continued to hinder progress with the case. The caseworker never consulted with her supervisor after the mother began missing drug tests to discuss screening the case into court to ensure the mother's compliance. The mother continued to miss scheduled drug tests and failed to respond to the caseworker up until the time of her third child's birth.

The mother called the caseworker the day after the boy was born and told her that the baby had tested positive for drugs. The mother then admitted to the caseworker using drugs one month prior to the baby's birth. The caseworker informed the mother of possible Department involvement but did not attempt to verify any of the information provided by the mother. An OIG review of hospital records showed that, although the baby had tested negative for drugs, the mother had tested positive for cocaine. The caseworker met with the mother once after the child's birth. However, in the two-month period following this meeting, the caseworker made numerous unsuccessful attempts to visit the family at home or contact the mother by phone. The mother finally called the caseworker but could not offer an explanation for her failure to respond earlier. The caseworker told the mother that the absence of drugs in her son's system at birth indicated the mother had been abstaining from drug use, but before the case could be closed the mother would have to complete two months of successful drug tests. The mother agreed to the plan and made an appointment for the following week.

Three days later, on New Years Eve, the mother was smoking crack at midnight in the family home when she heard celebratory shooting. The mother collected her two month-old son and sought shelter inside a cabinet where she continued to smoke cocaine. The child died that morning; the medical examiner determined cocaine asphyxiation was the infant's cause of death. The mother pled guilty to endangering the life of a child and was sentenced to ten years in prison.

Infants subjected to passive inhalation of cocaine smoke can experience a number of developmental consequences including seizures, neurological and respiratory problems and language delays.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Once a mother has had a child who was born substance-exposed and has an open Department case because of her substance abuse, all Child Protection Investigators should be required to follow up with the hospital after the birth of a second child to determine whether the mother had been involved with substances at the time of that birth.

The Department agrees that if we have any type of open case on a mother because of the birth of a substance-exposed baby, attempts should be made to monitor subsequent births for substance exposure. Hospitals that test for substance exposure are required to report positive findings to the hotline.

The issue here is not whether the baby was substance exposed, but rather whether the mother was tested to determine possible continued substance abuse.

2. Department Procedures should be amended to reflect this policy.

See response to recommendation #1.

3. As the OIG has previously recommended, "In a case with an indicated finding, the Department should not close the case because of a parent's refusal to cooperate with services. Rather, they should attempt to screen the case into court while monitoring the safety of the child."

The Department agrees and, in collaboration with the Inspector General, has incorporated this recommendation into Best Practice.

4. This redacted report and the accompanying articles should be used as a teaching tool for intact family workers.

The Department agrees. A redacted report was shared with the Division of Training for use in training of intact family workers.

5. This redacted report and the bibliography of articles concerning postnatal substance exposure should be shared with the Cook County Medical Examiner's Office.

The Department agrees. The OIG shared the report.

6. The report should be shared with the Cook County Death Review Teams and with the Chief of the Juvenile Division of the Cook County State's Attorney's Office.

The Department agrees. The OIG shared the report.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

A 14 year-old boy was killed in an automobile accident. The driver of the car was subsequently charged with Driving Under the Influence. The State Central Register received a report that the boy's mother was aware that the driver, a family friend, was under the influence of drugs when she allowed her son to accompany him. At the time of the boy's death, his family had an open Intact Family case with the Department.

INVESTIGATION

The mother and her three sons, ages 14, 13 and 9, had become involved with the Department two years earlier after moving back to Illinois from another state. The mother decided to return to Illinois after a non-relative perpetrator sexually abused the two older boys and forced them to perform sexual acts with the nine year-old. Following the family's return to Illinois, child welfare workers from the other state contacted Illinois DCFS workers to refer the family to the Department. The other state had provided counseling to the boys, but their participation was sporadic as a result of their mother's reluctance to have the boys repeatedly discuss the events. Workers also stated the mother took medication for a bi-polar disorder and was defensive about her ability to care for her children. Based on this information, a Department worker referred the mother for homemaking and counseling services in Illinois. The boys' participation in counseling was inconsistent, as the mother frequently failed to transport them to sessions. The mother was not interested in services and the case was closed.

One year later, the mother called a crisis worker to report that she had beaten her then 11 year-old son and was going to commit suicide. The worker called police who went to the home, arrested the mother and took the boys into protective custody. The worker also contacted the hotline and a Child Protection Investigator was assigned to the case. The investigator interviewed the mother in jail and learned she was taking a number of psychotropic prescription medications. The mother characterized the incident as a spanking that had gotten out of hand and stated that the 11 year-old had discipline problems and was difficult to control. The investigator reported that the mother expressed to her sons her desire to leave them in foster care upon her release from jail. The mother singled out the 11 year-old for blame regarding the situation. The investigator interviewed the boys' maternal grandmother who stated that the mother was bipolar and often neglected to take her medicine as scheduled. A mental health examination conducted the day after the mother's arrest noted the mother admitted suicidal ideation but stated her children were her reason for living and she would wait until they were grown to commit suicide. The mother's boyfriend, who lived in the family home, told the investigator the mother could not reason well when she did not take her medicine, which happened often. The mother signed a release of information consent for her psychiatrist to provide her records to the Department worker. However, the mother then requested that her doctor talk to the worker rather than send the records. The psychiatrist spoke with the worker's supervisor and reported the mother was as good as she had ever been and was complying with treatment. Because the Department was still obtaining information regarding the mother, the supervisor was unable to ask the psychiatrist specific questions that could have provided more useful information. If the workers had pursued the medical records, the extent of the mother's mental illness, exemplified by setting herself on fire in front of her children, would have been discovered.

At a shelter care hearing following the mother's release from jail, it was determined that the children should be returned home. This decision was based on the belief that the mother's behavior had stabilized and that it was her first involvement with the Department. The court ordered the mother to adhere to her medicine schedule and cooperate with all Departmental and mental health services deemed necessary for her treatment. Three weeks after the hearing, the Child Protection investigator learned from the intact family worker that the mother was uncooperative, refused to attend parenting classes and was threatening to beat the 11 year-old. The investigator recommended that the mother be indicated for abuse because of cuts' welts and bruises and risk of harm. The supervisor approved the finding.

Throughout the mother's involvement with intact family services she exhibited volatile, erratic behavior directed towards her children, her boyfriend and child welfare professionals. The mother resisted services; missing more than half of her parenting classes, refused to attend counseling and canceled home visits by workers. When unannounced visits were attempted, the mother became hostile and confrontational. Reports of workers described the mother's behavior as frightening and unpredictable. In addition, concerns were raised that she might be abusing some of the psychotropic drugs she had been prescribed. The mother attributed a great deal of her behavior to stress caused by her children, particularly the 11 year-old. The teacher of the 11 year-old told the worker that the boy was immature and unable to perform schoolwork at an appropriate level. His counselor expressed the belief the boy had Attention Deficit Hyperactivity Disorder (ADHD). However, the mother refused to allow him to be tested or medicated for the condition. There is no indication that child welfare professionals involved in the case investigated the possibility that the 11 year-old's behavioral problems were the product of his mother's unstable behavior rather than the source of her stress. The 14 year-old was described by teachers and counselors as being unusually mature and serving in the family as a mediator between the mother and the 11 year-old. The older boys were described as being guarded when answering questions regarding their mother and protective of her despite her behavior towards them at home. There was no plan in place to educate the boys about the nature of their mother's psychological condition and or how to cope with her acting out or help her maintain her composure when she ran the risk of experiencing an episode.

Despite the increasing evidence the mother was a danger to herself and her children, the boys remained in her custody and the Department continued efforts to keep the family intact. The poor communication between Department workers, counselors and mental health professionals prevented the involved workers from constructing a complete view of the mother's ability to parent or a comprehensive plan for providing effective, integrated services to the family. The services that were provided were often reactive in nature as professionals responded to a crisis situation rather than instituting an outline for service delivery and compliance, supported by monitoring and communication between the various providers.

Following the death of the 14 year-old, the mother's mental health deteriorated, ultimately resulting in a suicide attempt and hospitalization. The other boys resided with relatives until the Department took them into protective custody after the mother signed herself out of the hospital against medical advice. The boys are residing separately with relatives. The permanency goal is to return the boys home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. When the Department screens a case into court and a parent has mental health issues the worker should request a court order for the mental health records if the parent refuses to sign or rescinds a release of information.

The Department agrees.

2. Because of the large geographic area and lack of mental health resources in the Southern Region, the Department, in conjunction with Southern Illinois University, should develop a mobile parenting assessment team for the region to provide comprehensive evaluations of parents with a mental illness history. The team should consist of a psychiatrist, psychologist, social worker and a coordinator. The team should be based on the model of the teams already established in Cook County.

The Department agrees to explore this recommendation.

In June 2001, the OIG met with Southern Illinois Department Administrators to discuss several DCFS cases in Southern Illinois and the dearth of mental health resources in the region. In August of 2001, the Inspector General and the Director of DCFS met with Southern Illinois University to discuss the implementation of a

Parenting Assessment team and the possibility of federal grants for rural psychiatry. To date, the Department has not implemented this project.

3. The Department should designate clinical consultants with expertise in mental health that caseworkers, supervisors and investigators can call upon for assistance, education and information.

The Department currently employs 23 clinical psychologists and clinicians with mental health specialization that provide consultation, assistance in case planning and education for both DCFS and POS child welfare staff. These psychologists report to the Office of Psychology services in the Clinical Division and provide direct consultation to staff and participate in clinical staffings.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

A one month-old girl was mauled to death by a dog owned by her 16 year-old mother. The 16 year-old's family had an intact case with the Department until five months prior to the baby's death.

INVESTIGATION

The family first came to the Department's attention two years earlier when a relative who was caring for the baby's mother, then 14, and her 17 year-old sister requested assistance in obtaining food, clothing and benefits for the girls. The case was referred for voluntary support services. A private agency was assigned to provide the services. The private agency worker learned upon accepting the case that the sisters were living with the relative because their mother was a drug addict. The private agency attempted to assist the relative to obtain guardianship for five months before closing it, after the relative decided not to pursue guardianship of the girls. At that time, the older sister had enlisted in the military and the 14 year-old returned home to live with her mother. In her closing summary, the worker recorded that the 14 year-old was happy to be home with her mother. The mother, however, was still a regular drug user. The private agency did not arrange counseling for the 14 year-old, as the relative caretaker had requested, because the 14 year-old left the extended family home before it was secured.

Four months after the case was closed, the hotline received a report against the mother alleging she failed to provide adequate food and shelter for her children. The report was unfounded. However, a similar allegation was made to the hotline one month later. The Child Protection Investigator assigned to the second report indicated the mother for inadequate shelter and inadequate supervision. The Investigator determined that the house where the mother and daughter were living in was a drug house. The mother told the Investigator the house had been left to her following her own mother's death, however the investigator learned the grandmother was still alive and residing with one of her other children. The Investigator arranged for the daughter to reside with her maternal aunt until her mother could locate suitable housing and transferred the case to the Department's Intact Family Services (IFS). The Investigator noted that the daughter was truant, sexually active and in need of sex education and that the mother admitted having a drug problem and required substance abuse treatment. The Investigator stated that both mother and daughter needed counseling.

The IFS records were marked by incomplete and inaccurate reports, a lack of substantive involvement with the family was noted and an overall failure to adequately assess the mother's ability to care for her daughter or the girl's likelihood to progress under her mother's supervision. While the mother's long-standing substance abuse problem was a primary obstacle facing the family, the worker minimized the severity of the problem and overlooked information provided by the mother regarding widespread substance abuse among her immediate relatives, including the drug related deaths of two siblings. The worker relied on the mother's self-reports of success in overcoming her addiction without independent confirmation. Although funding was approved for the mother to submit to periodic drug tests, no such tests were requested. The IFS worker told OIG investigators that she believed the mother's self-report that she was drug free so the worker did not pursue testing.

During the first two months of the case, the IFS worker only saw the family twice, but learned that during the interim, the daughter had missed 33 days of school, been suspended twice and her boyfriend had been wounded in a shooting, and that the family was living with the mother's boyfriend and his mother. The worker did not conduct background checks on these residents or conduct a safety assessment of the home. The worker had never referred the daughter for sex education services because the daughter denied being sexually active. However, during the second home visit, the daughter told the worker she had "a problem" and requested counseling. The worker sought and received authorization for the daughter to receive 24 hours of individual counseling. A month later, the worker began closing the case, based on the mother's promise that her employer would pay for her daughter's counseling, which had still not begun. The worker's

evaluation of the client service plan rated all the mother's tasks as satisfactorily completed, including notifying the Department of address changes (she had not), sending her daughter to school (she had missed 33 days or more) and encouraging her daughter to attend family planning (counseling had never occurred). The worker stated she rated the mother's educational compliance as satisfactory because she sent her daughter to school and it was not her fault if the girl did not stay or left early. The worker could not explain her positive ratings in the other areas. The closing summary also contained a significant amount of inaccurate and contradictory information regarding the length and magnitude of the mother's substance abuse problems. The IFS worker's supervisor approved the case closing. The worker's supervisor was unaware of Rule 302.350 Services Delivered by the Department of Children and Family Services, which stated that family planning services were among services delivered by the Department. The supervisor failed to provide substantive guidance to the worker during her handling of the case and, as such, was unable to conduct an effective evaluation of the worker's conclusions about the family that provided the basis for the decision to close the case. Five months after the supervisor and worker completed the forms to close the case, the daughter delivered her child. One month later, the infant was mauled to death by the dog.

The Department lacks rules or procedures specifically for Intact Family Services, which has caused significant inconsistencies in service delivery and confusion around the type of families appropriate for Intact Family Services. DCFS staff is currently expected to adhere to Rule 315 Permanency Planning. However, a policy transmittal (99.3) stated that Rule 315 was intended for "out of home cases only."

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department should consider terminating the IFS worker's employment. The history of her performance is not indicative of problems correctable by training.**

If the IFS worker is permitted to continue her employment, the Department should consider disciplinary action against her for failure to meet Administrative Procedure (5) requirements and Intact Family Services program objectives. The IFS worker: (1) failed to adequately assess the family's needs, (2) failed to provide services to the family, (3) closed the case without evidence that the family's needs were addressed, (4) routinely wrote overdue case entries of client contacts, (5) failed to see the family at least once each month, and (6) produced poorly prepared documents that were unfinished, unsigned or contained misinformation. The IFS worker will require close supervision, detailed supervisory instructions with time lines for completion, verification of her contacts and their content, and verification that she followed instructions.

The Department agrees. The IFS worker received a 25-day suspension and is being closely supervised. The employee grieved the discipline. The grievance is pending.

2. **This report should be reviewed and discussed with the IFS worker's supervisor, including: a discussion of issues pertaining to her lack of follow-up with the worker to ensure that instructions were followed, her failure to ensure that identified services for the family were provided prior to closing the case, and her failure to place documentation of her numerous written and oral reprimands in the IFS worker's personnel file and hold pre-disciplinary meetings, rendering her "discipline" ineffective.**

The Department agrees. The IFS worker's supervisor was counseled and the report was shared with her.

3. **The Department should require the supervisor to attend a Labor Relations training on proper procedures for implementing discipline.**

The Department agrees. The worker's supervisor will attend the next Labor Relations training on proper procedures for implementing discipline.

4. **The Department should clarify the purpose of Rule 315 Permanency Planning and its use by Intact Family Services.**

The Department agrees and has developed a comprehensive best practice guide regarding intact family services. The Department is currently translating the best practice guide into a policy directive.

5. **The Department's Associate Deputy Director, DCP-Cook County, should review and discuss with DCP Cook County administrators, Rule 302 Services Delivered by the Department of Children and Family Services, and supervisors' interpretation of the rule.**

The Department agrees. DCFS Associate Deputy Director discussed Rule 302 with staff.

6. **The Department should train child protection and DCFS/POS child welfare staff to forward additional substance use/abuse information gathered during the course of an investigation or delivery of Intact Family Services, to the Office of Alcoholism and Substance Abuse provider. This information can be extremely useful to the OASA provider in formulating: a more accurate client profile; testing the accuracy of client self reported information; providing additional information the client may be unable to supply because of the stigma and inherent denial associated with substance misuse/abuse. This supplemental information can be invaluable in determining whether or not a client is experiencing problems with alcohol or other psychotropic substances; whether or not the client needs substance abuse treatment; and, should treatment be indicated, making a referral to the appropriate level of care.**

The Department agrees. This recommendation is addressed in Substance Affected Families Policy 99.13. Training for staff on this policy was completed when the policy was issued. In addition, a training video is available.

7. **Portions of this report should be used as a learning tool with the private agency's extended family support program worker as it pertains to her involvement with the family.**

The Department agrees.

The OIG shared a redacted report with the private agency. The worker left the agency prior to the receipt of the OIG report. The OIG requested that the agency therefore share the report with the former worker's supervisor and director of the family support program.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION

An 11 year-old girl who had a seizure disorder drowned after suffering a seizure while taking a bath in her home. Eight months earlier, the girl's parents had been the subjects of an indicated report for medical neglect after failing to adequately manage her condition.

INVESTIGATION

The family became involved with the Department after the 11 year-old was found unconscious in the hallway of a building near the family's home following an apparent seizure. The girl was taken to a hospital emergency room where she was treated and released. The treating physician called the State Central Register (SCR) to report that blood tests performed while she was at the hospital showed she had not been taking the medicine required to control her seizure disorder. The doctor also stated that the girl had been treated at the same hospital after a similar incident one month earlier and tests conducted at that time had also found she was not taking her medication.

The girl had suffered from the seizure disorder for seven years and was prescribed two medications she was required to take three times daily. The father told the child protection investigator that on the morning of the incident he had given the girl her medication, however the girl stated that she is responsible for taking her medicine but had not done so on that day. There is no evidence in the case record that the investigator discussed the prior incident with the family. Following the visit, the investigator was instructed to develop a safety plan by her supervisor, which required the investigator to contact the girl's regular physician, create a plan with the family for the administration of the girl's medication during the investigation. The investigator was also required to contact the reporter who made the call to SCR.

After receiving these instructions from her supervisor, the investigator allowed 48 days to elapse before resuming her work on the case or implementing the required safety plan. The investigator resumed work on the case by again meeting with her supervisor who reiterated her previous directives and instructed the investigator to visit the family again as she had not seen them in over 30 days. The supervisor also directed the investigator to complete the case within six days in order to remain in compliance with the Department requirement to complete Child Protection Investigations during a sixty-day period. Four days later, the investigator made unsuccessful attempts to contact the reporter, an alternate contact provided to SCR, and the police officer called to the scene of the girl's collapse. The investigator then attempted to contact the doctor identified by the mother as the girl's personal physician but was told by staff at that hospital there was no one by that name on staff. She was able to locate a doctor with a vaguely similar name at another hospital who had once treated the girl seven years earlier and recorded his name in her case notes. The investigator then attempted to visit the family but the parents were not at home.

The following day, the deadline for completing the investigation, the investigator received a return phone call from the mother. The mother stated she did not know the correct spelling or pronunciation of her daughter's regular physician's last name although she did possess all pertinent information for the doctor that treated her son for his similar condition. The mother told the investigator she currently had an adequate supply of medicine for the girl but she did occasionally run out when she lacked enough money to pay for refills which she said cost $30. The mother stated that the girl's seizure had occurred during one of these periods and at the time of the incident she had been without her medicine for three days. At the conclusion of the conversation, the investigator informed the mother the case would be indicated for medical neglect. The investigator did not attempt to verify the cost of prescription refills. In an interview with the OIG, the investigator said although she doubted the prescriptions cost $30, she believed the mother might not always be able to afford to get immediate refills. An OIG investigator learned during a single phone call to the mother's insurance provider that the company covered 100% of the cost of prescription refills.

Following failed attempts to reach the emergency room doctors or the involved police officer, the investigator met with another worker who was acting supervisor while the regular supervisor was on vacation. The investigator submitted her recommendation to indicate and close the case without providing services and monitoring despite her failure to meet several fundamental Department requirements for completing an investigation, such as speaking with the emergency room doctors and the police officer, the reporters in this case. The investigator neglected to obtain the girl's medical records which documented her history of seizures related to periods of time when she did not take her medicine. The investigator also failed to identify the girl's regular physician or question why her mother was unable to provide basic information about the doctor's identity. The recommendation to indicate the parents for medical neglect and close the case was approved by the acting supervisor. In an interview with the OIG, the acting supervisor told investigators she felt pressure to close the case as it had reached the 60-day deadline. The acting supervisor stated she did not believe the case would meet the standard for an extension but did not pursue the possibility. The case closing did not include a follow-up provision to ensure the girl's medicine was regularly administered. In interviews with the OIG, both the investigator and acting supervisor expressed their belief that post-closing monitoring of families was not a function of the Department. Eight months after the case was closed, the girl drowned in her bathtub after suffering a seizure.

The girl's death prompted another hotline report and a second Child Protection Investigator was assigned to the case. The second investigator visited the family and questioned them regarding the girl's medicine intake. The statements given to the second investigator by the mother, father and various siblings contained several discrepancies regarding her compliance with taking her recommended dosage and who was responsible for ensuring it was administered. Although the girl's regular physician was identified in the supporting information provided to the second investigator, he failed to contact the doctor. Instead, the second investigator repeatedly attempted to speak with the physician who had treated the girl once seven years earlier whose name was included in the record of the first Child Protection Investigation. The second investigator also neglected to obtain confirmation of the girl's cause of death or whether blood tests showed the presence of her medicine in her system. A half-full bottle of medicine brought to the hospital with the girl had not been refilled for almost one year.

Instead of demanding a thorough investigation, the Child Protection Manager overseeing the second investigation approved the investigator's recommendation to indicate the parents for death by neglect, medical neglect and substantial risk of physical injury based primarily on the family's conflicting stories and the previous indicated report for medical neglect. The surviving children remain in the home, and the family is currently receiving intact family services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue disciplinary action against the first Child Protection Investigator.

The Department agrees. The Child Protection Investigator received a 10-day suspension. The employee grieved this discipline. The grievance is pending.

2. The Department should pursue disciplinary action against the first Child Protection Investigator's acting supervisor.

The Department agrees and the acting supervisor was counseled.

3. This case should return to the Cook County Child Death Review Team to consider whether a referral should be made to the Illinois State Police for evaluation of criminal charges against the girl's parents.

The Department agrees and the report was shared with the Child Death Review Team. No referrals or recommendations were made

4. This report should be shared with the second Child Protection Investigator, his supervisor, and the Child Protection Manager.

The Department agrees and the report was shared.

5. This report should be shared with the worker and supervisor providing intact family services to the family.

The Department agrees and the report was shared.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION

A nine-year-old girl with cerebral palsy died ten months after being returned to her mother and two and a half months after her case was closed in court. The Medical Examiner determined that her death was due to blunt abdominal trauma. Although the Department indicated the child's mother and the paramour for the death, it was not able to determine who inflicted the blows on the girl. The girl's death was the sixteenth hotline allegation against the mother.

INVESTIGATION

The mother of the girl was fourteen years old when she gave birth to her first child, a girl who had cerebral palsy and was developmentally delayed. The Department took custody of the girl after the mother was indicated for medical neglect for her failure to obtain treatment for her daughter. The girl was placed with her paternal grandmother with whom she stayed until she returned home to her mother five and a half years later.

The mother had six other children after her daughter was born. About a year after the girl was placed in care, the Department took custody of three other children who remained in care for four years. Prior to the girl's death, fifteen hotline reports had been made to the Department. The mother was indicated on eight of the hotline reports, including five for medical neglect, one for risk of harm, one for burns by neglect as to the girl with cerebral palsy, and one of substance misuse for the last child who was born substance exposed. Reports that were called in but not indicated included medical neglect, and cuts, welts and bruises.

During the time the girl was in care, the mother participated in numerous services including a psychiatric evaluation, psychological examinations, a bonding assessment, parenting classes, therapy and anger management. Although the evaluations offered contradictory information and different diagnoses, they did reveal a history of depression, chronic anger, hostility and verbal and physical aggression towards child welfare staff, and suicide attempts.

The girl returned to her family five and a half years after coming into care. Although the mother had multiple problems and an extensive history with the Department, there was general agreement among child welfare staff that the mother had made significant improvement and that it was safe to return the girl to her. When the girl returned home, her mother was caring for five other children, all under seven years of age. Services in place when the girl returned home included counseling for the mother, homemaker services, and monitoring by child welfare staff. Less than a mother after the girl returned home, hospital staff reported to the hotline that the girl had suffered burns that had occurred when she had tried to run her own bath water. There were different opinions among those who had worked with the girl as to whether she would have been able to turn on the bath water by herself. The Department indicated the mother for burns by neglect and homemaker services were increased. At about the same time, staff at the girl's school called the hotline regarding marks they had observed on the girl. The DCP investigator unfounded the report based on interviews with the treating physician and homemaker who had observed the girl's self abusive behaviors that included hitting and biting herself.

The case was closed in court seven months after the girl returned home. At the time the case was closed, the mother was pregnant with her seventh child. Child welfare staff felt that the mother had sufficient support with the paternal grandmother who took care of the child on most weekends, child care for the new baby, a paramour who was supportive and helped out with the children, day care, continued therapy, and effective anger management. Although child welfare staff had concerns about the mother's anger, they noted that she was calmer and had had fewer incidents of anger. Staff was more concerned about the mother's ability to follow through with medical treatment for the girl since it was this issue that had first brought the case to the attention of the Department and had been the focus of most of the hotline reports.

Four days after the case had been closed in court, staff at the hospital reported to the hotline that the mother and her newborn had tested positive for cocaine. Because the previous agency did not have intact family services, the case was assigned as an intact family case to a different agency than the one that had worked with the mother for the past six years. Because of lack of funding for certain services, the agency was unable to provide the mother with respite and therapy that the mother requested. The new baby stayed in the hospital for a few weeks and was then released to the mother. About six weeks after the baby was born, staff at the girl's school noted two incidents in which they observed bruises on the girl. The case manager who had worked with the case for the past two years went to the school and did not observe any bruise on the girl. In the second incident staff observed bruises but thought they might have been self-inflicted (the girl had a history of self abusive behaviors). No hotline call was made on either incident. A caseworker visited the home a week before the girl's death and reported that everything was fine.

Because none of the evaluations had competently addressed the issue of how the mother's mental health might affect her parenting abilities, the OIG requested that the mother receive an assessment from the Parenting Assessment Team. The Parenting Assessment Team concluded that the mother's other children were at risk for maltreatment. The Department took custody of the children who remain in care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Children with developmental disabilities should have a Life Plan similar to a Life Plan developed for use with developmentally delayed people to minimize the challenges they present to the caretaker or the parent after the child returns home. Such a plan would help caretakers meet the child's needs and ensure a smoother transition when the child returns home or moves to a different caretaker. (The Life Plan was developed by Sheila Ryan-Henry, ACSW, Executive Director, Seguin Retarded Citizens Association, and Shu-Pi Chen, DrPH, RN, Professor, College of Nursing, University of Illinois at Chicago.)

The Department agrees and the Clinical Division will develop a standard Life Plan, with guidelines, for wards with developmental disabilities. The Life Plan will be reviewed with the caretaker/parent before a child returns home. Additionally, the Clinical Division will include the Life Plan as part of the developmental disability training curriculum.

2. Current Department licensing rules require that the maximum hot water temperature shall not be more than 115 degrees in a foster home that accepts children under the age of ten or who are developmentally disabled. Prior to the return home of a child with developmental disabilities, the worker should arrange for an agency that provides services to persons with disabilities (United Cerebral Palsy, Access Living, Easter Seal, the Rehabilitation Institute of Chicago, etc.) to conduct an occupational/safety review of the home to guide the case manager and educate the family on how to make the home environmentally conducive and safe for the disabled child.

The Department agrees that a home study referral to Illinois Assisted Technologies (IAT) or similar agency will be made, by the caseworker, when return home or unsupervised visits for a developmentally disabled ward are being considered.

3. The Child Protection Investigator should be counseled by her supervisor for her failure to review prior reports against the mother, for her failure to adequately assess risk, and for her failure to obtain information relevant to the investigation.

The Department agrees. The employee resigned before counseling could be completed.

4. The Department should counsel the intact family caseworker for her failure to properly monitor

the services offered by private agencies in their intact family cases and for her failure to provide leadership in ensuring that the receiving agency received the records it needed to provide services in this case.

The Department agrees. The employee was counseled.

5. a) The Department should not contract with the doctor in this case for future parenting assessments involving disabled children or mentally ill parents.

The Department no longer contracts with the doctor.

b) The Department should refer the completed parenting assessment for investigation as to why the referral did not go to the Parenting Assessment Team. The findings should be reported to the Director and the OIG. The Department should ensure that its screening protocol provides for referrals of mentally ill parents to the Parenting Assessment Team.

The assessment was referred for review. *No implementation status provided* Psychologists have been instructed to refer all parents with mental illness to the Parenting Assessment Team..

6. In previous cases the OIG has recommended that prior to the return home, a collaborative staffing be held among all the professionals who had provided services to the family within the last year. This staffing should include the treating physician and the child's teacher. This recommendation should be part of the Return Home Protocol

The Department, through the Best Practice Initiative, has addressed case closing for intact cases and placement cases. Intact cases require that 30 days prior to closure, there must be a staffing of service providers, a child and family team meeting and an aftercare plan developed with the family. Placement cases require extensive work prior to the return of the child, in addition to extensive contact with the family for the first 30 days after returning home and continued contact for up to six months.

7. Reports to the court should be comprehensive, including at a minimum parental involvement and the parent's cooperation with services, all incidents of domestic violence, concerns regarding compliance with the service plan (especially focusing on issues that brought the family to the attention of the Department), how the child is doing across critical settings such as school, health, and therapy, concerns voiced by other professionals who have worked with either the caretaker, or the children, life changes that affect caretaking (such as a new pregnancy), and CANTS and LEADS.

The Department agrees.

8. It is important that workers have information as to whether a parent or the caretaker is receiving disability benefits. The Department should contact the Illinois Department of Public Aid to determine how the Department can access that information and make it available to caseworkers.

The Department agrees. DCFS caseworkers have access to public aid data.

9. The Division of Child Protection should consult with staff at the medical institute involved in this case to review with them lessons learned from this case.

The Department agrees. The Deputy Director of the Division of Child Protection has met with the social worker at the medical institute.

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION

Police found a 10 year-old boy who was lost and wandering alone at night. He could not give police his address. The boy told officers of severe, ongoing physical abuse inflicted by his mother. When the boy was found, the Department's Division of Intact Family Services (IFS) was servicing the boy's family. A private agency worker referred the case for a review of the prior intact services.

INVESTIGATION

The family became involved with the Department one year earlier after the boy's teacher contacted the State Central Register (SCR) and reported that he had arrived at school with linear welts and bruises on his face extending from the corner of his eye to his hairline. The Child Protection Investigator assigned to the case completed a body chart documenting loop marks and scabs covering the boy's arms, face and torso as well as bruises of varying ages over his entire upper body. The investigator interviewed the boy's mother who admitted hitting her child with a belt for poor behavior and wetting the bed. The mother also stated that corporal punishment was the only form of discipline with which she was familiar. The investigator noted that the family's home was "filthy," that the boy and his two siblings, a four year-old girl and a one year-old boy, were wearing dirty clothes and that the mother consistently referred to her oldest son in a derogatory manner. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) plan that concluded the children would be in immediate danger if the children continued to live under current conditions. The investigator instructed the mother to refrain from corporal punishment, improve the condition of the home, update the children's immunizations and ensure they attended school. The investigator referred the mother for parenting classes and transferred the case to Intact Family Services.

From the outset, the intact family worker failed to comprehend the precarious living situation facing the children or the high probability the mother would be unwilling or unable to adequately care for them. The family was living with the maternal grandmother. The mother told the worker they had been evicted from city housing for failing to pay back rent of $161.26. Both the worker and his supervisor identified homelessness as the primary issue for the family. The only services provided to address the serious abuse issue was parenting classes, which the mother failed to attend for a full year.

The 10 year-old's school records showed that during the previous year he had missed 88 of 173 school days. He was performing at a kindergarten level. During the time the intact family worker was assigned to the case, notices of non-promotion were issued three times and the boy's teacher reported she was unable to complete a progress report for the child because he had not spent enough time in school. The intact worker provided no services designed to ensure the boy's attendance at school. In addition, although the worker spoke to the school principal, he never met with the boy's teacher to involve her directly both in ensuring the boy's academic progress and monitoring his physical and emotional well being. The worker failed to note the potential connection between the boy's chronic absence from school and the possibility that his mother continued to abuse him. The four year-old girl was developmentally delayed and was not enrolled in head start. Despite her obvious educational needs, the worker's only action was to provide the mother with a list of daycare centers. After the mother informed him that the few centers she contacted had no spaces available, the worker did not address the issue again.

Both the worker and his supervisor believed that workers were only permitted to observe areas of children's skin that were in plain view. This inaccurate understanding of Department Rule and Procedure prevented the worker from conducting or requiring simple examinations that could have discovered the continuing abuse at an earlier stage. In addition, despite learning early on that the mother was not attending her parenting classes, in direct violation of the safety plan implemented by the Child Protection Investigator, the worker ignored the mother's non-compliance. Both the worker and his supervisor neglected to approach the family's case with

the urgency it required based on the event that necessitated Department involvement and the mother's behavior following the initiation of services. Both the worker and supervisor explained that they did not treat the case as high risk because they assumed that if the risk of subsequent abuse was high, the case would not have been assigned to the Intact Family Services Unit. No one ever assessed the depth of the abuse in the family.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. In intact family cases where an issue is physical abuse (similar to return home cases where the issue was physical abuse, as outlined in a prior OIG report), the worker should meet with the child's teacher or day care provider and request that he or she notify the worker if the child is absent for two consecutive days. The request should be incorporated into a CERAP Safety Plan and a copy should be given to the teacher or day care provider. In addition, when there is a pattern of absenteeism, the worker must regularly meet with the teacher to get attendance reports.

The Department agrees and has developed a comprehensive best practice guide regarding intact family services. The Department is currently translating the best practice guide into policy directive.

2. While DCFS Rules provide specific guidelines for when and how it is permissible to view children's bodies to look for physical abuse, the rules provide no guidelines for intact family workers. Intact family workers must be able to monitor children for abuse when (1) the presenting problem for case opening was physical abuse or (2) when the worker reasonably suspects the child may have been physically abused (e.g., the child makes a statement of abuse or the child exhibits a mark on his clothed body that is suspicious for abuse). Procedures, similar to those set out for child protection workers, must be established for intact family workers to assess children for physical abuse.

The Department agrees and has developed a comprehensive best practice guide regarding intact family services. The Department is currently translating the best practice guide into a policy directive.

3. The boy's current caseworker should ascertain if the boy has had a comprehensive developmental assessment within the last year. If not, the caseworker should arrange for such an assessment.

Because of the boy's age, a comprehensive developmental assessment was not completed. However, in October 2001, the child received a psychological evaluation and subsequent special education assessment by the Chicago Board of Education. The recommendations made from these assessments have been implemented.

4. The Department should pursue disciplinary action against the IFS worker's supervisor for her failure to recognize physical abuse as the primary problem in this family and assess further risk of injury, account for differences in CERAPS, and develop a safety plan.

The Department agrees. The supervisor received a written reprimand.

5. The Department should pursue disciplinary action against the IFS worker for his failure to recognize physical abuse as the primary problem in this family and assess further risk of injury.

The Department agrees. The worker received a one-day suspension.

6. The Department should ensure that data about the re-abuse of children, by age breakdown, is incorporated into Division of Child Protection (DCP) and Intact Family Services training.

The Department agrees. The training curriculum is currently under revision. This will be included in those revisions.

7. The Department should target special intact family services teams to service cases with indicated findings of physical abuse. The teams should be trained using the latest research on the recognition and treatment of physical abuse and be proactive in requesting court intervention to promote parental compliance.

The Department believes that having special intact family services teams that specialize in physical abuse only is inappropriate for the majority of our cases. Most cases involve multiple social issues and workers involved must be able to identify and provide appropriate service for all the issues presented.

DEATH AND SERIOUS INJURY INVESTIGATION 11

ALLEGATION

A two year-old boy was beaten to death by his mother's girlfriend. At the time of the child's death, both the mother and her girlfriend had open child welfare cases with separate private agencies. The girlfriend had four indicated abuse reports against her and two of her children had been removed from her care.

INVESTIGATION

The mother's family first became involved with the Department after the boy tested positive for cocaine at birth. The mother was indicated for substance exposed birth and entered a drug treatment program. Two weeks later the mother abruptly left the program and, after admitting continued drug use, she was indicated for risk of harm and the boy was placed in a foster home. Nine months later the mother entered an inpatient drug treatment program and resumed participation in services. The mother successfully completed the treatment and was transferred to the outpatient program which included housing provided by the organization. The mother continued to comply with services and, following a positive assessment of her ability to care for her child, the boy was returned to her custody. Following reunification, the mother continued participating in services and secured employment after graduating from a job-training program.

The mother needed day care services supplemented by a private baby sitter. The babysitter enlisted by the mother was a friend, another resident of the housing facility in which she and her son lived. Upon learning of the babysitter, the caseworker conducted a Child Abuse and Neglect Tracking System (CANTS) check on the woman. The CANTS check found the babysitter had several prior indicated reports including risk of harm to her own son and inadequate supervision of five children while she was employed as a residential child care worker. The inadequate supervision report also involved an indicated report against an unknown perpetrator for sexual penetration. The babysitter gave an incredible explanation of the indicated findings claiming that the incident that occurred while she was a child care worker was because she discovered sexual abuse by another worker against a child at the facility. The caseworker accepted the babysitter's explanation and allowed her to continue providing care to the boy. An OIG review of the police investigation into the incident at the facility found the babysitter's involvement had been substantially more significant than she indicated to the caseworker. Notes in the police file showed the babysitter had initially been uncooperative with the investigation and several other employees of the facility reported the woman was abusive towards children who lived in the home. In addition, the OIG conducted a Law Enforcement Agency Database System (LEADS) check of the babysitter's criminal history. The check showed the woman had an extensive history of arrests as well as convictions for battery, retail theft and obstruction of justice. The caseworker never conducted a LEADS check to ascertain the babysitter's possible criminal history.

During her involvement with the family, the caseworker also became aware that the mother had developed a relationship with another woman who spent a great deal of time with the boy. The caseworker requested the woman's name and birth date in order to conduct a background check. The mother provided the information to the caseworker verbally. The caseworker's recorded spelling of the girlfriend's name was incorrect. Compounding the problem, the Soundex system, which is designed to find any name that sounds like the names searched, failed because the Soundex program did not identify the particular misspelling as a "sound-alike." As a result, the CANTS report returned to the caseworker showed the girlfriend had no prior history of abuse. In reality, the girlfriend had four previous indicated reports against her and two of her three children had been removed from her custody. Following the boy's death, the girlfriend confessed to police that she beat the two year-old to death while the mother went to work and a doctor's appointment.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should require that anyone doing a CANTS check on a potential caretaker obtain a copy of that person's driver's license or state ID to ensure the correct

spelling of their name. This would omit the possibility of incorrect name spellings leading to inaccurate CANTS findings.

Although not all individuals have a driver's license or state ID, the Department agrees that efforts should be made to ensure the correct spelling of a potential caretaker's name during a CANTS or LEADS check.

2. The Soundex system should be adjusted to equate soft "c" and "s" sounds.

The Department agrees. The SACWIS system does equate soft "c" and "s" sounds.

3. This report should be used as a teaching tool for training purposes with the involved private agencies.

The Department agrees. A redacted report was shared.

4. This report should be shared with the private agency that handled the mother's case to counsel the caseworker not to rely on self-report information for circumstances surrounding such serious allegations.

The Department agrees.

The OIG shared a redacted report with the caseworker's private agency. The private agency did not agree that the caseworker should be counseled.

DEATH AND SERIOUS INJURY INVESTIGATION 12

ALLEGATION

A six year-old boy died of hypothermia after his foster mother held him in a bathtub of cold water for 45 minutes as a means of discipline. The foster mother had previously been the subject of an unfounded Child Protection Investigation following the boy's disclosure of a similar incident.

INVESTIGATION

The foster mother had originally been licensed in 1995 but transferred to a second private agency for unknown reasons. The second agency placed a six month-old boy in her home, however after that agency closed, the foster mother's license was transferred to a third agency. During the course of these transfers, the majority of records regarding the foster mother's training, history of care, family composition and other pertinent information disappeared from the licensing case file. A former worker from the private agency that issued the initial license stated that prior to the transfer, staff members had serious concerns regarding the foster mother's ability to care for children, but there was no documentation of their concerns in the licensing file. The third private agency made no attempt to contact previous workers involved with the family or to reconstruct the licensing file. In addition, agency workers were unaware until after the boy's death that two teenage girls the foster mother presented as her nieces, who often served as caretakers, were actually the woman's daughters and lived in the home. Although one of the few original documents remaining in the file mentioned the foster mother lived with her daughter, agency personnel did not question this information, which could have alerted them to the foster mother's misrepresentation of her family history. During the course of the police investigation, following the boy's death, it was learned the foster mother had instructed her daughters to comply with the deception to enable her to receive public aid funds on their behalf. No effort was made by the private agency to ascertain whether the foster mother was receiving public aid benefits.

A Child Protection Investigation was initiated after the boy told his therapist that the foster mother had forced him to stand in a cold shower because he had taken a cupcake without permission and that she sometimes struck him in the head. The Child Protection Investigator assigned to the case spoke to the therapist, who expressed her belief the boy was not in immediate danger. Based on the therapist's recommendation, the investigator did not remove the boy from the home. She did not see the boy for three days, at which time, he recanted his previous allegations, and stated that the incidents had never occurred. The allegations were unfounded. The supervisor assigned a new caseworker to provide services to the foster family. Although the new caseworker conducted monthly visits, the case notes contained little substantive information or useful observations regarding the quality of life in the home.

Throughout the course of the foster mother's involvement with the private agency, staff found her to be uncooperative and resistant to child welfare services. The foster mother frequently described the boy to workers and therapists as being dishonest, unruly, aggressive, prone to hallucinations and suffering from speech delays. These characterizations influenced the opinions of the child welfare workers and therapists who provided services to the family. Although the boy frequently reported being denied food as punishment and told numerous individuals he had no sources of stimulation, such as toys or books, in his home, the foster mother relied on the boy's unsubstantiated history of lying to explain his statements. There were also concerns the boy was not being adequately supervised, including reports from workers that the foster mother left the boy (then 5 years-old) alone outside to wait for rides to visits with his mother and an incident when he left the home and traveled public transportation alone to a large urban area. The agency initiated action to remove both children from the home, however the foster mother appealed the decision and the two sides agreed to engage in mediation. Following the session, the agency agreed to allow the children to remain in the home based on the foster mother's assurances she would comply with services. The agency failed to monitor whether the foster mother fulfilled the agreement.

Although private agency staff was aware of the boy's poor attendance at school during the previous academic year and addressed the issue during mediation, no effort was made to confirm his enrollment or interact with school personnel. The caseworker wrote in the case notes that the boy attended school regularly whereas school records showed he missed more than one-third of class days. The caseworker also failed to obtain an education report required to conduct an Administrative Case Review (ACR) in accordance with Department rule. An ACR was held one month prior to the boy's death. However there was no indication from the case record that the reviewer questioned the caseworker's reports regarding educational compliance or received the required documents. No one involved with the family case; private agency staff, the therapist, the child protection investigator or the ACR reviewer, ever contacted the boy's teachers or personnel at his school. In an interview with the OIG, the boy's teacher stated that although the child often seemed sad and withdrawn he did not present any of the behavioral problems described by the foster mother and repeated throughout case documentation. The teacher said that she frequently observed the boy taking multiple meals during lunch periods but that when she questioned the foster mother, the woman replied that the child was greedy.

Involved child welfare professionals neglected to ensure that a comprehensive approach to providing services to the foster children in the home was employed. Individuals responsible for various aspects of service delivery failed to interact with their professional counterparts which prevented all of those involved from developing a complete understanding of the living situation experienced by the two children in the foster home. Although the six year-old's therapist and his foster brother's occupational therapist worked in the same hospital, there is no indication that any collaboration occurred between the two, despite their involvement with children in the same foster home. The hospital's inability to implement an ecological approach in its treatment of families was indicative of the absence of an integrated strategy for providing services to the children.

An investigation initiated by the OIG following the six year-old's death found a number of violations committed by the private agency during their handling of the case. The OIG investigator examined the files of other cases and found several additional instances in which the work performed by agency personnel failed to meet Department standards. In an interview with the OIG, the agency's licensing supervisor was unable to provide an explanation for the inadequate work and was unfamiliar with numerous, fundamental aspects of licensing procedure. The supervisor has since accepted a similar position with another private agency.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Inspector General has had other cases in which a foster parent's or parent's public aid status would have been important information for the licensing entity or the worker to consider in their assessment of the suitability of the person as a caretaker. The Department should require that a public aid check be completed when licensing a foster parent or in a Child Protection investigation of the parent or caretaker.

The Department agrees that a public aid check would be beneficial in verifying who is living in the home. All Department staff has access to public aid screens. The Department will issue a reminder to staff to utilize this tool in identifying who is living in the home.

2. The licensing supervisor was unfamiliar with some licensing rules and procedures. The private agency where she is currently employed should ensure that she receives training on Department Licensing Rules and Procedures.

The Department agrees.

The licensing supervisor is no longer employed in child welfare.

3. Prior to mediation, the Department should require that a full school report on the child or children who are the subject of the mediation be prepared and made available to all parties and the mediator.

Mediation is no longer a part of the Department's due process. The clinical division now reviews all placement moves. The Department agrees that when school issues are pertinent to the review, all school records should be reviewed.

The Inspector General believes that in all cases where placement of a child is at issue, school performance is pertinent.

4. The Department must ensure that wards are receiving quality mental health services. In contracting with any entity providing mental health services to wards, the Department must require that the mental health providers use an ecological approach and contact the appropriate school personnel to obtain information about the child in the school setting.

The Department agrees. A Best practice resource committee has been formed and is developing a protocol that will require practice standards for mental health treatment providers. The protocol will include the OIG recommendation.

5. The ACR reviewer's supervisor should review documentation in cases under his review to ensure that the ACR reviewer is discharging his duties regarding the educational needs of wards.

The Department agrees. The Program Manager has reviewed the employee's feedback and also spends once a week observing the employee during reviews.

DEATH AND SERIOUS INJURY INVESTIGATION 13

ALLEGATION

A five year-old boy required emergency room treatment for seizures induced by water intoxication. The boy was also found to have numerous bruises at various stages of healing. The boy had resided in a foster home placement for 10 months prior to his hospitalization.

INVESTIGATION

The foster mother had been licensed through a private agency since 1996 for a maximum of four children in her home. Prior to the boy's placement, the private agency's licensing worker learned the foster mother was caring for the infant daughter of a friend in addition to the four children already placed in her home. Although the number of children exceeded her capacity and constituted a violation of Department rule, the licensing worker recorded that the foster mother was in full compliance with licensing regulations. The licensing worker did not discuss the issue of non-compliance with the foster mother until six months later, at which time another relative agreed to assume responsibility for the infant. The licensing worker informed the Vice-President of the agency that she would conduct a follow-up visit. However, the visit did not occur and the licensing worker did not return to the home for eight months.

Two different caseworkers from the agency serviced the four children placed in the home. Although a homemaker assisting the foster mother continually noted that the boy had a frequent habit of defecating in his clothes as well as various locations around the house and throwing and smearing feces and that he seemed increasingly despondent and withdrawn, this information was never shared with the boy's caseworker. Other problems in the foster home were not addressed. A second homemaker's services had to be discontinued as a result of the foster mother's rude behavior and refusal to cooperate with procedures. Both homemakers documented that they observed the foster mother's aggressive, derogatory treatment of the children in general and the boy specifically. In an interview with the OIG, the first homemaker stated the foster mother believed the boy's bowel control problems were intentional which greatly influenced the way she behaved towards him. Neither the involved caseworkers nor their supervisor ever investigated any of the homemakers' concerns or spoke with them directly regarding their observations of the dynamics in the home.

Because of the boy's frequent, uncontrolled bowel movements, he was referred for Screening Assessment and Support Services (SASS) Crisis Intervention/Client Assessment. The initial assessment resulted in a diagnosis of adjustment disorder and conduct disturbance because of problems with his primary support group. No therapeutic services were provided for the boy in general or to address his encopresis.

The foster mother sought medical treatment for the boy's uncontrolled bowel problems. A number of physicians were consulted regarding the boy's encopresis. However, his caseworker did not ensure that doctors, many of whom were based in the same hospital, collaborated regarding the boy's care. One physician eventually began the boy on a course of treatment that required the foster mother to administer periodic enemas. After the boy was brought to the hospital suffering from seizures induced by water intoxication, medical investigators traced the cause to the foster mother's overuse of the enemas. Paramedics and treating physicians also observed ligature marks on the boy's wrists and ankles, indicating he had been forcibly restrained. The foster mother initially stated she tied the boy to his bed in order to prevent him from acting out and throwing feces. The foster mother later contradicted these statements and said she had not seen any bruises on the boy and was unaware of how they might have occurred. The foster mother was indicated for child abuse.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency should be placed on hold based on the findings of this report including:

A. Failure to ensure that the boy was provided with the services he required while placed in the foster home. In this case, private agency workers demonstrated a pattern of service referrals with no follow

up. Thus, no services were successfully put into place.

B. Failure of the private agency's licensing division to adequately monitor the home. First, the foster home was out of compliance with licensing standards, and without consequence, from June 1998 until at least January 2000. Second, during the time that the boy was placed in the home—from August 1999 until May 2000, the licensing division did not address the concerns raised by the homemakers regarding the treatment of the boy as possible licensing violations.

The Department agrees. The agency was placed on hold June 5, 2002. The hold was released on June 27, 2002 after consultation with the OIG.

The OIG shared a redacted report with the private agency. The Inspector General met with the Executive Director, agency administrators, and members of the Board of Directors to discuss the report. The private agency submitted a corrective plan to address the deficiencies noted in the OIG report. The agency amended internal procedures as follows: (1) case assignment procedure will include contact between the case manager and the child's teacher/social worker at time of case assignment to request notification from the school in the event a child is absent for more than two consecutive days; (2) case management supervision will include a discussion of client service provider reports; (3) licensing monitoring visitation procedures will require documentation of licensing violations on a Licensing Violation Report submitted to the supervisor for signature and attached to the monitoring record; and (4) multi-disciplinary staffing procedure will require a quarterly staffing with case managers, supervisors, licensing representatives, and clinical staff in cases where two or more children with different case managers are placed in the same home.

2. In order to ensure that licensing violations are adequately addressed, the Department should require that upon discovery of a violation, a written plan of action is established. This plan should include 1) the specific changes needed to rectify the violation, 2) a reasonable time-line for compliance with an expected date of completion, 3) a follow-up home visit within two weeks of the expected date of completion with the licensing worker and supervisor to ensure that the home is no longer in violation.

The Department agrees and a comprehensive rule and procedures for licensing monitoring, complaint investigations and enforcement is being developed.

3. The Department should require that in cases where two or more children (including recently adopted children) are placed in a foster home and those children have different caseworkers from the same agency, a staffing should be held in order to facilitate the integration of information about the children and the home.

DCFS Procedures 315 require that within 72 hours of placement that the worker meet privately with the child just placed as well as all other foster children in the home who are not on their caseloads. The Department agrees that communication between all caseworkers of children in the home is important. There should be discussion regarding the needs of the individual children and to ensure that the placement is appropriate. The Department agrees to develop a policy that will address this issue.

4. Upon case assignment, a caseworker should visit a child's school and meet with his/her teacher and request that the teacher contact the caseworker or supervisor if a child is absent for more than two consecutive days. Upon receipt of that information, a caseworker should conduct a home visit.

The Department currently runs an attendance hotline for reporting children's absences and has a process for follow-up with the worker and developing action plans when truancy occurs. The Department agrees that discussions between workers and teachers should be ongoing.

5. The licensing worker should be counseled for failure to adequately follow up once it was discovered that the foster mother was in violation of Rule 402.15.

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

The Licensing Representative on this case is no longer employed with the private agency.

6. The boy's caseworker should be counseled for failure to follow through on SASS' recommended services including: speech therapy, respite care, mentoring, individual and family counseling.

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

The Case Manager on this case is no longer employed by the private agency.

7. The caseworker's supervisor should be counseled for poor supervision on this case. Overall, the supervisor failed to assess the severity of the problems that the boy was experiencing in the home, as evidenced by the following examples:

A. Reviewed homemaker's notes but failed to assess the high-risk nature of the home.

B. He failed to follow through, or ensure that the caseworker followed through on the recommendations made by SASS which included:

1. **Speech therapy**
2. **Mentoring**
3. **Respite care**
4. **Individual therapy**
5. **Family therapy**

C. Although he knew that over three months had passed since a referral was made to ITS, he did not aggressively pursue any other treatment alternatives, thus leaving the boy languishing in the foster home.

D. Although the supervisor had knowledge of the boy's ongoing behavior, he failed to ensure that a home visit was conducted after the foster mother gave a 14-day notice for removal of the siblings from her home.

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

The private agency did not counsel the supervisor on this case. The private agency reports that the supervisor was a newly assigned supervisor who has gained experience, knowledge, and crisis management skills.

8. The Department should refer this report to the Inspector General-Board of Education because of the failure of the boy's school to maintain complete and comprehensive records. The records that were located and sent to the OIG were illegible, undated, and provided no insight into the boy's reported absences.

The Department agrees, but has asked the OIG to make the referral.

9. This report should be shared with the Administrator of Intensive Therapeutic Services (ITS) because of their failure to refer the boy for appropriate services once they received the referral from the private agency. When the OIG attempted to follow up on the referral, it was discovered that ITS lost the referral sometime after February 2000, and consequently no therapeutic services were put into place for the boy.

The Department agrees and the report was shared.

10. The Department should assess the ITS program to determine whether additional staff is necessary to fill Department needs.

The Department agrees and integrated a number of services, including ITS, into a new community based system of care effective July 1, 2002.

11. This report should be shared with the director of SASS because of SASS' failure to provide services to the boy. The SASS record from this case did not indicate that there were any in-person contacts with the boy, and none of the tasks identified on the Individual Treatment Plan were completed.

The Department agrees and the report was shared.

12. This report should be shared with the Agency Performance Team Monitor for the private agency.

The Department agrees. The report was shared.

13. A pediatric incontinence clinic should be explored as the primary treatment option for foster children with encopresis.

The Department agrees to look at the issue with the DCFS Medical Director.

DEATH AND SERIOUS INJURY INVESTIGATION 14

ALLEGATION

A three year-old boy with complex medical issues died after suffering a seizure. At the time of the boy's death, his family had an open case with the Department for Intact Family Services (IFS).

INVESTIGATION

Prior to the boy's birth, his mother had been the subject of indicated reports for cuts, welts and bruises and risk of harm for hitting her nine year-old daughter. The mother successfully completed her case plan with IFS and the case was closed. One year later, the mother gave birth to the boy who experienced several serious health problems and required extensive, diligent medical attention. At the age of six months, the boy required hospitalization after suffering respiratory arrest and resulting brain disease caused by a lack of oxygen. Upon discharge, the boy was scheduled for several follow-up appointments as well as a referral for a zero to three program. His mother failed to pursue these courses of treatment. Five months later, his paternal grandmother brought the boy to a hospital emergency room with a high fever and severe dehydration. The boy was treated and released. The boy returned four days later after symptoms reoccurred. The attending physicians were concerned about possible medical neglect and contacted the staff social worker. The social worker reviewed the boy's medical records and interviewed the mother and paternal grandmother. The mother agreed to attend all future scheduled appointments, but the boy received no medical attention for seven months until his grandmother brought him into another hospital emergency room for fever, vomiting and diarrhea.

One week later, the boy was admitted to the hospital for failure to thrive and malnutrition. The mother stated the boy had been receiving treatment at another hospital and had been taking his medication, however hospital staff contacted the other institution and found the boy had not been seen in over six months. Blood and urine tests performed on the boy were negative for traces of his medication.. Hospital staff called the State Central Register (SCR) and a Child Protection Investigator was assigned to the case. The investigator indicated the report against the mother for failure to thrive and the supervisor approved the recommendation. Upon being released from the hospital, the boy was placed with his grandmother through a private arrangement and the case was referred for intact family services.

The grandmother proved to be a capable, dedicated caretaker for the boy, but her efforts were impeded by the mother's obstruction of the boy's treatment. The mother failed to provide the grandmother with the boy's medical card, required for doctor visits, despite repeated promises to do so. The mother received the boy's disability benefits but did not transfer the funds to the grandmother. The family's caseworker documented in her notes the mother's refusal to cooperate with the grandmother and the Department and the detrimental effect her actions had on her son's welfare. Despite the mother's obstruction of her son's care, the status of the case was never changed from Intact Family Services. No attempt was made to screen the case into court. Four months after the boy was placed in the grandmother's home she found him lying unresponsive on the floor. The boy died of a seizure and the accompanying restriction of oxygen to his brain. Involved physicians stated the grandmother had taken exemplary care of the boy and were surprised by his sudden death.

The initial decision to offer services to the family without screening the case into court ignored the mother's previous involvement with the Department following her indicated report for striking her daughter. In addition, the mother's failure to comply with the conditions of service and refusal to cooperate with the grandmother and the Department demonstrated a pronounced risk to the welfare of a medically complex child. The mother's blatant disregard for her son's health constituted behavior suggesting the mother would not be an adequate caretaker and should have prompted the supervisor to screen the case into court.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should develop guidelines for the use of private arrangements pending child protection investigations

and provision of services such as:

a. An evaluation should be conducted at the outset of a private agreement, that the threat to safety, giving rise to the need to remove the children can be addressed through the private caretaker agreement and that the parent is cooperative both with the placement agreement and any service plan.

b. The evaluation should include a realistic assessment of the duration of the private care taking agreement.

c. After an agreement has been in place for 30 days and every 30 days thereafter, there must be a reevaluation to consider the continued advisability of the private agreement, examining the strength of the family, its' history, and the amount of time it will take before the child/children can be returned to their natural parent.

d. Intact family workers and child protection investigators will be instructed to secure full consent from parents so that private caretakers have full knowledge of all relevant information. A child's safety cannot be assured when the private caregiver does not have full information.

e. The natural parent must fully cooperate with all directives made by the Department. The consequences of non-cooperation will be explained to the natural parent. Once non-cooperation is apparent in a case the Department should reassess the continued advisability of the voluntary placement.

f. If it is determined that the child/children will not return to their natural parent(s), the caretaker should be given the opportunity to gain guardianship via probate court.

The Department agrees. When it is necessary to remove children from their home because of a safety issue, a safety plan is developed that may require that a child reside with a relative or family friend while services are provided to the parent. Department procedures require that safety plans be short-term temporary interventions. If a child cannot safely return home then the worker would be required to formalize the arrangements which may include either probate or juvenile court action. Department Procedure 300 requires a plan that contains a time frame for implementation and continued monitoring and a contingency plan if the primary safety plan is no longer useful. Procedure 300 is also being revised to require that safety assessments for children who have been found to be unsafe must be repeated on a weekly basis to re-evaluate the child's status. Parents are now required to sign a statement indicating that they agree to the terms of the safety plan and understand the consequences of noncompliance.

2. Share this report with the intact family services worker and supervisor and use this report as a teaching tool.

The Department agrees. The report was shared.

3. Discipline the child protection investigator's supervisor for his failure in attempting to screen the case in because of the mother's already established pattern of disregard to the boy's fragile medical condition.

The Department agrees. The supervisor received a written reprimand.

DEATH AND SERIOUS INJURY INVESTIGATION 15

ALLEGATION

A 14 year-old girl who was a Department ward committed suicide while residing in a residential home.

INVESTIGATION

The girl was first taken into Department custody when she was one month old along with her two year-old brother. The children were placed with a couple that later adopted them. While the adoption was pending, the family moved to a neighboring state. County child welfare workers in the neighboring state had expressed reservations about the adoption and requested that the Department reimburse the county for any services provided to the family. A child welfare administrator in the neighboring state said that although the Department had verbally offered to reimburse the county, the arrangement was not formalized and no funds were ever received from the Department.

Beginning when the girl was 10 years old several traumas occurred in her life. The adoptive father died as a result of an accident that the girl witnessed. The adoptive mother and grandmother, who lived with the family, died of natural causes. The children began exhibiting behavioral problems and the girl entered counseling for depression. After the mother's death, a couple that had been living with the family was given temporary custody of the children. When problems developed with the placement, the child welfare workers determined the children should be removed from the couple's care. At that time, the girl was in Illinois visiting her biological grandmother. The child welfare workers decided to leave the girl with her biological grandmother in Illinois. The brother was also sent to live with the grandmother. No legal steps were taken to formalize the arrangement with the grandmother, though she was receiving the children's social security benefits. A child welfare administrator from the neighboring state expressed the belief that the children had purposely sabotaged, through their behavior, the placement with the family friends. The administrator further expressed the belief that no other family in the rural community was willing to accept them. The administrator stated that he felt it was unnecessary to take legal action because of the biological relationship between the children and the grandmother. No evaluation was made of the grandmother's home or community because workers believed the children were familiar with them since they had visited previously and, therefore, would be comfortable.

The children, who were used to a small community, had difficulty adjusting to living in a metropolitan area. The children had a volatile relationship with their grandmother and experienced problems establishing themselves in their new school. After an altercation between the girl and her grandmother, during which the grandmother suffered a broken arm, the girl was removed from the grandmother's and eventually placed in the residential home. The girl's behavior continued to deteriorate following the separation from her brother and she exhibited symptoms of depression. The boy was removed from the grandmother's home and placed through private guardianship with a couple in the neighboring state in the town where he had grown up. The girl wanted to be placed with her brother. The Illinois caseworker attempted to accomplish this placement with the assistance of the girl's Guardian *ad Litem* (GAL). The caseworker met resistance from the neighboring state's county child welfare administrator who did not want the girl returned to their area and stated they would not provide services. The local administrator contacted the Interstate Compact Unit of Illinois to make his objections known, claiming that the boy was already experiencing problems in the home. The Interstate Compact Unit contacted the caseworker and the GAL and pressured them not to go forward with the placement. The GAL ignored the Interstate Compact Unit's request and proceeded to attempt to have the girl placed with her brother. The adversarial relationship between workers in the two states created a hostile environment that impeded comprehensive, collaborative servicing of the case. Conflicts between involved child welfare professionals interfered with their ability to make decisions based on the best interests of the child.

The girl was allowed to visit the home several times prior to the possible placement. However, the visits were

marred by the girl's defiant, disobedient behavior and confrontations with the foster parents. The foster parents ultimately informed the Department they would no longer consider themselves as a placement for the girl. When informed of the couple's decision, the girl became more depressed. In light of previous suicidal ideation, her therapist at the residential home requested she be supervised closely by staff until bedtime and monitored frequently throughout the night. Staff of the residential home complied with the request and provided close observation of the girl during the next three days. Despite the measures taken, the girl hanged herself in a bathroom after locking the door where she had gone for a shower. The OIG determined that although staff monitored the girl closely, she should not have been permitted to go into a room that could be locked to outsiders.

After the initial report was submitted a controversy arose regarding an incident report covering the evening when the girl learned that she would not be joining her brother, which was three days prior to the suicide. Two versions of the incident report were made public. A further investigation was conducted. A draft incident report was typed on the computer in which the author claimed that the girl had threatened suicide that night. The draft had been written as justification for stopping the girl from running away by falsely claiming that she threatened to harm herself. By account of all persons present in the home that evening, the girl repeatedly denied she had any intent to harm herself. She became angry after being confronted several times by staff about their concerns. The following day, staff brought her to her psychiatrist to whom she also denied any thoughts to harm herself. For the next two days the staff kept a close watch on the girl. However, the girl hanged herself causing her death the following morning. The controversy arose because the draft incident report was amended, by the original author, after the girl's death. Though, because of the circumstances of the death, it was felt that it would have been prudent for the residential home to have provided, in the girl's record, both versions of the incident report, it was found that the facility had not altered the record with any intent to deceive and that the final version of the incident report was a true reflection of what had occurred on the evening in question.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The "Team Up To Save Lives" CD-Rom on suicide prevention, produced by the University of Illinois at Chicago Department of Psychiatry and Ronald McDonald House, should be distributed to all residential programs that contract with the Department.

The Department agrees.

2. This report should be shared with the private agency that runs the residential home, the Interstate Compact Unit and the Department's Child Death Review Team.

The Department agrees and the report was shared.

The OIG shared a redacted copy of the report with the private agency. The Inspector General met with the Executive Director and members of the Board of Directors to discuss the report.

Addendum Recommendations:

3. The supervisor of the author of the two versions of the incident report should document, in an administrative file, the oral reprimand given to the author. The residential home should issue a caution to staff that there is no justification for attributing false statements to children.

The Department agrees. The OIG shared the report with the residential facility.

4. **The investigation and its addendum should be shared with the girl's psychiatrist, relevant**

members of the residential home's clinical, administrative and treatment staff. Using the girl's investigation as a case study the above relevant parties, with selected Board members and ethicists, should examine the problem of a well respected program manager violating a basic ethical tenet and professional regulation by attributing harmful and untrue statements to a child (threats of suicide) to justify protective actions that under the amended Rule would not be considered a violation of restraint limits. The residential home needs to consider whether experienced program managers supported by a timely clinical consult can have the discretionary judgment to use "extended restrictions" in cases similar, where self-destructive behavior is observed. Such a review can help direct future ameliorating strategies. Dr. Gewirth's 2002 article on the weighing of harms on the subject of confidentiality in child welfare practice may prove helpful in weighing the rights and harms that existed in this case.

The Department agrees. The OIG shared the report with the psychiatrist and the residential facility.

5. A careful clinical plan for discussing any questions or concerns that the girl's brother has regarding the recent press about his sister's suicide should be undertaken. A visit by a person trusted by the brother should be arranged with his guardian's and present therapist's input prior to any public announcements about this investigation. (The Inspector General found that its Rule of confidentiality was violated when information contained in the June Report was shared without the permission of the Inspector General. The sharing of the confidential material took into account no clinical consideration of possible harm to the girl's brother. At the time of her death he voiced sadness over some of the news accounts of his family. He remains vulnerable and high risk for depression. The research reported in the first Investigation warns of suicide risks for youth who lose parents at a young age. The Inspector General discussed this concern with involved professionals.)

The Department agrees.

The OIG sent a letter to the brother's foster parents informing them of the completion of the investigation and offering to answer any questions they or the brother might have. The foster parents have not responded.

DEATH AND SERIOUS INJURY INVESTIGATION 16

ALLEGATION

A 17-month old boy died of closed head and cervical injuries caused by blunt force trauma. At the time of his death, there was an open child protection investigation. Immediately after the boy's death, his 8-month old sister was hospitalized with pneumonia and an ear infection, and was diagnosed with failure to thrive. The OIG initiated an investigation pursuant to its directive to investigate all child deaths in which there was an open DCFS case.

INVESTIGATION

The boy and his sister were the children of a young girl who had been involved with DCFS since the age of eleven, when her brother was indicated for sexually molesting a younger sister and forcing her to watch. The girl later stated that the brother had molested her as well. When the girl was fourteen, her father was indicated for sexually exploiting her. On two later occasions, both her parents were indicated following incidents of physical violence against her. When she was sixteen years old, she was taken into state custody.

At the time she became a DCFS ward, the girl had a known history of anger issues, homicidal ideation and diagnoses of borderline personality disorder and post-traumatic stress disorder. She briefly excelled academically when she was in the highly structured environment of an alternative detention program. The DCFS supervisor and caseworker nevertheless placed the girl in a Supervised Independent Living program after a short stay in foster care, and did not pursue options such as group homes, extended family or specialized foster care.

The independent living program was run by a private agency under contract with DCFS. The agency accepted the girl into its program, although a similar program had rejected her as unsuited for independent living. In the girl's first six months in the program, she went through three apartments because of threats of eviction and violations of rules. She had frequent police contact for harboring runaways, and numerous people were in and out of her apartment at all hours, prompting complaints from neighbors and landlords. She was frequently truant from school, was suspended multiple times and earned failing grades. She ran away for more than a week, and engaged in unsafe sex, frequent altercations and drinking. Case information strongly suggested that she was raped twice in the first three months of independent living. She was pregnant within seven months of entering the program. The agency staff never reevaluated her placement and service needs, apparently operating under the false assumption that the only alternative to supervised independent living was emancipation. The agency staff also failed to pursue the possibility of placing the girl with a maternal aunt in another state who had expressed an interest in her well being.

Although the agency staff repeatedly threatened the girl with discharge from the program for violation of expectations and rules, the threats were empty. On at least two occasions, the DCFS Administrative Case Reviewer threatened to place the girl in a more restrictive setting if she did not change her behavior, but did not follow through. The girl's history of sexual abuse was never addressed in counseling. Although there was strong evidence that the girl was raped while in the program, the staff failed to pursue medical care or crisis counseling on the girl's behalf.

The girl gave birth to a baby boy after having been in the independent living program for fifteen months. Her boyfriend, the baby's father, lived with her in her apartment in violation of program rules, but took on much of the responsibility for the baby's care and the household. The girl was very dependent on the boyfriend, and was inconsistent in her attention to the baby's needs. The girl's second pregnancy was confirmed when the baby boy was three months old. The program caseworker noted that the girl was still failing to make progress toward any of her goals, such as completing a GED or obtaining employment, and that she risked losing her DCFS guardianship. The girl was involved in a physical altercation when she was six months' pregnant, refused to pay rent, and yelled and raised her fist at her DCFS worker when her behavior was criticized. The

DCFS worker called the hotline following this incident because the degree of the girl's anger made her fear for the baby's safety. The hotline took the report as information only. Around the time of her second anniversary in the program, the girl gave birth to a daughter, four weeks prematurely.

The agency's Independent Living Program was designed for the general teen ward population. The girl's agency caseworker did not receive any training to work with pregnant or parenting teens. The agency staff members were unaware that DCFS has a Downstate Teen Parent Coordinator whose job is to provide resources and consultation regarding pregnant and parenting wards. (The Teen Parent Coordinator relies on Unusual Incident Reports and reports from ACR reviewers to identify pregnant wards; in this case, the Coordinator never received any reports.) A parenting assessment was not performed on the girl, even though she came from a dysfunctional family and had a problematic history including aggressive behavior.

A few months following the second birth, the program therapist who had been treating the girl, albeit without addressing her sexual abuse history, resigned and a new therapist took her place. The girl admitted that she "felt abandoned again" and told the new therapist that she struggled with frequent anger but tried to respond appropriately for her children. A week later, her son was stepped on during a fight that occurred between guests in the girl's apartment. The girl told the therapist that she had no real friends other than her boyfriend, whom she described as someone she could rely on and trust, something she had never had before.

Shortly thereafter, the boyfriend was arrested for robbery and incarcerated. He was subsequently convicted for theft and is serving a four-year sentence. Case notes from all the professionals who had contact with the girl showed a significant deterioration in her coping skills following his arrest. She left utility bills unpaid to try to save money for his bail, had no strength for daily tasks, allowed the apartment to become dirty, neglected the daughter's immunizations, cried frequently, and fixated on her hopes for his return. The children were not clean and the girl was observed feeding them sour milk in dirty bottles. The boy was eating his feces and both children's growth had significantly declined. Agency staff emphasized practicalities about cleanliness, attention to the children's needs and pursuit of a job with the girl but did not recognize the signs of major depression or consider the risk posed to the children.

Subsequently, the girl obtained a job and left the children with friends overnight while she worked. Program staff failed to check on the identities of these friends or the safety of the children while out of the girl's care. A program administrator later stated that the agency did not view the children as its responsibility.

The children's pediatrician was becoming increasingly concerned about their declining weight, late immunizations and filthy state and the pediatrician's nurse contacted program staff. The therapist and the caseworker responded by continuing to talk with the girl about ways to manage her stress during the boyfriend's absence. In the meantime, a Public Health nurse had been assigned to the family following the daughter's birth and made several visits to the home but did not document seeing the new baby or any observations about her condition. The pediatrician's nurse again contacted the program staff with concerns about missed appointments, the son's habit of eating feces, the daughter's drastically low weight and the filthy condition of the children. The pediatrician never called the hotline; however, her nurse called a County Public Health nurse who, while newly assigned to the case, called the hotline to report the children's filthy condition and possible malnourishment.

The child protection investigation was initiated for inadequate food and environmental neglect, although the reporter alleged possible malnourishment. The investigator never pursued whether the more serious conditions of malnourishment or failure to thrive might be present, but merely limited her investigation to the allegation codes. She did not ask the pediatrician adequate questions to determine why the children were below the growth line, although she did note expired and sour food in the girl's apartment, a lack of formula for the daughter, and an extremely filthy and unbaby-proofed apartment. The Division of Child Protection

(DCP) supervisor accepted the investigator's work at face value and did not read investigative notes that would have revealed the investigator did not recognize or ask about factors contributing to malnourishment or failure to thrive.

Three weeks after the DCP investigation began, the boy died as a result of closed head and cervical injuries caused by blunt trauma. The girl was charged with first-degree murder and later pled guilty to involuntary manslaughter and aggravated battery of a child. Her daughter was hospitalized and diagnosed with failure to thrive and was placed in foster care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should amend Division of Child Protection procedures to include 'Factors considered' for inadequate food in investigations of malnutrition and failure to thrive; and require a multidisciplinary staffing within 48 hours of receiving an abuse/neglect report of failure to thrive (allegation 81) and malnourishment (allegation 83), using the Nursing Child Assessment Satellite Training (NCAST) methods of assessment, as previously recommended in two 1999 OIG reports.

The Department agrees and will work toward implementation.

2. Child Protection Investigators should be reminded during CERAP training not to limit their investigation to the initial allegation(s), as previously recommended in a 1999 OIG report.

The Department agrees that it is important that investigations not be limited to the allegations reported initially. This is included in child protection training and has been reiterated repeatedly. An additional reminder will be sent to investigative staff.

3. The Department should train DCP supervisors, investigators, Intact Family workers and Teen Parent programs on recognizing, identifying and differentiating between failure to thrive, malnutrition and inadequate food.

The Department agrees.

DCFS Personnel

4. The DCFS Supervisor should be counseled for placing the teen ward in an independent living program without an evaluation of her placement needs or consideration of her behavior, history and diagnosis. The supervisor failed to reassess the appropriateness of the placement when the ward demonstrated an inability to manage her living arrangement and when she became a parent.

The Department agrees. The supervisor was counseled.

5. The DCFS Case Manager should be counseled for failure to reassess the appropriateness of the teen ward's placement in independent living when she demonstrated an inability to manage her living arrangement.

The Department agrees. The employee was counseled.

6. A redacted copy of this report should be used as a learning tool for the DCP Supervisor and Child Protection Investigator.

The Department agrees. The report will be shared.

7. The DCP Supervisor should be advised to routinely read investigation notes of pending investigations rather than relying solely on the CPI's verbal statements and perspectives. Such a practice will enable him to more effectively function as a supervisor.

The Department agrees. The DCP Supervisor has been so advised.

Downstate Teen Parent Coordinator

The ACR administrator should do a trend analysis to identify systemic and employee specific problems in the completion of ACR feedback forms regarding pregnant or parenting wards, and their distribution to the Downstate Teen Parent Coordinator. The ACR Administrator should put a corrective action plan in place for any failure by a reviewer to notify the Downstate Teen Parent Coordinator of a pregnant or parenting ward.

The Department agrees.

9. The DCFS Downstate Teen Parent Coordinator (the "Coordinator") should conduct a trends analysis to determine those agencies that fail to meet the Hill mandate. She should alert the Field Managers, in writing and quarterly, of her findings.

The Department agrees. The Coordinator is currently involved in a records review of downstate cases to determine the extent, quality, timeliness, comprehensiveness, and cohesiveness of services provided to Hill/Erickson class members.

10. The Coordinator needs to develop a procedure to identify downstate pregnant and parenting wards. Such a procedure should include: (1) Quarterly checks of downstate Independent Living Programs to determine whether they have pregnant or parenting wards that have not been identified. If so, the Coordinator should hold the program director responsible for ensuring an Unusual Incident Report is generated; (2) The Coordinator should obtain quarterly lists of wards who receive child support to determine whether there are parenting wards of whom the Coordinator was not notified via an Unusual Incident Report. The Coordinator should then ensure that a UIR is generated; (3) The Coordinator should meet with the ACR administrator on a quarterly basis to share and coordinate collected information to ensure the delivery of mandated specialized services to this population.

The Department agrees. The Division of Education and Transitional Services has developed a comprehensive plan to address the Inspector General's issues.

11. Independent Living service providers should be sanctioned if they fail to complete and submit Unusual Incident Reports to the Department.

The Coordinator should notify Contracts Administration of agencies that are not submitting UIR's as it is a violation of their contract.

Services for Independent Living are provided to the Department under a contractual arrangement.

DCFS contract monitors will be notified and should follow- up on agency's failure to comply with DCFS Rule and Procedure.

12. The Coordinator should bring together and coordinate trainings for Health Works providers and pregnant and parenting teen program service providers on research based interventions for working with at-risk youth.

The Coordinator has been identified as a member of a training workgroup for the development of a research based training curriculum to be implemented state wide. The Coordinator will reinitiate twice yearly P/PT provider symposiums/round table meetings to provide peer support, information on P/PT population, and techniques and direction to increase effective service provision to the P/PT population.

13. This report should be shared with the Hill Monitor.

The Department agrees. The OIG shared report with the Hill Monitor.

The Contracting Agency

14. The OIG understands that there is a merger of the contracting agency with another private child welfare agency. A copy of this report should be shared with second agency's Board of Directors.

The Department agrees.

The OIG shared a redacted copy of the report with the private agency and the Agency's Board of Directors. The Inspector General met with the Executive Director, agency administrators, and a member of the Board of Directors to discuss the case and review the findings.

15. The agency should create a procedure to enable linkage and communication with medical providers regarding medical issues. The agency nurse who supports other programs in the agency should be responsible for implementing this procedure.

The Department agrees.

The private agency will continue to emphasize with its case management staff the importance of collaborative case staffings for every client in the independent living program.

16. Portions of a redacted report should be used with the agency therapist, as a learning tool.

The Department agrees.

The employee is no longer employed by the agency.

Medical Professionals

17. A copy of a redacted report should be shared with the pediatrician.

The Department agrees. The OIG shared the report.

18. The Department should ensure that the Family Case Manager, who was involved in this case, not be permitted to work as a Family Case Manager for DCFS wards or their children.

The Department agrees.

GENERAL INVESTIGATION 1

ALLEGATION The OIG reviewed several full case records of pregnant and parenting teens to assess the quality and appropriateness of service delivery to the wards and their children. One file revealed that a young, developmentally delayed teen mother had custody of her child. The file raised concerns about the child's safety.

INVESTIGATION The child came to the attention of the Department in November of 1993. The then five year-old child and her younger brother were found alone in an abandoned building, the mother prostituted for drugs, and family members also prostituted the child.

The child underwent at least four psychological evaluations over the years, and all consistently found her to be functioning at the borderline intelligence level. She was diagnosed with mental health problems. Her foster placements were repeatedly disrupted because of her inappropriate sexual behaviors with peers, her brother, younger children, and adult men, and because of her running away. A Sexually Aggressive Children and Youth (SACY) plan was developed for the child and stipulated that she had to be supervised around children at all times.

The child's placement needs were reviewed by the Placement Review Team (PRT), which recommended placement in a residential treatment facility that specialized in working with sexually aggressive youth. A SACY assessment completed later that year echoed the recommendation from the PRT. The child's therapist agreed that the child needed a residential facility away from Chicago where she would not have access to those things that reinforced and supported her runaway behavior.

In June 2000, while the twelve year-old girl was still living in the home of her foster parent, it was discovered that she was pregnant and had several sexually transmitted diseases. The foster parent agreed to care for the child until she could be placed in a residential treatment facility. The foster parent enrolled the girl in a school for pregnant girls, where she had one-on-one supervision. The girl was involved in after-school activities and the foster parent also had her involved in the YMCA and obtained a counselor to work with the child.

The girl told the foster parent that the foster parent's son had sex with her. The foster parent called the hotline to report this and an investigation was initiated. The girl later recanted her statements and the investigation was unfounded.

Various assessments completed around the time of the pregnancy showed that the girl had been diagnosed as Bipolar with Paranoid features. Her foster parent reported that the girl was highly sexual, stated she wished she were dead, and that her baby would be dead in three months. The foster parent stated she believed that the girl should be in a locked facility.

The girl's workers were concerned about whether she should be placed with her baby after the birth. The girl's case was transferred for service to the Teen Parent Service Network. The agency was told to explore adoption for the baby and to provide counseling services around adoption. The DCFS supervisor, writing an overview of the child's case, stated that the girl had expressed a desire to have the foster parent adopt her baby after she gave birth.

The girl gave birth to a baby girl. At a Teen Parent Service Network (TPSN) staffing, held two days after the baby's birth, it was noted that the girl wanted to place her baby for adoption. Workers also noted that the girl had no interest in parenting the baby, and made comments that threatened the baby's safety.

The hospital called the hotline and, after investigation, the report was indicated. Although the Child Protection investigator attempted to have the case screened into court, the state's attorney instructed her to offer the child/mother services and to take protective custody if the baby becomes at risk in the mother's care.

A revised SACY protective plan required the foster parent to get up at least three times each night to check on the girl. The foster parent was to supervise the girl on a 24-hour basis. One month after the girl gave birth, the foster parent reported that she had caught the child rubbing the baby's face against her clothed breast in a manner that appeared to be for sexual gratification. Following this incident, the girl was not permitted to have nighttime contact with her baby.

The private agency's worker first visited the foster home around that time. The foster parent claimed she presented the worker with a notarized informal care plan that she and the girl had made, in which the girl expressed that she wanted the foster parent to care for her baby. The worker denied that she ever knew about an informal care plan. The worker claimed that either the child's GAL or DCFS legal had advised her that the girl could not make a decision concerning the placement of her child because she was a minor.

The worker disagreed with the foster parent's assessment that the baby was at risk in the care of the girl. The worker believed the foster parent's concerns were motivated by the foster parent's desire to parent the baby. The worker and foster parent also argued over the issue of adequate lighting for the girl's room. The worker believed that the foster parent was not upholding her part of the protective plan and that this set up the girl to fail. The worker believed that the expectation that the SACY plan had for the foster parent to rise three times every night and provide 24-hour supervision was reasonable.

The TPSN Developmental Disability Specialist and the private agency worker called DCFS Legal noting risks to other children in the foster home if the child remained. DCFS Legal recommended that the girl be removed from the home.

At 10:00 pm, the workers went to the foster home unannounced to remove the girl and her baby from the foster home. The workers did not bring a car seat to transport the baby, so they borrowed the foster parent's grandson's car seat, which was not returned until two months later. The new foster home did not have a crib, and the workers allowed the baby to sleep in a washbasin lined with pillows. The new foster parent lived with her 21-year-old grandson, who had a lengthy history of arrests. Prior to the move, the workers did not verify if the girl's services could continue in the new foster home and, in fact, learned that the therapy services could not continue in the new placement. Although the girl repeatedly expressed her desire that her baby remain in the home of her former foster parent, the worker never discussed the matter of leaving the baby with that foster parent. The worker stated that there was no need to discuss this; because the baby was not a ward, the child and her baby would be moved together.

The new foster parent had been licensed by a private agency in 1996. Although special needs children had been placed in the foster home before, it was not a specialized foster home. According to DCFS records, the private agency received information on numerous occasions about criminal charges against the foster parent's grandson, including charges for a sex offense, assault and drug offenses. The sex offense involved aggravated rape of a fourteen-year-old girl. Each time, the licensing staff of the agency either accepted the grandson's explanations for the charges and recommended they be cleared based on the explanation, or simply filed the information away.

The new foster parent made repeated requests to have the girl and her baby removed from her home. The TPSN workers expressed reluctance to remove her from the foster home, despite the recommendations that the girl needed a residential treatment facility. The Placement Review Team postponed making a decision on the girl's placement until the Parenting Assessment Team (PAT) could provide additional information about

the child's ability to parent her baby.

The PAT report concluded that the girl's baby was in danger of physical and sexual abuse and neglect if left in the care of the girl. The PAT determined that the girl needed a placement that would meet her therapeutic needs, provide stability and close monitoring to ensure her safety. The report concluded there was no intervention that could be provided that would allow the girl to parent her baby.

The workers decided they wanted to have a second opinion, and they secured another psychological and parenting evaluation. The second report found that the girl functioned at the level of an eight-year-old. It further stated that the girl was not able to independently care for herself or her baby without returning to her previous behavior, which could ultimately lead to risk of harm, neglect or perpetration against her baby.

The workers decided to disregard both of these reports. As the girl had been going to counseling, had not engaged in inappropriate behaviors for several months and there was a protective plan in place, they believed that the baby was not at risk.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

This report should be read in conjunction with OIG report File No. 02-0354. The problems identified in both cases extend to the larger developmentally delayed population. Systemic recommendations can be found in the previous report. The following recommendations are specific to the findings of this case:

DCFS

1. The Department must commit to ensuring the implementation of the Parenting Assessment Team recommendations.

The Department agrees.

2. The Department should review the content and quality of the private agency's foster home licensing records for the pregnant and parenting teen population. The Department should also review the agency's assessment of facts relating to criminal background information.

The Department will review a sample of the private agency's licensing records.

The OIG shared a redacted copy of the report with the private agency. The agency agreed to cooperate with the Department in a review of the licensing records. In addition, the private agency initiated an internal review of the licensing records and is revising the procedures for assessment of criminal background information.

3. In cases in which an applicant, licensee, or household member has a criminal history record, the licensing worker should not rely solely on the individual to present the information relating to the criminal charge or conviction in making a recommendation regarding licensure. Instead,

(a) **the Department's Central Office of Licensing Background Check Unit should obtain the underlying documents and forward the documents to the private agency along with the notice of the criminal history; and**

(b) ***The Notice to Central Office of Licensing: Recommendation and Rationale* form (ENF 14B) should be amended to include a certification from the agency or decision-maker that "criminal background information was assessed in**

accordance with Administrative Procedure #6, including reviewing and assessing underlying documents."

The Department agrees.

4. The Department and supervising agencies must ensure that foster parents caring for developmentally delayed youth are capable of providing assistance with the child's schoolwork and other daily living tasks.

The Department has developed an Integrated Assessment process that will address foster parent(s) capability in relation to the child(ren).

5. The Department should ensure the development of specially trained foster homes to work with developmentally disabled parenting adolescents.

The Department agrees.

6. The transfer of children's case records continues to be a serious systemic problem, which entails a dual responsibility. The Department must commit to ensuring that complete records follow the child. Service providers are equally obligated to secure children's records in order to meet their responsibilities to the child and family.

The Department agrees.

The private agency agreed to work with the Department and other private agencies to ensure complete records follow the child.

7. The private agency worker should be disciplined up to and including discharge in accordance with the personnel policies and procedures of the agency.

The Department agrees.

The private agency caseworker was terminated.

8. The Developmental Disabilities Specialist should be disciplined up to and including discharge in accordance with the personnel policies and procedures of the supervising agency.

The Department agrees.

The specialist was terminated.

9. The licensing supervisor should be disciplined in accordance with the personnel policies and procedures of the private agency.

The Department agrees.

The licensing supervisor will be required to attend additional training on Department licensing procedures.

10. This report should be shared with the Clinical Supervisor and she should be counseled on biases that impact decision-making.

The Department agrees.

11. This report should be shared with the Hill-Erickson attorney for the purpose of her work with TPSN to remedy existing misinterpretations of the Hill order by the providers in the TPSN network.

The Department agrees. The report was shared.

SACY

12. SACY therapists must review children's case records (See prior OIG reports: An Investigation of Current Practice in Cook County with State Wards who are Designated as Sexually Aggressive, June 1999 and June 2000).

The acronym SACY is no longer being utilized. The program has been revamped and is called Children and Youth with Sexual Behavior Problems. Therapists will receive case record information upon referral for treatment.

GENERAL INVESTIGATION 2

ALLEGATION After being raped by a school bus attendant, a developmentally delayed teenage ward filed a lawsuit against the Chicago Board of Education through an attorney, hired by the Guardian of DCFS. The complaint made was that the DCFS Guardianship Administrator's Office had improperly terminated the attorney's representation.

INVESTIGATION The teenage ward became involved with DCFS in 1997, when she was sixteen years old, when her mother was indicated for mental injury and environmental neglect. The girl had a full-scale IQ of 44. It was determined that she was trainable mentally handicapped (TMH). A person with an IQ between 40 and 54 is considered moderately mentally retarded. Only 11% of individuals with mental retardation have skills as limited as this teen's were. Moderately mentally retarded individuals can achieve only partial independence.

In May 1998, the girl told school staff that she thought she was pregnant and the father was a school bus attendant. The teen's decision-making capability was limited and there was no evidence of appropriate counseling, geared toward the teens' cognitive abilities.

The child abuse investigation against the bus driver was put on hold pending the police investigation. The police investigation was suspended, awaiting the birth of the baby for DNA evidence. When the police investigation was suspended, the child protection unit unfounded their investigation, but advised the police to notify the hotline if DNA tests showed the attendant was the father. By the time the baby was born and DNA testing confirmed that the bus driver was the father, the teen had turned 18 years-old. The Hotline would not accept the allegations against the bus driver as a child abuse report. Although the school bus attendant was not indicated for child sexual abuse, he was criminally convicted and is currently serving a prison sentence.

The workers then struggled with finding an appropriate placement for the teenage mother and her baby, who was not a ward. She was placed in a home for pregnant and parenting teens and became part of the Teen Parenting Service Network (TPSN). The workers provided the teen with services that were specific to her needs as a mentally retarded parent. Throughout the teen's involvement with TPSN, she expressed ambivalence about parenting her child, sometimes considering placing her child for adoption.

Although all professionals noted the teen's limited abilities to care for herself and to parent, the only assessment conducted used the Daniel Memorial Life Skill Assessment tool, which is not appropriate for developmentally delayed individuals. While DCFS Procedures noté that use of this tool "might not be appropriate" for youth with developmental disabilities, they do not prohibited its use for the population. The TPSN handbook requires use of this tool for teens, without distinguishing between its use for developmentally delayed and other teens.

Because of the teenager's cognitive limitations (she was found incapable to make financial decisions and partially incapable of making personal decisions) and because it was noted that the teen would never be able to care for her son on her own, the workers began exploring foster placements for the teen and her son that could turn into an adult living arrangement once she was 21 years of age. The teenager and her son were eventually placed in the home of an unrelated, older caregiver who had been a teacher's aide at the teen's school. The older caregiver was less than one year from retirement. The worker initiated the process to secure an adult guardian for the teen but never completed a home safety assessment. Specialized home and child safety training never occurred, leaving the child vulnerable to the mother's limited understanding and to household safety risks.

The TPSN staff member responsible for staffing cases of developmentally disabled clients had neither

training nor extensive experience working with developmentally delayed teens. She did not seek assistance from the DCFS Specialist for Developmentally Delayed Youth. It was only after the teen's situation appeared in the news media that a staffing was convened for the teen. The TSPN staff member could not provide OIG investigators with the number of teen parent wards with developmental disabilities, although she was responsible for staffing those cases on an annual basis.

During the management of the teen's case, workers contacted the Guardianship Administrator's Office of DCFS to research the viability of a lawsuit against the Chicago Board of Education on the teen's behalf. The Guardian hired an attorney to represent the teen. The attorney began advocating for the removal of the ward from the adult guardian's home, because of several environmental concerns. The OIG learned that the issues of an appropriate placement for the teen and her son, and whether the Guardian could discharge the teen's attorney, were pending before the juvenile court. To avoid duplication of efforts and because the available forum was adequately addressing these issues, the OIG did not investigate them. The investigation and recommendations focused on the serious systemic problems presented relating to services provided to developmentally delayed pregnant and parenting teens.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

DCFS

1. The Department needs to develop a procedure for working with the various functional levels of developmentally delayed wards that are parenting. Procedure 302.Appendix N, Sub-part C is insufficient.

The Department agrees.

2. The Department needs to develop a written procedure for notifying the Guardian's Office that a developmentally delayed ward that is moderately or severely mentally retarded is pregnant.

The Department agrees.

3. The Department should ensure that the resources of the Department's Specialist on Developmentally Delayed Youth are shared with the child welfare field, through the use of the D-net or some other easily accessible network.

The Department agrees.

4. The Department's Specialist on Developmentally Delayed Youth needs to develop a system by which the direct child welfare worker assigned to a developmentally delayed ward and the worker's supervisor are immediately notified of support services available to them. This notification should be recorded/placed in the child's record.

The Department agrees.

5. The current process of tracking developmentally delayed wards is insufficient. SACWIS should develop and maintain a database in consultation with the developmentally delayed Specialist, to identify and track developmentally delayed/mentally retarded wards. The database must be reliable and valid in order to be an effective tool.

The Department agrees.

6. The Department should revise Appendix M sub-part (c) of procedure 302 to clearly state that

the Daniel Memorial Life Skill Assessment should not be used with any of the Department's wards. The Department should consider using the ICAP assessment tool or the Vineland Adaptive Assessment with a ward that is identified as having a developmental disability. This should be incorporated into the revisions of 302.Appendix M subpart (c).

The Department agrees. In February 2002, DCFS sent notice to all psychology service providers that the Daniel Memorial Life Skill Assessment is no longer to be used when assessing a ward that is identified as having a developmental disability. Caseworkers were also advised.

7. Counseling surrounding resolution of pregnancies should be handled by an agency that is separate from DCFS or TPSN. If a ward decides on adoption, the ward should be provided immediate access to adoption services. A list of adoption agencies should be compiled so that such adoption services are accessed on a rotating basis, if the Purchase of Service agency does not provide a full-range of private adoption options.

The Department agrees.

8. Supervisors from the Child Protection Division should meet with all police departments concerning the importance of securing DNA testing and communicating the results of the testing to SCR as quickly as possible. In cases of child sexual abuse where resolution of the investigation hinges on the collection of DNA evidence, an exception should be built into the rules to allow for these cases to remain open until DNA evidence is obtained.

The Department has recently initiated a contract with the Chicago Children's Advocacy Center for services to young girls who become pregnant as a result of rape, incest or assault. DNA testing can be coordinated as part of that program.

9. This report should be shared as a learning tool with the DCFS Guardianship Administrator.

The Department agrees. The report was shared.

TPSN

10. TPSN needs to identify and train a special cadre of workers and supervisors on how to work with developmentally delayed pregnant and parenting wards. TPSN Intake should include, as part of the information gathered during the intake process, information concerning whether the pregnant/parenting ward has a developmental disability and the nature of that disability. Once a ward is identified as having a delay, that ward should be assigned to one of the workers that is part of this specially trained unit.

TPSN is in the process of hiring an expert in working with the developmentally disabled to oversee the development of services to the Department's developmentally disabled wards. A private agency recently contracted to provide specialized placement and casework services for developmentally disabled mothers and their children.

11. TPSN's specialist for developmentally disabled wards should have a background in developmental disabilities, including special education, and applied behavior analysis.

The Department agrees.

12. Section IV.9 of the TPSN handbook is confusing and the Department should make a condition of contract renewal that the handbook be revised and updated to reflect current Rules and Procedures. Although section IV.9 of policy states Rule 301.80 must be followed when placing wards 18 and older in unlicensed non-relative homes, some of the requirements of Rule 301.80 are not included in TPSN procedures. The TPSN handbook needs to be revised to include information on procedures for working with developmentally delayed wards and their children. Presently, the only guidance provided is in V.5 Transition Planning, which refers the worker to Procedure 302. Section IV.7 of the TPSN handbook must be revised to exclude developmentally disabled youth from being assessed with the Daniel Memorial Life Skill Assessment. The handbook should clearly state that this tool should not be used with low-functioning youth; rather, ICAP or the Vineland Adaptive Assessment should be used.

The Department agrees.

GENERAL INVESTIGATION 3

ALLEGATION

A two year-old girl who had been living with her grand aunt since her birth was removed from her home by the private agency following the completion of an adoptive home study. The child was placed with her grandmother and brother. The grand aunt complained to the Department's Clinical Review Coordinator that the removal was unwarranted and based on inaccurate information obtained by the private agency.

INVESTIGATION

The private agency's concerns regarding the woman's suitability as a caretaker stemmed from the discovery of significant incidents in the woman's past as well as her depiction of those events when questioned by agency personnel. The grand aunt has been married seven times. In 1987, the woman's three sons were removed from her custody and adjudicated as abused after it was learned that her husband at the time had seriously mistreated them on multiple occasions. The husband's actions included tying one boy to a dog post in the yard without food or water for seven hours on a hot summer day, and on another occasion making him stand while periodically slamming his head into a van and dousing him with ice water. The husband also forced another child to lick urine off the floor as punishment for missing the toilet while using the bathroom. While the grand aunt observed the latter two incidents and her husband admitted to all three, she persisted in supporting him and downplayed the severity of the incidents while the Department serviced her case.

A criminal history evaluation of the woman showed a previous conviction for possession of a controlled substance. The grand aunt explained that she had been "framed" by a supervisee after she took unauthorized prescription medication from her and gave her $5.00, allegedly to buy non-prescription pain relievers. The OIG investigation discovered that the Department of Professional Regulation was moving to revoke the grand aunt's nursing license based on a complaint by a nursing home that the disappearance of controlled substances from pharmaceutical supplies coincided with the beginning of the woman's employment at the facility. After leaving the nursing home, the woman began working for a private physician. After she was terminated from the position, the physician was contacted by a pharmacy and alerted that the woman had attempted to obtain painkillers with prescriptions attributed to him. In an interview with the OIG, the physician stated the woman had never been a patient of his and that the signature on the prescriptions was not his.

The private agency was also concerned that the grand aunt had told the grandmother that DCFS workers were following her and that on one occasion she had driven the children across state lines in an effort to elude the workers. The grandmother also shared that the grand aunt had been suicidal in the past. The grand aunt claimed to staff she had never suffered from substance abuse issues or contemplated suicide. She attacked the grandmother's credibility, claiming that the grandmother was lying in order to get custody of the child. The OIG review of her 1987 involvement with the Department revealed that the grand aunt had related past treatment for alcoholism and a prior suicide attempt.

The Clinical Placement Review found the evidence presented by the woman to be more compelling than that offered by the private agency. The woman's explanations for her previous involvement with the Department, law enforcement, and professional organizations were accepted by the review team without critical analysis or any attempt to confirm the veracity of her denials. The Clinical Placement Review team was told by Department personnel that the grand aunt had been previously involved with the Department. Neither the reviewer nor her supervisor sought to review the Department's 1987 records, which led to the removal of the grand aunt's children from her custody.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Clinical Placement Reviews should include procedures that require analysis of substantive issues, emphasizing the intrinsic worth of objective facts over subjective self-reports.

In addition, the procedures should include the requirement that factual discrepancies that implicate risk be identified and, until resolved by objective documentation, must be presumed as continuing risk factors.

The Department agrees. The current procedures for conducting Clinical Placement Reviews will be reviewed for comprehensiveness.

2. The Clinical Review team should uphold the conclusions drawn by the private agency in it's Adoptive Home Study of the woman that she is not a suitable candidate to be an adoptive parent.

The Department agrees.

3. This report should be shared immediately in draft form with the Department's Legal and Clinical Offices to assist in decision making.

The Department agrees. The report was shared.

GENERAL INVESTIGATION 4

ALLEGATION

A private agency removed two sisters (ages 4 and 5) from a relative foster home where they had been placed since birth, because of growing concerns about the relative's live-in paramour. The two sisters were placed with other siblings, who had been adopted by the relative and her paramour. The girls were removed after their older sister disclosed physical abuse. After they were removed, both girls disclosed allegations of sexual improprieties by the paramour. The relative requested an administrative review of the removal decision and the Department's clinical representative, who conducted the review, ordered the private agency to return the girls, while further assessments were conducted. The agency sought the involvement of the OIG because they believed the girls would not be safe in the home.

INVESTIGATION

The girls were initially removed from the relative foster home after the hotline was called because their older sister had bruises on her thigh, allegedly caused by the paramour. The private agency determined that the children were at imminent risk of harm and should not be returned to the relative's home. They were placed with another relative. In the new relative home, the older sister disclosed that she felt pressured to sleep in the same bed as the paramour. The four year old reported seeing the paramour naked and taking showers and baths with him, the relative and other siblings.

Since 1999, the agency had cited the foster family for licensing violations because the children slept in the same room as the parents and the paramour had anger management issues. The paramour claimed to have adopted the Native American culture and insisted on the children sleeping in the same room, a practice he claimed was common in Native American culture. The agency was concerned that the relative and paramour continually failed to correct the licensing violations. None of the people involved; the paramour, the relative or the children, were of Native American descent. The paramour had several arrests within the prior five years for battery, including domestic battery; in addition, he had older charges for drug possession. The private agency had cleared the criminal history information, based only on the paramour's self-report, because of the age of the drug charges and the fact that none of the battery charges involved violence toward children, but required the paramour to address his anger management problems. The paramour refused. A later licensing concern was raised after the oldest sister disclosed that the paramour had hurt her genital area, while washing her "too hard" in the bathtub. The relative was instructed that the paramour could not be in the minors' presence when they were washing, undressing or changing clothes. The agency determined that the paramour had "boundary issues" with the children.

The Clinical Placement Review was conducted as a mediation. Although the clinical evaluator determined that further assessments were needed, she made an initial determination that the children should be returned to the relative's home, pending the outcome of the assessments. Prior to making that determination, the clinical evaluator did not review the full record and minimized the possibility of inappropriate sexualized behavior or violence as well as the foster parent's history of failing to address the sleeping situation and the anger management issues. The paramour's assertion that his sleeping practices were based on Native American culture was accepted at face value, and the private agency was chided for not being culturally sensitive. The child's discomfort and feelings of being forced to sleep in the family bed were ignored. The clinical evaluator also failed to critically assess criminal history information.

The assessments ordered by the clinical evaluator found that the relative had a personality disorder, which, if left untreated, could compromise her ability to protect children in her care. The psychological on the paramour determined that he had a personality disorder with "histrionic, narcissistic and schizotypal features that appears to impact on his ability to set and maintain appropriate boundaries with the children."

After another hotline call was made, alleging that both younger sisters claimed that the paramour had digitally

penetrated them while bathing them, and the adopted son disclosed physical abuse by the paramour, the paramour was required to leave the home. The relative made it clear that she would not end her relationship with the paramour. The OIG intervened to ensure that the children would be removed. The children are now placed with an aunt.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This report should be shared with the clinical evaluator as a teaching tool.

The Department agrees and the report was shared.

2. Clinical review staffings should not proceed until the reviewer has read all relevant records. Management needs to develop realistic procedures addressing caseloads and information gathering techniques to permit adequate investigation during the ten-day period (five days to convene the review and five days following the review to complete the assessment).

The Department agrees that for clinical review staffings, a reviewer should read all relevant records before making recommendations. The ten-day timeframes provided for completion of a clinical review are guidelines for the reviewers, however, reviews may be completed in less than ten-days or may extend for a longer period of time if necessary.

3. The clinical supervisor must approve any clinical recommendation (including interim) that waives a licensing violation.

The Department agrees.

4. The clinical evaluator should be re-trained on the clinical interplay between control issues and anger and domestic violence.

The Department agrees and the employee was re-trained.

GENERAL INVESTIGATION 5

ALLEGATION

Three sisters, ages 17, 14 and 10, were removed from the home of a couple they had been living with for five years in a pre-adoptive placement. The couple complained to the Department's Advocacy Office about the girls' removal as well as other aspects of the Department's handling of the case including delays in licensing and adoption proceedings, failure to reimburse the foster parents for necessary expenses, and failure to provide services for another foster child who had previously been placed in the home.

INVESTIGATION

The three girls became involved with the Department and were subsequently removed from their parent's custody primarily as a result of the father's drug involvement and the mother's continuing struggles with mental illness. The two oldest girls were initially placed with the foster couple and their sister with a family friend while awaiting an out-of state placement with their paternal aunt and uncle. The relative placement was completed, however it was terminated after six months following allegations of physical abuse and inappropriate disciplinary methods by the aunt and uncle. At the time of the placement, the aunt's twin sister who also resided in the area was listed as the girls' alternative caregiver. Upon the girls' return to Illinois, all three were placed with the couple who had temporarily cared for the eldest two sisters. The girls lived with the couple and their two children, ages 12 and 7, for five years prior to their removal by the Department. After the girls had been in the home for two years, the couple accepted a 10 year-old boy as another foster placement. The boy, who was a special needs child, had been rejected by 26 agencies and had an extensive history of problems and failed placements.

After the girls had been in the home for three years, the couple met with a Department adoption specialist to discuss adopting the girls. Efforts to advance the adoption stalled when the foster parents and the adoption worker could not agree on the amount of the adoption subsidy. The couple expressed concerns regarding their ability to support multiple children in college simultaneously, dental coverage for the girls and the youngest sister's diagnosed learning disability.

Almost one year had passed since the girls' mother had relinquished her parental rights. If an adoption petition was not entered before the one-year time period elapsed, rights would revert to the mother and the Department would be required to recommence termination proceedings. The caseworker and an adoption worker met with the foster mother to discuss the need to enter a petition prior to the one-year time period elapsing. By this time, the relationship between the foster parents and the Department had deteriorated over the delays in obtaining the adoption subsidy and both sides reported resistance and non-cooperation. The couple ultimately filed an adoption petition on the day of the deadline for filing. Subsequently, issues involving renewal of the couple's foster parent license and an Unusual Incident Report (UIR) regarding an argument between the father and the oldest daughter prompted the adoption worker's supervisor to instruct her to suspend processing the adoption subsidy request until these situations were resolved.

The behavior of the children in the home began to deteriorate. The foster parents reported to the caseworker that the girls' were acting out and the boy began displaying increasingly aggressive behaviors both at home and in school. At this time, the foster mother also began experiencing an undiagnosed medical problem, eventually determined to be a herniated cervical disc. Both the caseworker and her supervisor told the OIG they were unaware of the mother's medical problem. The combination of ongoing problems within the home and the foster parents' perception of Department unresponsiveness resulted in the foster parents issuing a 14-day notice to have all four foster children removed from their care. Eight days after the notice was issued, the father dropped the boy off at a shelter after determining they could no longer control his behavior. Miscommunication between the foster parents and the caseworker over the situation further strained their relationship with the Department. The caseworker stated to the OIG that she repeatedly lobbied the foster parents to reconsider their notice without success. However, when the worker arrived at the home to remove

the girls, the couple stated they had changed their minds and wanted them to remain. The caseworker contacted her supervisor and advised her of the situation. The supervisor consulted with the Regional Administrator and the Regional Clinical Advisor and was instructed to remove the children.

The Department identified the twin sister of the aunt the girls briefly lived with as a potential placement, despite the fact she had made no attempt to contact them in five years and despite the fact that she had been listed as an alternate caregiver by the aunt who had permitted the girls to be abused. Meanwhile, the former foster parents continued to aggressively lobby the Department to have the girls returned. Although not their religion of origin, the girls had accepted the faith of their former foster parents. Their new foster parents were of a different faith and did not permit the girls the opportunity to continue to practice their adopted faith. The Clinical Advisor, who had taken part in the decision to follow through on the girls' removal from the foster home, was assigned to conduct a clinical evaluation and determined the girls should remain in the new foster placement until the Department fully assessed the viability of placing the girls with their aunt. In conducting her assessment, the Clinical Advisor failed to interview the oldest girl and neglected to inform the other two girls that the possibility of returning to their previous foster parents was an option. Nonetheless, the Advisor relied heavily on the fact that the girls never asked to return to their former foster parents. In an interview with the OIG, the Clinical Advisor stated she was unaware of the previous failed out-of-state placement because she had not read the entire case file. Another clinician was asked to conduct an assessment and, after reviewing the full record and conducting a thorough examination including meeting with all three girls and clearly delineating their options, determined it was in the children's best interests to be returned to their previous foster home. The girls have since been returned to the couple's care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Appropriate standards regarding clinical reviews should be developed to reiterate that a complete review of the record is necessary prior to making any case decisions and should address conflicts and potential bias.

The Department agrees. The current procedures for conducting clinical reviews will be reviewed comprehensiveness.

2. The Regional Administrator should review this report.

The Department agrees. The Regional Administrator reviewed the report.

3. The Regional Clinical Advisor should be counseled for performing an inadequate clinical assessment.

The Department agrees and the employee was counseled.

GENERAL INVESTIGATION 6

ALLEGATION Foster parents for three sisters were indicated for torture and risk of harm. The couple alleged that the Child Protection Investigator assigned to the case was biased against them and accused the investigator and the Department's Central Licensing Office of unprofessional conduct.

INVESTIGATION One year after accepting the three siblings (ages 3, 4, and 5), the foster parents requested that the youngest girl be removed because of behavioral problems. Just prior to the request for removal, the family had begun home-schooling the girls. The Guardian of the Department notified the foster parents that it would not permit home-schooling of foster children.

Prior to the girl's removal, the foster parents had twice been the subject of licensing investigations after informing private agency staff they had used corporal punishment against her. The couple steadfastly expressed their belief that corporal punishment was an appropriate method of reprimand and, during license renewal, refused to sign the document agreeing to refrain from physically disciplining the children.

Following the girl's removal, the foster parents made disparaging remarks about her to her new foster mother, calling her a thief and a liar and describing the child as "evil." The couple opposed sibling visits between the girl and her two sisters who remained in their home. The couple stated the girl terrorized her sisters with violent outbursts and that the children feared being forced to spend time with her. The foster parents refused to comply with the agency's request to have the other two sisters submit to a psychological evaluation in order to establish a possible basis for the couple's fears regarding sibling visits. Although the youngest girl, who was three when first placed with the couple, had demonstrated overly aggressive behavior in the past, there was no documentation of any violence directed towards her sisters other than one minor incident.

In accordance with Department Rules, the case plan required two sibling visits per month. The couple appealed the private agency's decision to require two sibling visits per month. However, by the time that the appeal was heard, the youngest girl's foster mother decided that while the sisters remained with the couple, sibling visits were too painful for the child and she acquiesced in ending the visits. The Administrative Law Judge (ALJ) determined that visits should be discontinued. Department policy regarding sibling visitation is based on significant research. Department Rule expressly prohibits depriving a child of sibling visitation as a means of discipline.

The couple separately appealed the Guardian's decision to prohibit home-schooling. The Department was not present at the hearing but demanded that the private agency present its view. The Department did not provide the agency with its rationale and was unable to cite any specific rule prohibiting the home-schooling of wards. The ALJ ruled the foster couple could continue to educate the girls in their home.

After the youngest girl was removed from the couple's home, she stated that the foster parents had previously made her hang from a bar in the basement and placed duct tape over her mouth as punishment. This disclosure led to both licensing and child protection investigations. Although the child protection investigation was unfounded, the agency's licensing division cited the foster parents for violating the prohibition against physically restraining a child and failing to cooperate with the requirement to agree to refrain from corporal punishment. The agency did not take action against the couple because they believed the practice only involved the youngest girl who was no longer in the home. The two older girls later informed their Guardian *ad Litem* that they were also made to hang from a pole in the basement as well as run laps around the house as discipline for misbehavior, which prompted a second Child Protection investigation.

The second Child Protection Investigator assigned to the case interviewed the foster parents who stated that a

private agency worker had condoned their use of "exercise" punishments. The investigator did not believe the children were safe in the home and thought they should be removed pending the completion of the investigation. When the investigator arrived at the home to remove the girls, she was confronted by the foster parents and a number of their friends. The couple reiterated their belief in corporal punishment and stated they knew of several other foster parents who employed physical discipline on wards. The investigator responded that the couple should provide the names of those people so that the foster children in their care could also be removed. Although this statement provided the basis for the couple's complaint that the investigator threatened to remove children from their friends' homes, the OIG found no evidence to suggest the investigator acted in an unprofessional manner. The sisters were removed and ultimately placed in the foster home with their sister.

The investigator indicated the couple for torture and risk of harm, however both findings were subsequently overturned on appeal. The decision to overturn the finding of risk of harm was based in part on the determination that the risk of harm posed by hanging from a bar in the basement of a home under adult supervision had not been articulated. Although the investigator had recorded in her notes that the structure in question was a chin-up bar, it was later learned that the girls had been made to hang from electrical conduit pipes. Following the investigation, the private agency informed the couple that it did not intend to renew their foster care license. After the Department attempted to resolve the problems between the couple and the agency, it was decided that the couple's foster care license would be renewed and transferred to another private agency. A six year-old boy with significant behavioral problems has since been placed in the couple's home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This report should be shared with the new private agency's Licensing Division to ensure that it has full information for monitoring the foster home. The New agency should partner with the six year-old's school to ensure the continued maintenance of his educational needs and to ensure increased opportunities to develop pro-social skills.

The Department agrees.

The OIG shared a redacted report with the private agency. The agency shared the report with the licensing supervisor and assigned licensing staff. The agency's licensing staff is also working closely with the assigned caseworker for the children.

2. This report should be shared with the Administrative Hearings Unit to determine whether additional training is necessary for administrative law judges concerning withholding sibling visitation or home-schooling.

The Department agrees. The report was shared.

3. The report should be shared with DCP, Regional Licensing and the original private agency to use in a grand rounds forum.

The Department agrees. The report was shared.

The OIG shared a redacted copy of the report with the private agency that originally licensed the foster home.

GENERAL INVESTIGATION 7

ALLEGATION

On December 4, 2001, the Illinois State Police contacted the OIG for technical assistance in their investigation of a DCFS ward who resided at a residential treatment facility for sexually aggressive adolescents. The ward had mailed threatening, sexually explicit letters, to the Secretary of State and a State Representative. The following day, the OIG was contacted by the residential treatment facility for advice on what to do in light of DCFS Legal's written directive that it was not to screen the ward's outgoing mail. The letter noted that the ward was to "resume his mail privileges." The letter cited the ward's "right" as delineated in DCFS Rule 327.4, Control of Mail.

INVESTIGATION

The treatment facility was worried that the ward would get into more trouble if his outgoing mail was not monitored. The OIG intervened because Rule 327.4 specifically permits the Department to "withhold or screen" mail in "extreme circumstances" and for "the specific purposes of protecting the recipient or others from harm, harassment, or intimidation."

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

DCFS Legal was contacted and agreed that the residential treatment facility could hold the ward's outgoing mail and submit it to the DCFS Guardian for a determination of what to do with the mail.

GENERAL INVESTIGATION 8

ALLEGATION

A day care center worker was indicated for sexual abuse against a child in his care and for risk of harm to his own three children. He was fired from his job and was required to move out of his home so his children would not be removed from the mother. After the indicated findings were overturned on appeal, the OIG was asked to investigate the initial Child Protection investigation.

INVESTIGATION

The Child Protection investigation was initiated after the mother of a four year-old girl who attended the day care center contacted the center's director and reported the girl had stated a male teacher molested her bottom. The director called the State Central Register (SCR) and a Child Protection Investigator was assigned to the case. A Victim Sensitive Interview (VSI) was coordinated between the family, the investigator, local police and the designated interviewer. During the interview, the girl volunteered information prior to being asked, reiterating the allegations of abuse. The girl stated that the incident had occurred once during the children's naptime while the other teacher assigned to the class was out of the room. The girl also provided names of other children she said were on their cots around her at the time but did not see the abuse because they were sleeping.

Following the interview, the investigator contacted the teacher's wife, who was also employed by the day care center, and informed her that the teacher must immediately move out of the family's home and could not have unsupervised contact with the couple's three children. Two days later, the investigator and a Department licensing worker visited the day care center. The investigator recorded that she observed the classroom and was informed of procedures during naptime. There was no evidence in the case file that the investigator observed the room as it would be arranged for the children to take naps or requested staff to assist in a scene reconstruction. Three days later, the investigator conducted an interview with the teacher and his family. Both parents denied the allegations and their children stated they understood the concept of inappropriate touching and said they had never experienced or witnessed any behavior of that kind. The teacher later suggested to the investigator that the girl might have confused her back with her bottom; however, the reasoning behind this theory was not pursued. Although the investigator recorded in her notes that the couple's two youngest children had blond hair and blue eyes, a photograph later produced at the appeal hearing showed all three children to have dark hair and brown eyes.

The investigator then conducted interviews with eight children from the day care center, ages three to five. The investigator neglected to record the last names of four of the children and, although her supervisor stated consent forms were obtained, none were found in the case file. Aside from one child who did not respond to questioning, all of the children were able to identify inappropriate touching and stated they had not experienced or witnessed any such behavior. Prior to meeting with the children, the investigator had been instructed by her supervisor to arrange the interviews and then indicate the report against the teacher if no new information was obtained. In an interview with the OIG, the supervisor stated that the denial of other students having witnessed or received inappropriate contact would not have constituted "new information."

The supervisor approved the investigator's decision to indicate the teacher for sexual molestation of the girl and risk of harm to his three children. In an interview with the OIG, the supervisor stated that the decision to indicate the report for sexual molestation was supported by the girl's consistent statements and the teacher's opportunity to have committed the abuse. The supervisor's determination did not seem to consider exculpatory evidence that contradicted her conclusion. In interviews with the OIG, both the investigator and her supervisor stated the indicated report for risk of harm was based solely on the indicated report for sexual molestation. The supervisor stated that because she believed the teacher had abused the girl, it stood to reason that he was likely to abuse his own children until evidence was presented to prove otherwise.

The Administrative Hearing judge who presided over the expungement hearing overturned the indicated finding, noting critical gaps in the investigation. The investigator had failed to critically examine the scene or interview other adults that might have been present during the alleged incident.

In an interview with the OIG, the investigator's supervisor stated that the investigator had drawn a diagram of the room but that the illustration was inconsistent with the girl's statements regarding the number of children who could have slept near her. The diagram was not included in the investigator's case file. OIG investigators visited the day care center during naptime and found that the internal layout of the facility allowed high visibility between areas and that the girl's cot would have been located in plain view of the hallway where the other teacher was located at the time the abuse allegedly occurred.

The case was referred for Intact Family Services (IFS) and the teacher was referred for a psychosexual evaluation. During the evaluation, the teacher acknowledged having been previously tried on a charge of Involuntary Manslaughter and being found not guilty. The evaluator did not ask any further questions regarding the incident. The teacher had previously told the child protection investigator that his criminal history was incorrect, however there was no indication she attempted to verify his previous involvement with law enforcement.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue disciplinary action against the child protection investigator's supervisor for her failure to ensure a substantive investigation including a scene investigation with an accurate description of naptime practices and for exhibiting a contributory bias towards a false positive finding.

The Department agrees. The supervisor was counseled.

2. DCFS should revise procedures to require a scene investigation in all DCP investigations of abuse, provide guidance on how to conduct a scene investigation, and clarify that scene investigation and mock demonstrations are necessary components of an investigation.

The Department agrees and procedures will be revised. In addition, a notice will be sent to all DCP staff of the requirement that in all formal investigations the investigator must review the scene where an alleged incident took place.

3. **Currently, Department Procedures 300 – Appendix B for allegations Sexual Molestation, Sexual Penetration, and Sexual Exploitation, lists required documentation for indicating a report including, "Scene observation and demonstration with anatomically correct dolls may provide valuable collaboration to statements provided by victim or alleged perpetrator." The Department should revise these procedures to separate the categories of 'scene investigation' and 'demonstration with anatomically correct dolls'. The revised procedures should also include guidelines for appropriate circumstances for use of anatomically correct dolls.**

In sexual abuse investigations, to the greatest extent, the Department relies on professional interviewing staff at Child Advocacy Centers. The Department agrees to review the procedure for clarification.

GENERAL INVESTIGATION 9

ALLEGATION

An eighty-four year-old foster mother was arrested after she tied her two year-old foster child to his car seat and left him alone in a car while she went into a store.

INVESTIGATION

The woman and her husband were initially licensed as foster parents through a private agency in 1988 when they were 72 and 64 years old, respectively. Although the foster father's doctor documented that the foster father suffered from coronary artery disease and hypertension, the licensing worker noted both foster parents were healthy. The couple was licensed for placement of up to three children between the ages of two and five. Shortly thereafter, two children, ages one-and-a-half and six years old, were placed in their home. After four months the couple requested the removal of the older child, stating they felt their advancing age prevented them from "keeping up" with children over six. The child was removed and another two year-old child was placed in the home.

Six months before the couple's license was due for renewal, the foster mother was hospitalized for a possible heart condition. Two months after she was released from the hospital, the foster father died of stomach cancer. The foster father's death, which occurred in 1990, was not noted in the licensing file and, in fact, no mention of his death was recorded until eight years later, when a home study addendum was added in 1998. Three months after the foster father's death, two more children under the age of two were placed in the home of the recently widowed 74 year-old woman. Soon afterward, when the foster home license was up for renewal, the assigned licensing worker recommended the license be renewed with an increased capacity from three to four, the number of children already in the home. The license was renewed and, in addition to the increased capacity, the upper end of the age range of children that could be placed in the home was raised from five to ten years of age. There was no record or explanation as to how or why the age range was expanded.

In 1994, the private agency recommended renewing the foster mother's license for four years. At the time, the foster mother had been caring for three siblings, all of whom were under the age of five. The licensing file contained no indication that the 78 year-old woman's health was taken into consideration when the license was renewed.

In a 1998 medical report, when the foster mother was 82 years old, her doctor documented that she had Type II diabetes, high cholesterol and gout. The physician stated that these conditions could negatively affect her ability to care for children and recommended that only children aged 12 to 18, who would be better able to care for themselves, should be placed in her home. In an interview with the OIG, the private agency licensing worker assigned to the foster mother stated she was aware of the woman's medical issues but believed they were easily managed and did not preclude caring for children. In recommending renewal of the foster care license, the licensing worker suggested the capacity be reduced from four to two children but did not adjust the age range requirements, despite the recommendation in the doctor's report. The license was renewed for placement of up to three children between the ages of two and ten.

One year later, three siblings, girls aged five and nine and a one year-old boy, were placed in the home. Although the foster mother had previously told the licensing worker she had difficulty managing children with behavioral problems, the sisters, who had both been recommended for counseling and one of whom had a history of acting out, were deemed suitable for placement in this home. The oldest girl was removed from the home after one month at the foster mother's request. During a subsequent home visit by the children's caseworker, the 84 year-old foster mother stated that the children were hyperactive. The foster mother also informed the private agency that she was willing to work with children with behavioral disorders but that she would require assistance from the agency.

The following month, August, the foster mother left the two year-old boy in the car, tied to his car seat, while she entered a store. Upon her return to the car, she found police officers waiting. A Child Protection Investigator assigned to the case cited the foster mother's age in his report and noted she may have been "unable physically to provide adequate care." The foster mother told private agency staff she tied the child's ankles together so he would not climb out of his car seat while she was driving. Private agency staff noted the foster mother was extremely distressed by the incident and that she immediately surrendered her foster care license. The foster mother was subsequently indicated for Inadequate Supervision and Tying/Close Confinement. She was also charged by local police with child endangerment. In an interview with the OIG, the private agency's director of foster care told investigators that, because of the foster mother's involvement in a criminal case, the agency's attorney advised them not to provide her with additional support.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A redacted version of this report will be shared with the private agency. The Inspector General will meet with the agency's executive director and board members to discuss this report and the Older Caregiver Program.

The Department agrees.

The OIG shared the report with the private agency and met with the Executive Director and agency administrators and members of the Board of Directors to discuss the report and the Older Caregiver Program. Agency management shared the report as a teaching tool with the licensing staff involved in this case, as well as all foster care licensing and case management staff. The agency provided the OIG with a corrective action plan detailing steps to address deficits in identifying medical needs, assessment, placement decisions, and documentation for licensing and placement staff. The agency developed forms for staff to assist in making referrals to the Older Caregiver Project, and in conducting a comprehensive assessment of foster parents. It also developed procedures to follow in making critical case decisions and addressing and preventing foster home disruptions and transfers. The OIG will offer on-going training opportunities for the agency in providing services to older caregivers.

2. This report should be used as a learning tool for the private agency's licensing worker, the worker's supervisor and the licensing consultant involved with the foster mother. The private agency should consider sharing the issues and analytical points with all foster care licensing and case management staff.

The Department agrees. *(See response to Recommendation #1 above.)*

3. The private agency should conduct (on-going) assessments of all foster parents' capability (Rule 402.12), and it should carefully assess medical information and/or significant life changes that occur in foster parents' lives. The assessment should provide as clear a picture as possible of the foster parent's health, strengths, limitations, mobility, characteristics, parenting style and experiences, areas of discomfort or need for further training, etc. Support services, e.g., respite, should be provided where an assessment identifies such needs. The on-going assessment should be documented in the licensing file, and used as part of the tools employed to determine appropriate matches for placement.

The Department agrees. *(See response to Recommendation #1 above.)*

4. The Older Caregiver Program can assist the private agency with assessment and problem solving for foster families headed by caregivers aged 71 to 85.

The Department agrees. *(See response to Recommendation #1 above.)*

5. The private agency should develop agency procedures for appropriate matching of foster homes and children, which promote careful evaluation of the child's needs and permanency status as well as the dynamics and capabilities of the foster homes under consideration for placement, in accordance with Department Rules and Procedures. The process should include a staffing between licensing personnel and/or intake, and case management personnel, so that beneficial, informative dialogue can occur between staff familiar with the child's needs and those familiar with the foster parents. The staffing should be documented in the file.

The Department agrees. *(See response to Recommendation #1 above.)*

6. This private agency's licensing representatives and supervisors should discuss all pending licensing recommendations, assessing all pertinent information, prior to making a recommendation (e.g., recommendations for initial licensure and renewals, changes in restrictions to a license, recommendations regarding arrests/convictions). The discussion should be documented in the file.

The Department agrees. *(See response to Recommendation #1 above.)*

GENERAL INVESTIGATION 10

ALLEGATION

After a mother was indicated for child abuse when her son was born substance-exposed, the Department agreed not to take protective custody if the mother agreed to seek treatment and find a caregiver for her infant. A friend of the mother's, who was also a licensed foster parent, agreed to temporarily care for the newborn under a private agreement not sanctioned by the Department. The foster parent alleged the Child Protection Investigator (CPI) failed to inform her that the child was born drug-exposed and purposely mislead her in order to secure the placement. The foster parent also sought reimbursement for costs she incurred while caring for the child.

INVESTIGATION

The newborn was the fourth of his mother's five children to have tested positive for cocaine at birth. The mother had given up her eldest child for adoption while the other three resided with their maternal grandmother. The Investigator met with the grandmother and identified her as a suitable placement. The mother enrolled in a drug treatment program. The mother then informed the investigator that while the grandmother was unwilling to care for the baby, a friend who was a licensed foster parent would take the newborn.

The caretaker alleged that she explicitly told the Investigator she would only take the child if he was not substance exposed and was assured the baby had been born drug-free. The Investigator denied this conversation occurred and there was no record of such a discussion in the case notes. The Investigator stated that ,while she did not expressly inform the caretaker that the child had been addicted to cocaine, she believed the caretaker understood the newborn's condition. She based this belief, in part, on two conversations. During a conversation with the caretaker and the mother, the mother stated she had entered a drug rehabilitation program. The second conversation was with a nurse at the hospital who told the Investigator and the caretaker that the baby was not displaying any withdrawal symptoms at that time. The Investigator stated that since the Department had not taken custody of the baby and he was being placed as part of a private agreement, she was concerned that directly informing the foster parent of the baby's drug exposure might violate confidentiality.

A secondary issue identified was that, although the caretaker had two other children placed in her home by DCFS, the Investigator neglected to contact the Placement Clearance desk (PCD) to ensure that placing another child in her home would not violate her foster care license.

After the caretaker began experiencing problems with the baby, including incessant crying, she took the newborn for an examination and was informed he was experiencing drug withdrawal. The foster mother issued a 14-day removal notice for her foster children as she felt she could not properly care for them while dealing with the infant. The caretaker also contacted the Investigator and requested emergency funds. The Investigator told the caretaker she was not eligible for funds because the placement was made as a private agreement. The caretaker then requested the baby's removal and the newborn was subsequently placed in the home of the maternal grandmother.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should develop guidelines restricting the use of private arrangements pending child protection investigations and provision of services to include the following:

- An evaluation should be conducted at the outset of a private agreement, that a threat to safety, giving rise to the need to remove the children can be addressed through the private caretaker agreement and that the parent is cooperative both with the placement agreement and any service plan.

- The evaluation should include a realistic assessment of the duration of the private care-taking

agreement.

- After an agreement has been in place for 90 days there must be a re-evaluation to consider the continued advisability of the private agreement, examining the strength of the family, its history, and the amount of time it will take before the child/children can be returned to their natural parent.

- Intact family workers and CPI's will be instructed to secure full consent from parents so that private caretakers have full knowledge of all relevant information. A child's safety cannot be assured when the private caregiver does not have full information.

- The natural parent must fully cooperate with all directives made by the Department. The consequences of non-cooperation will be explained to the natural parent. Once non-cooperation is apparent in a case the Department should reassess the continued advisability of the voluntary placement.

- If it is determined that the child/children will not return to their natural parent(s), the caretaker should be given the opportunity to gain guardianship via probate court.

The Department agrees. When it is necessary to remove children from their home because of a safety issue, a safety plan will be developed that requires that a child reside with a relative or family friend while services are provided to the parent. Department procedures require that safety plans be short-term temporary interventions. If a child cannot safety return home, then the worker would be required to formalize the arrangements, which may include either probate or juvenile court action. Department Procedure 300 is also being revised to require that safety assessments for children who have been found to be unsafe must be repeated on a weekly basis to re-evaluate the child's status. Parents are now required to sign a statement indicating that they agree to the terms of the safety plan and understand the consequences of non-compliance.

2. **The case manager should review the case files of the mother's children who continue in relative foster care for permanency. If they are not likely to return home, the grandmother should be encouraged and assisted to attain private guardianship in probate court.**

The Department agrees. The children have been returned home.

3. **The OIG has recommended that Rule 301, concerning the Placement Clearance Process, require communication between DCFS employees and the PCD before children involved in private placement agreements are placed in foster homes, to ensure the placement does not exceed the home's licensed capacity.**

The Department agrees. The Placement Clearance Process is currently under review and this will be included in the revisions.

4. **Whenever the Service Appeal pamphlet is handed out, workers should take special effort to inform foster parents about the Advocacy Unit as a resource for problem resolution.**

The Department issued Administrative Procedure 21, Providing Assistance and Advocating for Children and Families. This procedure details the purpose and scope of the Advocacy Office for Children and Families. This procedure is also intended to inform staff of the availability of the Advocacy Office as a resource for clients and other members of the child welfare community.

GENERAL INVESTIGATION 11

ALLEGATION The OIG investigated a foster home where children had been placed for several years after allegations arose that the children were being abused and the environmental conditions in the home were deteriorating.

INVESTIGATION The foster mother had four children placed with her for several years, two sets of siblings. Each child had specialized needs. The two oldest had extensive histories of behavioral problems, including aggression and emotional outbursts. They had been in placement with the foster mother for over seven years. The 12 year-old girl had attempted to kill a cat and had attempted to have sex with another child. Her brother (10 years old) had a history of fire-setting, fighting, stealing and urinating throughout the house. The boy was psychiatrically hospitalized after he left the foster home. The other siblings, six year-old twins, had cerebral palsy, speech, language and cognitive delays and one required leg braces. They were hyperactive and easily angered. They both had a preoccupation with water, manifested by attempts to frequently drink out of toilets at home and at school. The twins had been in placement with the foster mother for almost five years.

In the year before the children were removed, two hotline calls were received concerning the foster home. First, a school that the twins attended called the hotline to report bruises on one of the twins, who stated that the bruises were from her foster mother hitting her with a belt. Seven months later, a different school called to report that one of the twins disclosed that her foster mother did not allow her to go the bathroom and had hit her with her hand and a belt. No marks were observed, but the teacher noted that the girl's leg braces did not fit well, which caused skin irritation.

The first investigation was unfounded after the girl recanted and stated that bruises were the result of a fight with her brother. The investigator confirmed that the twins frequently fought aggressively with each other and interviewed several professionals that described the foster mother as caring and doing a good job with difficult children. The second allegation was unfounded based on the following facts: the foster mother admitted restricting their access to the bathroom because of the twins' tendency to drink toilet water. She also admitted that she restricted their water access after 6 p.m. because they wet the bed. The investigator confirmed with a doctor that the twins had a "voiding dysfunction" and that school staff also found it necessary to restrict their bathroom access. The foster mother made an appointment to have the girl's leg braces adjusted and to seek professional help regarding their toileting problems. The corporal punishment allegations were unfounded because the investigator did not observe any bruises.

Later that year, the foster mother called the case manager to report inappropriate sexual behavior between the two older siblings. As a result, the foster mother was required to ensure that the siblings were never together unsupervised. That same month, the private agency conducted a licensing visit and observed serious environmental problems in the home. The children's bedrooms were dirty and smelled of urine. The bathroom, which was being remodeled, had no sink and the floor was half-laid with tile. There were holes in the walls; no knobs on the kitchen and second bathroom faucets and the 12 year-old's bed had no linens. The foster mother explained that it was the 12 year-old's responsibility to make her own bed, that the 10 year-old urinated in the home, and that the house was being remodeled. Corporal punishment questions were addressed by having the foster mother sign a statement agreeing not to use corporal punishment. The case manager thought that the children should be removed, but the licensing representative thought that the foster mother should be given a chance to correct conditions. Neither addressed the likelihood that the foster parent was overwhelmed. The agency did not offer assistance with identified problems, such as the 10-year old urinating in the home.

The following month, the 10 year-old disclosed to his doctor that his foster mother occasionally spanked him

with her hand and sometimes used a belt on his back. After learning of this, the case manager contacted the foster mother and notified her that all children would be removed from her home. In response, the foster mother brought all four children to the private agency and left. The hotline was never called as a result of the 10 year-old's allegations, because the agency determined that the only mark on the 10 year-old was an old scar that had been there before he came into care. The foster mother requested that the 12 year-old be allowed to return to her home. The agency complied and the foster mother sought to transfer her license to a new agency.

The investigation did not support the allegations of abuse by the foster mother or that deteriorating conditions in the home had been ignored.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency has recently transferred its foster care cases to another agency. In previous investigations, the OIG has encountered problems in the transfer of foster care cases and licensing files including lost licensing files, incomplete licensing files, and failure of agencies to comply with DCFS Rule 402.4 d) 2 requiring that a new licensing application be filed when there is a change in the supervising agency. The receiving agency must review all the licensing files they have received from the private agency to determine if the appropriate documentation required for licensure is contained in the licensing files. This documentation should include the following:

a) A new application
b) Licensing/Home Study
c) Family Home Information sheet
d) Copy of the Individual Licensing Summary
e) Medical Report
f) Evidence that a new site visit has occurred and that the home is still in compliance
g) References
h) Certificate of foster parent training.

In the event that any documentation is missing, the receiving agency must take immediate steps to complete the documentation. If, upon review of the licensing files, questions arise as to either documentation or the appropriateness of the placement of a particular child with his or her foster parent, the receiving agency should contact the private agency to obtain background information that might not be included in the file or ensure that new documentation is completed and placed in the file.

The Department agrees.

The OIG shared a redacted report with the agency and the agency's Board of Directors. The Inspector General met with the Executive Director and agency administrators and members of the Board of Directors to discuss the report. The agency will review the licensing files and complete any missing documentation. The OIG will provide technical assistance to the agency in conducting criminal background checks and obtaining underlying arrest reports for the foster homes transferred from the original private agency.

2. The private agency has transferred the foster mother's license to the receiving agency. Staff at a third agency, which is currently servicing the two older siblings, told the OIG Investigator that they declined to accept a transfer of the foster mother's license because she had been uncooperative with them. The receiving agency's licensing staff should conduct a licensing investigation based on the third agency's allegations of non-cooperation to determine whether existing problems warrant licensure action or increased licensing monitoring.

The Department agrees.

GENERAL INVESTIGATION 12

ALLEGATION

A mother, whose two children had been removed from her custody because of severe physical abuse, gave birth to a third child. The caseworker assigned to provide services to the family failed to contact the State Central Register (SCR) to report the baby's birth. There was a general failure by the private agency to provide services to the family for several months.

INVESTIGATION

The mother became involved with the Department after she brought her then three month-old daughter to a hospital and stated the infant had fallen off of a chair. Attending physicians found the child's severe condition, multi-system organ failure and serious brain injury, to be inconsistent with the mother's account. Hospital staff contacted SCR and during the Child Protection Investigation the mother admitted she had shaken the infant and thrown her around a room in her home. The infant girl and her one year-old brother were removed from the mother's custody and placed with their father who resided with the children's paternal grandmother. The case was referred to a private agency for services and a caseworker was assigned to work with the family.

The assigned caseworker had only been employed by the private agency for three months and had no previous experience in the child welfare field. In addition, the private agency involved was programmatically geared only to handle a foster care caseload, and did not generally provide services to intact families. Since the children were with their biological father, theirs was an intact family case. When the caseworker learned of the error, he informed his supervisor, but the case was not transferred for another year. In his interview with the OIG, the caseworker stated that both his supervisor and the agency's intake worker informed him that the case would be transferred and he was no longer responsible for providing services to the family.

Four months later a court hearing was held regarding the case, however the caseworker, who was still listed as the worker of record, did not attend. The presiding judge entered an order compelling the caseworker's supervisor to appear in court to explain why so much time had passed without any work being done on the case. The judge also asked a court facilitator to prepare a report. The facilitator's report found that a complete breakdown of communication between several private agency staff members had prevented the case from being transferred and caused the lapse in services. The supervisor submitted a written response to the court order stating he would ensure services resumed and that he had given the caseworker a "verbal warning" for failing to continue services until the case was transferred. In his interview with the OIG, the supervisor stated that although he told the court he had issued a verbal warning to the caseworker, in reality it was a discussion and the supervisor had not documented the meeting. The caseworker did not recall ever being reprimanded for his failure to service the case.

After the caseworker resumed his involvement with the family, he learned the mother was pregnant with her third child by the father. In his interview with the OIG, the caseworker stated he informed his supervisor of the mother's pregnancy but that the supervisor did not discuss the matter with him. The caseworker said he again notified his supervisor when the baby was born and was told to confirm the birth and attempt to contact the mother. The caseworker stated he was not instructed by the supervisor to contact SCR to report possible risk of harm to the infant. The caseworker said it occurred to him the baby could be in a potentially dangerous situation but he did not grasp the magnitude of the situation and was unsure how to proceed. In his interview with the OIG, the supervisor stated he would have directed the caseworker to contact SCR but could not recall if the caseworker ever informed him of the baby's birth.

The supervisor's statements to OIG investigators were frequently contradictory and raised questions regarding his credibility. Despite his recognition of the inappropriateness of the private agency's continued involvement in the case after learning the children had been placed in their father's custody, the supervisor neglected to ensure the case was properly transferred. In addition, the supervisor failed to provide adequate

instruction to an inexperienced caseworker, resulting in the family having no contact with the agency for four months. The supervisor's written statement to the court regarding having issued a verbal warning to the caseworker appeared to be an attempt to place the blame for mishandling of the case on the caseworker.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The private agency should discipline the supervisor in accordance with the agency's policy and procedures for his failure to adequately supervise the caseworker and misleading the court regarding having given the caseworker a "verbal warning."

The Department agrees.

The OIG shared a redacted report with the agency. The Inspector General met with the Executive Director and President of the Board of Directors to discuss the report. The supervisor on this case was discharged for conduct on this case and falsification of a supervisory document. The agency has conducted a review of other cases the former employee was supervising. No additional problems were identified in this review.

GENERAL INVESTIGATION 13

ALLEGATION A private agency caseworker did not report that a mother, previously indicated for abusing her son, had given birth to a baby.

INVESTIGATION The family became involved with the Department after the young parents brought their then three month-old son to an emergency room because of the child was having difficulty breathing. Attending physicians found the baby had two fractured ribs that were approximately four weeks old. Doctors determined the injury was caused by severe trauma. The parents were unable to explain how the injury occurred. After a Child Protection investigation, the parents were indicated for physical injury, and the baby was taken into protective custody and placed with his paternal grandmother. A family case was opened and assigned to a private agency caseworker.

Throughout his involvement with the case, the private agency caseworker demonstrated an unwillingness or inability to perform basic casework functions. A review of the case notes found few, often illegible, entries and a lack of substantive content. Pertinent information about the family and services received was absent. The caseworker never observed or monitored parent-child visits, leaving the responsibility to the foster parents. The baby's paternal grandmother, who served as his first foster parent, told OIG investigators she was disturbed by the mother's behavior during visits, particularly her apparent disinterest in spending time with her baby and her angry outbursts. The grandmother also stated that the caseworker failed to make monthly visits to her home and dismissed her concerns about the mother's behavior. The caseworker denied the grandmother related any problems to him. However, he acknowledged that the grandmother, as well as a counselor and psychologist who worked with the mother, reported that the mother had an anger control problem. The caseworker stated that he did not believe the mother's anger to be a potential risk factor because he had not personally witnessed such behavior.

Although the father presented as intellectually limited, the caseworker did not attempt to verify the father's educational history or ascertain if he had a developmental delay, which would make him eligible to receive additional services and support. The caseworker did not seek parenting assessments, which would have provided helpful information to the court. The caseworker believed parenting classes and couples counseling were the central services required to achieve family reunification; however, the caseworker did not ensure the parents complied with these services. Both parents were required by the Department to attend anger management classes and individual counseling, and the father was required to attend assertiveness training. Although none of these services were initiated, the caseworker stated in court that the parents were compliant with all services. The caseworker did refer the parents for psychological evaluations, but he provided the evaluators with little information regarding the reason for the referral and the expected goals of the evaluations.

After the caseworker learned the mother was pregnant with the couple's second child, he did not verify whether she was receiving pre-natal care or discuss childcare plans prior to the baby's birth. The caseworker informed the OIG investigator that, after the baby was born, he forgot to perform a safety assessment for the infant or call the State Central Register (SCR) to report risk of harm to the newborn. The caseworker contacted SCR after the Guardian *ad Litem* (GAL) instructed him to do so. The report was taken as information only because, according to the SCR operator who received the call, the caseworker gave a positive presentation of the parents.

The caseworker's personnel file contained an extensive history of poor performance, substandard case documentation, and failure to inform supervisors of significant case developments. It also indicated that he had provided inaccurate or false information in order to compensate for failing to perform his professional duties. Although the caseworker was identified as a problematic employee, steps were not taken to ensure

greater oversight of his work and subsequent supervisors were not informed of his history of substandard performance. The caseworker resigned his position with the private agency prior to the completion of the investigation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The private agency should carefully review all cases that were assigned to the caseworker to ensure accuracy of information and implementation of service plans.**

The Department agrees.

The OIG shared a redacted report with the private agency and the agency's Board of Directors. The agency conducted a review of the former employee's cases.

2. **The mother should be referred for a Child Abuse Potential Inventory (CAPI) assessment and be required to attend anger management training. This recommendation should be added to the Client Service Plan.**

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

3. **The father should be referred for a Vineland Adaptive Functioning Assessment and he should be referred to the Department of Rehabilitative Services for benefits to which he is entitled. This recommendation should be added to the Client Service Plan.**

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

4. **The referral forms for psychological evaluations should include a section that requires case history and the reason for involvement with DCFS.**

The Department agrees. In addition to the standardized referral form, the Department requires that the referral form be accompanied by required information, including a current social history, treatment notes, case history and reason for involvement.

5. **The Department's Clinical Services Division should ensure that consulting psychologists clarify questions and inquiries and obtain relevant information on referrals for psychological evaluations to achieve meaningful and useful evaluation.**

The Department agrees. The Department requires that, when the consulting psychologist reviews a request for a psychological evaluation, the psychologist must discuss with the worker the need for testing and any referral questions. A newly revised CFS 417 form will soon be released requiring the consulting psychologist, in consultation with the worker, to write out the referral questions for the examining psychologist.

6. **The OIG will share a redacted copy of this report with the caseworker's current employer, if any, in child welfare.**

The Department agrees.

The OIG shared a redacted copy of the report with the caseworker's current employer and discussed the matter with the Executive Director and President of the Board of Directors. The caseworker is being closely supervised by his new employer.

7. A referral of the caseworker will be made to the Employee Licensure Investigations Unit for possible licensure action.

The Department agrees. The caseworker was referred to the Employee Licensure Investigations Unit.

GENERAL INVESTIGATION 14

ALLEGATION

During the course of a previous investigation, the OIG determined that recommended services had not been provided to four special needs siblings living in a relative foster placement.

INVESTIGATION

The foster parents were caring for the four children of their niece and her husband who had lost custody because of substance abuse, medical neglect of the children and failure to comply with required services. The siblings were two boys, ages 13 and four, and two girls, ages eight and six. The six year-old girl and the four year-old boy had cerebral palsy and presented major, complex medical issues which required extensive monitoring, treatment and special supports. The girl was severely retarded, blind, incontinent, unable to communicate and non-ambulatory. She required a feeding tube and suffered from brittle bones, making her prone to fractures. The boy's legs were paralyzed but he had upper body control that afforded him some mobility. He was visually impaired and developmentally delayed. The boy's last name was also incorrectly recorded in Department records causing unnecessary complications for the foster parents on occasions they were required to present his documentation. The eight year-old girl had a history of being physically and sexually abused and required treatment. The 13 year-old boy was diagnosed with Attention Deficit Disorder (ADD) and had a history of behavior problems and substandard academic performance.

The OIG first became aware of the family's situation while investigating the billing practices of a home health care agency contracted by the Department to provide services to the two children with cerebral palsy. The foster parents were not responsible for the actions of the health care agency and never attempted to defraud the Department. Despite this, certain Department employees responsible for providing services to the family portrayed the foster parents as being responsible for the exorbitant health care costs. The employees disseminated inaccurate and discrediting information about the foster parents, which influenced decisions made by other Department personnel.

A Department nurse that worked with the family and her supervisor, a clinical coordinator, developed a hostile attitude towards the foster parents during their involvement with the case. The clinical coordinator and the nurse characterized the foster parents' efforts to obtain services for the children as opportunistic attempts to siphon funds from the Department. The nurse communicated to other Department staff that the foster parents suffered from Munchausen by Proxy Syndrome (a syndrome in which a caretaker intentionally creates or prolongs a dependent's illness to fulfill the caretaker's needs), though she was not qualified to make such a diagnosis and there was no clinical basis for such a determination. The clinical coordinator expressed her opinion that the two children with cerebral palsy should be institutionalized during an initial five-minute visit with the children in the family home. Although there was documented evidence that school personnel were unresponsive to the foster mother's attempts to enroll the children in their local school, the clinical coordinator and the nurse told other Department workers the foster parents refused to secure educational services. When the Department's Advocacy Office became aware of the foster parents' situation through a third party, the clinical coordinator and the nurse angrily accused the foster parents of lodging complaints about them and being ungrateful for the services provided to them.

The clinical coordinator and the nurse were found to be grossly negligent in their duties. Their biased thinking and conduct prevented other Department staff from developing a clear and accurate understanding of the family and taking appropriate action. Neither medically compromised child received the appropriate public education they were entitled to under federal law. The children's physician prescribed a number of medical devices, which had not been acquired. At no point during the Department's handling of the case did the involved child welfare professionals utilize an integrated approach to construct a comprehensive assessment and plan for providing services to the family. This failure placed undue pressure upon dedicated, attentive

foster parents and negatively affected the children in their care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The children should be assigned to a caseworker that possesses the skills necessary to manage medically complex and multiple special needs children within one family.

The Department agrees. The case has been transferred to another caseworker.

2. The Department's education staff, together with the foster parents, should:

- **Pursue the children's eligibility status for extended school year services through their Individual Education Plans;**
- **Arrange and attend a conference with school personnel for each child to ensure educational programming will meet their needs; and**
- **Provide the foster parents with an overview of their disabled children's educational rights and provide them with educational materials such as *A Parent's Guide: The Educational Rights of Students with Disabilities*, published by the Illinois State Board of Education.**

The Department agrees. The Division of Education and Transition Services is working with the family in addressing the educational needs of the children.

3. The clinical coordinator should be removed from the children's case. The Department should pursue disciplinary action against the clinical coordinator for acting on harmful biases, adhering to and irresponsibly communicating inaccurate information regardless of known facts, and exhibiting unprofessional conduct toward the foster parents. In her position of clinical coordinator, she is consulted for clinical assessment and direction, responsibilities that she failed to meet on behalf of the children.

The clinical coordinator had been previously discharged as a result of other infractions. The clinical coordinator's discharge was reversed and reduced to a 60-day suspension by the Civil Service Commission. This report will be used for additional discipline upon her return to work.

4. The Department nurse should be removed from the children's case. The Department should pursue disciplinary action against the nurse for her demonstration of harmful biases, irresponsible communication of inaccurate information regardless of known facts, and unprofessional conduct toward the foster parents. The nurse exhibited poor judgment when she formed a medical diagnosis that was beyond the scope of nursing practice.

The Department agrees. The Department nurse is no longer part of the children's case. In addition, discipline was initiated and the Department nurse received a 10-day suspension. The nurse grieved the discipline. The grievance is pending.

5. The clinical coordinator should be removed from supervising the Department nurse.

The Department agrees.

6. This report should be shared with the case manager, the caseworker, the Department's Chief Nurse, and the area administrator for the region.

The Department agrees and the report has been shared with the identified staff.

7. The Department should correct the four year-old boy's last name in the case records and database system.

The Department agrees.

GENERAL INVESTIGATION 15

ALLEGATION A couple was permitted to adopt two of their three grandchildren although the grandfather had a lengthy history of arrests. The OIG was asked to investigate whether the private agency caseworker assigned to the family deliberately withheld information regarding the grandfather's criminal history in order to facilitate the adoptions.

INVESTIGATION The three children, a 14 year-old boy and two girls, ages 6 and 3, had been placed in the custody of their maternal grandparents at different times because of their mother's continued substance abuse and inability to provide adequate care. The grandparents had also served as a placement for a fourth grandchild who tested positive for cocaine at birth and died within one month of unknown causes. Following termination of the parental rights, the grandparents expressed their interest in adopting the two eldest children.

The private agency caseworker initiated criminal and child abuse background checks of the grandparents. The grandfather had six arrests for assault and/or battery, one of which was for domestic battery, and one arrest for theft. The caseworker spoke with the grandparents regarding the arrest for domestic battery. Both grandparents stated the charge stemmed from an incident when the children's mother came to the grandparents' house while under the influence of drugs and the grandfather had to physically remove her from the home. The grandmother told the caseworker that the grandfather had never been abusive toward her or any of the children. Department procedures require workers to get underlying arrest reports to verify self-reported explanations.

The caseworker did not obtain the underlying documents and accepted the grandparents' accounts. The caseworker indicated that the grandfather's arrest history had been "cleared," meaning his offense was not sufficiently serious to prevent the children's placement and that the caseworker's supervisor had approved the decision. The caseworker also sent a letter, addressed "to Whom It May Concern," that was included in the case file stating the agency's knowledge of the grandfather's criminal history and acceptance of the grandparents' explanation. The information surrounding the adoption request was forwarded to the Purchase of Service (POS) Adoption Unit and an adoption supervisor subsequently approved the grandparents to adopt the two eldest children and to receive subsidies to assist in covering the cost of their care.

Following a change in the private agency's contractual status, the family's case was transferred to another private agency and a case manager was assigned to provide services. Soon after the case transfer, the grandparents sought to adopt the three year-old girl. The case manager stated that she did not review the case file and was unaware of the grandfather's criminal history or the previous caseworker's related information. At the grandmother's request, the case manager prepared the adoption subsidy application without including the grandfather's name but was later informed both names were required on the forms. In her interview with the OIG, the case manager stated she did not question the grandmother's request because she did not want to "pry." The case manager did not become aware of the grandfather's criminal history until she conducted her own criminal and child abuse background checks on the couple, three months after she was assigned the case.

Two months after receiving the results of the background check, the case manager went to the grandparents' home to discuss the criminal history. Although the grandfather stated he had difficulty controlling his temper, the couple did not explain the nature of the grandfather's previous arrests. The case manager proceeded with the subsidy request and submitted the completed application for approval to the POS Adoption Unit. The same adoption supervisor who approved the grandparents' adoption of the two eldest children this time denied both the adoption and the subsidy request based on the nature of the grandfather's previous arrests. In an interview with the OIG, the adoption supervisor stated he was unable to recall why he had approved the previous adoption despite the fact that the grandfather's criminal history report had not changed in the

interim. The adoption supervisor speculated that the letter addressed "To Whom It May Concern" sent by the initial caseworker during the first approval process was intended for him and influenced his decision.

Despite becoming aware of the grandfather's criminal history, the case manager did not seek additional information regarding his arrests or identify domestic violence as a possible safety risk in the home. The case manager recorded that the arrests were not the result of violence against the grandmother but instances when the grandfather was forced to physically remove the couple's adult children from their home.

The OIG obtained the underlying police reports regarding the grandfather's arrests. The reports showed that the arrests were in fact the result of complaints against the grandfather that alleged violence against his wife, his adult children and, in one instance, a nine year-old girl. The complaints also contained reports of the grandfather's attack on his wife and adult son with a knife; there was also a report that the grandfather verbally threatened the grandmother with a knife and gun during an argument related to the grandfather's use of drugs.

After reviewing the underlying documents, the case manager continued to minimize possible risks to the children in the home. The case manager stated she was unconcerned by the grandfather's threats because people "say things [they] don't mean in the heat of anger." The case manager did not determine whether the grandfather owned a gun and stated she was not concerned by reports of drug use because she believed the grandfather had issues related to alcohol consumption, although she did not refer him for a substance abuse assessment. In her interview with the OIG, the case manager stated that she did not consider obtaining the underlying police reports related to the grandfather's arrests but, if she had, she would not have known how to do so.

The private agency that accepted the family's case terminated the case manager's employment, citing her poor judgment and failure to provide proper documentation. The grandparents have begun individual counseling through the agency; however, the grandfather was again arrested for domestic violence against his wife but not convicted. The three children remain in the grandparents' home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. In its LEADS protocol, the Department should promulgate a procedure for workers to obtain underlying documents that support LEADS findings.

The Department agrees and continues to have ongoing discussions with the Chicago Police Department on sharing information.

2. The Inspector General's Office reaffirms its previous recommendation that "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 agrees. The Department is currently working with the Chicago Police Department to develop an inter-governmental agreement that provides for liaisons from both DCFS and the police department to work together to ensure better information sharing between the two agencies. Once established in Cook County, the Department will work to develop a statewide policy.

3. The family's case file should be reviewed by the Department's domestic violence coordinator to assess the appropriateness and effectiveness of the counseling in resolving the family pattern of domestic violence. If it is determined that the family can, with counseling, resolve these issues, the private agency providing services should enter into a formal agreement with the grandparents concerning their

participation in services.

The Department agrees. The Department's domestic violence coordinator did a thorough evaluation of this case and made recommendations for services for the family; however, the foster child has been removed.

The evaluation of this case conducted by the domestic violence coordinator was woefully inadequate. The coordinator did not review the case record, consult the safety plan in place for the children, staff the case with the private agency employees familiar with the family, conduct a criminal background check on the grandfather or access underlying arrest reports, obtain a copy of the order of protection against the grandfather, contact the grandfather's probation officer, or interview the children in the home or the grandparents' adult children, one of whom had reported an incident in which the grandfather assaulted the son with a knife. According to private agency staff, but denied by the Clinical Consultant and domestic violence coordinator, when the private agency contacted the DCFS Clinical Consultant and domestic violence coordinator about the safety of the home, the coordinator and DCFS clinical instructed the private agency supervisor that the Department would be recommending services for the family, and the supervisor should not remove the child. The domestic violence coordinator reported to the OIG that this was the first DCFS family involved with domestic violence that she had worked with; the Clinical Consultant asserted, "This was not my case." At a subsequent home visit, the supervisor observed multiple bruises on the grandmother's face. The grandmother reported that her husband had beaten her a couple of weeks earlier. The grandfather was still living in the home in spite of the Order of Protection. Given the extent of the bruising still visible after two weeks, the supervisor assessed that the grandfather did pose a risk to the grandmother and the children in the home. The private agency removed the three year-old foster child from the home and made a hotline call on the two adopted children for risk of harm. The hotline did not accept the call.

4. The private agency should have an agency training on the use of the LEADS protocol and the need to obtain underlying police reports.

The Department agrees.

The OIG shared the report with the private agency and the agency's Board of Directors. The Inspector General met with the agency's child welfare administrators and the supervisor on this case and a member of the Board of Directors to discuss the report. The case manager assigned to this case is no longer employed by the agency. The agency will reinforce with workers the importance of obtaining underlying police reports in cases where a criminal background check reveals a criminal history.

GENERAL INVESTIGATION 16

ALLEGATION

A private agency was alleged to have used Department funds, designated for care of DCFS wards, to finance the Agency's unrelated adoptions programs. It was also alleged that workers in the foster care program, designed to service physically disabled wards, were forced to contract for substandard nursing services for the wards, through a for-profit nursing agency, owned by the son of the foster care agency's executive director ("CEO"). Lastly, it was alleged that the CEO's son, while providing nursing services to a Department ward, solicited over $190,000 in "loans" from an elderly foster parent, and permitted his partner, also a board member, to accompany him to foster homes while he provided nursing services.

INVESTIGATION

A family-operated, for-profit adoption agency was reorganized as a non-profit agency providing foster care and international adoption services. The foster care division was financed almost entirely by DCFS funds; the international adoption division was financed with private funds only. Within seven years after the reorganization, the agency had secured a 2.2 million dollar contract from the Department to support its foster care budget, which provided specialized care for physically disabled wards. Since the agency's inception, family members dominated the management structure and individuals served multiple roles within the organization. The CEO was also board president; one board member was an original investor in the precursor, for-profit company and a foster parent; and some other board members were either investors or employees of the organization.

The investigation revealed that employees of the DCFS-supported foster care division received a substantial salary adjustment (bonus) at the end of the fiscal year. However, upon "receiving" the bonus, the employees were required to "donate" a substantial portion of the bonus (usually approximately 50%) to the agency's international adoptions program. The salary adjustment/bonus transactions enabled the transfer of DCFS foster care funds, intended to support DCFS wards, to the agency's private international adoptions program. A field audit, performed by the Department of Children and Family Services' Purchase of Service Division, Internal Audits, failed to identify the scheme as a method of using Department funds to finance non-Department services.

Numerous deficiencies, including lack of board oversight, lack of a cost allocation system by the program, inadequate evidence of expense purposes, and conflicts of interest were evident but not cited by the DCFS auditors. DCFS auditors did not review the agency's basis for allocation of common costs, which were paid out of the foster care budget.

There is no indication in the licensing records that DCFS Agencies and Institutions (A&I) licensing staff ever addressed or resolved the inherent conflicts of interest in the multiple relationships between the CEO and family members, foster parent, and board members.

The CEO's dual role, as Chair of the Board of Directors and CEO, prevented the board from providing independent oversight. The board did not have the authority to terminate the executive director. Board meeting minutes revealed that the board was not fully informed of agency business. Board records did not reflect that the board provided direction for the agency in the areas of finance or programs and personnel and, more often than not, the board was informed after the fact of significant business and major changes. The Board of Directors never addressed or may never have known about the financial transactions between the agency and foster parent. A finance committee met only to review employee salary adjustments (year-end bonuses) and the committee usually consisted of the CEO, one board member, a paid consultant and agency employees. There was no evidence that the full board approved the agency budget or salary adjustments, reviewed financial statements, as required by DCFS rules, or reviewed the CEO's performance or basis for salary increases. Board minutes usually did not include information regarding what materials, if any, were

reviewed or reflect decisions reached, votes, or actions taken.

The salary structure presented to the Board had little face validity. Relatives of the CEO were paid at higher levels regardless of salary ranges by position. The salary of the CEO was comparable with CEOs of non-profit agencies with an operating budget between four and seven times larger than the agency. The CEO's relatives staffed the agency's financial operations and the CEO either directly supervised her employed relatives or supervised their supervisor. Of the three highest paid employees, the CEO, the Vice President of Operations (a non-relative), and the Foster Care Director (daughter of the CEO), the CEO and her daughter received at least a 16% yearly salary increase while the VP received a 2.8% annual increase. The CEO's daughter was promoted and compensated at a greater rate than employees with similar credentials. Compensation rates for the same position varied by as much as 61.5%.

In addition, the investigation revealed substantial inequities in the agency's bonus and salary structures, when salaries and bonuses of non-relatives were compared with salaries and bonuses of relatives. The CEO was solely responsible for deciding the amount of the bonus. In one year, relatives of the CEO received bonuses between $8,000 and $10,000, and included relatives who worked part-time and whose bonus was more than half of their yearly salary. Non-relatives received between $700 and $6,000. Non-relatives uniformly gave 50% of their bonus to the international adoptions program, but relative employees donated between 16.7% and 33.3%.

A review of the nursing notes and care provided by the CEO's son revealed documentation that was confusing, lacked clarity in data and was inconsistent across time. Nursing notes minimized foster children's physical limitations or injuries. Treatment was not documented, including post-surgery care. In addition, the agency had no documentation to support the hours the nurse worked or to justify his pay. He was paid hourly for 80, and later, 140 hours a month and received a set travel allowance; he also maintained a full-time job elsewhere. He did not keep timesheets nor was there documentation of the agency's supervision of his work. The son admitted to bringing his partner, a non-nurse, who was also on the agency's board, to nursing appointments in foster homes. The partner did not recuse himself from board decisions affecting the son's salary or bonuses.

The son also admitted to soliciting an unsecured loan of over $190,000, at below market interest, from a 78-year-old foster parent, while the foster family was a client of his nursing program.

An independent accounting firm provided a yearly audit to the Department, in which it allocated costs between the two programs without basis. For instance, salaries for the adoptions program were only 1.1% of budgeted salaries despite the fact that the CEO spent considerable time traveling overseas for this program.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

Agency

1. **The Department should continue to contract with the agency if the following changes in the organization are enacted:**

   a. **There is a change in the language of the Executive Director's 10-year contract to ensure that the board has meaningful oversight over the Executive Director;**
   b. **The agency follows Council on Accreditation's nepotism standards, with special attention to financial operations;**
   c. **The agency contracts with a new accounting firm and avoids conflicts of interest in the future;**
   d. **Salary adjustments awards and donation solicitation should be separated – solicitation**

should include a statement of the voluntary nature of donations;

e. **The program committee of the board should distribute a confidential survey to foster parents about the types of respite that would be helpful; and**

f. **The personal and finance committees of the board should evaluate the agency's salary structure and establish a salary administration program that ensures that salaries are internally equitable and consistently applied (that the agency has a system for classifying positions, job positions are placed in a set of salary ranges, hiring salaries conform to established salary ranges, new hires meet qualifications, job descriptions, procedures for salary payment and for compensation of earned overtime, and performance appraisal system linked to salary administration program) and that no compensation paid out of DCFS funds reflects compensation incurred prior to the effective date of the contract.**

The Department agrees.

The Department has worked diligently with the Board and management to ensure implementation of the recommendations. The Department has advised the OIG that the agency has implemented recommendations b through f and is in the process of implementing a.

Referrals to Regulatory Agencies

2. The OIG has met with representatives of the Illinois Department of Professional Regulation. OIG is referring the nurse to the Illinois Department of Professional Regulation and the Illinois Association of Nurses for investigation of his conduct.

The Department agrees.

The Department of Professional Regulation refused to pursue charges against the nurse because the elderly foster parent had voluntarily loaned the money.

3. The OIG is referring the contracted CPA and independent auditor to the Society of Certified Public Accountants for examination of their relationships and practices involving the agency.

The Department agrees.

The referral was not made due to the unauthorized actions of an upper-level DCFS administrator that compromised the integrity of the investigation.

4. This report should be shared with the Council on Accreditation of Services for Families and Children.

The Department agrees.

The report was shared with the Council on Accreditation.

DCFS POS Monitoring

5. In order to ensure that our wards receive the care and services to which they are entitled, the Department must monitor that their needs are met from a financial, programmatic, and compliance perspective. Current weaknesses in the Department's fragmented system of monitoring contracting agencies may jeopardize IV-E federal funding. The Department's Monitoring Units (Auditing, APT,

and A&I) must achieve a comprehensive program and financial audit approach to agencies in order to hold agencies accountable to their fiduciary responsibility and ensure that Department funds are used to provide services to our children. The Inspector General should meet with the Units independently and collectively to determine how to meet our responsibility.

The Department agrees.

The OIG met with the POS Division and the DCFS auditor in January 2002 to discuss allocation of monitoring functions and coordinating Department response. The divisions were to develop a joint plan of action for submission to the Director and the Inspector General. None has been developed.

6. **A&I Licensing and APT monitoring should ensure agencies have an independent board and are in compliance with their Code of Ethics and Conflict of Interest policy.**

The Department agrees.

7. **Prior to conducting on-site audit reviews, DCFS Auditors should meet with the agency's APT and A&I Licensing staff, to gather and integrate Department knowledge of agencies and coordinate the extent, focus and division of labor for effective financial and programmatic audits.**

The Department agrees.

8. **Contracting agencies must submit a personnel matrix and cost center reports as part of the contracting and monitoring process to verify an appropriate and traceable cost allocation system across program and funding streams. Auditors must verify that DCFS funds are used solely to support contractual activities.**

The Department agrees

9. **When conducting on-site audit reviews, DCFS auditors should expand the scope of the field audit when evidence of conflicts of interest and other financial irregularities exist. The agency's response to Department audits should be further examined to verify the response.**

The Department agrees

10. **The Department should enforce current procedure in Rule 384 requiring that all contracting agencies submit their audits on a timely basis.**

The Department agrees.

11. **Contracted agencies' annual audits should be carefully reviewed to identify lack of full disclosure and adherence to accounting standards. DCFS auditors should advise agencies to bring their audit into conformity with generally accepted standards and, when indicated, the auditors should advise the board to consider changing auditors.**

The Department agrees.

GENERAL INVESTIGATION 17

ALLEGATION

The OIG opened an investigation after reviewing the Department's field audit report on a private child welfare agency doing business with the Department. The field audit was for the year ending June 30, 2000 and was completed in September 2001.

INVESTIGATION

The private agency provided group home and supervised independent living services for wards of the state and had contracts with DCFS since 1994. The contracts for FY 2000 amounted to more than $1.4 million dollars. The DCFS field audit showed that the agency was in serious financial trouble that dated back several years and would have difficulty correcting its financial problems.

Prior to the field audit DCFS had information on file dating back at least to 1997 that showed that the agency had outstanding payroll tax obligations with the IRS, the Illinois Department of Revenue, and the Illinois Director of Employment Security totaling several hundred thousand dollars. By the time of the field audit the agency's tax liabilities had risen to $1.3 million. A licensing reporting form filed by the agency in 1999 nevertheless falsely claimed that the agency was current with all tax liabilities and did not have a deficit. The annual contracts signed by the agency represented and warranted that the agency would notify the Department if it became insolvent but it never did so. The agency also did not fulfill its explicit contractual obligation to adhere to all applicable state and federal laws. The Executive Director admitted that when the agency began experiencing financial problems in 1995 he made a decision not to pay the federal and state payroll taxes.

DCFS Licensing had on file an academic transcript furnished by the agency's Executive Director that was suspect on its face as cut and pasted together. The Executive Director did not in fact receive any degree from the college involved. The field audit also revealed that the Executive Director, along with the agency's Chief Financial Officer and its chief Operating Officer, had set up a corporate entity through which they paid themselves fees as consultants to the agency whenever they worked past five p.m.

DCFS administrators acknowledged that the existing system for issuing, monitoring and auditing contracts is fragmented and inadequate. The administrators informed the OIG staff that they are developing a plan to achieve a uniform approach to contracts and auditing. The Office of Field Audits stated that the failure to routinely review submitted audits is the result of a lack of personnel. Field audits do not include a review of the agency contract.

A former DCFS licensing employee who had a history of negligence was responsible for licensing and monitoring the agency. The licensing record indicates that she did not verify the Executive Director's academic credentials.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discontinue all DCFS contracts with the private agency.

The Department agrees and currently holds no contracts with the agency.

2. The Department should initiate license revocation proceedings for all DCFS issued licenses held by the private agency.

The Department initiated license revocation proceedings for all licenses issued to the agency by DCFS.

3. The Department should never contract again with the Executive Director or license any agency that he establishes or over which he has administrative control.

The Department agrees.

4. The Department should review all current audits of purchase of service agencies for deficits. Any audit showing a deficit should be subject to further review, including a determination of whether the contract warranty regarding insolvency has been breached. If tax obligations have not been fully met, the Department should:

a) **Determine whether the agency has entered a payment agreement with the Internal Revenue Service and the payment schedule is being followed; and/or**
b) **Determine whether the problem can be resolved, and act accordingly (Rule 401, 384);**
c) **Issue a Provisional License with attached provisions and ensure monitoring of resolution when the problem is determined to have an achievable solution.**
d) **Agencies that are found, during the desk review, to be delinquent in payroll taxes should be placed on provisional license status in accordance with Rule 401.**

The Department agrees.

5. The Department should consider the sanction of disallowing the expense of the executive director's salary from the final due date until the audit is received for those agencies that do not submit an annual audit. Once the audit is received it should be subjected to a thorough desk review to determine if a field audit is necessary.

The Department has a practice of withholding all estimated current funding from agencies that do not submit timely audits and will not issue new annual contracts until all filing obligations are met.

6. The Department should hire a qualified Certified Public Accountant with experience in not-for-profit auditing procedures to manage and train the audit staff on conducting effective field audits and desk reviews consistent with Government Auditing Standards of the U.S. General Accounting Office.

The Department agrees.

7. Agencies should be required to submit all Board minutes to Licensing.

Board meeting minutes are routinely reviewed through our annual licensing monitoring visits and by agency performance team staff.

This response is contrary to the findings of the OIG investigation. While recent licensing files reveal that minutes are submitted, Agency Performance Team staff stated that they do not review Board minutes.

8. The proposed plan to integrate the functions of licensing, auditing, contracts and agency performance monitoring should be submitted to the Inspector General for review.

The Department agrees.

9. A team of licensing specialists should review all of the license records that were handled by the former licensing worker that licensed this private agency and also verify educational credentials. This recommendation has been made previously by the OIG.

The Department agrees.

INVESTIGATIVE REFERRAL	The OIG forwarded the college transcript of the Executive Director and a copy of the DCFS Audit on the private agency to the Illinois Attorney General's Office.

GENERAL INVESTIGATION 18

ALLEGATION

The doctor of two DCFS wards, children with cerebral palsy, prescribed twelve hours of home nursing care each day for each child, seven days a week. However, the nursing service sent one nurse to care for both children during a twelve-hour period. It was alleged that the nursing service double billed, charging an hourly rate for each child each twelve-hour period.

INVESTIGATION

Each day, the nursing service provided 12 hours of service to the children, billed for twenty-four hours of service, and paid its employee for 12 hours a day. The nursing service billed $50.00 per hour for each child. Based on the requirement of providing twelve hours of nursing care for each child each day, the nursing service was paid $1200.00 per day, or $8400.00 per week. That amounts to $436,800 a year for the two children. Nearly $200,000.00 of taxpayers' money was paid out to the nursing service for services not rendered to these children in the past fiscal year.

The responsibility of the Illinois Department of Public Aid (IDPA) is to pay the bill for DCFS approved services while the responsibility of DCFS is to determine the appropriateness of requests for service in relation to the reasonableness of the amount charged by the service provider. When the nursing service receives a referral for services with a doctor's prescription order, it completes IDPA's Prior Approval Request form and submits it to the Business Manager for DCFS for approval. The Business Office then forwards approved forms to the Prior Approval Unit of the IDPA. DCFS approval of the forms covers both services and hourly rates. However, neither DCFS not IDPA takes responsibility for the established rates and the DCFS Business Manager stated that, if the request falls within an acceptable range, the request is accepted. (Although OIG staff repeatedly attempted to contact the Business Manager for further information, her voice mail was always full, prohibiting access to her, although she was in the office.)

The Prior Approval Request forms are reviewed and approved by the Medical Liaison for the region. Before the form is approved, the Medical Liaison only verified whether the child is eligible for IDPA payment. The Medical Liaison also could not explain how rates are established for home health care. To the Medical Liaison's knowledge, there is no monitoring or verification of services provided to children. Although the Medical Liaison had received and approved the Prior Approval Request forms for the two children at issue in this case, she had not been aware that the children resided in the same home.

Workers at the IDPA stated that the nursing service was properly billing for the care of the two children. Billing should be submitted on each individual child, regardless of whether the children share the same health care professional. However, it was the worker's understanding that Medicaid only paid $65.00 per day for in-home nursing services, and the remaining amount would be paid by DCFS. The worker stated that payment rates for services provided to wards would be set by DCFS. A supervisor with IDPA's Prior Approval Unit stated that IDPA had been concerned with the high home service rates approved by DCFS for wards of the state and, in some cases, the lack of evidence of need.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG has referred this case for investigation to the Office of the Inspector General of the Illinois Department of Public Aid (IDPA). This report and related materials were shared with the OIG of IDPA.

The Department agrees.

2. DCFS needs to collaborate with IDPA to reform procedures for:

- **Rate setting for home health services for DCFS wards;**
- **Rate setting for home health services to more than one child in the same home;**

- **Approval of requests for services and payment rate; and**
- **Ensuring accuracy of billings.**

The Department agrees in principal and will work with the Department of Public Aid to clarify procedures for home health services, the approval rates and the approval process to be used.

3. DCFS Agency Performance Teams (APT) should conduct an initial review of all DCFS children receiving home health services to ensure that the child is receiving approved services (type of service, hours per day, days per week, kind of professional providing service, shared placement). APT staff should periodically review these children for monitoring purposes. Information should be shared with DCFS personnel who approve Prior Approval Requests for follow up on those children's cases for whom APT identifies concerns. The IDPA reports a total of 297 DCFS children served in fiscal year 2001.

The Department agrees. Semi-monthly Agency Performance Team file reviews will examine all DCFS wards health records and all negative findings will be shared with DCFS personnel.

4. The supervisor of the Business Manager for DCFS should determine whether the Business Manager regularly maintains a full voice mail and, if so, she should address this issue with her.

The Department agrees. The employee's current supervisor has been notified to monitor this issue of full voice mail and discuss it with the employee if necessary.

GENERAL INVESTIGATION 19

ALLEGATION

A 17 year-old girl in protective custody of the Department was not taken to her temporary custody court hearing because staff at her residential home believed she was delusional and a potential danger to herself. It was alleged the girl was kept out of court in order to prevent her from providing damaging testimony against a Department Child Protection Investigator.

INVESTIGATION

A Department Child Protection Investigator was transporting the 17 year-old girl, who had been in Department custody for three days, when their vehicle was involved in a rollover accident. The investigator refused medical treatment for herself and the girl and contacted the girl's residential home for assistance. When a worker from the home arrived at the scene, the girl told her that the investigator had been drinking alcohol while she was driving. The worker immediately informed officers at the scene and the investigator was subsequently arrested and charged with Driving Under the Influence. The residential worker then took the girl for a medical examination before returning her to the residential home.

Police officers contacted the State Central Register (SCR) to report the incident and a Child Protection Investigation was initiated. In cases involving Child Protection Investigators, Department rules require the investigations be conducted by a different regional office than that of the subject. However, SCR directed this report to the investigator's home office. The SCR administrator stated that the investigation was sent to that office because the report was taken on a holiday and it would have been difficult for an investigator from an understaffed office in another region to interview the girl within 24 hours as mandated by procedure. The SCR administrator stated that the office that received the report was under strict instructions to transfer the investigation to another region after the girl was interviewed. An investigator from the subject's home office, who was also a union representative, interviewed the girl before the case was assigned to a second investigator in another region. When the second investigator interviewed the Child Protection Investigator, the first investigator accompanied her as her union representative. In an interview with the OIG, the first investigator stated he did not believe there was a conflict of interest in his involvement in the case as both an investigator of a report against a co-worker and union representative for the same co-worker regarding the same report.

Two days after the accident, the girl became angry with staff at the home and complained that maggots were coming out of her radiator and crawling in her bed. The girl had previously complained to the resident therapist that she saw roaches, however staff assured the therapist there were no bugs in the girl's room. The therapist contacted Screening, Assessment and Support Services (SASS) to request an assessment of the girl to determine her mental state. The girl told the SASS worker that the maggots were coming from decaying food that was stuck inside the radiator in her room. She also told the SASS worker about the car accident and expressed her general distrust of Department personnel because the investigator, "who was supposed to help [her] was drunk and almost killed [her]." In her notes, the SASS worker recorded being told by staff from the home that in addition to the girl's room being bug-free, the car accident had never occurred. The SASS worker identified the girl as being traumatized by her entry into Department care and in need of further evaluation. The SASS worker's conclusions were passed along to the residential home's psychiatrist who ultimately diagnosed the girl with Major Depression with Psychotic Features and prescribed her psychotropic drugs. The SASS worker did not obtain the girl's medical records prior to conducting the evaluation, which would have documented the car accident. In her interview with the OIG, the SASS worker could not recall who told her the car accident account was false and was surprised to learn from OIG investigators that the accident had occurred.

The day after the SASS evaluation, the girl was scheduled to appear in court for a temporary custody hearing. When a Department worker arrived at the residential home to transport the girl, staff informed her the girl had

been acting strangely the previous day. In an interview with the OIG, the Department worker stated she talked with the girl and found her to be very angry and upset. Based on the girl's demeanor and the staffs' accounts of her "delusional" statements, the Department worker determined the girl was at risk of running away or jumping out of the car and decided it would be inappropriate to take her to Court. The Department worker informed both her office as well as the Court and left word for the Guardian *ad Litem* (GAL) to visit the girl at the residential home. The GAL visited the girl later that day and found her to be behaving normally. Although the Department was awarded temporary custody at a court date one week later, the girl ran away from the residential home prior to the proceedings.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A union representative indicated she would like to continue a philosophical discussion on the apparent conflict of interest suggested by actions of the first investigator/union representative. The Union should be offered the opportunity to meet with the Ethics Advisory Board if it wished to discuss the issue.

The Department agrees.

The OIG Ethics Board invited the Union and OIG representatives to participate in a discussion of this issue. The Union did not respond. The Ethics Board advised that the dilemma be addressed internally by the Union.

2. The State Central Register should be instructed that a hot line call involving a Department employee must be sent for the mandate as well as the investigation to a county other than where the employee works.

The Department agrees. It has been reiterated to SCR staff the appropriate steps to take when a hotline report is made against a DCFS employee.

3. When a SASS worker is doing an evaluation of a child at a shelter, they should read the medical records available on the child and the current running record as part of the evaluation process.

The Department agrees. Notice was sent to all Cook County SASS providers on April 3, 2002.

4. The worker from the residential home who arrived at the accident scene should be commended on meeting her responsibilities in this case in an appropriate fashion.

The Department agrees. The worker was commended on September 16, 2002.

GENERAL INVESTIGATION 20

ALLEGATION A 16 year-old Minor Requiring Authoritative Intervention was placed in a home with a convicted child sex offender. The child welfare specialist assigned to the girl's case did not conduct a criminal background check prior to placement, but misrepresented to the court and courtroom personnel that she had conducted a criminal background check and that it showed no criminal history.

INVESTIGATION The girl, who had a long history of conflict with her biological parents, became involved with the Department after being involved with a local mental health agency for crisis services. During the next six weeks, the girl ran away from home several times and was questioned by police regarding her knowledge of her boyfriend's involvement in a burglary, a crime the boyfriend subsequently admitted to committing. The girl acknowledged being present at the scene and observing her boyfriend in possession of stolen guns. Police also responded to a domestic disturbance call at the home of the girl's paternal aunt, prompted by an argument between the girl and her parents. During the argument, the mother had thrown a glass onto the floor and the girl was cut by flying shards. Officers noted the injury was minor and girl declined treatment at the time, although she later received sutures at a local hospital. Police contacted the State Central Register (SCR) to report the incident. The SCR operator declined to accept the report but stated he would forward the information to the girl's assigned emergency counselor. When the girl was located after running away once again, the girl's mother and paternal aunt signed a mutual consent allowing the girl to reside with the aunt. The girl remained in the aunt's home after the consent expired.

The Assistant State's Attorney filed a petition for Adjudication of Wardship based on the girl being a Minor Requiring Authoritative Intervention and a shelter care hearing was scheduled. In preparation for the hearing, the emergency counselor presented the Assistant State's Attorney with a social history assessment. The assessment mentioned the argument between the girl and her mother that led to the domestic disturbance call; however, it did not include information regarding SCR's decision not to accept the call or the determination by police that the girl's minor injury was caused accidentally. The assessment also did not include information regarding the recent criminal activity of the girl's boyfriend or her peripheral involvement. The counselor expressed her opinion that the environment created by the paternal aunt and her husband would be positive for the girl and stated the parents were attempting to obstruct the girl's placement without good cause. In a pre-court conference, the father stated to the girl's Guardian *ad Litem* (GAL) that his opposition to his daughter's placement in the home was based on the uncle's previous conviction for child molestation. In her assessment, the counselor described the father, who has cerebral palsy, as "talking incoherently, babbling, not making any sense." Although the aunt had previously informed the girl's caseworker that she and her husband were divorced, the counselor's notes included statements by the aunt that the two were married and lived in the same home. The girl stated to those present at the conference that the uncle no longer lived in the home.

Prior to the hearing, the caseworker represented to both the Assistant State's Attorney and the Assistant Guardian *ad Litem* that she had conducted a criminal background check on the aunt and uncle and that the results of both were negative. Based on the worker's representation, the Assistant States Attorney and the Assistant Guardian *ad Litem* decided to support continued placement with the paternal aunt. In open court, the father reiterated his objection to his daughter's placement in the home. The caseworker affirmed to the Judge that both the aunt and uncle had passed criminal background checks. The judge granted the aunt temporary custody of the girl and she continued to reside in the home.

After the hearing, the caseworker performed a criminal history check and learned that the uncle had been convicted of sexual penetration. The caseworker then contacted the OIG for assistance in analyzing the

criminal history information and specifically asked the OIG whether the fact that the man was not required to register as a sex offender might mean that the girl could safely reside in the placement. The OIG informed the caseworker that placement of the girl in the home would not be safe and offered to procure underlying arrest reports to get more information. The arrest reports and other information retrieved disclosed that the victim of the abuse was a girl under the age of 13 and that the abuser was prohibited from having contact with anyone under the age of 18. The casework specialist never informed the OIG that the girl was already placed in the home -- nor did she inform the court of the correct criminal history information.

In an interview with the OIG, the caseworker stated she had requested two Law Enforcement Agency Database System (LEADS) checks prior to appearing in court and both had shown the aunt and uncle had no criminal histories. SCR records documenting all LEADS requests disclosed that no request was made by the caseworker until the day after the court hearing.

Despite learning the uncle was a convicted child sex offender, the caseworker did not contact the Assistant State's Attorney or the Guardian *ad Litem* to inform them that the information provided to the court had been incorrect. The caseworker completed a Child Endangerment Risk Assessment Protocol (CERAP) indicating that child sexual abuse was suspected and that the girl's safety was of immediate concern. The caseworker's safety plan included provisions that the aunt would not allow the uncle to have unsupervised contact with the girl. In an interview with the OIG, the caseworker stated that she believed the uncle no longer resided in the home, despite recording in her case notes on the day she completed the CERAP the aunt's admission that she and her husband were still married. Although a number of government documents, including vehicle registration and tax forms, showed the family home as the uncle's residence, the caseworker stated she accepted the uncle's various explanations for the discrepancy. The aunt and uncle's biological children eventually admitted that their father lived with them in the family home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be disciplined up to and including discharge for not conducting a criminal history check prior to approving a placement in a non-relative home, for not alerting juvenile court professionals when she learned of the uncle's criminal history, for failing to provide the OIG with full information regarding the date of the girl's placement and for lying to the OIG about having contacted SCR prior to the court hearing.

The Department agrees. Discipline was initiated and the employee resigned with no reinstatement rights.

2. This report should be shared with the emergency counselor's mental health agency for consideration of discipline against the counselor for her failure to include critical information in the Social History for court, her failure to properly assess the father's fears regarding placing the girl with his sister and for demonstrating insensitivity toward a client with disabilities.

The Department agrees.

The OIG shared a redacted report with the mental health agency. The agency shared the report with the worker as a teaching tool. The agency will also begin requesting local law enforcement to conduct criminal background checks prior to placing a child in a licensed foster home.

GENERAL INVESTIGATION 21

ALLEGATION

During an unrelated investigation, the OIG discovered highly inappropriate personal messages sent by a Department employee through the Department's electronic mail system.

INVESTIGATION

While conducting another investigation involving the Department employee, the OIG discovered an electronic mail message sent by the employee to an individual in another state. The message was filled with pornographic imagery and contained threatening language directed at the recipient and his wife. Further examination of the employee's electronic mail transmissions found five additional personal messages the employee had sent to friends and family members during the previous six-month period.

The out-of-state recipient of the e-mail message told the OIG that the Department employee had previously sent him several similar messages but declined to provide the messages to the OIG. The recipient stated he was disturbed and embarrassed by the situation and that if the employee continued to contact him he would notify the police.

Department Rules and Procedures expressly prohibit the use of the Department's electronic mail system for non-business related matters or for disseminating material considered offensive to any individual or group. The employee had previously signed an Electronic Mail Certificate of Understanding, which explains that e-mail is not private and is to be used only for official Department purposes. The employee confirmed she had read and understood the terms of the Certificate of Understanding.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The Department should discipline the employee for violating Department Rules and Procedures regarding appropriate and responsible use of the Department's electronic mail system.

The Department agrees. The employee was discharged. The employee appealed the discharge. The Civil Service Commission reduced the discharge to a 60-day suspension.

GENERAL INVESTIGATION 22

ALLEGATION

A Child Protection Investigator was arrested and charged with battery after a woman accused him of making unwanted sexual advances while he was conducting an in-home follow-up visit.

INVESTIGATION

The investigator was assigned to a case involving a mother who allegedly physically abused her 14 year-old son. After conducting initial interviews, the investigator returned to the family home to conduct a follow-up visit and establish a safety plan. A family friend present in the home during the visit told police the investigator made lewd remarks and attempted to kiss her. The investigator contended the woman made suggestive comments to him and that he had kissed everyone present in the home on the cheek upon his arrival because the practice is a custom inherent to his cultural background.

In an interview with the OIG, the investigator acknowledged kissing the mother, children and two other family guests when he arrived at the home. He stated that the woman jokingly asked him why he didn't kiss her, at which point he positioned his face in front of her so she could give him a kiss. The investigator also stated that he stayed and ate dinner with the family at the mother's invitation. The investigator denied making advances toward the woman but stated she asked him for information regarding an unrelated case involving the Department. The investigator said he declined to discuss the case with the woman but provided her with his business card and pager number so she could speak with the case supervisor.

The investigator's actions while conducting a formal child abuse investigation were in complete disregard of Department policy. The investigator allowed himself to become involved in a social relationship with the family while ostensibly conducting an inquiry into possible physical abuse of a child. By acting in an unprofessional and irresponsible manner while performing his duties, the investigator compromised the integrity and standing of the Department in the public arena.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The Department should pursue discipline against the investigator for the unprofessional conduct he admitted during his interview with the OIG. If the investigator is convicted of battery, the Department should pursue further discipline.

The Department agrees. The employee received a three-day suspension. The employee grieved the discipline. The grievance is pending.

GENERAL INVESTIGATION 23

ALLEGATION

A Department employee misrepresented herself and misused her position in order to obtain confidential information regarding criminal proceedings involving her adult son.

INVESTIGATION

The employee's son was facing prosecution in another state for delinquent child support payments. The employee contacted the Assistant State's Attorney handling the case and presented herself as her son's caseworker from the child support division of the Department. The employee stated that her son had made child support payments directly to his child's mother and that she could provide proof. The employee then faxed a letter to the attorney on Department letterhead purporting to support her statements. During a subsequent telephone conversation, the attorney told the employee confidential information regarding the status of the outstanding child support payments. The attorney questioned the custodial parent about the direct payments she supposedly received. The custodial parent denied receiving any payments and informed the attorney that the father's mother worked for the Department and had the same name as the person the attorney knew as the father's caseworker.

The employee denied misrepresenting herself to the attorney. Although the employee had no history of disciplinary action, her inability to maintain a clear division between her personal and professional responsibilities compromised the Department's credibility with an officer of the court.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The employee should be disciplined for misrepresenting herself in her position as a Department employee for personal advantage.

The Department agrees. The employee received a 7-day suspension. The employee grieved the suspension. The grievance is pending.

GENERAL INVESTIGATION 24

ALLEGATION

Two Department employees exchanged personal long distance calls and sent each other electronic mail messages unrelated to their professional responsibilities. In addition, it was alleged the employees scheduled their attendance at Department training sessions to facilitate overnight visits.

INVESTIGATION

The two employees held similar positions within the Department but were located in different cities. Despite the couple's denials, an OIG review of electronic mail transmissions between the two employees found a number of messages that were distinctly romantic in nature. There were a number of long-distance calls between the two employees originating from their offices, however the content of these contacts could not be verified. There was no evidence to support the allegation that the employees stayed in the same hotel during multiple-day Department training sessions.

The employees' misuse of the Department's electronic mail system was in violation of the terms of use established in the Department's employee handbook. The employees' disregard of Department rules also compromised their ability to set positive, professional standards of behavior for the employees they supervise.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The employees should be counseled regarding improper use of state property and responsibilities as supervisors.

The Department agrees. The employees were counseled.

2. A copy of this report should be redacted and the facts disguised and then used for training of supervisors.

The Department agrees. A redacted copy of this report will be used in training for supervisors.

GENERAL INVESTIGATION 25

ALLEGATION

A Department Administrator and her husband adopted two special needs children through the Department, then separated and filed for divorce. Although the husband informed the Department of his new address, only his wife (a Department Administrator) received notice of an upcoming Adoption Subsidy Review. The husband alleged that his wife used her position within the Department to receive an unusually high adoption subsidy and that she misused adoption subsidy funds. He also complained of the Department's failure to notify him of the review.

INVESTIGATION

The two children adopted by the couple, both seven year-old boys, had special needs and required increased support and services which necessitated adoption subsidies. There was no evidence of improper conduct on the part of the Administrator in securing the original subsidy agreements. After the OIG received the initial allegations, multiple additional allegations and complaints were received. The couple was involved in an acrimonious divorce and custody battle in Domestic Relations Court and the OIG determined that was the appropriate venue to resolve most of the questions raised.

In addition to the adoption subsidy, the Department hired an in-home behaviorist. The administrator had specifically requested the behaviorist, but did not inform Post-Adoption workers that the behaviorist's mother was a personal friend and a Department employee indirectly subordinate to the mother. A custody evaluation completed for the Domestic Relations Court found that both parents believed the behaviorist was biased in the mother's favor and frequently overstepped bounds of her position by denying the father access to the children. The behaviorist stated to the evaluator her belief that she "worked for [the mother]." In addition, concerns were raised regarding the behaviorist's practice of bringing her own infant child into the home since one of the boys demonstrated aggressive and impulsive behavior and could potentially be a safety hazard to the baby.

Following the couple's separation, the father sent a letter to the Director of the Department to serve as notice of his new address. The letter was intended to ensure that the father would be notified of the biennial review of the adoption subsidy the couple received. The Director forwarded the new address to the Post Adoption Unit, however workers in the unit were unsure as to how the information should be entered into the computer system so that the father could be made aware of the review. As a result, only the mother was notified of the subsidy review.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should develop and implement procedures in the Post Adoption unit requiring notification of both parents, in the event of divorce or separation, of the biennial review and of any activity on the adoption subsidy agreement and before either parent can make changes to the agreement, as long as the Department is notified of changes in the address of either parent. In the interim while awaiting procedures, the Post Adoption Unit should manually notify any non-residential parent of which they are aware. In addition the Department will make available to either party upon request copies of all post adoption materials. These procedures should be incorporated into a revised Post Adoption Handbook.

The Department agrees. Rule 302.310 Adoption Assistance has been redrafted and includes this recommendation.

2. Provided the Domestic Relations Court agrees, the Department should terminate its contract with the in-home behaviorist. As the in-home behaviorist has been a caretaker for some time, this termination should be done gradually while a new plan is being put into operation. The Department should inform the Domestic Relations Court of the conflict of interest for the Department Administrator

in continuing to have the in-home behaviorist. The Department can suggest as an alternative that Domestic Relations Court consider some of the recommendations offered by the Domestic Relations Court evaluator.

The Department agrees and the in-home behaviorist's contract has been terminated.

3. The father should be notified of his right to administrative appeal of the Adoption Subsidy Agreement and Review. If the Director agrees, the father should be informed that the Department is recommending the removal of the in-home behaviorist.

The Department agrees and the father was notified.

GENERAL INVESTIGATION 26

ALLEGATION

A Day Care Licensing Specialist, employed by the Department, received a substantial monetary gift at her workplace from an anonymous source. After being instructed by superiors that the gift might constitute a conflict of interest, the worker deposited the money in her bank account. The superior referred the question to the Conflict of Interest Committee, who determined that the employee had to return the money. The worker maintained the money had come from her boyfriend.

INVESTIGATION

An unknown male delivered $503 in cash along with fortune cookies in a Chinese food take-out box to the licensing worker at her office. The employee opened the gift in the presence of co-workers, where all present noted that there was no indication of the identity of the sender. The licensing worker stated to co-workers and her supervisor that she was not aware of her benefactor's identity. The supervisor told the licensing worker she would have to inquire as to the propriety of accepting the gift. After the supervisor departed to seek consultation, the licensing worker left the office and deposited the money into her bank account. The Department's Conflict of Interest Committee subsequently conducted a review and determined that, because the money was delivered to the licensing worker anonymously at her office, it was implied the gift was related to her professional capacity and therefore constituted a conflict of interest. When the supervisor informed the licensing worker of the committee's decision a few days later, the licensing worker stated she had learned that her boyfriend had sent her the money. The licensing worker was asked to provide basic information about her boyfriend, such as his name and whether he was involved with a child welfare agency. The licensing worker refused to provide any information to substantiate her claim and threatened to take legal action if the "harassment" against her continued.

In an interview with the OIG, the licensing worker presented investigators with a notarized statement signed by an individual who identified himself with two initials and a last name. In the body of the statement, the individual presented himself as the licensing worker's boyfriend and claimed to be the source of the cash gift. The licensing worker initially refused to supply the individual's first and middle name, stating he "did not want to get involved." The licensing worker stated that the money was part of a loan she had requested from the individual. Later during the interview, the licensing worker provided the names but claimed she did not know the man's address or date of birth. The OIG reviewed the security log that visitors to the Department office building were required to sign upon entry. There was no record of anyone arriving to see the licensing worker that day.

The man identified by the licensing worker as her boyfriend consented to being interviewed and met with OIG investigators. During the interview, the man was unable to provide information as to the location or circumstances of how he and the licensing worker met. The man said the money was a gift delivered to the licensing worker's office with the intention of making an impression on her fellow co-workers. The man told investigators that he had enlisted the help of a friend who delivered the gift while he waited in his car downstairs. The man stated he knew his friend only by his initials and was unaware of his address or telephone number. In addition, the man told investigators he could not remember where he obtained the fortune cookies. When questioned about his occupation, the man informed investigators he was a commercial truck driver. An OIG review of records obtained from the Secretary of State's office showed the man did not possess a commercial driver's license. When presented with this information during a follow-up interview, the man stated he drove the truck infrequently and "would worry about it if the cops stop [him]."

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The licensing worker should be disciplined for insubordination and breach of ethics, up to and including discharge and should comply with the requirements of the

Conflict of Interest Committee which required her to return the $503 to the General Revenue Fund of the State of Illinois.

The Department agrees. The employee returned the $503 to the General Revenue Fund. The employee received a three-day suspension on July 31, 2002. The employee grieved the suspension. The grievance is pending.

GENERAL INVESTIGATION 27

ALLEGATION

A mother presented school administrators with a letter that appeared to be from the Department of Children and Family Services. The letter recommended that two of the mother's children be allowed to continue attending a school outside of their district. The children were not involved with the Department and the letter was signed by the mother's sister, a Department caseworker.

INVESTIGATION

School district officials informed the mother that her two children would no longer be allowed to attend their current school because an independent investigation verified the family lived outside the designated boundaries. In addition, the school district demanded reimbursement for costs incurred in providing the children's schooling. After being notified of the decision, the mother and grandfather attended a meeting with school district officials. The mother presented the officials with a letter, purporting to be from the Department, that contained a recommendation that the mother and her children should reside with the grandfather, whose home was inside the school district. The letter was signed with the name of the caseworker and a telephone number to call with any questions. Based on this evidence, the school district reversed its decision and agreed to allow the children to remain at the school. In a letter to the OIG, the Assistant to the District Superintendent stated that officials based their decision solely on the letter from the Department, despite substantial contradictory evidence, due to their belief and respect for the Department as a reputable public agency. Officials were unaware that the Department caseworker who signed the letter was the mother's sister or that the children were not involved with the Department in any way.

Based on information obtained from copies of the letter provided to the OIG, investigators were able to determine that it was faxed from the caseworker's home to the house identified as the mother's actual residence on the morning of the meeting with school district officials. In separate interviews with the OIG, the mother and the caseworker provided unconvincing, contradictory accounts regarding the creation of the document. The caseworker denied writing or signing the letter and stated she was unaware of the document's existence until her superiors brought it to her attention. The caseworker said that one morning while she was on leave from work, the mother (her sister) arrived at her home. The caseworker speculated that the mother used that opportunity to use an existing letter from the caseworker's briefcase to create the new document and fax it to her own home without the caseworker's knowledge. The caseworker refused to submit a signature for handwriting analysis. OIG investigators noted the letter contained a great deal of language specific to the Department and found that the phone number included for further contact was the caseworker's cell phone number. The caseworker stated she often allowed her sister to borrow the phone.

The mother claimed to have constructed the letter using another document on Department letterhead she found in the caseworker's home; however, the mother was unable to explain basic details of how she was able to do so. The mother's description of the process betrayed a lack of understanding of how such a project could be accomplished. The mother frequently contradicted her own statements during her interview, including whether or not the caseworker was present in the home while she allegedly created the letter. The mother also stated she did not know to what phone the number contained in the body of the letter connected. The mother's statements during her interview were not credible and, when considered along with the caseworker's reluctance to provide useful information, resulted in OIG investigators' determination that the caseworker was at least complicit in creating the letter, if not directly responsible for using Department resources for purposes of fraud.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The Department should pursue disciplinary action against the caseworker for conduct unbecoming a Department employee.

The Director agreed to discipline. *However, the Department only implemented a counseling session with the worker in which she was instructed not to leave Department letterhead somewhere where someone else could access it. This counseling session will not be included in her personnel file.*

GENERAL INVESTIGATION 28

ALLEGATION	A Department employee was arrested for possession of cannabis while sitting in a parked car along with a young child outside of the State of Illinois building.

INVESTIGATION

An officer observed the employee sitting in the passenger seat of a car stopped in a no-parking lane outside of the State of Illinois building. The driver was not present and a young child was seated in the rear of the vehicle. The officer saw the employee roll what he believed to be a marijuana cigarette while sitting in the vehicle. When the officer approached and confronted the employee, the employee made an attempt to conceal the objects in her possession. Upon inspection of the vehicle, the officer found a total of 6.5 grams of what tests confirmed to be cannabis located on the passenger side of the car where the employee had been seated. The employee stated to the officer that she worked for the Department but was on vacation and had traveled to the building with relatives on an errand.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The employee should be disciplined for conduct that raised reasonable doubt concerning her suitability for continued state employment in her present assignment and adversely affected the confidence of the public in the integrity of the Department.

The Department agrees. The employee was discharged effective April 16, 2002. The employee appealed the discharge. The Civil Service Commission reduced the discharge to a 120-day suspension.

GENERAL INVESTIGATION 29

ALLEGATION

A Department caseworker threatened her supervisor during a meeting called to address the supervisor's concerns regarding the caseworker's unprofessional behavior.

INVESTIGATION

The supervisor had scheduled a counseling session to discuss what she considered to be the caseworker's recent poor job performance and acts of insubordination. During the meeting, the caseworker became increasingly loud, agitated and verbally combative. The supervisor ended the session, opened her office door and instructed the caseworker to leave. On her way out of the office, the caseworker advanced towards the supervisor and said, "I am the wrong person for you to mess with." When the supervisor asked the caseworker if she was threatening her, the caseworker repeated the statement. A Department employee confirmed that a heated meeting took place between the supervisor and the caseworker that day but was unable to relate any specific comments made by either party. An employee told OIG investigators that the caseworker's continued presence in the office since the counseling session caused the employee to fear for her own safety in the workplace.

The caseworker claimed that she was not at work on the day in question, and had never been involved in a counseling session with her supervisor. She denied threatening her supervisor at any time. An OIG review of the caseworker's electronic mail transmissions found a message sent to the supervisor on the day the session was said to have occurred that referred to the meeting. The caseworker's personnel file contained numerous references to rude and threatening behavior toward supervisors. In 1999, the caseworker was dismissed from the Department for inappropriate and threatening behavior and two counts of insubordination. Nine months later, the Civil Service Commission rescinded the termination and imposed a 30-day suspension, allowing her to return to her position. The caseworker's reinstatement included a provision that allowed for her to be disciplined up to and including discharge if she was involved in another incident of insubordination.

The OIG determined that the caseworker had made a threatening statement to her supervisor. The Department's Employee Handbook expressly prohibits any kind of aggressive behavior directed towards co-workers, clients or members of the general public. The caseworker's verbal threats against her supervisor were in direct violation of Department policy and the specific conditions of her reinstatement.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue discipline against the caseworker up to and including discharge for violation of the Department's workplace violence policy and conduct unbecoming a Department employee.

The Department agrees. The employee was discharged. The employee appealed the discharge. The appeal is pending with the Civil Service Commission.

GENERAL INVESTIGATION 30

ALLEGATION

The Office of the Inspector General was asked to investigate an allegation that a Department of Children and Family Services employee was using a state computer during work hours to access pornographic websites.

INVESTIGATION

The OIG, with the assistance of the Office of Information Services, analyzed computer data. After conducting interviews, the OIG investigation focused on a contractual employee. Investigators from the OIG confronted the full-time contract employee. The contractor admitted using a state computer to access pornographic sites.

After his interview with the OIG, the employee immediately resigned his position.

GENERAL INVESTIGATION 31

ALLEGATION

A caseworker was accused of engaging in a sexual relationship with an adult client who had lost custody of her two children.

INVESTIGATION

The OIG made several attempts to interview the mother; however, she did not make herself available for questioning. When investigators were able to meet with her she appeared to be intoxicated. The mother did not confirm to the OIG investigators her prior allegations that she had sexual relations with the caseworker after he promised to help her regain custody of her two children.

The OIG interviewed the caseworker who denied any sexual relationship with the client. The worker did inform OIG investigators that, prior to working for the Department, he had been a substance abuse counselor and had worked with the mother in that capacity. He also stated that both his family and the client's family attended the same church and that she had been to his home as part of a Christmastime outreach program. The caseworker's supervisor told the OIG she was aware of the worker's previous relationship with the client but assigned the case to him because of his experience dealing with substance abuse issues. The supervisor did not believe the prior relationship constituted a conflict of interest.

The Department's Code of Ethics for Child Welfare Professionals clearly outlines the factors that constitute "multiple relationships" and why Department personnel should take steps to ensure such situations do not arise. In this case, the worker's familiarity with the client, both through his previous professional involvement with her and their personal relationship through their church, could potentially interfere with his ability to make reasoned, objective decisions regarding her case. In addition, the mother could have unrealistic expectations of the caseworker and feel betrayed if he makes decisions related to the case that she feels are not to her benefit. At a minimum, the pre-existing relationship between caseworker and client could be construed by an outside observer as an apparent conflict of interest, undermining the public's trust in the Department.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker and his supervisor should participate in a consultation to review the conflict of interest provisions of the Code of Ethics for Child Welfare Professionals.

The Department agrees.

SERVICES TO TEEN PARENTS

Introduction

The Office of the Inspector General (OIG) received six cases selected by the Teen Parent Service Network [1] for the Hill Class attorney and monitor as a representative sample of the network services to DCFS pregnant and parenting wards. The OIG investigated services provided to the sample's population and three additional teen parent cases. The Director has received full investigative reports on two of the three additional cases investigated by the OIG and has agreed with the recommendations in the reports. The findings from the third case are included with the sample cases investigated in this report for a total of seven TPSN sample cases.[2] The Director previously accepted OIG recommendations on the subject of teen parent wards (noted on page 68 of the OIG 2002 Annual Report) and has directed the OIG to "work directly with the Teen Parent Service Network to address deficiencies in the current system."

A comprehensive review of the sample's entire case files found that the parties' reliance on the selected "relevant file documents" (the TPSN comprehensive assessments, TPSN parenting assessments, ProFile data and case review documents) and TPSN's follow up documents created a limited perspective to the depth of problems within this service delivery system.

Investigation

The OIG's investigation of the seven cases and two completed investigations recently submitted to the Director, found seven major areas of concern in addition to an absence of competent case management, service delivery, and more ameliorative strategies to the present and future risks that these families may face.

The major areas of concern include:

1. Violence
2. Education
3. Community Approach
4. Home Safety
5. Compliance with Services
6. Intake and Assessments
7. Medical Services

In this report, problem areas and suggested solutions will be presented followed by shortened case exemplars.

I. Violence

PROBLEM:

Violence is a recurring theme in the family and community lives of the TPSN sample wards and those in their immediate circles. While the OIG's investigation reveals violence in the domestic and public lives of these wards, there is an absence of interventions designed to address impulsive violent behaviors or protection from attacks from others. For example, three of the young women in the TPSN sample experienced domestic violence and two were violent to other members of their family or community. A

[1] It should be noted that these cases were self-selected and were not chosen in accordance with research standards for random selection.

[2] This case was not a part of the original sample, but was added to this report because of the similarity of problem issues. The OIG is separately investigating cases of wards 14 and younger whose pregnancy may have been the result of sexual exploitation.

nineteen-year-old male in the TPSN sample had a juvenile conviction for sexual violence resulting in placement at an out of state locked facility. He was recently attacked by the mother of his child resulting in 25-30 stitches. The two investigative reports previously sent to the Director also revealed the prevalence of violence. The first involved the rape of a seventeen-year-old ward whose level of developmental disabilities made her especially vulnerable to exploitation and incapable of raising a child. The second report involved the sexual exploitation of a thirteen-year-old child with aggressive impulses who functioned as a seven-year-old.

Programs that offered alternatives or countered the effects of aggression were not present in the TPSN sample cases. In the thirteen-year-old's case, the caseworkers ignored the risks to the child's infant that resulted from the mother's developmental vulnerabilities and impulsivities.

SOLUTION:

Henggeler, Schoenwald, Borduin, Rowland and Cunningham's treatment manual, Multisystemic Treatment of Antisocial Behavior in Adolescents (1998), gives clear empirical bases for social-ecological strategies that have the highest probability of leading to desired outcomes for adolescents with violent behaviors. Selected interventions match the cognitive and social developments of the youth, caregiver, and significant change agents in the youth's world. The intensity of the intervention and the link between treatment fidelity and clinic outcomes requires a specially trained cadre of social workers and caseworkers with an organizationally capable and committed agency to provide the interventions.

Because of the high intensity of violence in the TPSN sample, the Inspector General recommends that the TPSN Service Management Team develop a Multisystemic Treatment unit (MST) for young parents exhibiting antisocial behaviors. The unit developed by TPSN should provide services adhering to the time frame (4-6 months) of the MST model. A commitment to the research component of the MST is necessary for program integrity and outcomes can only better inform the field. TPSN should determine the mechanism of referrals, coordination and level of Regional Service Partners case management service during delivery of the MST services.

In cases involving the dual phenomena of family violence and mental illness, a family system psycho-educational model is needed. A study of family preservation programs that included looking at programs geared toward family members with mental illness indicated that using this approach helped reduce relapse, hospitalization and symptoms. The study stated: "...These services educate family members about the etiology of mental illnesses...the structure of the mental health system and the use of medications. Moreover, they include problem solving and communications skills training for working with people who have mental illnesses...and with others within the family system."[3]

In one sample case that involved both domestic violence and mental illness, services for the young mother who had an unstable, mentally ill partner needed to be supplemented with the above interventions. The paternal side of the family demonstrated a willingness to participate in a family systems approach to protect the children and the mother as well as to maintain the father's compliance with mental health treatment. See prior OIG recommendations on this issue.

Less intensive programs for interventions with violent verbal and moderate physical aggression such as social skills trainings, mediation skills, and anger management are not present in these cases. Such resources need to be available to this community of young families. In all cases were there is domestic violence the caseworker must talk to the extended family.

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[3] Fraser, M.W., Nelson, K.E., and Rivard, J.C., Effectiveness of Family Preservation Services. Social Work Research, 21, 138-153 (September, 1997.)

Additionally, the Chicago Children's Advocacy Center (CAC) has agreed to work with parenting teens and the Department to provide mental health services to teens 14 and younger who have a history of sexual abuse and/or whose pregnancy was the result of sexual exploitation.

Case Exemplars:

1. **Lara Dean**[4] has a history of aggressive behaviors and violence including community violence, domestic violence and possible gang activity. The major episodes of violence in Lara's life (both as an aggressor and a victim) include:

Date	Incident of Violence
Mar 1998	The father of Lara's first child was arrested for the kidnapping and rape of a 50-year-old female cab driver.[5]
Mar 1998	Lara has two indicated reports of abuse/neglect against her son. In March 1998, he was stabbed on the buttocks by a knife that Lara was carrying to a fight. The second indicated report was for inadequate supervision.
Jun 1998	Lara physically "attacked" her grandmother/foster parent and was verbally abusive. Her grandmother (who was 60 years old at the time) did not sustain any injuries, but she did file a police report.
Jun 1999	Lara's boyfriend was shot and killed after an altercation on the street in June 1999. Throughout the case record, caseworkers note their suspicions that Lara is gang-involved.
Dec 1999	Lara ran away to Tennessee after a physical altercation (with her maternal aunt) in her foster home that resulted from her second pregnancy and because she left her son unattended.
Jan 2000	Lara pursued battery charges against the cousin of the natural father of her second child.
Apr 2000	Lara has reported to TPSN workers that her son's father "sometimes forced her to comply in sexual situations."
Jul 2000	Lara was observed by her worker after a fight with a girl in her neighborhood. She reportedly appeared injured (i.e. bruises, cuts, missing hair), but refused treatment. Lara has a history of fighting.

2. **Kaitlin Edges** has been a victim of domestic violence by Odell Drayton, the father of her three children. Odell suffers from schizophrenia and resists taking his medication. Following the closing of the mental health center, his compliance with treatment became inconsistent. [6] It appears that incidents of domestic violence occurred when he was not taking his medication.

Date	Incident of Violence
Aug 1996	Odell was arrested in Texas for aggravated assault against a woman (not Kaitlin), which was later, reduced to a misdemeanor. He was in college at the time and had to return home for mental health services for schizophrenia.
Dec 1999	While Kaitlin was in an independent living program, her case manager noted she

[4] The names of the clients in this report have been changed. All names, except those of professional references, are fictitious.

[5] Father of Lara's first child was convicted of aggravated criminal sexual assault. He has been sentenced to 48 years in prison.

[6] Records indicate that Odell has never abused the children.

	came to the office with a bruise on her face. The caseworker suspected domestic violence but Kaitlin insisted she hit herself in the face with the door and the glass hit her in the face. The caseworker discussed domestic violence services but did not talk to the paternal grandmother to see if there was a problem. Kaitlin's partner accompanied Kaitlin to many of her counseling and parenting sessions and appeared cooperative. The grandmother wanted her son to receive mental health services and would have cooperated in family therapy. A LEADS check would have alerted the caseworker to Odell's 1996 arrest.
Jan 2000	Kaitlin's therapist noticed two black eyes. Kaitlin revealed that she had been in a dispute with Odell.
Mar 2000	Odell claims that he shook Kaitlin once and she called the police. He was arrested but not convicted for this incident.
Oct 2000	Odell was arrested for domestic battery against Kaitlin.
Nov 2000	Kaitlin's caseworker made an unannounced home visit. She saw that Kaitlin had a black eye that Kaitlin stated was from Odell's physical abuse.
Jan 2001	Odell and Kaitlin were involved in a domestic violence incident that resulted in Odell's arrest. Odell's mother and Kaitlin obtained an order of protection against Odell.

In domestic counseling, Kaitlin appeared to defend Odell. Psycho-education family services may help Kaitlin and Odell's mother understand the correlation between Odell's non-compliance with medication and tendency toward violent behaviors and the risk to the child. When interviewed by an OIG investigator, the family agreed to cooperate with the local mental health center's Parenting Assessment Team program. All family members signed consents and the OIG obtained the necessary records for the assessment. Odell has begun receiving mental health services.

II. Education

PROBLEM:

The OIG's investigation found there is a pervasive failure on the part of the caseworkers to appreciate the critical importance of providing appropriate educational opportunities to pregnant and parenting wards. In the sample cases there is no well-planned effort to obtain appropriate educational experience, nor is there an aggressive program to keep the wards in the educational system. Instead, referrals to GED programs with little or no follow-up are treated as adequate solutions. This mild intervention has pushed many of the wards' legal entitlements beyond acceptable limits. The loss of educational opportunities, especially when a young person is already struggling to overcome the hardships associated with a history of abuse and neglect and early pregnancy is troubling if the young person has any hope of building a sustainable future for his/her family. In the seven TPSN sample cases, the GED was promoted as the only educational focus for wards regardless of their learning capabilities or IQ. Previously, the OIG has reported, "GED classes are inappropriate and legally questionable alternatives for wards whose learning problems included developmental disabilities. Such inappropriate educational programming is a recipe for future failures and the abandonment of parental responsibility of our wards."[7] Additionally, DCFS Procedures 312, January 15, 1997, states, "Caseworkers are responsible for knowing the educational programs, services and protections guaranteed under state and federal law to all children who are eligible for special education services...a youth may be enrolled in a GED program only if they are ineligible to be enrolled in the public school district..."The young people in the sample had moderate to severe attendance problems and became accustomed to not attending school and not having negative consequences for their behavior. The severity of the truancy problems in this sample population is not

[7] See OIG report #97-IG2309- (May 1999.)

reflected in the TPSN quality assurance reports. Workers unrealistically relied on the student's self-management and adaptive skills when most of the students demonstrated poor self-management. In addition, wards with developmental disabilities were routinely given the Daniel Memorial Assessment, disregarding the Department's recognition that an adaptive behavior assessment "is a more appropriate instrument for this [developmentally delayed] population."[8] TPSN's continual administration of the Daniel Memorial Assessment on wards with developmental disabilities is a violation of DCFS Procedure 302 Appendix M Subpart (c).

Research shows that graduating from high school or receiving vocational training is critical for obtaining post-secondary education or getting a good job. Further, "The likelihood of slipping into poverty is about three times higher for high school dropouts than for those who finish high school. Between 1992 and 1993, 5.1 % of high school dropouts became poor, compared to only 1.8% of those with at least a high school diploma."[9] It is also well documented that teens that drop out of high school face enormous odds for achieving financial success in life. The U.S. Department of Education found that "in terms of employment, earnings, and family formation, dropouts from high school face difficulties in making the transition to the adult world."[10] Research also indicates that "by the time people reach prime working age (25-54), the medium personal income of those with a high school degree ($18,235) is almost twice that of those who dropped out of high school ($10,4000.) The income of those with a college degree ($35,125) is more than three times that of high school dropouts. Ongoing changes in the U.S. economy have increased the financial costs of dropping out of high school. Between 1973 and 1999, for example, the average hourly wage (adjusted for inflation) of high school dropouts fell 23 percent. The deterioration of wages among poorly educated workers has hit the youngest workers the hardest."[11] This factor often is implicated in the deterioration of the family formation and family stability among young adults.

A recent report by the Federal Interagency Forum on Child and Family Statistics discusses the importance of a parent's consistent employment and notes the positive effects that it has on children in the household. The study notes that steady employment positively affects "children's psychological well-being ... and improve[s] family functioning by reducing the negative effects that unemployment and underemployment can have on parents."[12]

Since a working parent offers a strong positive role model for children, those growing up in a family without a regularly employed parent do not experience the positive effects that such a parental figure offers. Also, some scholars note that the routinization of household schedules that typically accompanies full-time work is beneficial for children.[13]

SOLUTION:

1. Organizational Details:
   a. Caseworkers should develop a morning routine for school pick-ups for the students who are or are beginning to be truant. If a student develops a pattern of truancy for any reason, the TPSN worker should convene an immediate staffing including the teen parent, foster parent, TPSN education liaison and the Guardian *ad Litem* (GAL.)
   b. TPSN should provide bus or cab service to transport the teens to school and their children to daycare until the teen has a stabilized attendance pattern.

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[8] Ibid
[9] 2001 Kids Count Data Book Online, The Annie E. Casey Foundation.
[10] Ibid
[11] 1998 Kids Count Data Book, The Annie E. Casey Foundation.
[12] Ibid
[13] Ibid

c. Reliable center-based or day care home resources are needed to support school attendance, remedial educational activities and compliance with after school requirements (including detentions), thereby reducing unrealistic childcare demands on overextended grandparents.
d. TPSN should explore the use of The American Correspondence School for teens with a 7th grade or above reading level who need to make up lost credits due to previous truancy problems.

2. Caseworker Tasks:
   a. Baseline of environmental (eco-perspective) supports and obstacles to school attendance and performance.
   b. Identify a supportive network of people (across friends, family and school) who can assist the teen with homework assignments and who are invested in the school success of the teen parent.
   c. Help the family develop daily schedules (for both the wards and their children) from the morning to bedtime including home activities after school and places to study both in and out of the home.
   d. Keep a record of weekly attendance including calling the school to determine the number of days (and classes) that the teen has attended that week.

3. Supervisor Tasks:
   a. Review the student's educational records, IEPs and medical records with the caseworkers to identify significant issues and develop realistic goals.
   b. Obtain educational resource consultation as needed.
   c. Develop a remedial action plan as necessary and review for success or revisions.
   d. Ensure that all services for children who have learning disabilities or developmental disabilities are geared toward school achievement and skills enhancements. Assistive technologies for parents with vision and hearing impairments should be provided.
   e. If one conservatively estimates 10% of the Teen Parent population has developmental disabilities or severe learning disabilities (3 grades behind in reading), then the Department must carefully examine the casework focus on these teens. As recommended in another OIG report, each of the Regional Partners should have at least one specially trained caseworker to carry a special needs developmentally disabled caseload. Both the supervisors and case managers need training in how to effectively serve parents with upper moderate and borderline developmental disabilities.

Case Exemplars:

1. **Lara Dean** was attending 9th grade at a local high school when she became pregnant with her first child in 1997. She subsequently transferred to a school for pregnant teenagers in April 1997. Lara returned to school for 10th grade in the fall after she gave birth to her son. A Child's Summary from her December 1997 service plan stated that Lara was truant and was not attending school regularly. The form asks whether a conference has taken place and whether there was intervention. Both answers are marked "n/a." There was no mention in case notes of Lara's school progress until February 10, 1998, when the high school reported that Lara had missed 27 days of school since the start of the year. Lara was subsequently dropped from the high school. Lara completed a GED program at a local college but has not passed the GED exam. No educational assessment was found in the file.

2. **Kaitlin Edges** is a 21-year-old mother of three children.[14] There are varying reports of her IQ which range from 62-75. She has consistently scored at a 6th grade reading level. Kaitlin attended high

[14] Kaitlin's children are in DCFS custody as a result of her being indicated after one of her children was scalded in the bathtub with hot water. The permanency goal is return home.

school where she completed 10th grade, however she later dropped out and was moved into an independent living program at the age of seventeen.[15]

Since Kaitlin dropped out of school, her caseworkers have maintained a focus on Kaitlin completing the GED, in spite of her low reading level. Kaitlin has taken the GED exam multiple times and has not passed. The caseworker wanted Kaitlin to pursue college and assisted Kaitlin in filling out college applications. Kaitlin is pregnant with her third child. As her TPSN case was being closed, Kaitlin was told by her caseworker to send in her college applications.

3. **Sarah Marry** is a 14-year-old mother of a two-year-old child. In spite of her worker's repeated attempts to engage her in school, she vehemently refuses to attend. A psychological evaluation noted that "an alternative educational program...[would be] highly recommended as a typical grammar school setting would not likely maintain her interest or focus." Nonetheless, Sarah's TPSN caseworker continues to attempt to engage her in a regular school.

4. **Max West** is a 19-year-old male who fathered a child at the age of 18. His daughter resides with her natural mother. According to a psychological assessment in March 1996, Max has an IQ of 94. When he was returned from an out-of-state facility at the age of 15 he violated his probation, ran from a group home, and never attended school before he was referred to the TPSN program. At the time of the referral he was enrolled in high school. Within a few months he was dropped from that high school because of truancy issues. A high school counselor informed an OIG investigator that they attempted to contact both a caseworker and the foster parent to set up a meeting to address Max's truancy. (This attempted contact occurred prior to Max's case being transferred to TPSN.) While at the high school, he was still on probation for his criminal sexual assault conviction. His stepfather often covered for his truancies. The caseworkers did not convene a meeting with his probation officer, school and stepfather to assure he complied with his delinquency court order to attend school (see MST recommendation on page 3.)

III. Community Approach

PROBLEM:
The TPSN Mission states,

"Teen Parent Service Network seeks to bring together the community's best resources to provide pregnant and parenting wards with comprehensive care and services..."

A community approach was practically non-existent in the selected TPSN sample. Caseworkers were unfamiliar with family support and community resources. The average distance between the agency and a teen's home was 11.87 miles.[16] In the Marry case, the caseworker's agency was located over 26 miles from the teen's placement. In the Jefferies case, although the caseworker was based only a few miles from the young mother's suburban home, she insisted the mother use city resources because the worker was familiar with those as opposed to those located in the girl's community. It appeared that the caseworkers could not identify formal and informal community resources within a mile of the young family's home or school. Early Headstart programs, school based counseling and daycare sites were left unexplored or untapped by the caseworkers. Youth were routinely given phone numbers or forms for seeking their own daycare resources despite the knowledge that (1) child care is one of the biggest obstacles standing in the way of successful school attendance, (2) many of the teens do not possess the

[15] A conflicting report in the case record indicates that Kaitlin may have completed the 11th grade in 1999.
[16] These distances were determined by an Internet travel site (see www.mapquest.com) using the addresses of the foster homes and the caseworker's agency location.

skills to successfully negotiate this service on their own and (3) in many cases the teens' behavioral history did not demonstrate a likelihood that they would follow through to obtain the services and to responsibly maintain them. Furthermore, it is unrealistic to assume that home daycare providers without the support of the teen's agency would welcome a teen parent who does not demonstrate the maturity and responsibility necessary to indicate they would be a stable client. Overburdened, elderly grandparents were expected to take on the extra burden of childcare.

Most workers appeared to need training on a task-centered model of linkage that contained pragmatic assistance with resource location, option exploration, resource selection, resource connection and verification of resource assistance.

Applying research literature to our young and often vulnerable teen parent population, we know that long term visitations by service providers have been effective in prevention of child abuse and neglect (MacMillian et al., 1994.) Research does tell us that the effectiveness of parent training, drop-in centers, classroom education and short-term visitation remains inconclusive. Yet, most studies on long-term visitation programs do not tell us about the mechanisms of the home visiting-what the home visitors did during these visits.

A review of the interventions used on the selected teen parent sample provided by TPSN and several other cases may offer a beginning step in analyzing present field practices, their efficacies and help in developing a methodology for evidence-based practice for DCFS's teen parent population. What we should expect from the field if we develop key strategies for intervention from differing branches of research (education, public health, eco-behavioral, developmental psychology, learning theory) is improving programs and employing workers capable of critical thinking.

SOLUTION:

Implement LAN 67 family conference services pilot for the maternal and paternal extended families. A five -week applied intervention program for LAN 67 TPSN case managers and their supervisors in family conferencing and multisystemic approaches will be conducted. Supervisors will select at least one case for a family conference. Community mediators from the community will conduct the family conferences on the selected cases with the case managers functioning as family coordinators. Each case manager and supervisor will complete an Ecomap for one of the young families in their caseload.

The Ecomap is a hands-on, educational tool that workers should develop in conjunction with the teen parents in an effort to educate and reinforce a network of community resources. The Ecomap should be used as an assessment of the environmental obstacles and personal and community strengths. The task-centered child welfare practitioner involves family members and relevant collaterals in developing the target problems and gives reasonable advice and guidance in the anticipation of obstacles and the exploration of resources and services necessary to problem reduction.

Daycare Success Strategies:

It is necessary for young teens to successfully obtain and maintain safe and stimulating childcare resources. TPSN workers should be trained on how to model, role-play, and rehearse the repertoire of behaviors that a parent needs to obtain and maintain quality daycare. For example, being respectful and incorporating responsible behaviors such as coming to daycare with an adequate supply of diapers, and being on time and courteous in drop-offs and pickups so as not to be dropped by the service provider. Often, problems arise because of the teen's immaturity and lack of experience in appropriate behavior when obtaining a service. (See home and child safety recommendations p. 12.) Data shows that formal

child care centers best meet the developmental needs of children by providing a safe environment, cognitive stimulation, structure, warmth, and appropriate discipline.[17]

Home Visits:
Currently, the TPSN program only requires in-home visits twice monthly. An intensive home visits program similar to the one used in the early phases of the Intact Family Recovery Program is more appropriate for this population of young families. When the case is first received, visits should occur in the home twice weekly for at least six months until the teen is stabilized in the role of parent and able to maintain the appropriate developmental tasks of adolescence. In cases with high-risk factors (e.g., developmental disabilities, chronic truancy, multiple births, substance abuse or domestic violence) the intensive home visits should continue throughout the first year of the case unless there are clear indications that the risk factors have been alleviated. The purpose of increased visits is to create a supportive and monitoring presence in the teen's life from the earliest stages.
Additionally, this high level of interaction allows the worker to assess the teen's strengths and problem areas and provide teaching opportunities and support.

Case Exemplars:

1. **Rhonda Jefferies** lives in Illinois. Her caseworker routinely referred Rhonda, who was visually impaired, to services in the city rather than Rhonda's community because the worker was "more familiar with city resources."

2. **Sarah Marry** is a 14-year-old mother. Initially, she was given a list of home daycare providers and told to select one.[18] This was in spite of her ongoing truancy from school for a year and her lack of prosocial skills. She was not an attractive candidate to any reasonable home day care provider.

IV. Home Safety

PROBLEM:
In three of the seven cases reviewed from the TPSN sample, home safety and child hazards were apparent and were inadequately addressed. The research literature from public health provides in-home strategies to lower the environmental risks present in these homes.

SOLUTION:
1. All supervisors and caseworkers should be trained to teach young parents how to conduct a home and child safety check in their home and in homes where the children routinely visit.

2. Supervisors should test the reliability of the worker's applied training.

3. TPSN should adopt and utilize the Intact Family Recovery Home Safety Checklist.

Case Exemplars:

1. a. **Kaitlin Edges**, the mother of twin toddlers, lived in an apartment in which poisonous bait was used for rodent control. The exterminator who was sent in by the agency used poisonous bait in a home with twin toddlers. One of the twins was found with the rat poison pellets in her mouth, which Kaitlin removed and tried to induce vomiting. She did not call the child's pediatrician, but

[17] Welfare, Children & Families, A Three-City Study. Child Care in the Era of Welfare Reform: Quality, Choices and Preferences.
[18] Eventually, Sarah's caseworker assisted her in identifying childcare.

did report the event the next day to her caseworker. A consulting nurse to TPSN instructed her to call poison control if it should recur. No one went to the home to help the mother remove remaining poison packets.

b. Kaitlin reported that the wall behind one of the light switches in her apartment became hot when the switch was left on. The agency sent a handyman, who was not an electrician, to check the problem. Fire safety training warns of overheated or faulty wiring which is not uncommon in older inner city apartments.

c. Kaitlin commented that she did not want to use car seats for her newborn twins, preferring to carry the infants because the car seats were too big. Her caseworker noted that she agreed with the young mother and took no actions taken to remedy the situation.

d. While preparing to move into her new apartment, Kaitlin scalded her toddler daughter in bathwater: The water temperature from the faucet was 140 degrees.

e. In January 1999, a nurse visited Kaitlin's home and found Kaitlin sleeping on the couch with her two infants. Additionally, Kaitlin was heating her home with the stove. The nurse did not address these safety concerns with Kaitlin.

2. In **Rhonda Jefferies'** overcrowded relative foster home there was a fire and there was no indication that a fire escape plan had ever been discussed with the teen mother.

3. **Doreen Smith** (who was trainable mentally handicapped) and her toddler son moved into a home that had not been childproofed. Electrical extension cords were hanging from the VCRs and TV and electrical sockets were uncovered.

4. **Maria Kendall's** TPSN clinical specialist and caseworker placed a one-month-old infant at risk of SIDS, using a washbasin lined with pillows as a bed for the infant.

V. Compliance With Services

PROBLEM:

Teen parents responsible for providing adequate care for young children cannot be expected to progress or succeed without the assistance and guidance of involved child welfare professionals. However, not all teen parents involved with the program possess the self-motivation to maintain the required level of participation. The current TPSN model does not include any negative consequences for teen parents who do not follow through with their educational or vocational responsibilities, leaving program administrators with no means of ensuring the parents' compliance.

The majority of teens in the sample had a history of non-compliance with services. Many of them refused to attend school or to obtain and maintain employment. In some cases, the workers made attempts to engage the teen in school, a GED program or vocational training, but the teens remained non-compliant. However, they continue to receive financial support in spite of non-compliance. This discrepancy actually serves to discourage unmotivated parents from actively attempting to meet program requirements and does not educate them on natural, real-life consequences.

SOLUTION:

In order to promote participation in services and to strengthen the Department's ability to maintain higher levels of compliance, TPSN must penalize teen parents who do not either actively attend school 90% of the month or maintain appropriate employment for 90% of the month or make reasonable efforts to obtain

employment.[19] Currently, DCFS wards receive $102 per month regardless of their participation in school or employment. The requirements and sanctions currently implemented in the TANF program incorporate financial sanctions for non-compliance. TPSN should adopt a system of sanctions to be utilized in its program.

A solution for TPSN sanctions incorporates a tiered sanction system with natural consequences for teens with chronic non-compliance with services. This approach could be administered in a similar manner to the Memorandum of Agreement utilized in the Intact Family Recovery (IFR) program. The advantage to this method is the clear level of communication and understanding of the expectations and consequences by all involved parties.

- **Level 1** – (First infraction) The personal spending money allotted weekly to the teen parent will be reduced by 50 percent. Benefits are restored as soon as the client cooperates.

- **Level 2** – (Second infraction) The personal spending money allotted weekly to the teen parent will be reduced by 50 percent. In addition, the teen will be picked up by truancy services on a daily basis and be transported to school or job. If the client cooperates with services during the three-month span, benefits are restored the following month.

- **Level 3** –(Third infraction) The personal spending money allotted weekly to the teen parent will be reduced by 50 percent. In addition, the teen will appear before a judge at Juvenile Court to be ordered to go to school or seek employment. Cash assistance will be reinstated after that time if the client cooperates during the sanction period.

Reconciliation is attempted prior to sanctions being imposed in order to provide the client with an opportunity to offer explanations or to begin immediate cooperation with service requirements. By implementing a clear, defined system of escalating penalties for non-compliance, the program will maintain a degree of leverage in influencing the behavior of clients, incorporating a measure of institutional control that is sorely lacking in TPSN.

VI. TPSN Intake and Assessments

PROBLEM:

The TPSN program plan states the intended goal of the Comprehensive Assessment should be to "serve as a guide for setting goals, developing service plans, and identifying areas that facilitate or impede achievement of the goals." (TPSN Program Plan 2.3.1) The OIG investigation revealed that this intended goal is almost completely overlooked. While TPSN has an assessment tool that often contains important information about the ward's capabilities and needs, there is an overall failure to address the needs after they are documented. In all seven of the TPSN cases reviewed by the OIG, Comprehensive Assessments were completed but there was little focus on the problem issues that were identified in the assessment. In some cases the assessments provided valuable information. However, adequate measures were not taken to assess risk and provide services based on the information gathered in the course of the assessment. Overall, the assessments appeared to be an exercise in gathering information rather than assessing risk and strengths and providing appropriate services.

[19] The above percentage requirements are based on the minimum requirements of the local public schools for truancy requirements and dismissal.

SOLUTION:

Intake

When TPSN receives a UIR informing them of the pregnancy of a teen ward, they should immediately request the full case record of that teen. Currently, only name, demographics, recipient number, DCFS number, region/site/field number and social security number are requested. (TPSN Program Plan 2.2.2.) A face-to-face hand off must occur (between TPSN and the Regional Service Partner) within 24 hours of TPSN receiving the case.

Comprehensive Assessment

Prior to beginning the assessment, the worker must read the entire case record. The assessment should involve the caregiver, support network, and the teen parent. Once a problem issue is identified, a specific plan for dealing with that area should be established. For example, if a worker indicates in the assessment that the ward is frequently truant, baseline data should be presented, and the caseworker should detail the specific plan for how to ensure that the ward attends school rather than state that it is the ward's responsibility to attend school. Additionally, the caseworker should list the sources of information gathered during the assessment.

The assessment should identify high-risk factors such as becoming pregnant at or prior to age 15, history of school failure, truancy or school drop out, gang involvement, violence or history of substance abuse.[20]

Areas covered under the Comprehensive Assessment should be expanded to cover (1) the developmental stage of the child and the developmental age of the parent and (2) safety and other needs of the teen's child, (3) the ecological fit between the needs of the young family including their living environment and strengths and to target well-defined problems with developmentally appropriate interventions designed to promote responsible behaviors and decrease irresponsible behaviors.

Staffing

A staffing should occur within 30 days of receipt of the case, and after the Comprehensive Assessment has been completed. The staffing must include the teen parents, foster parents, relatives (including grandparents of the infants) the GAL, and significant others such as probation officer if applicable. Any case involving mental illness (or dual diagnosis with mental illness and developmental disabilities) should be referred to the Parenting Assessment Team (PAT), which is the best resource available to accurately assess mental illness and parenting. Any recommendations made by PAT must be followed by TPSN.

Multiple Births

In the year 2001, there were four teens who gave birth to twins. One of those teens was indicated for risk of harm. In 2000 the OIG completed a child death investigation of a recently discharged TPSN teen parent who was a parent of twins. The rate of indicated reports on TPSN parents of twins behooves special attention.

Several examples of this practice of form over substance follow:

1. **Rhonda Jefferies'** Parenting and Comprehensive Assessments both contain information that indicate areas that need to be addressed in order to help her develop necessary skills such as education and parenting.
    a) The Parenting Assessment noted that the daily routine for her two-year-old child included: "child wakes up around 1:00 in the afternoon. The child goes asleep late at night sometimes she will be up until 1:00 in the morning" and "she [child] sits quietly for a long time." According to the assessment, Rhonda's discipline techniques consist of yelling at the child.

[20] DePaul/DCFS Teen Parent Project- Year 5 Report, Karen S. Budd, Ph.D, (1995-96).

b) In spite of frequent documentation in the case record that Rhonda has severe vision deficits, the Comprehensive Assessment makes no note of the problem. It does, however, state that her last vision exam was in 1996.

2. **Max West's** record notes that Max was convicted of criminal sexual assault involving a young girl. As a result of this conviction, Max was designated a SACY ward. There is no indication in the file that a copy of Max's SACY protection plan was ever obtained by his worker. What makes this even more disturbing is that Max is the father of a one-year-old girl. Max has rejected all services, and is presently on run. His probation case was terminated unsatisfactorily.

VII. Medical

PROBLEM:

Pregnant girls who are 15 years or younger or are in high-risk categories (such as those with developmental disabilities) need careful attention. Because of their lack of maturity and emotional and intellectual limitations, these girls need dependable professional intervention to help them realistically address their pregnancy and adoption options, and to obtain good pre-natal care and effective birth control methods. Most case managers in the sample were not aware of the immunization status of the teen's children.

SOLUTION:

Resources already exist that could supplement TPSN by addressing the needs of very young and high-risk teen mothers in a more coordinated and dependable way. Some Title X clinics are specifically set up to deal with teens family planning and pregnancy. These centers could be used as support centers for pregnant and parenting teens. Doctors and social workers at these centers are experienced in assessing teens and communicating effectively with them.

DCFS could implement a clinic-centered program for pregnant and parenting teens in a variety of ways. Three or four of the established, well-respected clinics could be chosen to cover different geographic areas within Cook County. Once very young or high-risk pregnant teens are identified by TPSN, pre-natal care and counseling could be provided at the clinic closest to each teen's residence. Teen parents within each area could later be transported by van or other means to a regularly scheduled once-a-week, early evening parent training session at the clinic where they have already been seen. Follow-up care after childbirth, birth control information, and pediatric care for newborns could be obtained at the same clinic, which by then would have an established relationship with each teen. When appropriate home visits are conducted by clinic personnel, a coordinated system of transportation should ensure greater attendance. Weekly parent training sessions are offered at Title X teen clinics. Coordination with these clinics would yield more effective parenting education strategies. The continuity of the relationship between clinic personnel and teen parents would likely increase the motivation of teen parents to return for postnatal medical care, counseling and pediatric care. Services can be accessed even after the parent emancipates from wardship.

Additionally, the caseworker needs to assist the ward in making initial appointments and should accompany the ward to the doctor. The worker should discuss concerns and rehearse medical questions that the ward might want to raise with the doctor. Depending on the ward's capabilities, this modeling may have to continue until the ward appears capable of completing the task on his/her own. If the worker does not accompany the ward, the medical records can be obtained with consents.

Case Exemplars:

1. **Crystal Dean** contracted trichmoniasis as reported in January 1998. There was no evidence of follow-up for this condition. Additionally, Crystal was diagnosed with Hepatitis B in June 2000. Again, there was no evidence of follow-up medical care.

2. **Rhonda Jefferies** is a 20-year-old mother of a two-year-old. Her vision without glasses is 20/200.[21] According to an institution for the blind, Rhonda is legally blind with this level of vision. It should be noted that legally blind does not always mean that a person is totally without sight. However, it is a benchmark for eligibility of certain benefits and services such as SSI. Rhonda's case record reflects that she has a full scale IQ of 54 and she reads at a grade level of 4.9. Rhonda failed the 8th grade twice and subsequently failed the 9th grade. Multiple references in her education records and case record indicate that her failures in school may be directly related to her vision problems. In spite of that, her caseworker only recently realized that Rhonda was visually impaired. Similarly, there is a possibility that her IQ test was compromised by her vision problems. This possibility was never explored by TPSN.

[21] Based on the OIG's recommendation, Rhonda recently had an eye exam. According to the eye doctor, Rhonda's corrected vision is 20/100 and 20/70.

CHILD WELFARE EMPLOYEE LICENSURE ACTION SUMMARIES

I. RECOMMENDATIONS FOR DENIAL

An applicant for a Child Welfare Employee License had worked for three private agencies consecutively. He was terminated from each agency for falsification of his employment applications. In his application for licensure, he claimed to have had a bachelor's degree in child psychology from an accredited university in Texas and a certificate in early childhood development from the City Colleges of Chicago. An investigation by the OIG licensure unit revealed that the applicant did not graduate from the university in Texas. He had altered a copy of his Chicago Public High School transcript to make it look like it was from a university in Texas. The investigation further revealed that the applicant did not receive a certificate in early childhood development from the City Colleges of Chicago and that he was more than 30 days delinquent with child support payments, totaling $49,000, in three separate states. Based on the findings of the OIG investigation, the application for licensure was denied.

An applicant for a Child Welfare Employee License had been indicated for sexual abuse for sexually molesting his daughter's girlfriends during sleepovers. The finding was upheld on administrative appeal. The OIG recommended denial of licensure based on the indicated finding.

A child protection investigator was indicated for abuse for instructing DCFS clients about how to administer corporal punishment to their children without leaving marks. He demonstrated spanking techniques to clients by placing children (sometimes teenage girls) on his lap and striking them on the buttocks with his hands. The indicated finding was upheld on administrative appeal. The OIG recommended denial of his application for licensure based on the indicated finding.

II. RECOMMENDATIONS FOR HEARING/LICENSURE ACTION

A licensed child protection investigator falsified records in investigating a father for physically abusing his four year-old child. After interviewing the father, who denied the abuse, the investigator falsely recorded interviews with the mother and others that he had not interviewed. The falsified interviews contained fabricated facts that supported unfounding the report against the father. Within ten days of the investigator's recommendation to unfound, the child suffered life-threatening injuries at the hands of her father. The OIG recommended that the investigator be discharged and initiated proceedings to revoke his license. The investigator was discharged and failed to appear for the hearing. The Administrative Hearing Judge issued a finding of abandonment. A determination of revocation of the investigator's license is pending.

A licensed child welfare employee was arrested for domestic battery and indicated for child abuse after an incident in which he physically assaulted and threatened the minor daughters of his girlfriend. The criminal prosecution of the battery was dismissed when the victims failed to appear. The administrative appeal of his indicated finding was dismissed for failure to notify the hearings unit of the dismissal of the criminal case. The Circuit Court is considering whether the administrative dismissal will be upheld. The OIG initiated revocation of licensure proceedings. The proceedings are being held in abeyance, pending the Circuit Court decision. The Department placed the employee on desk duty based on the indicated findings.

A licensed child welfare specialist became involved in a court proceeding for a Minor Requiring Authoritative Intervention. The parents of a 16 year-old girl alleged that she was beyond their control. The girl wanted to live with her aunt, but her father strongly opposed the placement because he believed

that the man that his sister lived with was a convicted sex abuser. The licensed child welfare specialist failed to conduct a criminal background check on the man prior to court, but falsely claimed to the court and courtroom personnel that she had conducted a criminal history background check which showed no criminal history. As a result, the court approved placement of the girl with her paternal aunt, over the objections of her father. After the hearing, the child welfare specialist did arrange for a criminal history check and learned that the man had been convicted of and imprisoned for aggravated criminal sexual abuse/penetration. She then failed to notify the court or other involved professionals of her serious error. She contacted the Office of the Inspector General for assistance interpreting the results of the criminal history background; the worker believed that the fact that the man did not have to register as a sex offender suggested that his criminal history would not be a bar to placement of the 16 year-old girl. The OIG told her that the criminal history was very dangerous and agreed to retrieve and analyze underlying documents for more detail. The OIG reported back that the underlying arrest report disclosed that the victim of the criminal sexual abuse had been a female child under the age of 13 at a time when the man was over 40. The child welfare specialist never notified the OIG that the girl had already been placed in the home nor did she contact any court professionals until the OIG became aware of the placement and required her to immediately remove the child. The OIG recommended that the specialist be discharged and initiated proceedings to revoke her child welfare license. The specialist resigned and surrendered her child welfare employee license.

The OIG investigated allegations that a child protection investigator developed personal relationships with female DCFS clients and molested a minor client. The investigation uncovered evidence that the investigator had lived with a DCFS client for several months. Another client was approached by this CPI when she arrived at a DCFS office to meet with her case manager. The CPI invited her to move into his home with him and she agreed; however, she left after the first night because he made unwelcome and inappropriate sexual advances towards her while she slept. This CPI also fondled a fourteen year-old DCFS ward, asked her to move in with him, offered her alcoholic beverages, fondled her seventeen year old girlfriend and offered her alcoholic beverages; fondled a twelve year-old girl from his neighborhood, sexually molested a disabled woman, and left the scene of a traffic accident. Based on the OIG investigation and recommendation, the Child Welfare Employee Licensure Board temporarily suspended his child welfare employee license pending the revocation hearing.

COOPERATION WITH LAW ENFORCEMENT AGENCIES

CASE 1

A 5 month-old child was seriously injured in her home. The case was investigated by the Division of Child Protection (DCP) and indicated to an unknown perpetrator because so many people were in the home at the time. Protective custody of the child and another sibling was taken and a Petition for Adjudication of Wardship was filed in Juvenile Court. The State's Attorney of the county requested that the petition be dismissed without adjudication because he did not believe he could prove allegations against the parents. The OIG advocated with the State's Attorney and the local Death Review Team to determine alternate theories that would ensure the child's safety. The State's Attorney took the case back into Court for temporary custody.

CASE 2

The OIG became aware of a situation where an older caregiver was having problems keeping an elderly minister away from her adolescent granddaughter, whom she had adopted. The granddaughter had been pregnant a couple of times and the minister arranged an abortion. Once the OIG was able to identify the minister that was exploiting the granddaughter, the OIG solicited the assistance of the Child Advocacy Center and the Chicago Police Department to bring about charges against the minister. The adolescent was placed in a residential treatment center and an order of protection against the minister was secured.

CASE 3

During the course of an investigation involving a private agency where the Executive Director of that agency was also a foster parent of two wards, the OIG learned that the Executive Director's live-in boyfriend was a drug dealer and a convicted felon wanted by the Immigration and Naturalization Service (INS) for deportation. The OIG obtained all the information and documentation regarding the convicted felon and turned the information over to INS.

CASE 4

In an investigation that began in FY 01 after an employee was arrested and charged with Driving Under the Influence, the OIG learned that the Office of the State's Attorney was unable to locate a primary witness for the trial. The DUI charge was issued when the worker became involved in an accident while transporting a minor child for whom the Department was responsible. The primary witness was the minor child. The OIG located the child and made her available to the State's Attorney for the trial.

CASE 5

The OIG worked on an investigation in cooperation with the Illinois State Police (ISP) regarding a worker who claimed to have obtained criminal background information on a potential foster parent through a State Trooper. The worker falsely informed the court that the potential foster parent was cleared by a Law Enforcement and Agency Data Systems (LEADS) check, when in reality he was a convicted child sex offender and the child placed with him was consequently placed at risk.

CASE 6

The OIG learned that a 71 year-old pastor maintained a sexual relationship with the 14 year-old granddaughter of an elder caregiver involved in the OIG's Older Caregiver Project. The pastor had been charged with contributing to the delinquency of the child, but the case was dismissed when the child failed to appear in court. The OIG referred additional information and evidence to the child abuse hotline and to the police. The pastor was indicated for child abuse and is currently administratively appealing the

indicated finding. The OIG also referred the girl to the Child Advocacy Center Collaboration Project (see discussion under "OIG Initiatives") for victim services.

CASE 7
The OIG investigated the theft from a ward who had received a settlement for an automobile accident in which he had been involved about 9 years earlier. The check for the settlement was made out to the ward, who had just turned 18. As he had no bank account, the private agency worker offered to see that the check was deposited for him. The worker solicited the aid of a friend, who worked at the Department of Public Aid (DPA). The DPA worker deposited the check in her personal account and withdrew all of the money in increments, without giving any to the young man. Once the evidence and documentation was obtained, the OIG turned the case over to the Illinois State Police, Internal Investigations Division and notified DPA, as it involved one of their employees.

CASE 8
The Department paid grandparent foster parents for the care of their two grandchildren that were living with them out of state. The Department learned that the parents had moved back to Michigan and that the children were actually living with their parents and not with the grandparents. The grandparents claimed that they had turned the money they received for foster care over to the parents. The Department does not pay for children to live with their natural parents. The case was turned over to the Office of the State's Attorney and to the Attorney General. The Attorney General's office decided to take jurisdiction and attempt to secure repayment of the money for foster care. The OIG provided assistance by obtaining all documentation and copies of vouchers paid.

CASE 9
A DCFS worker, who had a history of threatening fellow workers and had been reinstated in her job after termination for prior incidents, again threatened a fellow worker, who was frightened by the threat. The OIG investigators sought the assistance of the Illinois State Police to have the worker administratively charged, removed from the work premises and placed on administrative leave.

CASE 10
A complaint came to the attention of the OIG when foster care payment checks made out to a foster parent were forged and deposited in various checking accounts. The State Treasurer was attempting to have the banks pay back the money, as the checks were forged. One bank refused to pay back the money unless the Department corrected the situation, at which time the matter was brought to the attention of the OIG.

CASE 11
The Illinois State Police sought OIG assistance in an investigation of a DCFS worker based on failure to follow a Court order. After completing their investigation, the Illinois State Police advised the OIG that they had found no basis for the allegations.

CASE 12
During an investigation the OIG learned that a home health care service was double billing for in-home nursing services. After completing the investigation and obtaining the documentation, the OIG forwarded that portion of the case to the Department of Public Aid and to the Office of the State's Attorney for follow-up.

CASE 13
The OIG looked into a complaint of a foster parent regarding use of her social security number by a receptionist at a private agency. The OIG completed a criminal background check on the receptionist and found that she had already been convicted of identity theft in the case of the foster parent. The OIG put

the director of the agency in contact with the Office of the State's Attorney so the agency's record could be examined for more victims. At this time, the receptionist is facing numerous indictments on charges of identity theft.

CASE 14

A group home was being investigated by the OIG regarding allegations of female staff members engaging in sexual relations with the young men in the program. The OIG shared with State Police the information it had obtained in its investigation.

CASE 15

A complaint was sent to the OIG regarding a DCFS worker improperly accessing criminal history information regarding a household member of a fellow worker and passing the information on to fellow workers. At the same time that the OIG received the complaint, the complaint was made to the Illinois State Police (ISP), Internal Investigations Division. The OIG conducted its investigation in conjunction with the ISP. The allegations were not substantiated and the case was closed.

CASE 16

During the investigation of a private agency, it became apparent that there were serious financial problems with the agency. The irregularities appeared to be criminal in nature. The case was turned over to the Office of the State's Attorney and subsequently to the Attorney General's Office.

CASE 17

Police contacted the OIG when original client service records were found in an abandoned storage locker. The locker belonged to a former worker who had been disciplined previously for falsification of records. The OIG ensured that the records were returned and verified that the former worker was not working in child welfare.

CHILD DEATHS

The OIG receives notification from the Illinois State Central Register (SCR) of child deaths, reported to SCR, 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.[22]

The notification of a child death generates a preliminary investigation in which the death report is reviewed and computer databases are searched. If available, a chronology of the child's life is reviewed. When further investigation is warranted, records are impounded, subpoenaed, or requested, and a review is completed. When necessary, a full investigation, including interviews, is conducted. Reports are issued to the Director. In Fiscal Year 2002, the OIG received notification from SCR of 97 child deaths meeting the criteria for review. In 33 cases preliminary investigations were conducted. In 44 cases records were reviewed. In 6 cases reports were sent to the Director. Fourteen full investigations are still pending. Summaries of death investigations that resulted in major recommendations are included in the Investigations section of this report.

In examining what child deaths could have been prevented, the number of children who died in fires is most significant. Ten children died in fires in FY 02, seven more children than in the prior fiscal year. Five of those children were in families that had intact family cases open at the time of the fire. Intact family cases had recently been closed for two families. One family had a recently indicated child protection investigation. Two of the cases involved teenage mothers and their children. In response to these tragedies, the OIG immediately began to develop a training curriculum to address safety and has begun training caseworkers. The OIG established relationships with the Chicago Fire Department, the Lombard Fire Department Public Education Coordinator, and Cook County Medical Examiner's staff to train workers on fire and home safety. Training has been provided to intact family caseworkers and licensing workers. The training provides home and fire safety information and strategies to assist parents, caseworkers and licensing staff to improve the health and safety of intact families and teen wards and their children. The OIG Best Practice Staff has assumed responsibility for the training curriculum and has trained workers in Chicago and downstate, expanding the audience to teen parenting service network case managers.

Following is a statistical summary of the 97 child deaths received by the OIG in FY 02 as well as summaries of the individual cases.

[22] The limitations of this information should be noted. The State Central Register relies on coroners, hospitals, and law enforcement throughout the state to report child deaths to the hotline, even when the deaths are not suspicious for abuse or neglect. Currently, there is no statewide policy for the reporting of child deaths to SCR. Therefore, accurate statistical analysis of child deaths in Illinois cannot be performed because the total number of Illinois children dying each year is unknown. The Cook County Medical Examiner's policy is to report to SCR the deaths of all children autopsied at the medical examiner's office. The Child Death Review Teams throughout the State are requesting that coroners in Illinois report all child deaths to SCR. They have also requested that SCR receive child death certificates from the Bureau of Vital Statistics.

Homicide

There were a total of 16 deaths classified homicide in manner.

* 6 children died as a result of multiple trauma injuries
* 3 children died from gunshot wounds
* 3 children died from inflicted head trauma
* 2 children died from asphyxia
* 1 child died from alcohol poisoning
* 1 minor died as a result of multiple stab wounds

Perpetrators
* 6 paramours (5 male, 1 female)
* 4 fathers
* 2 mothers
* 1 stepfather
* 1 stepmother
* 1 ex-boyfriend of a ward
* 1 unrelated teenager, also a ward

Ages of Children
* 4 children under 6 months
* 2 children ages 12 to 23 months
* 4 children age 2 years
* 1 child age 3 years
* 1 child age 6 years
* 1 child age 14 years
* 1 child age 16 years
* 2 wards over 18 years (20 years)

Male/ Female Breakdown of Perpetrators
* 14 Males
* 6 Females

Ages of Perpetrators[23]
* Male perpetrators were from 17 to 45 years (4 were under 25; 7 were over 25)
* Female perpetrators were from 17 to 33 years (3 were under 25; 2 were over 25)

Number of Perpetrators Charged
* 18 of 20 perpetrators have been charged
  * 15 are awaiting trial
  * 2 have pleaded guilty
  * 1 has been found guilty
* 2 committed suicide

County
* 9 deaths in Cook County
* 2 deaths in DuPage County
* 1 death in Kane County
* 1 death in McDonough County
* 1 death in Ogle County
* 1 death in Tazewell County
* 1 death in Perry County, Iowa

Substance Exposure at Birth
*1 child was born substance exposed

Substance Abuse in Family of Origin
* 10 families had evidence of substance abuse

[23] There are three male and one female perpetrators of unknown ages.

Suicide

There were a total of 4 deaths classified suicide in manner.
* All 4 children hanged themselves.

Ages of Children
* 2 children were age 17
* 1 child was age 14
* 1 child was age 12

County
* 2 deaths occurred in Cook County
* 1 death occurred in Kankakee County
* 1 death occurred in St. Genevieve County, Missouri case management was in St Clair County
* 2 of the deaths occurred while the minors were incarcerated

Substance Abuse in Family of Origin
* 3 families had evidence of substance abuse

* All 4 children had been previously diagnosed with depression

Undetermined

A death is classified as undetermined in manner 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 and natural. Thus, there is a certain degree of suspicion attached to undetermined causes and manners.

There were a total of 9 deaths classified undetermined in manner.

* 6 children also had an undetermined cause of death
* 1 child died of smoke inhalation due to a house fire
* 1 child died from intrauterine hypoxia due to maternal cocaine use
* 1 child died from intrauterine asphyxia from cocaine intoxication due to maternal cocaine use

Ages of the Children
* 7 children were 3 months and under
* 2 children were 3 years

Substance Exposure at Birth
* 4 children were born substance exposed

Substance Abuse in Family of Origin
* 5 families had evidence of substance abuse

County
* 4 deaths occurred in Cook County
* 1 death occurred in DuPage County
* 1 death occurred in McLean County
* 1 death occurred in Sangamon County
* 1 death occurred in St. Claire County
* 1 death occurred in Winnebago County

Accident

There were a total of 17 deaths classified accident in manner.

* 9 children died from inhalation of carbon monoxide/smoke/soot or products of combustion due to house fires
* 2 children died from drowning
* 2 children died as a result of asphyxia due to overlay
* 1 child died from asphyxia due to trapping
* 1 child died from multiple injuries due to a motor vehicle striking a pedestrian
* 1 child died as a result of multiple injuries sustained in a motor vehicle accident
* 1 child died as a result of mechanical asphyxia due to neck compression (hanging)

Ages of Children
* 3 children were 3 months or younger
* 5 children were 12 to 24 months
* 2 children were 2 years
* 2 children were 3 years
* 1 child was 4 years
* 2 children were 6 years
* 1 child was 13 years
* 1 child was 16 years

County
* 1 death occurred in Clinton County
* 9 deaths occurred in Cook County
* 3 deaths occurred in Lake County
* 2 deaths occurred in Peoria County
* 1 death occurred in St. Clair County
* 1 death occurred in St. Louis County, Missouri case management was Madison County

Substance Exposure at Birth
* 3 children tested positive for drugs

Substance Abuse in Family of Origin
* 8 families had evidence of substance abuse

Natural

There were a total of 51 deaths classified natural in manner.

* 11 children died from Sudden Infant Death Syndrome (SIDS)
* 11 children died as a result of complications from premature births (9 of the mothers had histories of drug and/or alcohol abuse)
* 11 children died from progressive illnesses
* 7 children died as a result of respiratory complications or pneumonia
* 5 children died from cardiac disease or complications from heart problems
* 3 children died from complications due to sepsis
* 1 child died as a result of contracting meningitis
* 1 child died from complications of anemia
* 1 child died from dehydration due to gastroenteritis

Ages of Children
* 14 children were under 1 month
* 10 children were 1 to 3 months
* 5 children were 4 to 6 months
* 4 children were 7 to 12 months
* 4 children were 13 to 23 months
* 3 children were 2 years
* 1 child was 3 years

County
* 1 death occurred in Champaign County
* 28 deaths occurred in Cook County
* 2 deaths occurred in DuPage County
* 1 death occurred in Jackson County
* 1 death occurred in Kane County
* 1 death occurred in Kankakee County
* 1 death occurred in Lasalle County

* 1 child was 5 years
* 1 child was 6 years
* 1 child was 9 years
* 1 child was 11 years
* 1 child was 12 years
* 2 children were 13 years
* 1 child was 15 years
* 1 child was 16 years
* 1 child was 19 years

* 1 death occurred in Logan County
* 1 death occurred in Macon County
* 1 death occurred in Madison County
* 1 death occurred in McHenry County
* 6 deaths occurred in Peoria County
* 1 death occurred in Perry County
* 1 death occurred in Pike County
* 1 death occurred in Sangamon County
* 2 deaths occurred in St. Clair County
* 1 death occurred in Vigo, Indiana
  case management was in Edgar County

Substance Exposure at Birth

* 12 children were born substance exposed
  * 8 tested positive for cocaine
  * 2 tested positive for opiates
  * 1 tested positive for polysubstances
  * 1 tested positive –substance unknown

Substance Abuse in Family of Origin

* 23 families had evidence of substance abuse

* 6 babies were not tested, but the mothers admitted use or tested positive for substances

Deaths in Which the Manner of Death Was Ruled Homicide by the Medical Examiner or Coroner's Office

Case# 1 **DOB July 1998** **DOD December 2000**

Age at death: 2 years
Substance exposed: no
Cause of death: multiple trauma injuries due to child abuse, drowning
Perpetrators: Mother and her boyfriend
County: Cook
Narrative: Two-year-old child died of multiple injuries and drowning inflicted by her twenty-two-year-old mentally ill mother and her thirty-two-year-old boyfriend. The child had evidence of old injuries caused by physical and sexual abuse. The mother and her boyfriend were charged with first-degree murder and aggravated battery of a child. A court date is set for February 2003. The mother was indicated by DCFS for death by abuse and substantial risk of physical injury on her two surviving children, ages five months and three years. Prior History: The mother and her six siblings were made wards of the state in 1994 when her mother refused to pick up her up following her discharge from a psychiatric hospital. After she became a mother, the ward was placed in a supervised independent living program, although a therapist had recommended a residential teen-parenting program. The ward's case was closed with DCFS and the juvenile court when she turned twenty-one. She had two children at the time her case was closed, and she gave birth to a third child ten months later. The deceased was killed fifteen months after the ward's case was closed. The mother's prior criminal history consisted of two arrests for domestic battery and criminal trespass to land. The boyfriend had been arrested nine times for crimes involving violence, drugs, and property. The OIG is conducting a full investigation of this child's death. A report to the Director is expected.

Case# 2 **DOB January 2001** **DOD June 2001**

Age at death: 5 months
Substance exposed: no

Cause of death: excessive alcohol poisoning
Perpetrator: Father
County: Cook
Narrative: Five-month-old infant was found unresponsive by his twenty-two-year-old father around 9:00 p.m. Emergency personnel transported the baby to the hospital where he was pronounced dead on arrival. Toxicology results from an autopsy revealed that the baby had a lethal amount of alcohol in his system at the time of his death. The baby's father admitted to putting malt liquor in the child's bottle. The child's seventeen-year-old mother was at work at the time. The father has pleaded guilty to involuntary manslaughter and was sentenced to 5-½ years. He was indicated by DCFS for death by abuse. The parents have no other children. Prior History: The mother became a ward in February 1999 following her mother's death, several hospitalizations for suicidal ideation, and four arrests for juvenile delinquency. At the time of the baby's death, the mother was in an independent living program, residing with her son and, although unauthorized by the agency, her son's father. The mother's family had a long history of substance abuse and domestic violence. The mother experienced domestic violence in her relationship with the baby's father. The independent living agency offered to assist the mother in obtaining restraining orders or participating in domestic violence counseling, but the mother participated minimally. While the father had no prior relationship with DCFS, he was known to the criminal justice system. He had over twenty arrests and seven criminal convictions at the time of the infant's death. The OIG is conducting a full investigation of this child's death. A report to the Director is expected.

Case# 3 **DOB August 1999** **DOD July 2001**
Age at death: 23 months
Substance exposed: yes, cocaine
Cause of death: multiple injuries due to assault
Perpetrator: Mother's girlfriend
County: Cook
Narrative: Twenty-three-month-old child was brought to the hospital in a stroller by his mother's girlfriend. The child was pronounced dead on arrival and he was noted to have bruises on his back and shoulders. The thirty-three year old girlfriend later admitted to causing the child's injuries. The child was being babysat by the girlfriend while her thirty-year-old mother attended job training and substance abuse treatment. The girlfriend was charged with first-degree murder and indicated by DCFS for death by abuse. The girlfriend has three children; one has been adopted and two are in foster care with permanency goals of adoption. The mother does not have any other children. The girlfriend is awaiting trial and the next court date is set for January 2003. Prior History: The mother was a former ward who aged out of the system. As an adult, she was indicated for substance misuse when the baby was born substance-exposed in August 1999. A subsequent report was indicated for substantial risk of physical injury when the baby's mother prematurely dropped out of drug treatment and failed to alert workers to her whereabouts. The baby was taken into protective custody and placed in foster care. The mother participated in services and the baby was returned to her care in August 2000. The girlfriend has a history with DCFS dating to 1990. The girlfriend has been indicated on five reports involving neglect, including giving birth to a substance-exposed infant. Her two children entered foster care in July 1996. A third child, born in March 1999, was allowed to remain in her care, but was placed in foster care following the homicide. The OIG conducted a full investigation of this child's death. A report was sent to the Director on April 29, 2002.

Case# 4 **DOB July 2001** **DOD September 2001**
Age at death: 1-½ months
Substance exposed: no
Cause of death: closed head/neck injury due to blunt force trauma
Perpetrator: father
County: Kane

Narrative: One-and-a-half month old baby died after his thirty-year old father violently shook him causing fatal injures. The father confessed that he had shaken the baby in the middle of the night because he would not stop crying. Both parents were indicated for death by abuse. The father was charged with first degree murder. A pre-trial conference was held in December 2002. Prior History: In July 2001, a month and a half before the death of the baby, relatives called the hotline to report they had observed bruises on the baby's four-year-old sister. The Department investigated and indicated the father for cuts, welts, and bruises and risk of harm. The investigator implemented a safety plan whereby the children and their twenty-six-year-old mother were to live with the children's maternal grandparents, and the father was to have only supervised visits with the children. The case was referred for intact family services. Only a few days after the safety plan was set up, the mother had an argument with her father. She left her parents' home with the children and moved into a shelter. Over the next three weeks the mother and the caseworker met and discussed issues of homelessness and the father's physical abuse. On a Friday, the mother took the baby to the hospital because he was ill. On Saturday, the mother moved out of the shelter into a motel with her daughter and the father. On Sunday, the baby was released from the hospital and went to live in the motel. He died a few days later after he was shaken by his father. The OIG conducted a full investigation of this child's death and a report was sent to the Director on June 26, 2002.

Case# 5 **DOB May 1999** **DOD September 2001**
Age at death: 2 years
Substance exposed: no
Cause of death: massive retroperitoneal hemorrhage, spinal injury
Perpetrator: Mother's boyfriend
County: McDonough
Narrative: Emergency personnel were called after the mother's boyfriend found the child unresponsive. The child was transported to the hospital where she was pronounced dead. The twenty-six-year-old boyfriend confessed to bending the child backwards causing the fatal injuries. In December 2002 he pleaded guilty to first degree murder. He awaits sentencing. He was also indicated by DCFS for death by abuse. The mother was not charged or indicated. Prior History: The family came to the attention of DCFS in February 2001. The deceased and her five-year-old sibling were living with their twenty-four-year-old mother and the sibling's father. The hotline was contacted alleging inadequate supervision of the five-year-old child after he was found alone outside near a busy street. An investigation was conducted and unfounded. In March and April 2001, the child was found by police on two occasions wandering alone outside his home. Both parents were indicated for inadequate supervision and an intact family case was opened to provide services. Following the second investigation, the mother moved in with her boyfriend. He had one arrest in 1993 for battery. The OIG reviewed records in this case.

Case# 6 **DOB April 1981** **DOD September 2001**
Age at death: 20 years
Substance exposed: unknown, mother has a history of substance abuse
Cause of death: gun shot wound to the head and blunt trauma
Perpetrator: Multiple perpetrators
County: Cook
Narrative: Twenty-year-old ward was found dead on the second floor of her ex-boyfriend's apartment after neighbors called the police. The victim was naked, had been beaten, and had a gun shot wound to the head. Neighbors were able to give a description of the alleged perpetrators. Four people have been charged with first degree murder and aggravated battery. The next court date is in January 2003. The ward had been on run from her placement at the time of her murder. Prior History: From September 1990 through August 1991, the family received intact family services after the mother was indicated for cuts, welts, and bruises on the ward and her siblings. In September 1991, after the mother failed to participate in substance abuse services, the children were taken into custody. The ward had numerous

placements including group homes, treatment programs, and facilities for drug treatment, behavioral issues, and vocational training. At the time of her death she had been on run for one month.

Case# 7 **DOB August 2001** **DOD October 2001**
Age at death: 2-½ months
Substance Exposed: no
Cause of death: asphyxia
Perpetrator: Mother
County: Cook
Narrative: The baby suffocated when his seventeen-year-old mother covered his face and head with a stocking cap and tightly wrapped him in four blankets. The next morning her twenty-six-year-old boyfriend found the baby dead and they buried him in an unmarked grave. Several days later the mother showed the grave to the twenty-four-year-old father who eventually called the police. The mother has been charged with first degree murder and concealment of a homicidal death. Her next court date is in January 2003. The boyfriend pleaded guilty to concealment of a homicidal death and has been sentenced to five years. The mother was indicated by DCFS for death by abuse and the boyfriend was indicated for substantial risk of physical injury. Prior History: There was one prior investigation against the mother. It was unfounded. In September 2001 an anonymous caller reported that he saw the mother taking the baby out in the rain. The reporter stated the baby had been born prematurely and was not to be taken outside for six weeks. The investigator spoke to the baby's maternal grandmother with whom the mother lived. The mother and grandmother reported that the only place the mother had taken the baby was to a medical appointment and that she and the baby were driven there. The investigator saw the baby who appeared to be in good health and two neighbors reported that the child was well-cared for by the mother and grandmother. The OIG reviewed records in this case.

Case# 8 **DOB June 1999** **DOD November 2001**
Age at death: 2 years
Substance exposed: no
Cause of death: cerebral edema and cerebellar tonsillar herniation
Perpetrator: Boyfriend
County: Cook County
Narrative: Two-year-old child and his five-year-old sister were left in the care of their twenty-two-year-old mother's thirty-year-old boyfriend while she went to the store. She called 911 when she returned and noticed that her child was not breathing. The child had bruising to his face, head, abdomen, legs, and arms. The boyfriend confessed to pulling the child out of the bathtub and violently shaking him. The boyfriend was charged with first degree murder and is awaiting trial. He also was indicated by DCFS for death by abuse. The mother was indicated for substantial risk of physical injury to her children. Prior History: In April 2001, the Indiana Department of Family Services (DFS) called the Illinois State Central Register to report that several patrons of an Indiana bowling alley witnessed the boyfriend hitting the one-and-a-half-year-old child in the head and pushing his head into a wall. The child was taken for a medical exam, but the doctor found no visible injuries. The DCP investigation against the boyfriend was unfounded for substantial risk of physical injury based on the lack of physical evidence of abuse and the investigator's opinion that the witness statements were not consistent with reported incident. The OIG conducted a full investigation of this child's death. A report was sent to the Director on June 24, 2002. *The investigative report of this child's death is in the Appendix.*

Case# 9 **DOB December 1984** **DOD November 2001**
Age at death: 16 years
Substance exposed: no
Cause of death: gun shot wound to the head
Perpetrator: Stepfather

County: Ogle
Narrative: Police found sixteen-year-old girl face down in a ditch. She had suffered blunt head trauma and a gunshot wound to the head. The teen's mother called police after she was kidnapped and driven around for hours by her estranged husband, the teen's forty-five-year-old stepfather. The stepfather made the mother drive past the ditch and told her he had killed her daughter there. The mother was able to escape and call authorities. The perpetrator is believed to have committed suicide on the bridge of a river. Prior History: The family came to the attention of the Department in October 1999 when the stepfather was indicated for sexually abusing the mother's granddaughter. He moved out of the home following the investigation. The mother allowed him back into her home and the stepfather was indicated in July 2001 for sexually abusing the teen. The mother made him move out and she got an order of protection against him. An intact family services case was opened following the second indicated case. The OIG reviewed records in this case.

Case# 10 **DOB November 1998** **DOD December 2001**
Age at death: 3 years
Substance exposed: no
Cause of death: blunt force injury to head
Perpetrator: Mother's boyfriend
County: Tazewell
Narrative: Three-year-old child was brought to the emergency room unresponsive by her thirty-nine-year-old grandmother who was her legal guardian. The grandmother reported that the child had been in the care of the nineteen-year-old mother's boyfriend. The child suffered head injuries and died the next day. The twenty-three-year-old boyfriend was charged with first degree murder and is awaiting trial. He also was indicated by DCFS for death by abuse. Prior History: The grandmother had two service cases open between January 1988 and March 1992. More recently, in September 1999, the grandmother was indicated for substantial risk of physical injury when the grandmother's boyfriend beat her seventeen-year-old daughter with an extension cord until the grandmother intervened. The beating left cuts and bruises on her arms. The daughter went to live with her biological father. A third service case was opened on the grandmother. It remained open until July 2001. The nineteen-year-old mother's two children entered foster care after the child's death.

Case# 11 **DOB April 1999** **DOD February 2002**
Age at death: 2-½ years
Substance exposed: no
Cause of death: multiple injuries, blunt force trauma, child abuse
Perpetrator: Mother's boyfriend
County: DuPage
Narrative: Two-and-a-half-year-old child was brought to the hospital after being found unresponsive by his eighteen-year-old mother when she returned home from work. The child was bruised and had head injuries. He died three days later. The mother's twenty-two-year-old boyfriend had been caring for the child while the mother was at work. He was charged with first degree murder and is awaiting trial. He also was indicated by DCFS for death by abuse. The mother was indicated for substantial risk of physical injury to her children. Prior History: The mother was a subject of an intact family services case as a child. In August 1999 the mother was indicated for inadequate supervision of the deceased. No service case was opened because the mother agreed to leave the baby with the maternal grandparents. The mother and her boyfriend had one child together, a six-week-old baby that was taken into custody after the child's death. She remains in foster care. The OIG reviewed records in this case.

Case# 12 **DOB October 2001** **DOD February 2002**
Age at death: 4-½ months
Substance exposed: no

Cause of death: asphyxia, gagging
Perpetrator: Father
County: Cook
Narrative: Four-and-a-half-month-old baby was killed by her forty-year-old father who stuffed a wash cloth into her mouth to stop her crying. The infant's twenty-nine-year-old mother left the baby in the care of the father while she attended an appointment with the Department of Rehabilitative Services. An autopsy revealed prior injuries, including nine rib fractures. The father was charged with first-degree murder. His next court date is in February 2003. He also was indicated for death by abuse. The mother was not charged or indicated. Prior History: The infant's mother had a prior open DCFS case with regard to another child from 1992 to 1998. That child was adopted by his maternal great-grandmother in 1997. Two months prior to this infant's death, a hotline report was made alleging burns by abuse to the infant by her father. The parents reported that while the father was bathing the child, he accidentally knocked the hot water faucet on and the baby was burned by the hot water. The report was unfounded based on the treating doctor's opinion that the parents' history was consistent with the injury, indicating that the burns were likely accidental. The Department had no further contact with the family until the child's death. The OIG is conducting a full investigation of this child's death.

Case# 13 DOB July 1981 DOD March 2002
Age at death: 20 years
Substance exposed: unknown, mother had a history of substance abuse
Cause of death: multiple stab wounds
Perpetrator: Peer (alleged)
County: Cook
Narrative: A twenty-year-old ward was found stabbed to death in her apartment. She had been stabbed by a seventeen-year-old ward who was in the same independent living program and lived in the same apartment complex. A month prior, the seventeen-year-old had been involved in a domestic violence incident, and the twenty-year-old reported the altercation to the police. The seventeen-year-old was arrested and spent one month in jail. Upon her release from jail, agency staff mistakenly gave the seventeen-year-old keys to the twenty-year-old's apartment. Agency staff contacted the twenty-year-old to notify her of the mistake. The following morning, an agency worker saw the seventeen-year-old leave the complex wearing a jacket belonging to the twenty-year-old. The body of the twenty-year-old was discovered later that day and the seventeen-year-old was arrested for the murder. The seventeen-year-old was initially deemed not fit to stand trial and was ordered into treatment. In December 2002 she was found competent to stand trial for home invasion and first degree murder. She also has been charged with attempted murder for an assault that took place before the murder. Her next court date is in January 2003. Prior History: The twenty-year-old first came to the attention of DCFS at age five when her mother was indicated for inadequate supervision of four children. In December 1986, she and three siblings, ages five, four and eight months, entered foster care when their mother was incarcerated and left the children without a care plan. The children remained in DCFS custody and had numerous foster care and residential placements and psychiatric hospitalizations. The two older siblings also spent time in the Department of Corrections. The twenty-year-old lived in a residential setting between the ages of eight and thirteen, but was not in any subsequent placement for longer than five months. At the time of her death she had been in independent living for almost a year. The OIG is conducting a full investigation of this child's death. A report to the Director is expected.

Case# 14 DOB July 2000 DOD March 2002
Age at death: 1-½ years
Substance exposed: no, but the mother has a history of substance abuse
Cause of death: multiple injuries due to blunt force trauma
Perpetrator: Older sister's boyfriend
County: Cook

Narrative: One-and-a-half-year-old child was found unresponsive by his seventeen-year-old sister who alerted their grandmother. The grandmother took the baby to a fire station across the street and the child was transported to the hospital where he was pronounced dead on arrival. The boyfriend of the seventeen-year-old sister confessed to punching and hitting the child causing the injuries that led to his death. The seventeen-year-old boyfriend was charged with first degree murder and aggravated battery of a child. Pre-trial conferences began in December 2002. The boyfriend also was indicated by DCFS for death by abuse. Prior History: The mother has an extensive history with DCFS dating from 1989. She was indicated for child abuse and neglect six times and has given birth to three substance-exposed infants. In September 1991 an infant died because of dehydration, and she was indicated for medical neglect and inadequate supervision. In 1995 she was indicated for risk of harm when she gave birth to a child while incarcerated. The mother never cared for any of her children and allowed them to live with her mother. In August 1994, the children were formally placed by DCFS in the custody of their maternal grandmother. In August 1998 because of the grandmother's drug use, the children were removed from their grandmother's home and placed in a different foster home. Three of the siblings have been adopted by the foster parent. In July 2000, the seventeen-year-old went to a residential placement. In January 2002, she and her boyfriend, whom she met at the placement, went on run. They were living with the maternal grandmother when the boyfriend killed the child. The OIG conducted a full investigation of this child's death. A report was sent to the Director on December 9, 2002.

Case# 15 **DOB February 1996** **DOD March 2002**
Age at death: 6 years
Substance exposed: no
Cause of death: craniocerebral trauma
Perpetrator: Stepmother
County: Polk, Iowa
Narrative: Six-year-old ward died after being beaten by his twenty-seven-year-old stepmother. He had been placed with his father and stepmother in Iowa in November 2001. His stepmother was found guilty of first degree murder and is awaiting sentencing. Prior History: In December 1997 the child's father and stepmother, who were caring for him over the weekend, observed marks and took him to the hospital where he experienced bloody diarrhea, dehydration, and lethargy for four days. He had a mark on his buttocks consistent with an adult bite mark and various lesions on his face, hands, and back. Both biological parents were indicated for cuts, welts, and bruises, as the investigator was unable to determine who had abused the child, and there were concerns that there was a delay in care. The Department placed the child with his aunt and uncle while the father pursued a return home goal by participating in services with his wife. During one visit, the child had marks on his face that resembled tile marks after the stepmother took him to the bathroom. Her story of him falling did not seem consistent with the marks. Because of the child's developmental delays, he was referred to a diagnostic placement in October 2000. The father and stepmother moved to Iowa and the Department asked Iowa to complete a home study. Two home study reports were favorable and the child joined his father, stepmother, and three half-siblings in Iowa. The child welfare agency was supposed to monitor the home. Shortly after his arrival, the stepmother reported that the child was experiencing behavior problems. She later reported that things were fine. Five days prior to the child's death, he was taken to the hospital with a cut on his head from an alleged fall down the stairs. The child's guardian ad litem visited the family following this incident and reported no concerns. The OIG reviewed records in this case.

Case# 16 **DOB January 1988** **DOD April 2002**
Age at death: 14 years
Substance exposed: no
Cause of death: gunshot wound to head
Perpetrator: Father
County: DuPage

Narrative: Fourteen-year-old child was a victim of a gunshot wound by his father. In April 2002, the forty-three-year-old father stayed overnight at the family home. In the early morning hours, the father shot three of his children, killing one and injuring the other two, before turning the gun on himself and ending his own life. A younger child, who was not the biological child of the father, was unharmed.
Prior History: The family has been known to DCFS since 1986. There were at least five separate times that the family was referred for intact family services or child welfare services. At the time of the death, the family had an open intact family case since April 1999. The parents were divorced, but the father continued to be very involved with his children. There have been at least twenty-four child protection investigations of the family, with eight indicated reports for cuts, welts, bruises, risk of physical harm, and lack of supervision. Both parents were undergoing treatment for chronic depression and both had long histories of substance abuse. In addition, the forty-three-year-old mother had serious physical and mental health issues. The family was receiving in-home treatment services for the children because of behavior and mental health issues. At the present time the nineteen-year old lives at home with her mother and the two youngest children, ages thirteen and six years are in a foster home placement. A sixteen-year-old minor was in placement at the time of the deaths, having been placed out of the home through juvenile delinquency court. The sixteen-year-old was living in a foster home when he hanged himself in the backyard of his foster home during the night in October 2002. The OIG is conducting a full investigation of this case. A report to the Director is expected.

Deaths in Which the Manner of Death Was Ruled Suicide by the Medical Examiner or Coroner's Office

Case # 17 **DOB October 1983** **DOD September 2001**
Age at death: 17 years
Substance exposed: unknown, mother had history of substance use
Cause of death: hanging
County: Kankakee
Narrative: Seventeen-year-old ward committed suicide by hanging within 24 hours of being detained in a county jail for obstructing justice, obstructing police, and consumption of alcohol by a minor. The ward had been on run for two weeks from his supervised independent living program. The county sheriff's police investigated his death. On the evening of his death, the ward was reportedly acting normally and requested a pair of socks. Twenty minutes later during a check, he was found hanging by a bed sheet from the bunk bed. He left a brief suicide note, but did not express his reason for committing suicide.
Prior History: This child first came to the attention of DCFS in 1985, at the age of two, when he and two of his siblings were removed from their mother because of inadequate supervision. He and his siblings were removed from their mother's care on three separate occasions. By 1992, when this child was eight years old, he had experienced more than thirteen moves, including eleven placements and two hospitalizations to deal with his behavior. His mother had been a DCFS ward and has an extensive history of drug and alcohol abuse as well as criminal activity. In 1990, the mother moved to another state and has had limited contact with her children. The deceased had an extensive history with the juvenile justice system. He had no history of suicidal or homicidal ideations. He had one known episode of depression for which he received medication. At the time he entered supervised independent living, he did not appear depressed and was not on medication. He was enrolled in a community college. The OIG reviewed records in this case.

Case # 18 **DOB October 1983** **DOD October 2001**
Cause: hanging
Age at Death: 17 years
Substance Exposed: unknown, mother had a history of substance use
County: St. Genevieve County, Missouri (death), St Clair (case management)

Narrative: Seventeen-year-old ward committed suicide by hanging while incarcerated in a neighboring state. The ward had been on run from his placement since October 2000. He had been staying with family members in the neighboring state when he was arrested for stealing a gun. He was in jail awaiting trial. He had been taking medication for depression while in jail. Prior History: An intact family case was opened in March 1993 when the child was injured when his then fifty-year-old father and thirty-two-year-old mother whipped him with a belt. In July 1994, the child and his sister were taken into custody after his mother left marks on his face. The parents participated minimally in services. His father has been in prison. His mother was murdered in February 1999. In 1998, the ward was given a permanency goal of independence and his sibling was adopted that same year. The teenager had a substance abuse problem and a history of chronic runaway behavior. He suffered from recurrent depression, including suicidal thoughts and gestures, and he had been hospitalized for suicide attempts and treated with antidepressants. The ward had multiple placements and spent time in juvenile detention. The Department of Corrections placed the teen in a transitional living center in May 2000 where the ward remained until going on run in October 2000. The ward left a suicide note expressing grief over the death of his mother and the loss of contact with his father, his sister and his girlfriend, stating he did not feel there was a reason to live anymore. DCFS workers took proactive steps to locate the ward after he went on run, including contacting the police, the Center for Missing and Exploited Children, and family members. The OIG reviewed records in this case.

Case # 19 **DOB February 1989** **DOD November 2001**
Age at death: 12 years
Substance exposed: no
Cause of death: hanging
County: Cook
Narrative: Twelve-year-old ward committed suicide by hanging. He was found at home by his mother. The child had been diagnosed with major depression and was prescribed antidepressants. Prior History: The forty-four-year-old mother had one prior child protection investigation in May 2001 for mental and emotional impairment by neglect. The minor had been hospitalized for four days at a psychiatric facility for anger outbursts and destructive behavior at home. Toward the end of his hospitalization, a social worker called the State Central Register to report that the child's behavior had been caused by the mother telling the child she was leaving him to go out of state and that she had lupus and wanted to die to get away from him. During the investigation, the mother reported that she told her child she could die from the disease and that she wanted to go out of state because she felt stressed at home. Her son became angry and began destroying things in the house while she was at work. She also said that her son had gone camping the weekend prior to his hospitalization and had not taken his medication. The child and his older sibling corroborated their mother's story. A therapist confirmed that he was participating in counseling, and the case was unfounded. The OIG reviewed records in this case.

Case # 20 **DOB July 1987** **DOD February 2002**
Age at death: 14 years
Substance exposed: no
Cause of death: hanging
County: Cook
Narrative: Fourteen-year-old ward committed suicide by hanging herself from a sprinkler head in the bathroom of the residential facility where she lived. She had experienced major losses and separations and was under treatment for depression. Prior History: The child was removed from the care of her biological family when she was under a month old. She and her brother were placed in the same foster home. In 1990, the foster family moved to a small town in a neighboring state and shortly thereafter adopted the two children. In 1997, the father was involved in an accident and died of complications from surgery. In 1999, a grandmother who lived with the family died, and in 2000 the mother died of cardiac

problems. Child welfare officials in the neighboring state sent the girl and her brother to live in Illinois with a biological grandmother. The girl and her brother both experienced difficulties with the placement. In 2000, the grandmother was injured during a scuffle with the girl, and she decided she could no longer care for her. A dependency petition was filed and the girl was placed in DCFS custody. The girl struggled with anger and depression. She was hospitalized in late 2001 for suicidal ideation. Although she consistently denied thoughts of suicide, she was monitored for suicide. On the night in February 2002, while showering, she hanged herself from a sprinkler head. She died the following morning at the hospital. Her brother lives with a family in the neighboring state under private guardianship. The OIG conducted a full investigation. A report was sent to the Director on June 20 2002.

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 in manner 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 and natural. Thus, there is a certain degree of suspicion attached to undetermined causes and manners.

Case # 21 **DOB August 2001** **DOD October 2001**
Age at death: 2 months
Substance exposed: yes, cocaine
Cause of death: undetermined
County: Cook
Narrative: Two-month-old infant was found unresponsive on the floor next to a sofa by his thirty-seven-year-old father. The thirty-five-year-old mother said she had left him on the sofa sleeping an hour earlier. The father called 911 and the infant was transported to the hospital where he was pronounced dead. The baby's body was in an advanced state of rigor mortis. Prior history: This family came to the attention of DCFS when the deceased was born substance-exposed. The mother was indicated for substance misuse and an intact family case was opened. The father reportedly did not know his wife was using drugs. The deceased was an only child and the parents have separated since his death. The OIG reviewed records in this case.

Case # 22 **DOB October 2001** **DOD October 2001**
Age at death: 0
Substance exposed: yes, cocaine
Cause of death: intrauterine asphyxia due to cocaine intoxication due to maternal cocaine use
County: DuPage
Narrative: Baby of 28-29 weeks gestation was partially delivered by mother at home. Paramedics finished the delivery and instituted life-saving measures, but the baby was pronounced dead at the hospital. Prior History: The family came to the attention of DCFS in November 1997 when two children entered foster care because of parental neglect. A third child entered foster care in April 2000 at the age of six months after his twenty-eight-year-old mother and thirty-six-year-old father were indicated on three reports of substantial risk of physical injury to him. The older children were adopted in May 2000. The youngest child is in foster care and has a permanency goal of adoption.

Case # 23 **DOB August 2001** **DOD November 2001**
Age at death: 3 months
Substance exposed: no

Cause of death: undetermined
County: Cook
Narrative: Three-month-old was found unresponsive face down on an adult bed by her eighteen-year-old uncle. The eighteen-year-old mother left the three-month-old baby and her seventeen-month-old toddler in the care of their father and uncle. The twenty-one-year-old father left the children in their uncle's care while he went grocery shopping. The uncle laid the baby down for a nap on her stomach on a soft pillow on a bed. When he checked on her later, she was unresponsive. Prior History: The father was a ward whose case had been closed in August 2001. His brother was a ward whose permanency goal was independence. Their family came to the attention of DCFS in August 1987 when an intact family case was opened for abuse. The case was closed in September 1988. The brothers, along with five siblings, entered foster care in August 1993. None of the children returned home. Three of the siblings have aged out of the system. Two have permanency goals of independence. One lives with his father, and one has a goal of guardianship.

Case # 24 **DOB December 1998** **DOD January 2002**
Age at death: 3 years
Substance exposed: no
Cause of death: undetermined
County: Cook
Narrative: Three-year-old child was found unresponsive by his paternal grandmother with whom he was living. Attempts by paramedics to resuscitate him were unsuccessful. He was transported to the hospital where he was pronounced dead. The child was medically complex; he suffered from seizure disorder, cerebral palsy, severe brain damage, spasticity, reflux, asthma, and blindness. Prior History: This family came to the attention of the Department in April 1997 when the twenty-four-year-old mother was indicated for cuts, welts, and bruises and substantial risk of physical injury after her daughter arrived at school with a bruise to her right eye because of bad school papers. An intact family case was open from April 1997 to November 1997. In August 2001 the mother was indicated for the deceased's failure to thrive because she was not following through on the child's medical appointments. Instead of taking the child into protective custody, the Department allowed the mother to make an informal agreement with the paternal grandmother to care for the child and an intact family case was opened. The OIG conducted a full investigation of this child's death. A report was sent to the Director on June 12, 2002.

Case # 25 **DOB January 2002** **DOD January 2002**
Age at death: 9 days
Substance exposed: no, but parents had a history of drug use
Cause of death: undetermined
County: Sangamon
Narrative: Nine-day-old infant was found unresponsive by her maternal aunt who was caring for her. She was brought to the hospital where she was pronounced dead. Prior History: This family came to the attention of the Department in May 1999 when the parents were arrested in a drug raid. The parents were indicated for substantial risk of physical injury. In April 2001, three children were taken into protective custody following a domestic dispute in which the youngest child was injured. The mother and her boyfriend were indicated for substantial risk of physical injury on the three children. The two older children were returned to the mother's care in May 2001. The youngest remains in foster care. She has a permanency goal of return home.

Case # 26 **DOB October 2001** **DOD January 2002**
Age at death: 3 months
Substance exposed: no
Cause of death: undetermined
County: McLean

Narrative: Three-month-old baby was found unresponsive and upside down in his car seat. His twenty-two-year-old father was the last to see him and he was sleeping on an ottoman. In the morning his twenty-three-year-old mother found him face down in his car seat on top of a snow suit that had been laid out the night before. This was the second child to die in this family; the mother's sister had a child die in March 1999. Prior History: The mother was indicated in December 1997 for burns by neglect when her six-month-old daughter was brought to the emergency room with second degree burns. The mother left the baby unattended in a sink and the hot water was turned on by a two-year-old sibling. An intact family case was open from January 1998 to July 1999. In May 2001 an investigation was unfounded for medical neglect. There are three surviving siblings who remain at home. The OIG reviewed records in this case.

Case# 27 **DOB December 2001** **DOD March 2002**
Age at death: 2 months
Substance exposed: no
Cause of death: undetermined
County: Cook
Narrative: Two-month-old baby was found unresponsive face down in her crib by her thirty-year-old father. She was transported by ambulance to the hospital where she was pronounced dead. Prior History: The twenty-eight-year-old mother has an extensive history with the Department. She was a ward from February 1978 until she aged out of the system in April 1994. In September 1996 her two children entered foster care following an indicated report of physical abuse. Both children are placed with a maternal aunt and their permanency goal is subsidized guardianship. The mother did not comply with services. She has not maintained contact with her family, children, or caseworker, and her caseworker did not know the mother had another baby.

Case # 28 **DOB April 1999** **DOD April 2002**
Age at death: 3 years
Substance exposed: yes, cocaine
Cause: smoke inhalation due to house fire
County: St. Clair
Narrative: Three-year-old died in a house fire. He and a five-year-old sibling were at home with their thirty-one-year-old mother. The mother allowed the five-year-old to play outside while she and the three-year-old laid down for a nap. The three-year-old was found under a pile of clothing. Law enforcement is still investigating the circumstances of this child's death. Prior History: This family came to the attention of the Department in October 1995 when mother gave birth to a substance-exposed infant. An intact family case was opened. A second report was indicated also in October 1995 when the mother took her three-year-old daughter to the hospital after she complained of vaginal pain and it was discovered that she had gonorrhea. The perpetrator was unknown. The intact family case was closed in June 1997. Six months later, in December 1997, the mother was indicated for inadequate supervision after the hotline was contacted alleging the mother left her two-year-old and eleven-month-old in the car while she went into a mall to shop. The case was not reopened at that time. In April 1999 the mother gave birth to the deceased, her second substance-exposed infant. The intact family case was reopened and was open at the time of the fire. The OIG is conducting a full investigation of this case.

Case# 29 **DOB May 2002** **DOD May 2002**
Age at death: 0
Substance exposed: yes, cocaine
Cause: intrauterine hypoxia due to maternal cocaine use
County: Winnebago
Narrative: Thirty-seven-year-old mother presented at the hospital with an abruptio placentae. A c-section was performed to deliver the baby, but she was stillborn. The baby never took a breath. Both the mother and the baby tested positive for cocaine. Prior History: This family came to the attention of the

Department in August 1998 after mother gave birth to a substance-exposed infant. The mother was indicated for substance misuse and the family was referred to community resources to secure drug treatment and housing. In April 1999 DCFS was contacted a second time with allegations of medical neglect because the parents were not keeping clinic appointments for the substance-exposed infant who was discharged from the hospital on an apnea monitor. An intact family case was opened. While it was open, the mother gave birth to her second substance-exposed infant in December 1999. Protective custody was taken of the two children and they were placed in relative foster care. The parents participated in services and the children were returned home in June 2001. Their cases with DCFS and the juvenile court were closed in January 2002.The OIG reviewed records in this case.

Deaths in Which the Manner of Death Was Ruled Accident by the Medical Examiner or Coroner's Office

Case# 30 **DOB May 2000** **DOD July 2001**
Age at death: 14 months
Substance exposed: yes, cocaine and opiates
Cause of death: drowning
County: Cook
Narrative: Fourteen-month-old toddler was found with his head in a bucket of water at his fifty-five-year-old maternal grandmother's house. He was pronounced dead on arrival at the hospital. The child and his five siblings were in relative foster care with their grandmother at the time of the incident. DCFS investigated the grandmother for an allegation of death by neglect. It was unfounded, but because of environmental hazards in the home the surviving children were moved to two different relative caregivers. Prior History: The family came to the attention of DCFS in June 1993 when the mother gave birth to her second child. The infant tested positive for cocaine and the mother was indicated for substance misuse. In June 1994, the mother gave birth to her third child and was indicated a second time for substance misuse as this baby was also born substance- exposed. An intact family case was opened for services. The children entered foster care in August 1996 following three more indicated reports against the mother, one of which involved giving birth to a third substance-exposed infant. In August 1999, the children were returned to the care of their mother. In June 2000, the deceased was born substance-exposed and he and his siblings re-entered foster care. They were placed with their maternal grandmother where they remained until their removal in December 2001. The court is seeking termination of parental rights on the five remaining children. The OIG reviewed records in this case.

Case# 31 **DOB April 2000** **DOD August 2001**
Age at death: 15 months
Substance exposed: yes, opiates
Cause of death: smoke inhalation
County: Cook
Narrative: This baby and his twenty-nine-year-old mother died from injuries sustained after a fire broke out in their apartment. It is believed that the mother was sleeping while two of her children played with matches. The mother tested negative for drugs and alcohol at autopsy. Three of the mother's six children were living with her at the time of the fire. All five surviving children live with relatives. Prior History: The mother had been indicated three times by the Department for substance misuse. The first time was in 1995 when her newborn tested positive for opiates. The Department opened an intact family case, but the mother did not engage in services until after she gave birth to a second substance-exposed infant in September 1997. The mother entered a methadone treatment program, and in June 1998 the Department closed the family's case. The case was re-opened in June 2000 after the deceased child was born substance exposed. Initially the mother could not be located. A second worker was assigned and closed the case in June 2001 after the mother told her she successfully completed methadone treatment. This

child and his mother died two months later. The OIG is conducting a full investigation of this child's death. A report to the Director is expected.

Case# 32 **DOB June 2001** **DOD August 2001**
Age at death: 1 month
Substance exposed: yes, cocaine
Cause of death: asphyxia due to overlay
County: Cook
Narrative: One-month-old infant was found unresponsive by his maternal great grandmother while napping on the sofa with his nineteen-year-old mother. The paramedics were called and the infant was pronounced dead at the hospital. The mother was indicated for death by neglect. Prior History: The family came to the attention of DCFS in June 2001 when the deceased was born substance-exposed and the mother was indicated for substance misuse. DCFS opened an intact family case. The maternal great grandmother, with whom the mother and baby lived, planned on securing private guardianship of the infant with the agreement of the infant's mother and father. The mother's surviving child is in the private guardianship of the maternal great grandmother. The OIG reviewed records in this case.

Case# 33 **DOB January 2000** **DOD October 2001**
Age at death: 21 months
Substance exposed: no
Cause of death: Carbon dioxide intoxication, inhalation of smoke and soot due to apartment fire
County: Cook
Narrative: Twenty-one month-old child died in an apartment fire. His eighteen-year-old mother left him in the house alone while she went outside to talk to the twenty-year-old father. The father and a neighbor discovered the fire in progress and attempted to save the child, but were unable to locate him. Fire officials believe the child started the fire by playing with matches and/or a nearby space heater because of burns on his hands and clothing. The mother was indicated for death by neglect. Her other child, a three-year-old daughter, was in day care at the time of the fire and was subsequently removed from her mother's care. Prior History: The mother was indicated for inadequate supervision in March 2000. The mother, a ward of DCFS, ran from her residential center placement, without making a care plan for her children. The mother returned to the facility, but ran away again, going to her grandmother's house shortly before the deadly fire. The mother took her children with her to live at her grandmother's house. The mother has been a DCFS ward since April 1988. The mother is currently in an independent living program. The father was a ward as a child, but has had no open case with DCFS since January 1987. The mother's daughter remains in foster care, and the mother is engaged in services. The daughter's father is in the military and is stationed overseas. The OIG is conducting a full investigation on this child's death.

Case# 34 **DOB September 2001** **DOD December 2001**
Age at death: 2 ½ months
Substance exposed: no
Cause of death: asphyxia due to overlay
County: Cook
Narrative: Two and-a half month-old infant was sleeping in bed with his nineteen-year-old mother and two-year-old sister. They were visiting the paternal grandmother. The grandmother arrived home from work and found the mother asleep and the baby unresponsive. The paramedics were called and the baby was transported to the hospital where he was pronounced dead. Prior History: The mother has been a ward of DCFS since 1993. She had her first child in 1999 when she was sixteen years old. The deceased was her second child. The mother lived with her children in a foster home. She reported that she kept both her children in bed with her when they slept because she was afraid of crib death. The mother gave birth to her third child in September 2002. The OIG reviewed records in this case.

Case# 35 **DOB December 2000** **DOD January 2002**
Age at death: 1 year
Substance exposed: no, although there was evidence of substance abuse in the family
Cause of death: mechanical asphyxia due to neck compression, hanging
County: Clinton
Narrative: One-year-old child was taken to the hospital after her relative foster parent found her unresponsive with a pacifier ribbon wrapped around her neck. The child died two days later. It is believed that the ribbon that held the child's pacifier around her neck got caught on a crib rail, causing the ribbon to tighten around her neck. Prior History: The family came to the attention of DCFS in May 1998 when the thirty-one-year-old mother left her children, then ages one month, one year, and two years, in a car with the windows down and doors unlocked. The mother was indicated for inadequate supervision and the children were placed in the care of their maternal grandmother by private arrangement. In March 2000, the mother was indicated for medical neglect because her children had not received their immunizations. An intact family services case was opened. The case was closed in August 2000 after the family moved to another state. In October 2001, the Department investigated allegations of environmental neglect and substantial risk of physical injury because of domestic violence between the mother and her boyfriend. They were indicated and a case was opened for intact family services. The children entered foster care in December 2001 after a hotline report that the boyfriend had struck one of the children with a belt, leaving a bruise. The children underwent medical exams and the deceased was found to have a fractured tibia. The two siblings remain in foster care. The OIG is conducting a full investigation of this child's death.

Case# 36 **DOB August 1995** **DOD January 2002**
Age at death: 6 years
Substance exposed: no, but the mother has a history of alcohol abuse
Cause of death: multiple injuries due to automobile striking pedestrian
County: Cook
Narrative: Six-year-old child was pronounced dead at the hospital after being hit by a car while attempting to cross a busy street with his eleven-year-old brother on a Saturday afternoon. Police conducted an investigation and witnesses to the accident reported that neither child looked before darting across the street. Neither parent was present at the time of the accident. Prior History: This family came to the attention of DCFS in October 2001 when a report was unfounded for substantial risk of physical injury to the eleven-year-old after the child said he attempted to intervene in a fight between the thirty-five-year-old mother and thirty-six-year-old father. At the time of the death, there was a pending investigation for medical neglect because of the six year old's tooth decay. The allegation was in the process of being unfounded. The mother took the child to the dentist who reported the child had "bottle rot" on his upper front baby teeth and that the situation did not constitute a serious or long-term harm to the child. There are three surviving children who are residing with their parents at this time. The OIG reviewed records in this case.

Case# 37 **DOB March 1988** **DOD January 2002**
Age at death: 13 years
Substance exposed: no
Cause of death: drowning
County: St. Claire
Narrative: Thirteen-year-old nearly drowned in a hotel swimming pool and died nine days later. He and his seventeen-year-old brother were attending a family party at the hotel. Their mother left them at the hotel with family members. Prior History: The family came to the attention of DCFS in May 1994 when an intact family case was opened. The case was closed in August 1997. The child protection investigation report(s) leading to the case opening were expunged from DCFS records because of their age. In September and October of 2000 two calls were made to the hotline alleging that the twenty-

seven-year-old mother of five children, ages seven to thirteen, provided inadequate supervision and inadequate housing. The inadequate supervision allegation was unfounded and the inadequate housing allegation was indicated. A second intact family case was opened. It was closed in September 2001 when the family could not be located. The OIG reviewed records in this case.

Case# 38 **DOB October 1995** **DOD February 2002**
Case# 39 **DOB January 1998** **DOD February 2002**
Ages at death: 6 years, 4 years
Substance exposed: no
Cause of death: inhalation of products of combustion (house fire)
County: Peoria
Narrative: Siblings, ages four and six years, were unable to escape a house fire started when the four year old's twin brother played with a cigarette lighter. The child had a history of playing with fire. The parents and five siblings escaped the fire. The surviving siblings were taken into DCFS custody following the fire. The parents were indicated for death by neglect on the deceased children and inadequate supervision and substantial risk of physical injury on the surviving children. Prior History: The twenty-five-year-old mother and twenty-eight-year-old father had seven biological children ranging in age from four to nine years. The family came to the attention of the Department in September 2001 after the school reported that the five-and-a-half-year-old came to school with marks on her face. The case was indicated for substantial risk of physical injury and an intact family case was opened. The intact family worker addressed obvious safety issues such as the children's access to dangerous items and the children's educational needs after the mother decided to home school the children. The parents were not interested in participating in services and refused to agree to stop physically disciplining their children. In December 2001, the parents were indicated for inadequate supervision after an incident in which the then three-year-old twins turned the stove on and burned the contents of a pan while their mother was sleeping. At the time of the children's death, the worker was in the process of filing a petition for court involvement. The OIG conducted a records review in this case.

Case# 40 **DOB April 1985** **DOD March 2002**
Age at death: 16 years
Substance exposed: no, but there was evidence of substance abuse in the family
Cause of death: Carbon dioxide intoxication, inhalation of smoke/soot due to apartment fire
County: Cook
Narrative: Sixteen-year-old and her eight-month-old daughter died in an apartment fire. They were sleeping at her mother's home. The mother was sleeping on the couch and the teenager and her daughter were sleeping in a bedroom with the door locked. The mother heard screaming and saw smoke, but was unable to get to the girls because the door was locked. The teenager may have started the fire by smoking in bed. Prior History: This family had been involved with DCFS sporadically since 1988. The mother of the teen has nine children and has been indicated on several reports involving neglect, including two reports of substance misuse when she gave birth to substance-exposed infants. The case was last opened in April 1999 after the mother was indicated on a report of substantial risk of physical injury to the three children living with her. These children entered foster care at that time. The six other children, including the deceased, were living with relatives. The children in foster care have permanency goals of adoption.

Case# 41 **DOB December 2001** **DOD March 2002**
Age at death: 3 months
Substance exposed: no, however, mother has a history of drug use
Cause of death: asphyxia, trapping
County: Cook
Narrative: Three-month-old infant was in the care of his twenty-four-year-old father. The infant was given a bottle at approximately 6:30 p.m. and put on his stomach to sleep on the couch. When the father

checked on the baby at 3:00 a.m., he was unresponsive. The twenty-four-year-old mother was not home at the time. Prior History: An intact family case was opened in February 2000 after the mother gave birth to a substance-exposed infant. The case was closed in September 2001 when the family moved to Indiana. The intact family case was re-opened for three months following the child's death. There are three surviving children. The OIG reviewed records in this case.

Case# 42 DOB August 1999 DOD April 2002
Age at death: 2 ½ years
Substance exposed: no
Cause of death: surface burns and smoke inhalation injuries
County: St. Louis, Missouri (Death), Madison (Case Management)
Narrative: Two-year-old child died in a fire set by her four-year-old sibling playing with matches or a lighter. The four-year-old was playing under the couch where his thirty-nine-year-old mother was resting. The two-year-old was sleeping in another room. When the mother got up off the couch, it lit up. The mother succeeded in getting the four-year-old out of the home, but was unable to reach the two-year-old because of the intense heat and smoke. Prior History: This family came to the attention of DCFS in May 2000 when the deceased's sibling, then two-and-a-half years old, was found playing in the street unsupervised. The mother was indicated for inadequate supervision and an intact family case was opened from July 2000 until May 2001 during which time the mother was encouraged to safety proof her home and to contact the landlord to install child-proof locks on the doors. The OIG reviewed records in this case.

Case# 43 DOB April 1998 DOD April 2002
Age at death: 3-1/2 years
Substance exposed: no, however, mother has a history of substance use
Cause of death: multiple injuries due to automobile accident
County: Cook
Narrative: Three-and-a-half-year-old died from injuries sustained in a car accident. The child was in a car with his forty-three-year-old maternal grandmother who was his foster parent. The grandmother turned left and was broad sided. The child was wearing his seat belt, but was not in a booster seat. Prior History: The family came to the attention of DCFS in November 1992 when the then eighteen-year-old mother gave birth to a substance-exposed infant. The mother never cared for this child. The mother's two other children, ages two and three, entered foster care in April 1993 when the daughter tested positive for a sexually transmitted disease. The children were returned home in April 1994. The two children reentered foster care in January 1995 after an indicated report of inadequate supervision. The maternal grandmother adopted the children in July 1999. The deceased was also to be adopted by the grandmother.

Case# 44 DOB May 2001 DOD May 2002
Case# 45 DOB September 1999 DOD May 2002
Case# 46 DOB July 1998 DOD May 2002
Ages at death: 1year, 2 ½ years, and 3 ½ years
Substance exposed: no
Cause of death: carbon monoxide intoxication due to inhalation of smoke/soot
County: Lake
Narrative: Three siblings and their twenty-four-year-old mother perished in a second floor apartment fire. A fourth sibling, age six, managed to escape from the fire. The father of the three deceased children was at work at the time of the fire. It is unknown how the fire was started. Prior History: As a child the mother was a victim of sexual abuse by her mother's boyfriend and a perpetrator of sexual abuse to a younger sibling. In June 2001, two reports were called into the hotline against her as a mother. One report alleged that the mother left her four children, then ages one month, two, three and five years, alone, and the children had access to knives and other safety hazards. The mother was indicated for inadequate

supervision and substantial risk of physical injury to her children. She also was criminally charged with child endangerment. The second report was made by a hospital after the mother missed appointments for the then one-month-old baby. She was indicated for medical neglect. An intact family case was opened and the mother was participating in services at the time of the fire. The surviving child is with the grandmother who obtained guardianship through probate court. The OIG is conducting a full investigation of these children's deaths.

Deaths in Which the Manner of Death Was Ruled Natural
by the Medical Examiner or Coroner's Office or the Treating Hospital

Case# 47 **DOB July 2001** **DOD July 2001**
Age at death: 0
Substance exposed: not tested, but mother tested positive for cocaine
Cause of death: prematurity
County: Cook
Narrative: The baby, who was born at 20 weeks gestation to a thirty-two-year-old mother, died thirty-five minutes after his birth. The mother tested positive for cocaine, but the baby was not tested. The mother had not received any prenatal care. Prior History: The family came to the attention of the Department in February 1998 when the mother was indicated for environmental neglect, medical neglect and inadequate shelter on her one-year-old daughter. An intact family case was opened. In April 1998, the mother gave birth to a substance-exposed infant. In August 2000 the family's case was closed because DCFS was unable to locate them. The case was reopened in December 2000 when the mother gave birth to a second substance-exposed infant. The baby was taken into custody and placed with a relative. The two older children remained in the care of their mother. After the baby's death, the mother was indicated for substantial risk of physical injury on the two children in her care. In December 2001, the children were taken into custody and the mother was indicated for inadequate supervision, medical neglect, and substantial risk of physical injury because of her continued drug abuse. The three children have permanency goals of return home and the mother is working toward reunification with her children. The OIG reviewed records in this case.

Case# 48 **DOB August 1982** **DOD August 2001**
Age at death: 19 years
Substance exposed: unknown
Cause of death: Relapse of acute myeloid leukemia, pneumonia and hemorrhagic cystitis
County: Cook
Narrative: Nineteen-year-old was taken to the hospital for bleeding and clotting in his bladder. He died in the hospital a month later. He had leukemia. Prior History: This family has a history with DCFS dating from 1979 when the oldest son entered foster care. The thirty-eight-year-old mother has eleven children. Only the two youngest remain in her care. Earlier, the others were removed from her care. Some have aged out of the system, some have permanency goals of independence, and the remaining children were adopted. The deceased had been a ward since 1987. He was diagnosed with leukemia in 2000.

Case# 49 **DOB January 2001** **DOD August 2001**
Age at death: 7 months
Substance exposed: no
Cause of death: multiple systems organ failure due to sepsis due to spontaneous duodenal rupture
County: Cook
Narrative: This seven-month-old child was born with numerous medical problems including dysmorphic features. He died from multiple systems organ failure. Prior History: There was one prior indicated investigation involving this family. In April 2001, the twenty-two-year-old mother and twenty-year-old father were indicated for medical neglect of the baby. The baby, who had been ill since birth, was hospitalized after he showed up for an appointment malnourished. He was fed by tube and doctors suspected his mother was feeding him incorrectly. An intact family case was opened to ensure the child was fed appropriately and received adequate medical care. Following this indicated report, a geneticist saw the baby. Test results were not received until after the child died. They revealed a genetic problem that led to the child's death. The OIG reviewed records in this case.

Case# 50 **DOB April 2001** **DOD September 2001**
Age at death: 5 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome
County: Jackson
Narrative: Maternal grandmother and parents found the baby unresponsive and called the paramedics. Emergency room doctors pronounced the baby dead. DCFS investigated the death because of the family's previous involvement with the Department. The twenty-one-year-old mother and twenty-two-year-old father have two surviving children who were ages 1-½ and 3 years at the time of the baby's death. Prior History: In February 2000 the Department investigated a report of abuse to the parents' two children. The report was unfounded after the children had medical examinations and no injuries were found. The following month, DCFS began another investigation of a report alleging that the father had been seen shaking his baby. A medical examination revealed numerous bruises and a doctor opined that the baby was abused. During the investigation, the baby was informally placed with relatives. The father was indicated for abuse and an intact family case was opened. The parents agreed that the father would never be left alone with the baby in a caretaking role. The parents participated in some services and the extended family offered support. The case was closed after six months. The Department reopened the family's case after the infant's death to provide preventive services. The case remains open. The OIG reviewed records in this case.

Case# 51 **DOB February 1986** **DOD September 2001**
Age at death: 15 years
Substance exposed: no
Cause of death: Bronchopneumonia, cerebral palsy
County: Cook
Narrative: Fifteen-year-old child with a history of seizures, asthma and cerebral palsy experienced difficulty breathing. His thirty-one-year-old mother administered CPR and called for emergency assistance. The child was transported by ambulance to the hospital where he was pronounced dead. Prior History: The deceased's mother is a relative foster parent for four siblings. They have been placed with her since March 1999. In August 2001, DCFS investigated a report of environmental neglect against the mother. The report was unfounded after an investigator found no evidence to support the claim. The mother has two surviving children. Three of the foster children remain with the mother and have permanency goals of adoption. The fourth child was placed in a group home in July 2000 for behavior management problems. He continues to visit his siblings in the mother's home. The OIG reviewed investigative records in this case.

Case# 52 **DOB February 2001** **DOD September 2001**
Age at death: 7 months
Substance exposed: no, but the mother has a history of substance abuse
Cause of death: complications due to sepsis
County: Cook
Narrative: Seven-month-old medically complex ward died in the hospital. The baby had been admitted to the hospital two weeks earlier after his foster parent found him unresponsive. The baby had been born prematurely at 32 weeks gestation and experienced problems with sepsis, respiratory distress, and inability to take food by mouth. Prior History: From January 2000 to July 2001, the thirty-one-year-old mother of five children has been indicated on four reports of child abuse and neglect. An intact family case was opened in January 2000. In July 2001, the four youngest children, including the deceased, entered foster care after the mother was indicated for failure to thrive and substantial risk of physical injury. Three children remain in the system with permanency goals of return home. The mother is

making progress toward the return of two of her children. She is not making progress with the failure to thrive child who is medically complex.

Case# 53 DOB August 2001 DOD September 2001
Age at death: 1 month
Substance exposed: yes, cocaine
Cause of death: severe inborn error of metabolism, acidemia, disseminated intravascular coagulation, cardio-pulmonary failure
County: Cook
Narrative: One-month-old substance-exposed infant, who never left the hospital, died from his congenital medical complications. Prior History: This family came to the attention of DCFS in May 1987 when the twenty-three-year-old mother was indicated for inadequate shelter of her four children. The Department opened an intact family case until January 1988, a month after the mother gave birth to her fifth child. A second case was opened in May 1989, two months after the sixth child, a four month old baby, died in a house fire. In August 1990 the mother gave birth to her seventh child. The baby had medical problems and a month later the mother was indicated for medical neglect of her one-month-old son. Two months later, in November 1990, the baby was admitted to the hospital with malnutrition and died as a result of a metabolic disorder. The mother gave birth to her eighth and ninth children in October 1991 and October 1992. The ninth child tested positive for opiates and all the children were taken into custody. The mother gave birth to three more children in August 1995, September 1996, and August 2001. All tested positive for drugs and entered foster care. The oldest child has aged out of the system; three of the older children have goals of independence; one child is in subsidized guardianship; and four have been adopted. Three of the children are deceased. The OIG reviewed investigative records for this case.

Case# 54 DOB September 2001 DOD October 2001
Age at death: 12 days
Substance exposed: yes, heroin
Cause of death: hypoxic ischemic encephalopathy, maternal placental abruption
County: Cook
Narrative: Thirty-four-year-old mother was brought to the hospital with severe blood loss. An immediate cesarean section was performed and the baby was placed on life support. He tested positive for heroin. The baby was brain dead and taken off life support twelve days after his birth. Prior History: This mother of twelve children has a history with DCFS dating from February 1995 when an intact family services case was opened on her seven children. The case was closed in April 1996. One month later, the case was reopened when the oldest child, age fourteen, did not wish to remain in his mother's care. He was taken into custody and placed at a residential facility. He remains a ward and attends college out of state. The mother was indicated for substance misuse following the birth of the deceased in October 2001. An intact family case is open and the worker is attempting to provide services. The OIG reviewed investigative records in this case.

Case# 55 DOB August 2001 DOD October 2001
Age at death: 2 months
Substance exposed: no, but mother admitted to past prescription drug abuse
Cause of death: Sudden Infant Death Syndrome
County: Perry
Narrative: Two-month-old infant was found unresponsive by her twenty-eight-year-old mother. She was transported by ambulance to the hospital where she was pronounced dead. Prior History: At the time of the infant's death, there was a pending DCP investigation alleging substance misuse because the infant tested positive for barbiturates at birth. The investigation was ultimately unfounded after the mother's physician confirmed that the mother was given a drug during delivery that could cause the infant to test positive for barbiturates. The mother admitted to past abuse of prescription pain medication and her

doctor reported that he was monitoring her substance intake. The mother has a seven-year-old daughter who lives with her. The OIG reviewed records in this case.

Case# 56 **DOB December 2000** **DOD November 2001**
Age at death: 10 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome
County: Cook
Narrative: Ten-month-old baby was found unresponsive by her mother when she awoke in the morning. She and the baby had been sleeping together on a futon. The twenty-five-year-old mother called 911 and the child was taken to the hospital where she was pronounced dead. Prior History: At the time of the baby's death there was a pending investigation against the mother for medical neglect and substantial risk of physical injury of her three-and-a-half-year-old daughter. The child, who was diagnosed with herpes simplex and viral encephalitis, was ready for discharge from the hospital. Her medical condition required that her mother receive training on how to care for the child at home and the mother had failed to participate in the training. The investigation was ultimately unfounded after the mother completed the training sessions. The OIG reviewed investigative records in this case.

Case# 57 **DOB January 1999** **DOD November 2001**
Age at death: 2-1/2 years
Substance exposed: yes, cocaine
Cause of death: pneumococcal septicemia, multiple urocongenital abnormalities
County: Pike
Narrative: Two-and-a-half-year-old medically complex child died. He was born with multiple birth defects and had undergone multiple repair surgeries. Prior history: When this child was born substance-exposed in January 1999, his three siblings were already in foster care because of the thirty-six-year-old mother's neglect. The deceased entered foster care in March 1999. In October 2001 he was adopted by his foster parent who had cared for him since November 1999.

Case# 58 **DOB August 1996** **DOD November 2001**
Age at death: 5 years
Substance exposed: no
Cause of death: leukemia, sickle cell anemia
County: St. Clair
Narrative: Five-year-old child diagnosed with leukemia died after spending several days in the hospital. Prior History: The family came to the attention of DCFS in June 1997 when neighbors reported environmental neglect and inadequate food for the then ten-month-old deceased child and her two-year-old brother. The report was indicated on the eighteen-year-old mother and an intact family case was open until December 1997. In February 1999 the police called the Department alleging environmental neglect and substantial risk of physical injury after they were called to the home. The Department indicated the report and opened a second intact family case. Three months later a hospital reported that the deceased child possibly had a burn and that the family had no home. The children were taken into protective custody but were returned to their mother three days later. The intact family case remained open until August 2001. The family has had no further involvement with DCFS.

Case# 59 **DOB May 1992** **DOD November 2001**
Age at death: 9 years
Substance exposed: no
Cause of death: pneumonia/carcinoma of the brain
County: Madison

Narrative: Nine-year-old child had brain cancer. He was admitted to the hospital where he died fourteen days later. Prior History: The family's only involvement with the Department was a preventive services case that was open for a little over one month beginning June 2001. The parents have two surviving children.

Case# 60 **DOB October 2001** **DOD November 2001**
Age at death: 5 weeks
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome
County: Peoria
Narrative: This five-week-old infant had been laid on his side for a nap on a mattress on the floor. When his mother went to check on him, he was found unresponsive on his stomach. His death was determined to be from SIDS. Prior History: There was a child protection investigation pending at the time of this child's death for inadequate supervision of him and his two siblings, ages one and four, by their twenty-two-year-old mother and thirty-seven-year-old father. A neighbor reported that the parents left the children home alone while they attended a party across the street. The investigation was ultimately unfounded because the reporter was not credible and personnel of social service agencies involved with the family did not have any concerns about the parents' care of their children. This mother was a ward of DCFS from November 1989 until January 2000 when she turned twenty-one. While she was a ward, there was one prior investigation on the mother as a parent. It was unfounded and retained for harassment. The OIG reviewed records in this case.

Case# 61 **DOB November 2001** **DOD December 2001**
Age at death: 1 month
Substance exposed: yes, cocaine
Cause of death: congenital bronchial pulmonary dysplasia, pneumonia
County: Champaign
Narrative: The one month-old baby, who was born prematurely at 30 weeks gestation, died in the hospital one month after he was born. Prior History: This family came to the attention of DCFS in 1989. The thirty-five-year-old mother has had six children and has been indicated on seven child abuse and neglect reports. Two of the children entered foster care in December 1994 after one of them was born substance-exposed. In 1998 the older child was adopted and the substance-exposed child was released to the custody and guardianship of his father. A third child, born in November 1996, entered foster care following his birth because of his mother's prior history. He has been in the subsidized guardianship of a relative since April 2000. A fourth child, born in November 1999, was in foster care for two months before being released into his mother's care. The fifth surviving child has never lived with his mother and is no longer a minor. The mother has been in and out of substance abuse treatment since 1994. She had an open case until August 2000. After the deceased was born, the Department indicated his mother for substantial risk of physical injury to the deceased and the child living with her because of her continued drug use. The Department opened an intact family case. The mother failed to follow through with treatment and the father took custody of the child remaining in the mother's custody. The OIG is conducting a full investigation of this case.

Case# 62 **DOB December 2001** **DOD December 2001**
Age at death: 0
Substance exposed: unknown, baby was not tested; mother tested positive for cocaine
Cause of death: extreme prematurity
County: Cook
Narrative: Baby was born at 26 weeks gestation and died shortly after delivery. The mother tested positive for cocaine, but the baby was not tested. Prior History: The mother has a history of substance abuse dating from 1986. She was last treated at Haymarket in 1999 for cocaine addiction. She left

Haymarket in October 1999 and relapsed. She gave birth to a substance-exposed infant in December 1999. An intact family case was opened and the mother reentered substance abuse treatment. In April 2000, the mother moved out of state and the intact family case was closed. In September 2000, the mother moved in with her mother and wanted her mother to be named guardian of her baby. An extended family support case was opened through DCFS to assist the grandmother with the transition. The case was closed in January 2001. The mother has not had any further involvement with DCFS since the death of her baby. The OIG reviewed records in this case.

Case# 63 **DOB October 2001** **DOD December 2001**
Age at death: 2 months
Substance exposed: yes, cocaine
Cause of death: pericardial effusion
County: Cook
Narrative: Two-month-old baby born at 26 weeks gestation died of pericardial effusion. He was born substance-exposed and suffered respiratory problems. The baby never left the hospital following his birth. Prior History: This family came to the attention of DCFS in October 2000 when the twenty-eight-year-old mother gave birth to a substance-exposed infant. The baby was her fourth child. An intact family case was opened and attempts were made to engage the mother in substance abuse treatment. The case was closed in July 2001, three months prior to the birth of the deceased, when the family moved out of state. The OIG conducted a records review in this case.

Case# 64 **DOB August 1988** **DOD December 2001**
Age at death: 13 years
Substance exposed: unknown
Cause of death: cardiac failure, respiratory failure, HIV end stage
County: Cook
Narrative: Thirteen-year-old died in the hospital from complications of HIV. Prior History: This child came to the attention of the Department in August 1988 when he was diagnosed with a linear skull fracture. He was allowed to remain at home with his mother under an order of protection. The mother violated the order of protection when she left the child with a friend and did not provide a care plan. He was taken into DCFS custody in September 1988 and had lived with his maternal grandmother since. The child had two sisters, ages ten and eleven, who live with their grandmother. They have goals of guardianship and adoption.

Case# 65 **DOB November 2001** **DOD December 2001**
Age at death: 3 weeks
Substance exposed: baby not tested, but mother has history of substance abuse
Cause of death: severe bilateral pulmonary interstibal emphysema respiratory distress syndrome, extreme prematurity
County: Cook
Narrative: This baby was born prematurely and died from complications related to her premature birth. The baby never left the hospital. Prior History: The baby's thirty-five-year-old mother has given birth to ten children. The baby was the mother's third deceased child. One baby died from SIDS in 1993 when he was two months old. Another child died in 1995 at age three when he choked on a hot dog. The mother is an indicated perpetrator on four child abuse/neglect reports from August 1993 to April 1998 when her children were taken into DCFS custody. A child born in November 1999 entered foster care following his birth. None of the children will be returned to their mother; three of the children have permanency goals of independence, three have goals of subsidized guardianship, and one has a goal of adoption. Preliminary investigation only.

Case# 66 **DOB January 1988** **DOD December 2001**
Age at death: 13 years
Substance exposed: no
Cause of death: myocardial infarction
County: DuPage
Narrative: Thirteen-year-old child collapsed while working at the computer. He was taken to the hospital where he died two days later. Prior History: There were three prior investigations on the child against his forty-eight-year-old mother and fifty-four-year-old father. In September 1998, a physician called the hotline to report that the child suffered from a significant movement disorder, an anxiety disorder, and depression and that he had several hospitalizations. The physician stated that the mother was in denial about the child's psychiatric needs insisting that his problems were all medical. The child had been taken to several hospitals throughout the Chicago area and the Mayo clinic without a clear diagnosis. The report was unfounded. In July 1999, another Chicago hospital reported that the mother was refusing psychiatric care for her child and was found penetrating her son's anus and rubbing his penis to get urine for a medical test. The mother was indicated for substantial risk of physical injury to the child, but no service case was opened. In March 2001, the father was reported to have hit the child in the face and stomach with an open hand. The father admitted slapping his son on the stomach when he lay on the floor yelling and refusing to stand up. He did not leave any marks. The case was unfounded and DCFS had no further contact with the family. The OIG conducted a records review in this case.

Case# 67 **DOB November 2001** **DOD December 2001**
Age at death: 2 months
Substance exposed: no, but the mother admitted to heroin use a week prior to delivery
Cause of death: Sudden Infant Death Syndrome
County: Cook
Narrative: Two-month-old boy was found unresponsive by his foster father in his crib. He brought the baby to the foster mother who began performing CPR while he called 911. The child was pronounced dead soon after arrival at the hospital. The baby had tested positive for methadone at birth. His mother tested negative for substances, but admitted using heroin a week prior to the baby's birth. Prior History: This family came to the attention of DCFS in January 1994 when the twenty-seven-year-old mother gave birth to a substance-exposed infant. In December 1994 the mother gave birth to a second substance-exposed infant. In April 1995 the mother's five children entered DCFS custody. The deceased was the mother's six child. He tested positive for methadone at birth. The mother tested negative for substances, but admitted using heroin a week prior to the baby's birth. The mother was indicated for substantial risk of physical injury and the baby was placed in foster care following his release from the hospital. Two of the surviving children are in the subsidized guardianship of their maternal grandparents. The other three live with their maternal aunt and have permanency goals of return home.

Case# 68 **DOB October 1985** **DOD December 2001**
Age at death: 16 years
Substance exposed: unknown, but mother has history of substance abuse
Cause of death: pneumonia
County: DuPage
Narrative: Sixteen-year-old medically complex child was found in distress by a nurse at her residential facility. Paramedics were called and the nurse began CPR. The child was taken to the hospital where she was pronounced dead on arrival. Prior History: This family came to the attention of DCFS in 1992 when the thirty-two-year-old mother gave birth to a substance-exposed infant. Two subsequent reports of neglect were indicated and the mother's three minor children entered foster care. The deceased was placed in the residential care facility in 1995. Her two siblings were adopted in 1999 and 2001 by a relative foster parent.

Case# 69 **DOB February 1999** **DOD January 2002**
Age at death: 2 ½ years
Substance exposed: no
Cause of death: pneumococcal septicemia, sickle cell anemia
County: Cook
Narrative: Two-and-a-half-year-old child with a history of sickle cell anemia presented to the hospital with her foster mother. The child had a low-grade fever, but high oxygen saturation levels. The child was seen after waiting in the emergency room for a few hours. The child quickly developed an overwhelming infection that caused her death. Prior History: Four days after the child's birth, the hotline was contacted alleging substantial risk of physical injury to the child because of her mother's mental illness. The report was indicated and the mother asked the Department to take custody of her daughter. The child had lived with her foster parents since she was seven days old. They were in the process of adopting her. The mother had one older child who also had been a ward of the state since infancy. She was adopted in 1986 when she was twelve.

Case# 70 **DOB July 2001** **DOD January 2002**
Age at death: 5-½ months
Substance exposed: yes, cocaine
Cause of death: Sudden Infant Death Syndrome
County: Cook
Narrative: Five-and-a-half-month-old baby, who had a cold, was found by foster parent to be weak. The foster parent called an ambulance, but the baby quit breathing before the paramedics arrived. The baby was pronounced dead at the hospital. Prior History: The baby's thirty-seven-year-old mother was a ward from 1979 to 1983. In August 1988 she was indicated for inadequate supervision of her five-year-old daughter. An intact family case was opened until April 1989 when the mother completed services. The child entered foster care in June 1993 after two more indicated reports of inadequate supervision. A fourth inadequate supervision report was indicated when the child revealed she had been sexually abused by an unknown perpetrator while living with her mother. In October 1993 the mother gave birth to a substance exposed infant that immediately entered foster care. A third child, born in 1995, entered foster care in April 1997 when the mother was indicated for inadequate supervision after leaving her with an inappropriate caretaker. In July 2001, the deceased child was born testing positive for cocaine. He was allowed to remain with his mother until September 2001 when the mother left the child with an inappropriate caretaker. He was taken into custody and placed in the same foster home as his siblings. The oldest sibling has aged out of the system and the two younger siblings were adopted by the foster parent in April 2002.

Case# 71 **DOB January 2002** **DOD January 2002**
Age at death: 0
Substance exposed: no
Cause of death: complications of amnionitis (inflammation of the amnion in the mother), stillbirth
County: Cook
Narrative: Nineteen-year-old mother was admitted to the hospital after experiencing pain and bleeding. She was nine months pregnant. The baby died in utero by the time the mother reached the hospital. The mother is a ward. Her caseworker knew about her pregnancy and the mother received prenatal care. The mother planned to give the baby up for adoption and had chosen a couple to be the adoptive parents. Prior History: The mother's family became involved with DCFS in August 1989 when an intact family case was opened because of neglect. Two months later she was screened into the system and placed with a relative until 1997 when she moved to a foster home. She stayed in the foster home for two years before entering an independent living program in March 2000. The mother remains in the independent living program. Her two younger siblings were adopted in 1997.

Case# 72 **DOB October 2001** **DOD January 2002**
Age at death: 3 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome
County: Cook
Narrative: Three-month-old infant was found unresponsive on the sofa by his twenty-four-year-old mother. The infant was taken to the hospital by ambulance where he was pronounced dead. Prior History: The hotline was called in April 2001 with allegations that the deceased minor's three-year-old twin siblings had bruises from being hit by their mother's nineteen-year-old live-in boyfriend, the father of the deceased child. The investigation was pending at the time of the child's death. It was subsequently indicated for cuts, welts, and bruises and substantial risk of physical injury to the twins.
The OI G reviewed records in this case.

Case# 73 **DOB January 2002** **DOD February 2002**
Age at death: 13 days
Substance exposed: yes cocaine
Cause of death: severe intraventricular and bilateral subdural hemorrhage due to maternal cocaine use
County: Peoria
Narrative: Thirteen-day-old substance exposed infant, born at thirty-one weeks gestation, died before being discharged from the hospital. At the time of his death, there was an investigation pending against his mother for substance misuse and substantial risk of physical injury. Prior History: The deceased was the thirty-five-year-old mother's seventh child. The family has a history with DCFS dating from 1988. The mother has a substance abuse problem and has been investigated for child abuse and neglect seventeen times. In addition to chronic neglect, one of her children was sexually abused while in her care and two of her children were born substance exposed. All of the children eventually entered DCFS custody. The oldest child is placed with a relative and has a permanency goal of independence. The other five children have all been adopted. The OIG reviewed records in this case.

Case# 74 **DOB February 2002** **DOD February 2002**
Age at death: 0
Substance exposed: no
Cause of death: prematurity
County: Peoria
Narrative: Baby was born and died the same day. She was her twenty-eight-year-old mother's seventh child. All of the mother's children were born prematurely. Prior history: This family came to the attention of DCFS in January 2001 when following the birth of her fifth child, the mother was indicated for medical neglect and failure to thrive on her new baby. The baby was taken into DCFS custody where she remained until she returned home in March 2002. In September 2001, following the birth of her sixth child, the mother was indicated for substantial risk of physical injury to the newborn based on her prior history. The newborn was in foster care for three weeks and returned home. The family's case was closed in August 2002 and there have been no further reports involving the family.

Case# 75 **DOB January 2002** **DOD February 2002**
Age at death: 1 month
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome
County: Kane
Narrative: One-month-old infant was found unresponsive by his thirty-five-year-old mother. Emergency personnel were called and the baby was pronounced dead at the scene. The mother had a crib in her home, but she had moved the baby into her bed during the night. Prior History: The family came to the

attention of DCFS in January 1998 when the mother was indicated for malnutrition on her then three-month-old baby. An intact family case was opened on the mother and her six children. The family remained intact, although some of the children eventually went to live with their maternal grandparents. The mother also spent periods of time living with her parents. The intact family case was closed in February 1999. In September 2001 DCFS investigated the mother for substantial risk of physical injury after receiving a report that the mother asked her fifteen-year-old son's uncle to discipline him, and he was hit in the head with an instrument. The mother and children were living with the maternal grandmother at the time of the report and all family members denied that such an incident took place. The family has had no further contact with the Department. The OIG reviewed records in this case.

Case# 76 **DOB November 2000** **DOD February 2002**
Age at death: 15 months
Substance exposed: no
Cause of death: dehydration, gastroenteritis
County: Cook
Narrative: Fifteen-month-old baby was found unresponsive by his twenty-four-year-old mother. The toddler had been ill with a poor appetite, vomiting, and diarrhea in the couple of days before his death. His mother had taken him to the emergency room the day before he died. He was diagnosed with an ear infection and was prescribed antibiotics. The mother had not filled the prescription and went out with friends, leaving the baby in her mother's care. Prior History: The mother was a ward from 1988 to 1999 when she turned twenty-one. The mother and father were alleged perpetrators in two investigations by DCFS. Both were unfounded. In March 2001, a health clinic reported that the baby was behind on his immunizations and was being fed only one bottle a day. The case was unfounded when the parents brought the child's immunizations up to date, and the investigator confirmed the child was being fed appropriately. In October 2001, the baby was rushed to the hospital with burns to his torso, arms and hands. The parents stated that the baby had crawled off the bed and fell onto a hot iron that was sitting on the floor. Burn unit physicians felt the explanation was consistent with the injuries and the investigation was unfounded. The investigation remained open for two months to monitor the parents' medical follow-up of the baby's injuries. The OIG reviewed records in this case.

Case# 77 **DOB May 1990** **DOD February 2002**
Age at death: 11 years
Substance exposed: no
Cause of death: cardiac arrhythmia due to right ventricle dysplasia
County: Peoria
Narrative: Eleven-year-old boy had cerebral palsy and was mildly mentally disabled. He suffered from seizure disorder and enuresis. The boy lived in a residential facility, a voluntary placement by his custodial father. Staff found the child having an apparent seizure. They called 911, and the child was transported to the local hospital. He was later transferred to a medical center with a pediatric intensive care unit where he was placed on life support. His father made the decision to discontinue life support. Prior History: Two months prior to his death, the Department investigated a report that the child had been sexually molested by his mother's boyfriend during a home visit. The report was unfounded because of lack of evidence. The OIG conducted a records review in this case.

Case# 78 **DOB March 2002** **DOD March 2002**
Case# 79 **DOB March 2002** **DOD March 2002**
Age at death: 0
Substance exposed: twin babies were not tested, mother tested positive for cocaine
Cause of death: prematurity
County: Cook

Narrative: Twin boys were born at twenty-four weeks gestation. Both survived for only a few hours. The twenty-eight-year-old mother tested positive for cocaine, but the twins were not tested. Prior History: The twenty-eight-year-old mother has given birth to nine children, five of whom were born substance-exposed. She has an extensive history with the Department. The mother was a ward from 1986 to 1991 when she turned eighteen. She has been indicated as a parent on eleven reports between 1990 and 2002. Six of her seven children have been in foster care. They have all been adopted. Her youngest child never entered foster care, but had been living with his father. The father voluntarily placed the child with a friend who is in the process of adopting him. The OIG reviewed records in this case.

Case# 80 **DOB March 2002** **DOD March 2002**
Age at death: 0
Substance exposed: baby not tested, but mother admitted using crack cocaine prior to delivery
Cause of death: extreme prematurity
County: Cook
Narrative: Baby died shortly after birth because of extreme prematurity. His twenty-eight year old mother admitted to using crack cocaine prior to the baby's delivery. Prior history: The mother has a history with DCFS dating from 1993; she has been indicated for neglect on six reports. There are six surviving children, two of whom were born substance-exposed. All the children have been adopted.

Case# 81 **DOB October 2001** **DOD March 2002**
Age at death: 5 months
Substance exposed: no
Cause of death: respiratory failure, bronchopulmonary dysplasia, prematurity
County: Cook
Narrative: Five-month-old baby that was hospitalized since birth died. The baby was born at twenty-six weeks gestation and had been on a ventilator. Prior History: The baby was placed for adoption through an agency after his biological parents surrendered their parental rights. The adoptive family relinquished their adoptive rights in January 2002 and the child was found dependent by the juvenile court.

Case# 82 **DOB February 2002** **DOD March 2002**
Age at death: 19 days
Substance exposed: yes, cocaine
Cause of death: Sudden Infant Death Syndrome
County:, Cook
Narrative: The nineteen-day-old infant was found unresponsive, face down, in her crib by her thirty-four-year-old mother. The mother and infant resided at an inpatient drug rehabilitation facility. Prior to entering the inpatient facility, the mother had been attending an outpatient program. After testing positive for cocaine, the mother entered the inpatient facility, nine days before giving birth. Prior History: There was a pending DCP investigation for substantial risk of physical injury to the baby based on the mother's recent drug use. The family's history with DCFS dates to 1993 when the mother's only child, then age one, entered foster care for dependency. In March 1994 the mother had a second child who entered foster in April 1996 after she tested positive for a sexually transmitted disease. The children were placed with their maternal grandmother who was given subsidized guardianship in June 1998. In May 2000, the grandmother relinquished guardianship and the children reentered DCFS custody. The OIG conducted a records review.

Case# 83 **DOB September 2000** **DOD March 2002**
Age at death: 1-½ years
Substance exposed: no
Cause of death: pneumonia, trisomy 13

County: Cook
Narrative: One-and-a-half-year-old died in the hospital where he had been for ten days with pneumonia. There was a DNR order in place at the request of the child's biological mother who was present in the hospital at the time of her son's death. The child was medically complex. He was diagnosed with trisomy 13, a rare genetic disorder. He was hearing and visually impaired, had a G-tube for feeding, and suffered from respiratory problems. Prior History: This family came to the attention of DCFS in December 2000 when hospital staff contacted the hotline alleging medical neglect of the child by his twenty-two-year-old mother who had not taken the child for medical follow-up appointments to address his genetic disorder. The report was indicated for medical neglect and substantial risk of physical injury and the child entered DCFS custody in March 2001. He had a goal of return home. After a five-month stay in a residential care facility, the child was placed in a specialized foster home where he resided until his death. He was an only child.

Case# 84 **DOB September 2000** **DOD April 2002**
Age at death: 18 months
Substance exposed: no
Cause of death: pulmonary bleed due to complications from short-gut syndrome and liver disease
County: Cook
Narrative: Eighteen-month-old child was diagnosed with short-gut syndrome and liver disease. He needed a bowel and liver transplant. The child died from complications related to his illness. He had been hospitalized since December 2001. Prior History: This child entered DCFS custody in June 2001 after the mother abandoned him while he was hospitalized. The twenty-five-year-old mother has three older children who remain in her care.

Case# 85 **DOB March 2000** **DOD April 2002**
Age at death: 2 years
Substance exposed: no
Cause of death: hypoplasia of the left coronary artery
County: Sangamon
Narrative: Two-year-old child was found unresponsive by his mother. Attempts to resuscitate him were unsuccessful. A 911 call was made and the child was transported by ambulance to the hospital where he was pronounced dead. An autopsy revealed a congenital heart defect. Prior History: The family came to the attention of DCFS with two prior indicated reports of inadequate supervision. The first report was in December 2001 when the twenty-one-month-old child and a four-year-old sibling were found attempting to cross a busy street alone. The child was wearing only a diaper and his sibling was not wearing shoes when found by the reporter. The second report occurred in February 2002 when the child was again found outside unsupervised. In both cases, the father was indicated. The children's parents and the maternal grandmother, agreed to ensure the children were adequately supervised at all times. The OIG did reviewed records in this case.

Case# 86 **DOB March 2002** **DOD April 2002**
Age at death: two weeks
Substance exposed: possible (alcohol)
Cause of death: renal failure, prematurity
County: LaSalle
Narrative: Two-week-old baby was born at 22 weeks gestation, weighing less than a pound. The thirty-eight-year-old mother has a lengthy history of alcohol abuse. There was some suspicion that the child's premature birth was alcohol related, however, testing was difficult because of the baby's condition. The baby never left the hospital and died less than three weeks after he was born. Prior History: The mother's four surviving children have been in foster care since September 2001 because of alcohol-

related neglect. The children have permanency goals of return home, but the mother is making unsatisfactory progress toward their return.

Case# 87 **DOB February 1996** **DOD April 2002**
Age at death: 6 years
Substance exposed: no
Cause of death: respiratory failure, pneumonia, chronic lung disease, severe developmental delays
County: McHenry
Narrative: Six-year-old medically complex child was taken to the hospital after experiencing breathing problems on the school bus. She was transferred from the local hospital to a hospital with a pediatric intensive care unit. She remained hospitalized with pneumonia and died nine days later. She had several prior hospitalizations for pneumonia. Prior History: In 1996, at the age of four months, the child was violently shaken by her twenty-one-year-old father who was married to the nineteen-year-old mother. As a result of the shaking, the child was nonverbal, immobile, and visually impaired. She was fed through a feeding tub and suffered from cerebral palsy. The injuries to the child took place in a state on the East Coast. Afterward, the mother took the five-month-old child and her four-year-old sibling to Illinois to live with the maternal grandmother. In the eastern state the father was criminally prosecuted. He pleaded guilty to unlawful wounding in November 1997. He was given credit for time served and put on probation. In April 1998, the order of protection that allowed no contact between the father and his children was dissolved in the eastern state's juvenile court and the mother and father reunited in Illinois. They had another baby in February 1999. In June 1999, the four-month-old baby was diagnosed with head injuries and a healing rib fracture. The three children were taken into custody and were placed with the maternal grandmother. The parents participated in services and visited their children. In December 2001 the children were returned home to their parents against the recommendation of the private agency servicing the case. DCFS retains guardianship of the children pursuant to court order and the family continues to be monitored. ***Note:*** Because the child's death was from apparent medical causes, the hospital did not notify the coroner's office and the child's death was attributed to a natural manner. A coroner's inquest may have reached a different conclusion as the medical problems the child experienced were directly related to the inflicted trauma she suffered as a baby.

Case# 88 **DOB July 1998** **DOD May 2002**
Age at death: 3 years
Substance exposed: no
Cause of death: progressive neuromuscular disease, cerebral palsy
County: St. Clair
Narrative: Three-year-old medically complex child died after being transported to the hospital because of a seizure. Prior History: The thirty-seven-year-old mother of seven has a history with the Department dating to August 1988. She has been indicated on eleven child abuse and neglect reports involving her children. She had an intact family case open with DCFS from 1988 to 1995. The case was reopened from July 1996 to February 1997. It was reopened in March 1999 after the mother was indicated for medical neglect of the now deceased child. In May 1999 the mother was indicated again for medical neglect of the deceased and the baby was taken into custody. The other children were screened into the system in September 1999. The two oldest children have recently reached their permanency goals of independence. One child returned home to her mother when she turned seventeen. The remaining three children have permanency goals of return home.

Case# 89 **DOB April 2002** **DOD May 2002**
Age at death: 7 days
Substance exposed: yes, cocaine and opiates
Cause of death: acute heart failure, congenital heart disease
County: Cook

Narrative: Substance-exposed infant died from complications after heart surgery to correct congenital problems. The baby never left the hospital following her birth. Prior History: The baby was the thirty-three-year-old mother's second substance-exposed infant. The mother gave birth to a baby in May 1999 who tested positive for cocaine and opiates. After investigation, the Department referred the case to a private agency with a specialized program of intensive intact family services for substance-affected families. The mother participated in services, including substance abuse treatment, although she experienced some relapses during times of crisis. Following the death of her child, the mother successfully completed a treatment program and the family's case was closed in September 2002.

Case# 90 **DOB January 2001** **DOD May 2002**
Age at death: 16 months
Substance exposed: yes, cocaine
Cause of death: meningitis
County: Cook
Narrative: Sixteen-month-old toddler was taken to his doctor's office by his thirty-two- year-old mother after coming down with a fever. The doctor sent the child to the local hospital for tests, and he was transferred to the area children's hospital where he was diagnosed with meningitis. He died four days later when his parents made the decision to discontinue life support. The toddler had no history of illness. Prior History: Although the mother has two older children, the family's first contact with the Department was in January 2001 when the deceased child was born substance-exposed. An intact family case was opened as the mother agreed to participate in substance abuse treatment. Initially her participation in treatment was sporadic, however, following the death of her child she became more consistent in treatment. The case was closed in August 2002. The two older children, ages eight and sixteen, remain with their mother.

Case# 91 **DOB June 1989** **DOD May 2002**
Age at death: 12 years
Substance exposed: no
Cause of death: cardiopulmonary arrest due to multiple systems failure
County: Macon
Narrative: Twelve-year-old medically complex child died in her foster home of cardiopulmonary arrest because of multiple systems failure. The child suffered from cerebral palsy, spastic quadriplegic left estropia, seizures, scoliosis and contractures. The foster parents and two foster siblings were present at the time of her death. Prior History: The child entered foster care in July 1991 because her parents were unable to care for her. In October 1991 the juvenile court found the child dependent. In March 1993 she was moved to her third foster home where she remained until her death.

Case# 92 **DOB January 2002** **DOD May 2002**
Age at death: 4 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome
County: Logan
Narrative: Three-and-a-half-month-old baby boy was found unresponsive by his seventeen-year-old mother and twenty-three-year-old father when they awoke from a nap they took with the baby laying between them in bed. After an autopsy and scene investigation, the coroner determined the baby died from SIDS. Prior History: There was one prior report involving this family. In March 2002, the hotline was contacted alleging substantial risk of physical injury to the baby because of an incident of domestic violence by the mother against the father. The mother was arrested and charged with domestic battery. She was put on probation, and she and the father were ordered to take parenting classes. The family lived with the maternal grandmother who was seen as a protective factor for the baby. The report was indicated

a few days prior to the baby's death and an intact family case was in the process of being opened. The baby was the couple's only child. The OIG reviewed records in this case.

Case# 93 **DOB September 2001** **DOD May 2002**
Age at death: 8 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome
County: Cook
Narrative: Eight-month-old baby was found unresponsive lying on a couch by his nineteen-year-old brother. Prior history: There were three prior DCP investigations involving this family. The first was in April 2001 for cuts, welts, and bruises by neglect and inadequate supervision. It was alleged that while his eighteen-year-old brother was watching him, a three-year-old got out of his high chair and crawled out the window onto a balcony. The child was not injured and the report was unfounded. A second report was made in September 2001 for inadequate supervision and burns/scalding by neglect. A one-and-a-half-year-old child was burned while his nine-year-old brother was cooking spaghetti. Their mother was sleeping at the time. As a result of this indicated report, an intact family case was opened. The family was receiving services from the Department at the time of the baby's death. There are six surviving children in the family. The family is still receiving intact family services. This case is being investigated by the OIG.

Case# 94 **DOB January 2002** **DOD May 2002**
Age at death: 4 months
Substance exposed: yes, opiates
Cause of death: acute bronchial pneumonia
County: Death: Vigo, Indiana Case management: Edgar County
Narrative: Four-month-old infant died while being cared for by her maternal grandmother while her twenty-four-year-old mother was incarcerated. The infant, who was a twin, had a history of breathing problems since birth and had been previously hospitalized. She was seen by a pediatrician two days before her death with no medical follow-up recommended. Prior History: This family has been involved with the Department since October 2000. The mother had been indicated on three reports of neglect, in October 2000, March 2001, and August 2001, as a result of her alcohol use. In March 2002 she was indicated for substance misuse after giving birth to the deceased and her twin sister with opiates in their systems. The girls were the mother's fifth and sixth children. The family was receiving intact family services, however, a neglect petition had been filed and was pending in Edgar County at the time of the infant's death. The OIG reviewed records in this case.

Case# 95 **DOB May 2002** **DOD May 2002**
Age at death: 0
Substance exposed: no
Cause of death: extreme prematurity because of premature labor
County: Peoria
Narrative: Baby was stillborn at 20 weeks gestation. Twenty-four-year-old mother experienced difficulty throughout her pregnancy despite prenatal care. Prior History: The twenty-four-year-old mother was sexually abused as a child and was in foster care from 1989 to 1991. In August 1998 she was indicated for medical neglect of her own child. She was indicated a second time for medical neglect of the same child in February 1999. An intact family case was opened. In July 1999, the mother's two children entered foster care. Her third child entered foster care following her birth in July 2000. A fourth child, born in August 2001, was allowed to remain in her mother's care. The other children were returned to their mother's care in April 2002. The family's case remained open until September 2002. There has been no further contact with DCFS.

Case# 96 **DOB April 2002** **DOD June 2002**
Age at death: 2 months
Substance exposed: no, but mother has a history of substance abuse
Cause of death: Anemia
County: Kankakee
Narrative: Two-month-old baby was being taken to the hospital by his mother because he was ill. He stopped breathing in the car and was pronounced dead at the hospital. The baby was born prematurely at 32 weeks gestation. He had a history of transfusions for anemia due to Rh factor incompatibility. He had recently been released from the hospital. Prior History: This family came to the attention of DCFS in March 1995 when the twenty-six-year-old mother was indicated for substance misuse after giving birth to a substance-exposed infant. The infant entered foster care at that time. The mother gave birth to another child in March 1997. In September 1998, she was indicated for burns and substantial risk of physical injury when it was reported that the child had a burn under his right eye. He entered foster care at that time. The mother had a third child in February 1999 and was indicated for substantial risk of physical injury. The child entered DCFS custody at that time. The children were adopted by the same foster parent.

Case# 97 **DOB March 2002** **DOD June 2002**
Age at death: 2-½ months
Substance exposed: yes
Cause of death: Post hemorrhagic hydrocephalus due to intracranial hemorrhage
County: Peoria
Narrative: Two-and-a-half-month-old medically complex baby died from complications resulting from his condition at birth. The baby never left the hospital. His mother abandoned the child in the hospital and the hospital took legal action to secure a DNR order for the child. Prior History: This family came to the attention of DCFS in June 1996 when the eighteen-year-old mother gave birth to a substance-exposed infant. The child entered foster care and was adopted in June 1999. In November 2000 the mother gave birth to a baby and was indicated for substantial risk of physical injury based on her prior history and information that she was still using drugs and alcohol. The baby entered foster care and was adopted in November 2002.

OIG INITIATIVES

ETHICS

Child Welfare Ethics Advisory Board

The OIG Ethics Office facilitated the work of the Child Welfare Ethics Advisory Board as it deliberated about ethical issues uncovered in OIG investigations or submitted to it in inquiry form.[24] The Ethics Board devoted significant attention this year to the issue of what constitutes competent care for developmentally delayed wards that become pregnant. The Board considered the case of a ward functioning at the level of a five-year-old who was raped at age seventeen and was placed with her baby following his birth. Ethics issues identified by the Board that were later incorporated into the Inspector General's report included (1) the lack of an adequate assessment of the ward's parenting capabilities, (2) a failure to respect the ward's expressed preference for giving the baby up for adoption, (3) the need for the DCFS Guardian to continue to provide consents on behalf of compromised wards between the ages of eighteen and twenty-one, (4) a lack of staff that are adequately trained in assessing and managing children with developmental disabilities, and (5) a failure to consider the long term best interest of the baby. The Board asked for more information about the Teen Parent Support Network (TPSN), and reviewed a cluster of six cases submitted by TPSN. The Board reiterated its concerns that competent parenting assessments should be conducted with pregnant teen wards and that the safety and well-being of the children of teen wards should be a high priority.

The Board received an inquiry regarding the funding of a proposed panel on the proper use of psychopharmacological drugs with DCFS wards that are severely emotionally disturbed. Psychiatrists at the University of Illinois-Chicago maintain a database to track the use of such medications by wards and have noted a disturbing rate of "co-pharmacy" – the use of additional drugs to treat symptoms that may have been caused by the original drugs. The proposed panel would establish a standard of care for the use of such drugs. The question put to the Ethics Board was whether it would be ethical for pharmaceutical companies to fund this panel. The Board concluded that funding by pharmaceutical companies would create, at a minimum, an appearance of a conflict of interest and could compromise the credibility of the panel's conclusions.

The Ethics Board also addressed inquiries concerning the acceptance of gifts from clients and appropriate response to client violence directed at child welfare professionals. The Board endorsed the position that such gifts can only be accepted when they are without real market value, where acceptance of the gift promotes a professional goal, and where acceptance will not mislead the client about the nature of the professional relationship. The private agency whose employee was the subject of client violence was urged to develop a policy on reporting such violence to police and requiring a complete staffing on each

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[24] As of July 1, 2002, 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, MBA, Chancellor, Archdiocese of Chicago
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

incident to review the therapeutic needs of the client, the safety of the children, and security for staff members.

OIG Ethics Staff Initiatives

A major accomplishment this year of the OIG ethics staff was the completion of a video training program, entitled *Child Welfare Ethics Workshop: An Ethics Committee in Action.* The project was produced in cooperation with the Park Ridge Center for Health, Faith, & Ethics and Governors State University. The training package consists of an hour long video containing four dramatized case scenarios, each followed by a mock ethics committee discussion, a Leader's Manual, and a Participants' Guide. The training is designed to be used by public or private child welfare agencies to help staff identify and think through ethical dilemmas and to set up and work with agency ethics committees.

The ethics staff completed final edits of Volume I of the Ethics Handbook at the request of the Child Welfare League of America Press which is publishing the book under the title Ethical Child Welfare Practice and plans to market and distribute the book to a national audience in early 2003. The ethics staff continued to work on Volume II of the Ethics Handbook, which addresses ethical issues in child welfare supervision and administration.

The OIG ethics staff organized an initiative this year that was a direct outgrowth of the Ethics Board's work in fiscal year 2002. Several cases had come to the Board's attention where the involvement of clergy might have been helpful to wards in extreme circumstances, such as hospitalization or suspicion of a crime. A meeting was held at the University of Chicago on November 9, 2001 between hospital chaplains and other clergy, DCFS personnel, and students in the divinity and social work schools. Area ethicists directed breakout sessions. The ethicists encouraged the participants to identify areas where clergy and child welfare workers are unaware of each other's roles and responsibilities and to suggest ways that the two professions could work more cooperatively. Feedback from that meeting and from subsequent interviews with experts from both professions was collected and the ethics staff began drafting a handbook to be used by hospital chaplains and DCFS personnel when wards are hospitalized. The handbook will include an appendix with a summary of the religious beliefs of various denominations with regard to medical treatment and the capacity of children to make moral choices. The handbook will be completed in winter 2002/3.

The ethics staff conducted a training session in October 2001 at the request of the DCFS Cook North Regional managers. The ethics staff attended a preliminary meeting with the managers at which they identified ethical problems they had recently encountered in the region. The training was designed around hypothetical practice situations that the ethics staff created to raise the identified issues. Approximately forty managers and supervisors participated in the training. An in-house OIG training also took place this year in which OIG staff were given an overview of the kinds of ethical issues to watch for in investigations and the principles embodied in the Code of Ethics for Child Welfare Professionals.

Ethics issues which were addressed by the ethics staff on a more informal basis in response to inquiries from child welfare professionals in the field or OIG investigators included the parameters of confidentiality in casework, nepotism, agency acceptance of corporate underwriting of a special project, emergency use of an agency employee as a foster parent, and the improper assignment of a caseworker to a case where he had a prior professional and personal relationship with the client. The ethics staff continued to serve biweekly with representatives of DCFS' Internal Audits and Child and Family Policy Divisions on the DCFS Conflict of Interest Panel that determines whether outside employee activities or relationships constitute violations of DCFS Rule 437.

DCFS Ethics Officer

As Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General reviews the Statements of Economic Interest forms that senior DCFS employee are required to file by May 1 with the Secretary of State. The Inspector General and the ethics staff noted entries that could constitute conflicts of interest and requested further information from filers. Outside interests were grouped in categories where appropriate (such as private therapy or real estate practices) with a view to drafting cautionary letters to the filers on steps to take to avoid conflicts of interest.

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 that have delivered a first or second substance-exposed infant. In FY 2002 over 172 families with 516 children participated in the program. Over 75% of the families were able to maintain their children in safe homes while their parents engaged in treatment. 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 has been effective in compelling parents to complete significant courses of substance abuse treatment. Currently, the child welfare and substance abuse providers selected by DCFS 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.

OLDER CAREGIVERS

During the past year, 38 Cook County elderly caregivers received special assistance for pre and post adoption services. These services enabled the caregivers and their families to reach long term solutions to difficult lifespan problems including dependency concerns because of the physical and/or cognitive deterioration of the elderly adoptive or pre-adoptive parent, financial exploitation or instability, and inadequate housing conditions that threatened the family's well-being. Many of the caregivers reported an inability to adequately care for the children because of health issues, fatigue, or conflictual relationships with teenagers. The typical family referred for services from this developmental model was headed by a grandmother, great aunt, or adoptive/foster parent in their seventies caring for three children under the age of 10. Private agencies, DCFS and officers of the court referred families. They were asking for assistance in addressing a long-term solution to the family's permanency.

As caregivers age, the need for supportive services increases. Presently, there are 2,189 caregivers over the age of 65 that care for 4,467 children, 327 of whom are under the age of 5.

Age groups of older caregivers	Number of caregivers in age group	Total number of children cared for by each age group	Number of children under 5 cared for by each age group
65-69	1,188	2,536	224
70-74	611	1,205	69
75-79	286	554	30
80-84	81	130	2
85-89	16	28	1
90-102	7	14	1

ASTHMA

Following the investigations of the deaths of six foster children with poorly controlled asthma, the Inspector General recommended that the Department of Children and Family Services develop and train its caseworkers and children's caretakers on medically sound asthma practices. Because of the Department's inability to quickly reverse outdated and dangerous practices managing its children's asthma care, the Director asked the Inspector's General's office to assist him in quickly remedying problems of poor asthma management. Since Chicago has the highest asthma diagnosis and death rate in the nation and with 65% of our DCFS wards residing in Cook County, the OIG focused its Best Practice efforts on the proper and timely medical treatment of asthmatic children by foster care agencies serving that region. To enhance proper medical attention for all of its children, the Department agreed to and is developing a medical database to track the medical condition and needs of its children.

In FY 2002 the OIG Asthma Best Practice initiative trained over 1600 Cook County foster care workers and foster parents in the identification of asthma and the means to obtain adequate diagnosis, treatment and follow-up care for children with asthma. FY 2003 OIG efforts will transition to the Department the

training program of this approach to on-going statewide asthma training. One of the most disturbing findings from the FY 2002 OIG efforts was the inadequate management of DCFS' nursing staff. The present management structure of the nursing resources cannot harness a professional and timely response to an emerging health crisis of its children.

CHILD ADVOCACY CENTER COLLABORATION PROJECT

The OIG noticed a disturbing trend in which men who had sexually abused our teen and pre-teen wards were not being held accountable in the criminal justice system. Police and states attorneys noted the complexities and difficulties of dealing with the victim population, many of whom maintained relationships with the abusers. As a result, the OIG collaborated with the Cook County Child Advocacy Center to develop a program for our teen and pre-teen victims of sexual assault, provide therapeutic intervention and assistance in navigating their way through the criminal justice system.

CHILD ABUSE AND NEGLECT INVESTIGATIONS AND INTACT SERVICES

Abuse Investigations

- DCFS should require scene investigations in all abuse investigations.

- Complicated child abuse investigations can be compromised by an overemphasis on quick closure. Investigators are routinely rated in employee evaluations solely on how quickly they close cases, without a concomitant evaluation on the quality of those investigations. The OIG has observed several death and serious injury cases where a previous allegation of abuse was prematurely unfounded and closed. Closure rates for abuse cases should be calculated separately from closure rates for neglect cases within each DCP team. In teams where 30-day closure rates for abuse cases are high, there should be a review of unfounded abuse cases by the Field Service Manager.

- Training for investigators must include information gleaned from the Department's own databases suggesting increased vulnerability for certain age groups of children. In order to accomplish this, the Department should ensure that data about the re-abuse of children, by age breakdown, is incorporated into Division of Child Protection (DCP) and Intact Family Services training.

- Child Protection investigators must respond to relevant safety issues, not limiting their investigation to the specific initial allegation.

Intact Services to Physically Abusive Families

- Intact family services to physically abusive families must be recognized as precarious and high-risk. Child welfare workers must meet with the child's teacher or day care provider and request that he or she notify the worker if the child is absent for two consecutive days. The request should be incorporated into a CERAP Safety Plan and a copy should be given to the teacher or day care provider. In addition, when there is a pattern of absenteeism, the worker must regularly meet with the teacher to get attendance reports.

- The Department should target special intact family services teams to service cases with indicated findings of physical abuse. The teams should be trained using the latest research on the recognition and treatment of physical abuse and be proactive in requesting court intervention to promote parental compliance.

- The Inspector General previously noted a misinterpretation of constitutional requirements, which resulted in workers being trained to close intact family cases, after an indicated finding of neglect or abuse, when the parent refused to cooperate with services. Although the Department reversed its policy to require workers to attempt to screen the case into court while monitoring the safety of the child, the OIG has noted that the effects of the previous misinterpretation persist in the field.

- Currently, there are no Rules or Procedures specific to the provision of Intact Family Services. The Department should clarify which rules are applicable to Intact Family Services.

- While DCFS Rule 300 provides specific guidelines for when and how it is permissible to view children's bodies to look for physical abuse during an abuse and neglect investigation, the rules provide no guidelines for intact family workers. Intact family workers must be able to monitor children for abuse when (1) the presenting problem for case opening was physical abuse or (2) when the worker reasonably suspects the child may have been physically abused (e.g., the child makes a statement of abuse or the child exhibits a mark on his clothed body that is suspicious for abuse). Procedures, similar to those set out for child protection workers, must be established for intact family workers to assess children for physical abuse.

Coordination with Law Enforcement

- Over the course of investigations and services investigators and child welfare workers must verify the identity of subjects of the investigations and potential caretakers of the children through driver license or state issued identifications to assure correct birth dates and spelling of names. In addition to analyze information provided by criminal background checks, workers must obtain underlying arrest reports, and other pertinent documents, rather than merely accepting the self-reported explanation of the history provided by the subjects or caretakers.

- The OIG reaffirms its previous recommendation that 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. Whenever local law enforcement is also investigating allegations, child protection investigators and supervisors must work closely with law enforcement and review any available evidence.

- In cases of sexual abuse with DNA samples it is incumbent that Child Protection supervisors meet with all police departments to secure DNA testing results as quickly as possible. In cases of child sexual abuse where resolution of the investigation hinges on the collection of DNA evidence, an exception should be built into the Administrative Rule to allow for these cases to remain open in the SCR system until the DNA evidence is obtained.

- The OIG collaborated with the City of Chicago Children's Advocacy Center (CAC) to develop an evidence based therapeutic intervention for pre-teen victims and pregnant or parenting teen wards who were victims of sexual assault as well as helping them as potential witnesses navigate their way through the criminal justice system.

Home and Child Safety Checks

- All Intact and child welfare teen parent supervisors and caseworkers should be trained to teach parents how to conduct a home and child safety check in their home and in the homes where the children routinely visit. Supervisors should test the reliability of the worker's applied training. This training must included the dangers of shaken baby syndrome and leaving a child with a caretaker who is prone towards violence or is incapable of being patient with children.

Neglect Investigations and Child Welfare Services Involving Children's Failure to Thrive, Malnutrition, Inadequate Food or Parent Substance Abuse

- The Department maintains separate investigative allegations for *failure to thrive, malnutrition* and *inadequate food.* Each allegation requires a different set of evidence and relevant facts. DCP

supervisors, investigators, Intact Family and Teen Parent child welfare workers must be trained on recognizing, identifying and differentiating between the three separate allegations.

- The Department should amend Division of Child Protection procedures to include 'Factors considered' for inadequate food in investigations of malnutrition and failure to thrive; and require a multidisciplinary staffing within 48 hours of receiving a CANTS report of failure to thrive (allegation 81) and malnourishment (allegation 83), using the NCAST assessment.

- Once a mother has had a child who was born substance-exposed and the family has an open intact family case, workers must follow up with the hospital after the birth of a second child to determine whether the mother was involved with substances at the time of that birth.

- The Department should train child protection and DCFS/POS child welfare staff to forward additional substance use/abuse information gathered during the course of an investigation or delivery of Intact Family Services, to the Office of Alcoholism and Substance Abuse provider. This information can be extremely useful to the OASA provider in formulating: a more accurate client profile; testing the accuracy of client self reported information; providing additional information the client may be unable to supply because of the stigma and inherent denial associated with substance misuse/abuse.

Administrative

- To assist investigators and child welfare workers in properly identifying previously indicated caretakers the Soundex system should be adjusted to equate soft "C" and "S" sounds.

- When a hotline allegation is against a DCFS employee, the investigation must be immediately assigned to a county other than where the employee works. This requirement includes the 24-hour mandate to see the child.

- The OIG intervened when it learned that the Department had taken the position that non-investigative workers should not be permitted to question persons with relevant information in order to monitor a family's compliance with a safety plan. The position meant that intact workers could neither monitor compliance nor develop additional objective information for assessment purposes. The OIG argued that when relevant to issues of child safety and welfare, workers could contact collateral persons for objective information about the family.

- The OIG intervened when it learned that the Department had taken the position that a private agency responsible for a ward, accused of sending hate mail threatening violence, could not monitor the ward's outgoing mail. The OIG noted that when supported by a finding of best interests, ward's mail could be restricted. The OIG suggested that the ward's outgoing mail be sent to the DCFS Guardian's office for a best interest determination.

- The OIG participated on the Department's Confidentiality Rules and Procedures Task Force, which redrafted Rule 431.

Private Placement Arrangements During Course of Investigations and Intact Services

- The Department should develop guidelines restricting the use of private arrangements pending child protection investigations and provision of services where the threat to child safety cannot be

addressed by the private arrangement or where a parent is non-cooperative. In addition, workers must ensure that the private caretaker is privy to all relevant information needed to care for the child.

- When a child is the subject of an abuse or neglect allegation that would present a risk of harm if the child remained in the home, the Department may allow parents to designate a private placement agreement with an individual outside of the foster care system. Such agreements may impact on the foster care system when the private arrangement is with an existing foster parent. When the private arrangement is with a foster parent, the investigator must contact the Placement Clearance Desk (the unit that approves all foster home placements) before children involved in private placement agreements are placed in existing foster homes, to ensure the placement does not exceed the home's licensed capacity.

DOMESTIC VIOLENCE

- The OIG reaffirms its recommendation made in FY 98, that in all Cook County cases in which domestic violence is an issue (not just those in which domestic violence is the primary issue), the supervisor should consult with the Department's consultant on domestic violence as to the appropriate services that should be incorporated into the case plan. In addition, the domestic violence consultant should be available for the duration of the case and should be included in the joint staffing discussing the return home of children. The Department should track the number of referrals made to the consultant and should reassess the referral process three months after implementation of the new procedure on domestic violence.

HOLDING PRIVATE AGENCIES ACCOUNTABLE

- Current weaknesses with the Department's fragmented system of monitoring contracting agencies may jeopardize IV-E federal funding. The Department's auditing, licensing and performance monitoring units, while operating under one administrative unit, fail to provide a functional and integrative system of agency accountability.

  At a minimum the Department should:
  - Enforce Rule 384 requiring contacting agencies to submit their audits on time;
  - Require contracting agencies to submit a personnel matrix and cost center reports to verify an appropriate and traceable cost allocation system across program and funding streams. Auditors must verify that DCFS funds are used solely to support contractual activities;
  - Require agencies to submit all Board minutes to Licensing;
  - Sanction an agency that fails to submit the audit in a timely fashion by disallowing the expense of the executive director's salary from the final due date until the audit is received for those agencies that do not submit the annual audit on a timely basis. Once the audit is received it should be subjected to a thorough desk review to determine if a field audit is necessary.

- The Department's agency audit unit should hire a qualified Certified Public Accountant with experience in not-for-profit auditing procedures to manage and train the audit staff on conducting effective field audits and desk reviews consistent with Government Auditing Standards of the U.S. General Accounting Office.

- Contracted agencies' annual audits should be carefully reviewed to identify lack of full disclosure and adherence to accounting standards. DCFS auditors should advise agencies to bring their audit into conformity with generally accepted standards and, when indicated, the auditors should advise the board to consider changing auditors.

- Prior to conducting on-site audit reviews, DCFS Auditors should meet with the agency's APT and A&I Licensing staff, to gather and integrate Department knowledge of agencies and coordinate the extent, focus and division of labor for effective financial and programmatic audits.

- When conducting on-site audit reviews, DCFS auditors should expand the scope of the field audit when evidence of conflicts of interest and other financial irregularities exist. The agency's response to Department audits should be further examined to verify the response.

- The Department should review all current audits of purchase of service agencies for deficits. Any audit showing a deficit should be subject to further review, including a determination of whether the contract warranty regarding insolvency has been breached. If tax obligations have not been fully met, the Department should:
    - Determine whether the agency has entered a payment agreement with the Internal Revenue Service and the payment schedule is being followed; and/or
    - Determine whether the problem can be resolved, and act accordingly (Rule 401, 384);
    - Issue a Provisional License with attached provisions and ensure monitoring of resolution when the problem is determined to have an achievable solution.

- Agencies that are found, during the desk review, to be delinquent in payroll taxes should be placed on provisional license status in accordance with Rule 401.

- After learning that a home health agency was billing the state for 16 hours each day, even though the nurse for two children was only providing services for 8 hours a day, the OIG recommended that DCFS Agency Performance Teams (APT) conduct an initial review of all DCFS children receiving home health services to ensure that each child is receiving approved services (type of service, hours per day, days per week, kind of professional providing the service, shared placement). APT staff should periodically review these children for monitoring purposes. Information should be shared with DCFS personnel who approve Prior Approval Requests for follow up on those children's cases for whom APT identifies concerns.

- Agency and Institution Licensing and Agency Performance Team (APT) monitoring should ensure that agencies have an independent board and are in compliance with their Code of Ethics and Conflict of Interest policy.

- A team of licensing specialists should review all of the license records that were handled by a former agency licensing representative and also verify educational credentials submitted by agencies. This recommendation has been made previously by the OIG.

INEQUALITY OF RESOURCES IN SOUTHERN REGION

- Because of Southern Region's large geographic area and paucity of mental health resources child welfare families receive less than adequate parental mental health assessment. DCFS, in conjunction with the Southern Illinois University, should develop a mobile parenting assessment team for the region to provide comprehensive evaluations of parents with a mental illness history. The team should consist of a psychiatrist, psychologist, social worker and a coordinator. The

team should be based on the model of the parenting assessment teams already established in Cook County.

CLINICAL DECISION-MAKING

- Clinical Placement Reviews should include procedures that require:
  - Analysis of substantive issues, emphasizing the intrinsic worth of objective facts over subjective self-reports and require that factual discrepancies that implicate risk be identified and must be presumed as continuing risk factors until resolved by objective documentation;
  - A complete review of the record prior to making any case decisions and should address conflicts and potential bias;
  - Staffings not to proceed until the reviewer has read all relevant records;
  - Realistic procedures for addressing caseloads and information gathering techniques to permit adequate investigation during the ten-day period (five days to convene the review and five days following the review to complete the assessment);
  - Clinical supervisor approval for any clinical recommendations (including interim) that waive a licensing violation.

- To achieve meaningful and useful evaluations DCFS Clinical Services Division should ensure that consulting psychologists clarify referral questions and inquiries and obtain relevant information including case histories and reasons family is involved with DCFS.

- When a SASS worker is evaluating a child at an emergency shelter, available medical and case records should be reviewed as part of the evaluation process.

- The Department should assess the Intensive Therapeutic Services program to determine whether additional staff is necessary to fill Department needs.

- DCFS should designate clinical consultants with expertise in mental health who caseworkers, supervisors and investigators can call upon for assistance, education and information.

INADEQUATE SERVICES TO DEVELOPMENTALLY DISABLED WARDS

- The Department's specialist on developmentally delayed youth should develop a system by which the direct child welfare worker assigned to a developmentally disabled ward and the worker's supervisor are immediately notified and linked to available support services. This means of linkage should be recorded/placed in the child's record.

- The Department should revise Appendix M subpart (c) of procedure 302 to clearly state that the Daniel Memorial Life Skills Assessment should not be used with any of the Department's wards who are developmentally disabled. The Department should consider using the ICAP assessment tool or the Vineland Adaptive Assessment with a ward who is identified as having a developmental disability. This should be incorporated into the revisions of 302 Appendix M subpart (c).

- The Department needs to develop a procedure for working with the various functional levels of developmentally delayed wards that are parenting. Current procedures are insufficient.

- The current process of tracking developmentally delayed wards is insufficient. The Department's computer database should identify and track developmentally delayed/mentally retarded wards. The database must be reliable and valid in order to be an effective tool.

- Children with developmental disabilities should have a Life Plan to help caretakers meet the child's needs and ensure a smoother transition when the child returns home or moves to a different caretaker. (The Life Plan was developed by Sheila Ryan-Henry, ACSW, Executive Director, Seguin Retarded Citizens Association, and Shu-Pi Chen, Dr. PH, RN, Professor, College of Nursing, University of Illinois at Chicago.)

- Current Department licensing rules require that the maximum hot water temperature shall not be more than 115 degrees in a foster home that accepts children under the age of ten or who are developmentally disabled. Prior to the return home of a child with developmental disabilities, the worker should arrange for an agency that provides services to persons with disabilities (United Cerebral Palsy, Access Living, Easter Seal, the Rehabilitation Institute of Chicago, etc.) to conduct an occupational/safety review of the home to guide the case manager and educate the family on how to make the home environmentally conducive and safe for the disabled child. The Department needs to develop a written procedure for notifying the Guardian's office that a developmentally disabled ward that is moderately mentally retarded or more severely mentally retarded is pregnant.

MEDICAL

- The OIG Asthma Best Practice Initiative trained over 1600 Cook County foster care workers and foster parents in the identification of asthma and means to obtain adequate diagnosis, treatment and follow-up care for children with asthma. Since Chicago has the highest asthma diagnosis and death rate in the nation and 65% of our wards reside in Cook County, the OIG focused its Best Practice efforts on the proper and timely medical treatment of asthmatic children by agencies serving this region.

- The Department should explore the Pediatric Incontinence Clinic as the primary treatment option for Cook County foster children with encopresis.

- The Ethics Board was consulted on the propriety of permitting pharmaceutical companies to fund a proposed panel on the proper use of psychopharmacological drugs. The Board determined that, at a minimum, such funding would create an appearance of conflict of interest and could compromise the integrity of the panel.

FOSTER AND RESIDENTIAL CARE

Residential Care

- The "Team Up To Save Lives" CD-Rom on suicide and suicide prevention, produced by the University of Illinois at Chicago Department of Psychiatry and Ronald McDonald House, should be distributed to all residential programs that contract with the Department.

- Whenever families are advised of their right to administratively appeal a service decision, they should also be advised of the Office of Advocacy for Families and Children as a resource for problem resolution.

- Private agencies' should develop procedures for appropriate matching of foster homes and children, which promote careful evaluation of the child's needs and permanency status 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 301.60. The process should include a staffing between licensing personnel and/or intake, and case management personnel, so that beneficial, informative dialogue can occur between staff familiar with the child's needs and those familiar with the foster parents. The staffing should be documented in the file.

- In cases where two or more children (including recently adopted children) are placed in a foster home and those children have different caseworkers from the same agency, a staffing should be held in order to facilitate the integration of information about the children and the home.

FOSTER HOME LICENSING

- Private agencies licensing assessments should include assessments of foster parents' continuing capability and a careful assessment of medical information and/or significant life changes that occur in foster parents' lives providing as clear a picture as possible of the foster parent's health, strengths, limitations, mobility, characteristics, parenting style and experiences, areas of discomfort or where there might be need for further training, etc. as they relate to fostering children. Support services, e.g., respite, should be provided where an assessment identifies such needs. The on-going assessment should be documented in the licensing file, and used as part of the tools to determine appropriate matches for placement.

- Licensing representatives and supervisors should discuss and document for the file all pending licensing recommendations, assessing all pertinent information, prior to making a licensing recommendation to the Department (e.g., recommendations for initial licensure and renewals, changes in restrictions to a license, recommendations regarding arrests/convictions).

- The OIG has encountered problems in the transfer of foster care cases and licensing files including lost licensing files, incomplete licensing files, and failure of agencies to require that a new licensing application be filed when there is a change in the supervising agency. Private agencies receiving cases from another agency must review all the licensing files they have received to determine if the appropriate documentation required for licensure is contained in the licensing files. This documentation should include the following:
    - A new application;
    - Licensing/Home Study;
    - Family Home Information sheet;
    - Copy of the Individual Licensing Summary;
    - Medical Report;
    - Evidence that a new site visit has occurred and that the home is still in compliance;
    - References;
    - Certificate of foster parent training.

- The Department should require that a public aid check be completed when licensing a foster parent or in a DCP investigation of the parent or caretaker.

- Upon the discovery of a licensing violation, a written plan of action must be established. This plan should include 1) the specific changes needed to rectify the violation, 2) a reasonable time-line for compliance with an expected date of completion, 3) a follow-up home visit within two weeks of the expected ate of completion with the licensing worker and supervisor to ensure compliance.

POST ADOPTION SERVICES

- The Department should develop and implement procedures in the Post Adoption unit requiring notification of both parents, in the event of divorce or separation, of the biennial review and of any activity on the adoption subsidy agreement and before either parent can agree to changes to the agreement, provided the Department is notified of changes in the address of either parent. In the interim while awaiting procedures, the Post Adoption Unit should manually notify any non-residential parent of which they are aware. In addition the Department will make available to either party upon request copies of all post adoption materials. These procedures should be incorporated into a revised Post Adoption Handbook.

COLLABORATION WITH OTHER AGENCIES & DEPARTMENTS

- DCFS needs to collaborate with the Department of Public Aid to reform procedures for:
    - Rate setting for home health services for DCFS wards
    - Rate setting for home health services to more than one child in the same home
    - Approval of requests for services and payment rate
    - Ensuring accuracy of billings

- It is important that workers have information as to whether a parent or the caretaker is receiving disability benefits. The Department should contact the Illinois Department of Public Aid to determine how the Department can access that information and make it available to caseworkers.

- The Department must ensure that wards are receiving quality mental health services. In contracting with any entity providing mental health services to wards, the Department must require that the mental health providers use an ecological approach and contact the appropriate school personnel to obtain information about the child in the school setting.

COURT INVOLVEMENT AND ADMINISTRATIVE HEARINGS

- Reports to the court should be comprehensive, including at a minimum parental involvement and the parent's cooperation with services, all incidents of domestic violence, concerns regarding compliance with the service plan (especially focusing on issues that brought the family to the attention of the Department), how the child is doing across critical settings such as school, health, and therapy, concerns voiced by other professionals who have worked with either the caretaker, or the children, life changes that affect caretaking (such as a new pregnancy), and criminal or abuse history.

- When DCFS screens a case into court and a parent has mental health issues, the worker should request a court order for the mental health records if the parent refuses to sign or rescinds a release of information.

- Prior to mediation, the Department should require that a full school report on the child or children who are the subject of the mediation be prepared and made available to all parties and the mediator.

RETURN HOME

- In previous cases the OIG has recommended that prior to the return home, a collaborative staffing be held among all the professionals who had provided services to the family within the last year. This staffing should include the treating physician and the child's teacher. This recommendation should be part of the Return Home Protocol.

PREGNANT AND PARENTING TEENS

Violence

- The OIG reviewed a sample of cases from the Teen Parenting Service Network and noted a high intensity of violence in the sample. The Inspector General recommends that the TPSN Service Management Team develop a Multisystemic Treatment unit (MST) for young parents exhibiting antisocial behaviors. The unit should provide services adhering to the time frame (4-6 months) of the MST model. A commitment to the research component of the MST is necessary for program integrity and outcomes can only better inform the field. TPSN should determine the mechanism of referrals, coordination and level of Regional Service Partners case management service during delivery of the MST services.

- When the presenting problem in a teen parent case is verbal violence or low to moderate physical aggression, caseworkers must be skilled in intermediate interventions such as social skills trainings, mediation, and anger management techniques. In all cases were there is domestic violence the caseworker must talk to the extended family about safety issues.

Intake and Assessment

- When the Teen Parenting Service Network ("TPSN") receives an Unusual Incident Report informing them of the pregnancy of a teen ward, they must request and review the full case record. Currently, only name, demographics, recipient number, DCFS number, region/site/field number and social security number are requested. A face-to-face hand off must occur (between TPSN and the Regional Service Partner) within 24 hours of TPSN receiving the case.

- Prior to beginning the assessment, the worker must read the entire case record. The assessment should involve the caregiver, support network, and the teen parent. Once a problem issue is identified, a specific plan for dealing with that area should be established. For example, if a worker indicates in the assessment that the ward is frequently truant, baseline data should be presented, and the caseworker should detail the specific plan for how to ensure that the ward attends school rather than state that it is the ward's responsibility to attend school. Additionally, the caseworker should list the sources of information gathered during the assessment.

- The assessment should identify high-risk factors such as becoming pregnant at or prior to age 15, history of school failure, truancy or school drop out, gang involvement, violence or history of substance abuse.

- Areas covered under the Comprehensive Assessment should be expanded to cover (1) the developmental stage of the child and the developmental age of the parent and (2) safety and other needs of the teens' child, (3) the ecological fit between the needs of the young family including their living environment and strengths and to target well-defined problems with developmentally appropriate interventions designed to promote responsible behaviors and decrease irresponsible behaviors.

- A staffing should occur within 30 days of receipt of the case, and after the Comprehensive Assessment has been completed. The staffing must include the teen parents, foster parents, relatives (including grandparents of the infants) the GAL, and significant others such as probation officer if applicable. Any case involving mental illness (or dual diagnosis with mental illness and developmental disabilities) should be referred to the Parenting Assessment Team (PAT), which is the best resource available to accurately assess mental illness and parenting. Any recommendations made by the Parenting Assessment Team must be followed by TPSN.

Education

- Caseworkers should develop a morning routine for school pick-ups for the students who are or are beginning to be truant. If a student develops a pattern of truancy for any reason, the TPSN worker should convene an immediate staffing including the teen parent, foster parent, TPSN education liaison and the Guardian *ad Litem* (GAL.)

- TPSN should provide bus or cab service to transport the teens to school and their children to daycare until the teen has a stabilized attendance pattern. In addition, the TPSN needs to analyze and address obstacles to school attendance and performance.

- TPSN should explore the use of The American Correspondence School for teens with a 7th grade or above reading level who need to make up lost credits due to previous truancy problems.

- Teen parents who do not either actively attend school 90% of the month or maintain appropriate employment of 90% of the month or make reasonable efforts to obtain employment. (Percentages based on the minimum requirements of the Chicago Public Schools for truancy requirements and dismissal), must receive appropriate penalties.

Developmentally Delayed Pregnant and Parenting Teens

- Services to developmentally delayed pregnant and parenting teens raise distinct issues. If one conservatively estimates 10% of the Teen Parent population has developmental disabilities or severe learning disabilities (3 grades behind in reading), then the Department must carefully examine the casework focus on these teens. Each of the Regional Partners should have at least one specially trained caseworker to carry a special needs developmentally disabled caseload. Both the supervisors and case managers need training in how to effectively serve parents with upper moderate and borderline developmental disabilities.

- TPSN should hire a specialist for developmentally disabled wards with a background in developmental disabilities, including special education, and applied behavior analysis.

- TPSN needs to identify and train a special cadre of workers and supervisors on working with developmentally delayed pregnant and parenting wards. TPSN Intake should include, as part of the information gathered during the intake process, information concerning whether the

parenting/pregnant ward has a developmental disability and the nature of that disability. Once a ward is identified as having a delay, that ward should be assigned to one of the workers that is part of this specially trained unit.

Daycare Success Strategies

- It is necessary for young teens to successfully obtain and maintain safe and stimulating childcare resources. TPSN workers should be trained on how to model, role-play, and rehearse the repertoire of behaviors that a parent needs to obtain and maintain quality daycare. For example, being respectful and incorporating responsible behaviors such as coming to daycare with an adequate supply of diapers, and being on time and courteous in drop-offs and pickups so as not to be dropped by the service provider. Often, problems arise because of the teen's immaturity and lack of experience in appropriate behavior when obtaining a service. Data shows that formal child care centers best meet the developmental needs of children by providing a safe environment, cognitive stimulation, structure, warmth, and appropriate discipline. (Welfare, Children & Families, A Three-City Study. Child Care in the Era of Welfare Reform: Quality, Choices and Preferences.)

Effective Services

- Currently, the TPSN program only requires in-home visits twice monthly. An intensive home visits program similar to the one used in the early phases of the Intact Family Recovery Program is more appropriate for this population of young families. When the case is first received, visits should occur in the home twice weekly for at least six months until the teen is stabilized in the role of parent and able to maintain the appropriate developmental tasks of adolescence. In cases with high-risk factors (e.g., developmental disabilities, chronic truancy, multiple births, substance abuse or domestic violence) the intensive home visits should continue throughout the first year of the case unless there are clear indications that the risk factors have been alleviated. The purpose of increased visits is to create a supportive and monitoring presence in the teen's life from the earliest stages. Additionally, this high level of interaction allows the worker to assess the teen's strengths and problem areas and provide teaching opportunities and support.

- TPSN should train its caseworkers to conduct in-home observations and parental education on home and child safety. In addition to a home and safety assessment tool teen parent caseworkers should use an Ecomap to identify environmental obstacles and personal and community strengths. A task-centered child welfare caseworker involves family members and relevant collaterals in developing the target problems and gives reasonable advice and guidance in the anticipation of obstacles and the exploration of resources and services necessary to problem reduction.

- Sanctions should be tiered with natural consequences. The OIG suggests use of a Memorandum of Agreement to formalize expectations with the ward. The OIG developed a draft protocol for a tiered sanction system.

Medical and Counseling Services to Pregnant and Parenting Teens

- DCFS should consider identifying three or four established, well-respected clinics to cover different geographic areas within Cook County to provide pre-natal care and counseling. Consolidating medical treatment centers would enable coordinating transportation, follow-up, parenting classes and monitoring.

- Resources already exist in Cook County that could supplement TPSN by addressing the needs of very young and high-risk teen mothers in a more coordinated and dependable way. Some Title X clinics are specifically set up to deal with teens family planning and pregnancy. These centers could be used as support centers for pregnant and parenting teens. Doctors and social workers at these centers are experienced in assessing teens and communicating effectively with them.

- Counseling surrounding resolution of pregnancies should be handled by an agency that is separate from the Teen Parent Service Network (TPSN). If a ward decides on adoption, the ward should be provided immediate access to adoption services. A list of adoption agencies should be compiled so that such adoption services are accessed on a rotating basis, if the private agency does not provide a full-range of private adoption options.

- Since both the teen parent and their child are serviced by Health Works providers the pregnant and parenting teen program and Health Work service providers should be cross-trained on evidenced interventions for high risk young parents.

Downstate Teen Parent Coordinator

- The Downstate Teen Parent Coordinator does not receive Administrative Case Review Feedback or other notification of pregnant and parenting teens. The Department needs to analyze and address the obstacles to appropriate notification. A trend analysis to determine those agencies that fail to meet the Hill mandate should be conducted. The Field Mangers should be notified, in writing and quarterly, of the findings.

- Procedures to identify downstate pregnant and parenting wards should include: (1) Quarterly check of downstate Independent Living Programs to determine whether they have pregnant or parenting wards that have not been identified. If so, the Teen Parent Coordinator should hold the program director responsible for ensuring an Unusual Incident Report is generated; (2) the Teen Parent Coordinator should obtain quarterly lists of wards who receive child support to determine whether there are parenting wards of whom the Teen Parent Coordinator was not notified via an Unusual Incident Report.

Holding Private Agency Providers Accountable

- Independent Living service providers should be sanctioned if they fail to complete and submit Unusual Incident Reports to the Department when they learn that a ward is pregnant or parenting.

- Contracts Administration should be notified of agencies that are not submitting Unusual Incident Reports concerning pregnant and parenting teens, and should pursue such failures as a violation of their contracts.

RECOMMENDATIONS FOR DISCIPLINE

- A Child Protection Investigator should be discharged for falsifying investigative notes and failing to interview collateral witnesses, including a family physician, in a case in which a three-and-a-half year old boy was severely abused by his mother's boyfriend while three other reports of abuse of this same boy were pending. The Department should also discipline this investigator's supervisor for his lack of substantive supervision.

- A Child Protection Investigator should be counseled on investigative techniques and her failure to follow up on a father's report that he had recently been in jail in a case in which the father killed his six week-old son one month after being indicated for physically abusing his four year-old daughter.

- A caseworker should be disciplined for her failure to properly assess risk and for her failure to provide a safety plan for the children in an intact family physical abuse case in which the father killed his six week-old son one month after being indicated for physically abusing his four year-old daughter.

- An intact family services caseworker and supervisor should be disciplined for failure to recognize physical abuse as the primary problem in this intact family and assess further risk of injury, account for differences in CERAPs, and develop a safety plan when a 10 year-old boy, who was absent 88 of 173 school days, suffered on-going physical abuse by his mother.

- A DCFS administrator should be disciplined for disregarding her administrative responsibilities to ensure the integrity of a file after a father shot and killed one of his children and injured two others, for failing to give full disclosure to the Office of the Inspector General, for contributing to an appearance of impropriety and conflict of interest and for failing to ensure that an original document was provided to the Inspector General.

- A caseworker should be disciplined up to and including discharge for not conducting a criminal history check prior to approving a placement in a non-relative home, for not alerting juvenile court professionals when she learned of the criminal sex abuse history of a household member, for failing to provide the OIG with full information regarding the date of the child's placement and for lying to the OIG about having contacted the State Central Register.

- A Child Protection Investigator should be counseled by her supervisor for her failure to review prior reports against the alleged perpetrator, for her failure to adequately assess risk, and for her failure to obtain information relevant to the investigation in a case in which a nine year-old with cerebral palsy died due to peritonitis resulting from a small bowl laceration due to blunt abdominal trauma ten months after being returned to her mother and 2 months after her case was closed in court. The child's mother and paramour were indicated for the death, but not criminally charged.

- A caseworker should be counseled for her failure to properly monitor the services offered by private agencies in their intact family cases and for her failure to provide leadership in ensuring that a contracted agency received the records it needed to provide services in a case in which a nine year-old with cerebral palsy died due to peritonitis resulting from a small bowl laceration due to blunt abdominal trauma ten months after being returned to her mother and 2 months after her case was closed in court. The child's mother and paramour were indicated for the death, but not criminally charged.

- In a death case in which a teen mother killed one of her children, the child welfare worker should be counseled for placing a teenage ward in an independent living program without an evaluation of her placement needs or consideration of the girl's behavior, history and diagnosis and failing to reassess the appropriateness of the girl's placement when she demonstrated an inability to manage her living arrangement and when she became a teen parent.

- In a death case in which a teen mother killed one of her children, the child welfare supervisor should be counseled for failure to reassess the appropriateness of a teen mother's placement in independent living when the girl demonstrated an inability to manage her living arrangement.

- A Clinical Advisor should be counseled for performing an inadequate clinical assessment where she failed to review the case record and failed to interview one of the children in a case in which three sisters were removed from a pre-adoptive placement where they had been living for five years.

- A Child Protection Investigator and supervisor should be disciplined for failing to make required investigative contacts and review medical records in a medical neglect investigation in which a 14 year-old with a seizure disorder subsequently drowned after suffering a seizure while taking a bath.

- A private agency caseworker should be disciplined, up to and including discharge, for unprofessional and impulsive behavior and failure to present full case information to other professionals in a case of a developmentally delayed teen parent.

- A private agency clinical specialist should be disciplined up to and including discharge, for a lack of knowledge of resources, a lack of initiative, and poor judgment in a case of a developmentally disabled teen parent.

- A private agency licensing supervisor should be disciplined for failure to ensure follow-up of a household member's pending criminal charges in a case of a developmentally disabled teen parent.

- A private agency employee should be counseled on biases that impact decision-making in a case of a developmentally disabled teen parent.

- An employee in the Clinical Division should be disciplined for inappropriate/unlawful use of department electronic mail system, harassment, and conduct unbecoming a state employee.

- An intact family caseworker should be terminated for failing to adequately assess a substance abusing mother's ability to supervise her 16 year-old daughter who was frequently truant from school, had been suspended twice and whose boyfriend was wounded in a shooting in an intact case in which the 16 year-old's own one month-old daughter was mauled to death by the family dog.

- A caseworker should be disciplined for the use of cannabis in a car in the presence of a child outside of the State of Illinois building.

- A private agency caseworker should be counseled not to rely on self-report information for circumstances surrounding serious allegations in a case in which a child care provider in an intact family case had a history of indicated reports as to her own children.

- A private agency licensing worker should be counseled for failure to adequately follow up once it was discovered that the foster parent was in violation of licensing rules in a case in which a five year-old was repeatedly beaten by the foster mother.

- A private agency caseworker should be counseled for failure to follow through in providing for recommended services including speech therapy, respite care, mentoring, individual and family counseling in a case in which a five year-old was repeatedly beaten by the foster mother.

- A private agency administrator should be counseled for poor supervision on the case and for failing to assess the severity of the problems that the foster child was experiencing in the foster home in a case in which a five year-old was repeatedly beaten by the foster mother.

- A Child Protection Investigator in a death case should be disciplined for failing to attempt to screen into court a case in which the mother had already established a pattern of disregard for a child's fragile medical condition

- An employee with a history of rude and threatening behavior toward supervisors should be disciplined, up to and including discharge, for threatening her supervisor.

- A child protection supervisor should be disciplined for her failure to ensure a substantive investigation including a scene investigation with an accurate description of daycare practices and for exhibiting a contributory bias towards a false positive finding.

- A private agency should discipline the supervisor in accordance with the agency's policy and procedures for his failure to adequately supervise his caseworker and misleading the Court regarding having given the caseworker a "verbal warning" for failing to properly transfer a case from a placement unit to an intact unit and for not providing services to the family for over four months while awaiting the transfer.

- In a death case in which a previous abuse allegation was unfounded, the Child Protection Investigator received a five-day actual suspension for failure to contact the reporter, interview the perpetrator, contact informed police officers, and contact all collaterals. The OIG concurs with the discipline imposed and further recommended that this report be shared with the investigator as a teaching tool and that her child protection manager discuss with her actions she can take if she is directed to close out on an investigation that is incomplete.

- In a death case in which a previous abuse allegation was unfounded, the Child Protection supervisor received a five-day paper suspension for his failure to perform supervisory duties in the investigation in which he instructed the investigator to unfound the case one day after she received it and without contacting the reporter, interviewing the perpetrator, and collaterals. The OIG further recommended that this report be shared with the supervisor as a teaching tool and that the child protection manager review the report with him and discuss with him the importance of conducting comprehensive child protection investigations.

- A clinical administrator should be disciplined for acting on harmful biases, adhering to and irresponsibly communicating inaccurate information regardless of known facts, and exhibiting unprofessional conduct toward the foster parents of four special needs siblings.

- A DCFS nurse should be disciplined for her demonstration of harmful biases, irresponsibly communicating inaccurate information regardless of known facts, and exhibiting unprofessional conduct toward the foster parents of four special needs siblings.

- A Day Care Licensing Specialist should be disciplined for insubordination and breach of ethics for failing to follow supervisory instructions regarding a substantial monetary gift received at her workplace from an anonymous source.

- A caseworker should be disciplined, up to and including discharge, for signing a letter written to school administrators on Department letterhead recommending that the caseworker's sister's children (who are not DCFS clients) be allowed to continue attending a school outside their district in compliance with their alleged service plan.

- A Child Protection Investigator should be disciplined for unprofessional conduct of greeting members of a household, including subjects he was investigating with kisses and having dinner with the family.

- An employee should be disciplined for misrepresenting herself as a defendant's caseworker when she was actually his mother to an officer of the court.

- A caseworker and supervisor should participate in an ethics consultation to review the conflict of interest provisions of the Code of Ethics for Child Welfare Professionals for failing to recognize the potential conflict of a pre-existing personal and professional relationship between the worker and client.

- Two DCFS supervisors should be counseled for carrying on a personal affair over e-mail, violating the Department policy against improper use of state property and responsibilities as supervisors.

- A contractual employee working in Information Systems resigned his position after an OIG investigation revealed that he was accessing pornographic internet cites.

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Office of the Inspector General

REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File No: **02 OIG 0704**
Subject: **Death Investigation**
Minors: **Evan Grant (DOB: 6/99) (DOD: 11/01)**
Tamika Grant (DOB: 11/96)

CASE SUMMARY

Death Report

In November of 2001, Felicia Grant, mother of Evan and Tamika, called 911 from a neighbor's phone when she noticed that Evan was not breathing and her paramour, Melvin Corbit, was trying to revive him. The Child Abuse and Neglect Tracking System (CANTS 1) form reflects that 911 was called at 11:55 p.m. At that time, Evan was not breathing correctly, was choking, unresponsive, and coughing up blood and water. Additionally, Evan had bruising to his face, head, left abdomen, legs, and arms. Ms. Grant had left Evan and Tamika in the care of Mr. Corbit while she went to the store. The CANTS 1 further reflects that Mr. Corbit admitted that while in the bathroom he pulled Evan out of the bathtub and shook him violently. Evan Grant was pronounced dead at 12:28 a.m. the next day.

History

The Illinois hotline was notified when 2½ year-old Evan was brought into the emergency room of a hospital in a neighboring state and pronounced dead.[25] This was the second hotline call involving the family. On 4/13/01, just 7 months prior to Evan's death, the neighboring state's Department of Family Services (DFS) called the Illinois hotline to investigate when several patrons from a neighboring state's bowling alley witnessed Melvin Corbit hitting Evan who was 22 months old. Witnesses reported observing Melvin striking Evan several times, including hitting him in the head with an open hand and pushing his head forward until it struck the wall in front of him. Evan was kneeling on the ground with his coat over his head. The overnight mandate worker assigned to the case interviewed an officer of the local police department. The officer stated that he interviewed Mr. Corbit, who denied hitting the child. Mr. Corbit was arrested by the neighboring state's police for Battery of a Child, a class D felony in that state. The officers reported that Evan was red about the face when they first arrived at the bowling alley.

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[25] The Grant family and Mr. Corbit lived together in Illinois. As a result, Illinois DCFS is the agency that became involved with the family even though the 'A' sequence incident occurred in a neighboring state and Evan was pronounced dead at the hospital in the neighboring state.

Evan was taken to the hospital in the neighboring state and examined by a doctor who found no visible injuries. There were no reports of the other child, Tamika, being struck. The children were released to their maternal grandmother, Brenda Grant. The mandate worker spoke with Brenda Grant who reported that the children were seen at the hospital and there were no injuries. A second investigator interviewed Felicia Grant on 4/14/01, who denied any abuse by her paramour, Mr. Corbit. This investigator also saw Tamika and Evan on 4/14. The investigator did not observe any signs of abuse on either child. The investigator interviewed 5-year-old Tamika in front of her mother and grandmother. During that interview, Tamika reported that she saw Melvin Corbit hit Evan on top of the head with his hand while at the bowling alley.

On 4/18/01 Rochelle Matson was assigned the investigation. She spoke with Brenda Grant and learned that Mr. Corbit was still in jail in the neighboring state for felony battery and that Felicia and the children were staying with her. CPI Matson also spoke with Felicia Grant who denied any physical abuse by Mr. Corbit and stated that there were no injuries to Evan. Felicia Grant was of the opinion that the situation was misinterpreted. Ms. Matson also attempted, unsuccessfully, to speak with Becky Powell, the neighboring state DFS worker who called the hotline, on 4/19/01. Allegation # 22, substantial risk of physical injury, was unfounded on 4/19/01, six days after the hotline was contacted.

'A' Sequence

Police Investigation

Georgia Nicks, the bowling alley manager, contacted the state's police department on 4/13/01 about an ongoing incident of child abuse, which several patrons had witnessed throughout the night. Officers arrived at the bowling alley at 9:31 p.m. The police interviewed Felicia Grant and Melvin Corbit and observed Evan and Tamika Grant. Additionally, the police requested that witnesses in the case go to the police station to write and sign statements regarding the incident they observed. Four witnesses provided signed statements to the police department detailing the abuse that they had witnessed that night. Three of the witnesses went directly to the police station when Mr. Corbit was arrested. The fourth went to the police station to provide her statement after her shift ended at the bowling alley. One officer went to the hospital with Felicia Grant and the children for Evan to be examined, and Mr. Corbit was arrested and taken to the police station for further questioning. When questioned by the police, Mr. Corbit denied the allegations that he had hit Evan. A detective found the witness statements to be credible, providing strong enough evidence to charge Mr. Corbit with Battery of a Child and report the abuse to the state's DFS on 4/13/01.

DCP Investigation

Becky Powell was the mandate worker in the neighboring state and called the case in to the Illinois hotline at 11:47 p.m. on 4/13/01, when she learned that the family lived in Illinois. The overnight mandate worker made initial contacts and passed the case on to the weekend mandate worker. The overnight mandate worker attempted phone contact with the neighboring state's DFS worker, Becky Powell, spoke with a neighboring state police officer and spoke with Brenda Grant, maternal grandmother of Evan and Tamika. The officer stated that the police received a report that Melvin Corbit struck Evan with an open hand and a closed fist on the head and that he also kneed Evan in the head. There were witnesses who reported that Evan was crying while he was being struck. Witnesses also reported that Evan's mother, Felicia Grant, was bowling when the child was being struck and did not see the alleged abuse. The officer further stated that he interviewed Mr. Corbit who denied striking Evan. Mr. Corbit was arrested for battery of a child and was being held in jail in the neighboring state. The officers who arrived at the bowling alley first, reported that Evan was red about the face when they saw him. The police accompanied Ms. Grant and Evan to the hospital where Evan was examined and no visible injuries were found. Tamika and Evan had been released to their maternal grandmother, Brenda Grant. The overnight mandate worker requested a list of the witnesses and a copy of the hospital discharge form from the neighboring state's police officer. The officer also provided the overnight mandate worker with three

signed witness statements and supplemental narratives from two officers who went to the bowling alley. The witness statements detailed Mr. Corbit's actions throughout the night and supported the allegation of physical abuse of Evan. When the overnight mandate worker spoke to the maternal grandmother, the grandmother stated that the hospital found no injuries and she understood that witnesses at the bowling alley reported that Mr. Corbit was banging Evan on the head, made him sit in the corner with a coat over his head and made him sit on his knees.

The weekend mandate worker made his first investigative contact at 2:00 p.m. on 4/14/01. At that time he completed a Child Endangerment Risk Assessment Protocol (CERAP) at maternal grandmother's home and interviewed Felicia Grant, Tamika and Brenda, and observed 2 year-old Evan. Felicia Grant stated that the report was untrue, that Mr. Corbit had never hit either of the children, and that she does not allow corporal punishment of her children. When the weekend mandate worker spoke to Tamika, her mother and grandmother were present. Tamika stated that she saw Mr. Corbit hit Evan at the bowling alley on top of his head with his hand. While the weekend mandate worker may have questioned Tamika about whether or not she received any abuse herself, no such questions are documented. When the weekend mandate worker observed Evan, Evan was asleep. The weekend mandate worker notes indicate that *mom* says that there are no scars, bruises or signs of abuse (emphasis added).

CPI Rochelle Matson was assigned the investigation on 4/18/01. On that day, Ms. Matson spoke with maternal grandmother Brenda Grant on the phone and learned that Felicia Grant was staying with her and that Mr. Corbit was still in jail. She also spoke to Felicia Grant at that time. Ms. Grant stated that the whole incident was a misunderstanding and that Evan put his vest over his head because he was playing peek-a-boo. She did not see any redness on Evan and believes that everything was misinterpreted and the police report did not include any of the statements she gave to the police. She further stated that some of the people at the bowling alley said that the situation was racial. She was not asked to, nor did she provide, any names of collateral witnesses that could verify that the witness statements were racially motivated. Ms. Matson told the mother that the children could return home with her. Rochelle Matson staffed the case with her supervisor, Jordan Holmes, on 4/18/01. Mr. Holmes' supervisory instructions were to contact the reporter to verify the allegations and gather additional information and to see Mr. Corbit if he was out of jail. On 4/19/01 Ms. Matson attempted, unsuccessfully, to contact Becky Powell from the neighboring state's DFS. She then unfounded and closed the case, one day after the investigation was assigned to her, based on the lack of evidence of abuse at the hospital and the opinion that the witness statements were "not consistent" with the reporter's account of the incident.

Criminal History Review

The Illinois State Central Register (SCR) conducted criminal background checks on 4/13/01 on both Felicia Grant and Melvin Corbit. Felicia had one arrest, for retail theft in 1998, and no convictions. Melvin had no convictions, but he had a pattern of arrests for assault, including two for domestic violence. He had a total of 21 arrests over a 13-year period. Other arrests included five for invasion of privacy, two for disturbing the peace, and five for obstructing justice. This information as to Melvin's criminal history record was not further investigated during the course of the DCP investigation and underlying police reports were not obtained. Had the underlying documents for the arrests been requested, DCP would have learned that two of the assault arrests were for domestic battery, stricken on leave in court, as well as past charges for simple battery and aggravated assault. The alleged domestic battery victims were family members of, or shared a home with, the perpetrator. These underlying documents suggest a pattern of violent behavior.

'B' Sequence

Second DCP Investigation – Death Investigation

In November 2001, seven months after the A sequence investigation was unfounded, the Illinois hotline was called with a report of abuse on Evan. The report stated that Evan was pronounced dead at a hospital in the neighboring state. At the time Evan arrived at the hospital, he was not breathing correctly, was choking, unresponsive, and coughing up blood and water. Additionally, he had bruises to the face, head, left abdomen, legs, and arms. The report alleged that Melvin Corbit was the caretaker of Evan and Tamika when the incident occurred and that Mr. Corbit admitted to spanking Evan, pulling him out of the bathtub and violently shaking him. It was not believed that Tamika was a victim of abuse. Felicia Grant was not in the home when the abuse occurred. A CERAP was completed and the mother agreed for Tamika to stay with her maternal grandmother, Brenda Grant.

During the investigation of the 'B' sequence, the Child Protection Investigator interviewed Felicia Grant three times, interviewed Brenda Grant four times, interviewed Christopher Grant, maternal uncle to Evan and Tamika Grant, interviewed Tamika twice, set up a Victim Sensitive Interview (VSI) for Tamika, and maintained contact with the Cook County Sheriff's Department and the State's Attorneys Office, Abuse/Neglect Division. In order to investigate this case completely, DCP requested, and was granted an extension on this case.[26]

During the investigation of the 'B' sequence, DCP learned that Felicia had unrealistic expectations about how children should behave: she stated that Evan was a problem at times in that he did not listen, refused to help his sister clean the room, and he was always talking back (i.e., constantly saying "no") and was angry. The DCP worker noted that Felicia did not appear to understand typical behavior for a 2-year-old child. Additionally, DCP learned that Evan had developed a fear of water. He did not like to go out in the rain and did not like having water poured on him, but could tolerate taking a bath. Felicia did not know how the fear began, but stated that Mr. Corbit knew of this fear and, consequently, would discipline Evan by pouring water over his head. When asked, Felicia could not give a reason why she allowed Mr. Corbit to do this when she knew of Evan's fear of water.

OIG INVESTIGATION

Scene Investigation and Witness Interviews

The OIG investigatory team interviewed three of the witnesses to the 'A' sequence incident at the bowling alley in April 2001: Georgia Nicks (the bowling alley manager), Joslin Dell, and Rhoda Crown. Two of these witnesses, as well as Mr. Corbit and Felicia, belonged to a bowling league that played every Friday night. Mr. Corbit and Felicia were at the bowling alley for approximately three hours during league nights. The manager reported that on the night of 4/13/01, approximately 44 of the 48 bowling lanes were in use by the league. Upon entering the alley, you must walk up a few steps, which brings you to the level of the office and seating areas. Directly across from the front entrance is a low counter with chairs in front of it. The counter runs the entire length of the bowling alley with intermittent breaks to allow patrons to access the bowling lanes. In order to get to the lanes, you must walk down a few steps through these openings. Witnesses reported that on 4/13/01, Evan and Melvin Corbit were sitting just to the left of one of those openings almost directly across from the front entrance. Blanca Lopez, another witness to the incident, sat across the opening from Mr. Corbit and Evan. From where Evan and Mr. Corbit were seated that night, the rental desk is located to the left and the bathrooms are located to the right. The rental desk has a clear view of the seats and people in that area. Additionally, many people, including Ms. Crown and Ms. Dell, had to walk past Evan and Mr. Corbit several times that night in order to use the bathrooms.

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[26] Rule 300.90 states that a final determination on an abuse or neglect report should be made within 60 days from the time that the initial report is received. However, a 30-day extension may be requested, if necessary.

Ms. Nicks, the bowling alley manager, related that on a typical Friday night there would be dozens of children running around and playing games. Additionally, the noise in the alley is tremendous, with 5 people per open lane, music in the background, and the sound of bowling balls striking pins on the lanes. Over all this noise, two of the witnesses recall being able to hear Evan's head knock against the wall, when Mr. Corbit would push the child's head into the wall. Ms. Crown is a former public school teacher and is familiar with normal child behavior and corporal punishment of children, however, she felt strongly that the force Mr. Corbit used with Evan was excessive. Ms. Dell is currently a special education teacher and is also familiar with children and the use of corporal punishment. Ms. Dell stated that over the course of the weeks that Mr. Corbit and Ms. Grant participated in the league, she never saw Evan or Tamika eating. Additionally, she observed that the children were expected to sit quietly and still while Ms. Grant and Mr. Corbit bowled and that the children appeared afraid of Mr. Corbit.

When Ms. Nicks came to observe the situation, after she had been alerted to the problem, she noted that after Mr. Corbit hit Evan on the head, Evan curled up on himself, shook, and tried to get closer to the wall, and further away from Mr. Corbit. Each of these witnesses indicated that they would have been willing to speak with Illinois DCP if they had been contacted about the incident. Additionally, they were able to provide the name and phone number of a woman, Blanca Lopez, who had sat across the aisle from Mr. Corbit and Evan the entire night.

The OIG interviewed Blanca Lopez. Ms. Lopez stated to OIG investigators that she was 3 or 4 chairs down from Mr. Corbit and Evan at the bowling alley on 4/13/01. She saw Evan running around early on in the night and remembered that he appeared happy and was smiling. About 30-45 minutes into the game someone else pointed out the abuse to her. After that, she attempted to discreetly watch Mr. Corbit and Evan so as to not be seen by Mr. Corbit. She stated that Evan was sitting on his knees with a coat over his head and never moved from the position for approximately 2 hours. Each time Mr. Corbit came back from bowling he would stick his head under the counter and say something to Evan and then hit him with an open hand on the back of the head. The force of the hit would knock Evan's head forward into the wall. She thought that it was unusual that Evan just sat there and took the abuse without trying to run away from Mr. Corbit. She remembers that it was hot in the bowling alley and when the officers came and removed the jacket from Evan's face, he was flushed and sweating. Towards the end of the evening she reported the abuse to the management of the bowling alley. At all times she tried to ensure that Mr. Corbit would not know that she was watching or that she was the one who reported the abuse. After observing his actions throughout the evening she felt that Mr. Corbit might have become aggressive with her if he knew that she was responsible for the police being called. As a result, she insisted that her fiancé's father walk her out to her car that night when she left the alley.

The neighboring state's police department conducted all witness interviews. Illinois DCP made no attempts to contact eyewitnesses and a scene investigation was never completed.

Contacts with the Neighboring State Prosecutor and Law Enforcement

The prosecutor on the case provided the OIG with medical records from the hospital where Evan was treated and provided information on the status of the case. The charge of Criminal Battery to a Child is currently pending in the neighboring state. Additionally, the detective provided this office with his complete file on the case and offered to assist in any way. In his file, a fourth witness statement by an employee of the bowling alley was found which detailed abuse that was not evident in the other three statements. Significantly, this is the only statement that included an account of Mr. Corbit kneeing Evan in the head, a fact included in the CANTS 1, and a report of hearing Evan crying throughout the night.

Autopsy
At the time that this report was written, the autopsy on Evan Grant was still awaiting a final signature before it could be released. However, a preliminary oral report to the OIG indicated findings of Cerebral Edema, Cerebellar Tonsillar Herniation, fresh scalp hemorrhages and multiple recent and old bruises.

Review of Personnel Files
The OIG investigator reviewed the personnel files of CPI Rochelle Matson and her supervisor, Jordan Holmes. Rochelle Matson began working for the Department of Children and Family Services (DCFS) in May of 1993 as a Child Welfare Specialist I. She became a Child Protection Investigator (CPI) in March of 1995. At the time of the 'A' sequence, Ms. Matson had been a CPI for 6 years. Her annual evaluation in 1998 indicates that she is knowledgeable of DCFS/DCP rules and procedures. Additionally, it indicated that her case completion rate needed improvement. The 10-day completion rate goal of 70% was not met (Rochelle completed 22%.) nor was the 30-day completion rate of 85% (Rochelle completed 34%.). By her 2000 evaluation her 30-day completion rate had increased to 97% and she met or exceeded all expectations.

Jordan Holmes began working for DCFS in March of 1975 as a Social Worker I. He became a Public Service Administrator in October of 1997. His 1999 annual evaluation indicates that his team has exceeded the objective of 75% of investigation completed within 30 days (his team completed 94.3%) and the objective of 84% of investigations completed in regards to intake (Mr. Daniel's team completes 99.8%). By his 2000 annual evaluation, his investigation completion rate with regards to intake was 100% and his 30-day completion rate was 95.1%. His supervisor remarked that these rates were "exceptional."

OIG Interviews with DCP
In an interview with the OIG, Rochelle Matson stated that she had already been disciplined in connection with this case. In early November, shortly after Evan's death, she was put on desk duty. Desk duty continued until April 1st when she was given a 5-day suspension. She returned to her regular duties on 4/8/02.[27] She is currently appealing the discipline. Ms. Matson reported that she received the case on 4/18/01 from her supervisor, Jordan Holmes. She recalls that the witness statements in the file were varied and Mr. Holmes was of the opinion that they were inconsistent, which is the term she used in her write-up of the case. Ms. Matson recalled that on 4/19/01 Mr. Holmes approached her and instructed her to try to contact the reporter again, and then to initially unfound the case. He reasoned that the doctor found no evidence of abuse and that the witness statements were inconsistent. He further instructed Ms. Matson to indicate that Mr. Corbit was "inaccessible" on the CANTS 2 form. Ms. Matson did as she was instructed and closed out the case and completed the write-up on 4/19/01.

In his interview with the OIG, Mr. Holmes recalled the Grant case and stated that he recommended to Rochelle Matson that she initially unfound the case for several reasons. He stated that the witness statements conflicted with each other; the emergency room doctor found no evidence of abuse; both Felicia and Brenda Grant stated that Mr. Corbit had never physically disciplined the kids before; and there was some indication that the report may have been racially motivated. Since he did not see anything that raised suspicion at that time he directed Ms. Matson to indicate that Mr. Corbit was inaccessible because he was incarcerated out of state and to initially unfound the case. He stated that at the time he was under the impression that DCP could not cross state lines in the investigation of an allegation of child abuse or

[27] The discipline report was submitted to Ms. Matson's personnel file after it was requested and reviewed by OIG in January 2002. The discipline was verified by OIG following the interview.

neglect. Mr. Holmes informed the OIG that he had received a five-day "paper suspension"[28] from 4/30/02 to 5/6/02 in connection with this case.

ANALYSIS

DCP Contacts

Outside of the contact that the mandate worker made with the neighboring police officer, Illinois DCP had no contact with the neighboring state's police. No effort was made to verify the charges against Mr. Corbit, whether he was still in custody, or to attempt to gather any further information that the police may have had. Additionally, full medical records from the neighboring state's hospital were never requested. The officer faxed over a brief discharge form, but the doctor's notes were not requested, nor was any attempt made to speak with the doctor who examined Evan on 4/13/01. Furthermore, none of the witnesses to the incident were contacted by DCP and a scene investigation was not conducted. Before it can be determined that statements are truly inconsistent with each other, it is necessary to learn the context in which those statements were given and to verify them with the writers. A basic inquiry into where the incident occurred and who witnessed it was not done. Had DCP conducted a complete investigation into this case by contacting the collateral witnesses and completing a scene investigation, any inconsistencies in the witness statements could have been cleared up when it was learned that each witness saw the abuse from different places in the bowling alley, at different times, over a two-hour period. Additionally, the witnesses could have provided DCP with the name of another witness that had not completed a statement, but had sat near Mr. Corbit and Evan the entire night. Furthermore, the worker could have learned that two of the witnesses had experience teaching and working with children, which lends more credibility to their statements. Finally, had further contact been made with the neighboring state law enforcement, Ms. Matson could have learned that Mr. Corbit was still being held in the county jail, that the State's Attorney was pursuing the case for Criminal Battery of a Child, and could have received a fourth witness statement from another employee of the bowling alley. A full investigation could have provided enough facts to indicate the case for Risk of Harm.

When interviewed by the mandate investigator, Felicia Grant indicated her disbelief that the abuse occurred. She indicated that Melvin, her paramour, had never, to her knowledge, hit Evan or Tamika and that she doesn't allow corporal punishment of her children. The grandmother concurred with Felicia's statements. Felicia Grant stated that she believed that the report of abuse against Mr. Corbit was racially motivated. The mother's statements should have been weighed carefully against her interest in protecting her paramour, Mr. Corbit. Her allegation that the report of the abuse was racially motivated could have been evaluated by speaking with the witnesses on the case.

Evidence of Abuse

Research has indicated that while some bruises may appear almost immediately, some may take 24-48 hours to appear (Langlois & Gresham, 1991). Superficial bruises are more likely to appear quickly, while bruises with deeper tissue injury, such as an injury to a thigh, may take days to appear (Schwartz & Lawerence 1996). Evan was seen at the hospital in the neighboring state immediately after the abuse. At that time the doctor reported no signs of abuse. The mandate worker saw Evan the next day – approximately 15 hours after the abuse occurred – and saw no signs of abuse at that time. The mandate worker's notes do not indicate whether he made a visual inspection of Evan's body while he was sleeping or whether it was necessary to pull any covers back in order to do this. He appears to have taken the mother's word that there were no signs of abuse.

[28] A paper suspension involves a written suspension that is not actually carried out. The discipline goes on the employee's record, but no days or wages are lost and the employee continues to work as usual.

Safety Evaluation

In evaluating whether it was safe for Evan to remain in the home with Felicia Grant and Melvin Corbit, several errors were made. First, the statements of independent witnesses were disregarded in favor of the mother's denial of the abuse and allegation that the witnesses were racially biased. In fact, the mother's allegation of racial bias is the only indication of any bias in the witness statements. There is no explanation for this belief and there is nothing in the record to support the allegation. Second, there was no evidence that DCFS' paramour policy or LEADS protocol was followed.[29] The policy specifically states that child victims and non-involved subject children should be interviewed without the paramour and/or parent present. Tamika was interviewed while in the presence of her mother and her grandmother. Underlying documents were not requested regarding Mr. Corbit's criminal history. An initial criminal history report will not indicate whether an assault or battery was a domestic battery. This is only available through those underlying documents. Ascertaining the presence of domestic violence is important in evaluating the safety of the children in the home. Child abuse occurs in approximately 40% of homes where domestic violence is present (Appel & Holden, 1998). Third, the guidelines for allegation #22, Substantial Risk of Physical Injury, cite violently pushing or shoving the child into fixed or heavy objects as an example.[30] Evan was pushed against a wall repeatedly over a two-hour period.

The OIG, in a previous investigation, addressed the presence of domestic violence in abuse and neglect investigations and ongoing cases.[31] At that time it was recommended that the Department's consultant on Domestic Violence should be consulted in *all* cases in which domestic violence is an issue (emphasis added). The OIG investigator contacted the current Domestic Violence Program Coordinator for DCFS regarding their role in investigations and cases where domestic violence is present. The Domestic Violence Program Coordinator informed the investigator that she is consulted in cases where domestic violence is identified as a primary issue in the case. In cases where domestic violence is identified as a collateral issue she is rarely consulted. The previous OIG recommendation has not been fully implemented. Since domestic violence may not be discovered until the caseworker has worked on the case for some time and rapport has been established, the issues surrounding domestic violence may still be easily overlooked. Given the high rate of overlap between domestic violence and child abuse (Appel & Holden, 1998), it is imperative that domestic violence issues be adequately explored in abuse cases, especially when a parent or paramour has a history of arrest for alleged battery.

Rochelle Matson

Ms. Matson had six years of experience as a CPI when she was assigned the Grant case. She was familiar with DCFS policies and procedures. Her only investigative contacts during the investigation were two phone calls: one call to the maternal grandmother and the other call received from a woman who identified herself as Evan's mother. When her supervisor approached her and recommended that she unfound and close out the case, she should have been aware that the mandate was not met and the investigation was not complete. Ms. Matson closed out this case, at her supervisor's directive, one day after she received it.

Jordan Holmes

Before the case was completed and unfounded, Mr. Holmes had the opportunity to review the case file. A review of the case file would have determined that the reporter was never actually contacted and the perpetrator was not interviewed. In fact, Mr. Holmes' supervisory instruction to Ms. Matson was to interview Mr. Corbit *if* he was out of jail (emphasis added). Mr. Holmes and Ms. Matson were aware of Mr. Corbit's suspected pattern of violence from his criminal history record. There is no exception in the rules governing DCP investigations for alleged perpetrators that are in jail. The perpetrator must still be

[29] Rule 300, Appendix H, August 15, 2000.
[30] Rule 300, Appendix B as of June 1, 2000.
[31] See OIG case #970700.

interviewed within seven days and, in fact, jail may be the best place to interview the alleged perpetrator in cases where there is a suspicion of violent behavior. Furthermore, Mr. Holmes' belief that DCP could not cross state lines is unfounded. There is no DCFS rule or procedure that restricts an investigation to Illinois. While DCFS may not have jurisdiction outside of Illinois, a DCP worker may still conduct interviews, complete scene investigations, and contact law enforcement out of state.

Proper abuse investigations are difficult and intensive. Abuse allegations closed in less than 30 days should be the exception to the rule. Mr. Holmes' high 30-day closure rate (94.3%) may have investigative costs in abuse cases. Evan Grant's case was barely investigated at all. Given the fact that the investigation was woefully incomplete, it is unconscionable that Mr. Holmes would have approved, and even recommended, the unfounding of this case.

Recommendations

1. *This recommendation addresses personnel issues.*

2. *This recommendation addresses personnel issues.*

3. Mr. Holmes' poor supervision and inability to direct and/or conduct a full child protection investigation placed Evan Grant at risk of harm. Therefore, Mr. Holmes' supervisor should review unfounded investigations under Mr. Holmes' supervision within the past 12 months and the next three months.

4. DCFS should revise procedures to require a scene investigation in all DCP investigations of abuse, provide guidance on how to conduct a scene investigation, and that scene investigations and mock demonstrations are required components of an investigation. (Previous recommendation from OIG case #020811.)

5. In this case, had further contact been made with the neighboring state law enforcement, DCP would have learned that the alleged perpetrator was still being held in the county jail, that the State's Attorney was pursuing the case for Criminal Battery of a Child, and could have received a fourth witness statement from another employee of the bowling alley. DCFS should advise child protection investigators and supervisors to work closely with law enforcement when criminal charges for child abuse or neglect, related to the current case, are pending against an alleged perpetrator.

6. The OIG reaffirms its recommendation made on June 17, 1998, that in **all** cases in which domestic violence is an issue, not just those in which domestic violence is the primary issue, the supervisor should consult with the Department's consultant on domestic violence as to the appropriate services that should be incorporated into the case plan. In addition, the domestic violence consultant should be available as a consultant for the duration of the case and should be included in the joint staffing discussing the return home of children. The Department should track the number of referrals made to the consultant and should reassess the referral process three months after implementation of the domestic violence consultation referral process. (Modified from a previous recommendation from OIG case #970700.)

7. Closure rates for abuse cases should be calculated separately from closure rates for neglect cases within each DCP team. In teams where 30-day closure rates for abuse cases are high, there should be a review of unfounded abuse cases by the Field Service Manager.

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Office of the Inspector General

REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names are fictitious.

OIG No. 010732
Minor: Troy Ashford – 09/94 to 02/01
Subject: Death Investigation

Summary of Complaint

Troy Ashford, who was six and a half years old, died in February of 2001, after his foster parent allegedly placed him in a shower of cold water as a punishment. According to the Medical Examiner, Troy died of hypothermia due to immersion in cold water. The Medical Examiner's examination revealed substantial evidence of remote and recent external injury, as evidenced by scars, bruises, and abrasions. There had been one prior hotline report on this foster parent in May of 2000, also for having placed Troy in a cold-water shower as punishment. The Department unfounded this report.

Investigation of Facts

This investigation is based in large part on a review of the documents contained in the foster parent's licensing file and Troy's case file. The OIG investigator was unable to interview key Beta Agency personnel, the agency involved in this case, because they had left the agency. The OIG investigator has referenced some interviews made by staff from the Department's Agencies and Institutions Licensing Division in connection with its licensing complaint investigation of Beta Agency.

Summary

Troy Ashford became a ward in January of 1999 after a neighbor called the hotline when she found him wandering on the street. The Department subsequently indicated a report against his mother for inadequate supervision.[32]

The Department placed Troy, who was four and a half years old at the time, with his foster parent, Nancy Brady, shortly after he came into care. Troy remained with Ms. Brady until his death.

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[32] Although Troy's last permanency goal was return home, case documents indicate that his mother, who has a history of mental illness, had not been cooperative with services.

Ms. Brady was licensed in 1995 by a private agency, Alpha Services. In 1998, Ms. Brady transferred her license to another private agency, Delta Services, for a brief period. The record does not document the reason for the transfer nor the date the license was transferred. In April of 1998, Delta Services placed three month old Eric Carver in Ms. Brady's home. Delta Services closed and in June of 1998, the license and Eric's case were transferred to Beta Agency. Beta Agency placed Troy in Ms. Brady's home in January of 1999. Both Eric and Troy remained in Ms. Brady's home until Troy died. After Troy's death, the Department learned that Ms. Brady had two teen-age daughters whom she had claimed were her nieces and who had been living in the home, that Ms. Brady had been receiving public assistance for her daughters, that she had an older son, and that she had falsified her birth date on her licensing application.

In May of 2000, Troy's therapist called the hotline to report that Troy had told her that Ms. Brady had punished him by making him stand in a cold shower. A Child Protection worker investigated the report and unfounded it two months later. Because of concerns regarding the care and supervision provided by Ms. Brady, in August of 2000, Beta Agency issued a fourteen-day notice to Ms. Brady for the removal of Troy and Eric from her home. Ms. Brady appealed the decision. After mediation between the parties, they agreed that the agency would withdraw its notice, Ms. Brady would withdraw her appeal, and Troy would remain in Ms. Brady's home. Just one day before Troy died, a worker from Screening, Assessment, and Support Services (SASS) came to the foster parent's home to evaluate Troy in response to concerns by his therapist and the foster parent that Troy was having a psychotic episode. The SASS worker recommended that Troy receive a psychiatric evaluation and discussed services with the foster parent. Troy died the following day.

Troy in Ms. Brady's Home

Troy was almost four and a half years old when Beta Agency placed him in Ms. Brady's home in January of 1999. A social history completed by the Beta Agency caseworker in March of 1999 notes that Troy's mother had been admitted to the hospital the week before Troy came into care. Ms. Ashford reported a history of depression and non-compliance with medication, although at the time of the report she was taking Seroquel and Depakote. Ms. Ashford reported to the worker concerns she had about being kidnapped off the street. Her mother reported that Ms. Ashford sometimes had hallucinations. Troy was described as a child who stuttered. Later medical reports stated that Troy suffered from asthma.

Troy's first caseworker at Beta Agency was Amanda Swag. When Ms. Swag took Troy to Ms. Brady's home, she noted that Ms. Brady's ten-year-old and twelve-year-old "nieces" were at the home and that Ms. Brady said they visited daily and would be good interaction for Troy. After Troy died, Beta Agency and the Department learned that these "nieces" were actually Ms. Brady's seventeen-year-old and sixteen-year-old daughters who had lived in the home. On her foster care license application, Ms. Brady had claimed to live alone. According to notes in the file, Ms. Swag visited the foster home monthly from January through May of 1999. During this time Ms. Brady reported some problems with Troy including stealing, hiding food, aggressiveness with the other foster child (February visit), and enuresis (March visit).

Notes from a service plan dated April of 1999 about Troy's adjustment state that Troy was "quiet...mild mannered" and that his adjustment was "going well." In May of 1999, Ms. Swag questioned Troy regarding corporal punishment by Ms. Brady and Troy denied having ever been spanked by her. There is nothing in the record documenting why Ms. Swag asked Troy about corporal punishment, and it is not clear whether Ms. Brady was present at the time of this conversation. Notes from another service plan dated July of 1999 describe Troy as "very active," that Troy appeared to be "adjusting well" to his placement, and that Ms. Brady reported that he was a good child. According to her notes, Troy had begun to "wet and soil his pants at odd times, like playing, watching TV." She stated that Ms. Brady had spoken

with the doctor who recommended that she watch what Troy ate and limit his liquids after 6:00 p.m. to see if that would control the situation. The doctor also recommended counseling.

The record indicates that Ms. Swag did not make monthly home visits after May of 1999. There are no home visits recorded for the following: June, July, and August of 1999; October of 1999 through April of 2000; and June of 2000. The last recorded home visit by Ms. Swag was in September 1999.[33] According to Ms. Swag's notes, Ms. Brady said the doctor had prescribed a nasal spray to help with Troy's enuresis. Ms. Brady told the case manager she was going to enroll Troy in school. There is no further documentation in the file reviewed by the OIG investigator regarding other home visits until July of 2000 when Megan Kohler, who became the new worker assigned to the case, made her first home visit.

In October of 1999, Ms. Swag referred five-year-old Troy for a mental health assessment. Ms. Brady's description of Troy to the mental health worker included the following: sometimes a "regular" child and talkative but at other times very withdrawn, has encopresis and enuresis three times a week, very aggressive around children, walks out of the apartment, has nightmares, talks to himself, makes believe a lot, hurts himself by hitting his head and falling on the floor, breaks and throws things, has a pattern of excuses and lying, and has speech delays. The examiner wrote that the foster parent was "very caring and concerned" and seemed to have developed a good and close relationship with him. The examiner recommended that Troy receive speech therapy, individual and family therapy and enroll in a specialized preschool program.

Troy participated in his first therapy session on April 7, 2000, with therapist Alexa Sector.[34] It is unclear from the record why it took so long for therapy to begin. There is a note from Ms. Sector in March of 2000 indicating that she had set up two appointments with Ms. Brady who did not attend. Ms. Swag later told the therapist that Ms. Brady had been in the hospital.[35] Ms. Sector's plan was to provide short-term therapy for Troy's behavioral issues and then transfer him to another therapist for family therapy with his biological mother.

Although Ms. Brady attended Troy's first appointment, Ms. Sector wrote that Troy's "foster sister" accompanied Troy to one of the sessions and that Ms. Brady's "daughter" accompanied him to another session. Ms. Sector's notes state that Troy did not attend three of the sessions because of transportation problems as reported by Ms. Brady. On May 5, 2000, Ms. Sector spoke with Ms. Brady who had concerns about Troy and who was also concerned because his caseworker had left the agency and she had not been contacted by anyone. Ms. Swag left the agency sometime in April or May of 2000.

On May 16, 2000, Ms. Sector called the hotline to report allegations Troy had made to her concerning Ms. Brady. According to Ms. Sector's notes, Troy reported to Ms. Sector that Ms. Brady, who had accompanied him to that therapy session, had punished him for stealing a cupcake by making him stand in a cold water shower, that this had happened before, and that his foster mother had also 'whooped' him by hitting him on the side of the head with an "open hand." Ms. Sector noted that Troy began to cry as he told this. Ms. Sector called her supervisor and Troy repeated the same story in his presence.

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[33] According to an interview note by a DCFS Public Administrator who conducted a licensing complaint investigation of Beta Agency, the Quality Assurance Specialist at Beta Agency said Beta Agency terminated Ms. Swag's services because she had failed to make home visits.

[34] Although the examiner had recommended speech therapy, it does not appear as if Troy attended speech therapy sessions.

[35] The OIG investigator contacted area hospitals to determine if Ms. Brady had been hospitalized. None of the hospitals were able to confirm any hospitalization for Ms. Brady. The caseworkers' notes do not reflect any information or knowledge supporting Ms. Brady's alleged hospitalization.

Ms. Sector spoke to Ms. Brady about the allegations. Ms. Brady denied the allegations and told her when Troy had taken a cupcake without permission she had talked to him about his behavior. She said the only time he was in cold water was when he got into a shower before the water was warm. According to Ms. Brady, Troy had made false statements in the past after visits with his mother. Ms. Sector described Ms. Brady as "very cooperative," "very concerned," and willing to make the hotline call so that the matter could be investigated. Ms. Sector called the hotline staff who said they were busy and that they would return the call. She then left an "urgent" message for a case management supervisor at Beta Agency to call her. In the meantime, Ms. Sector completed a safety contract for Ms. Brady and Troy which they both signed before they left Ms. Sector's office. The contract stated that Troy would listen to Ms. Brady and follow the rules of the house, that no one would hurt him if he did not follow the rules, and that when he did not follow the rules, Ms. Brady would not allow him to have treats, to watch television, or to have playtime. Ms. Sector wrote that she did not feel Troy was in immediate danger while in Ms. Brady's care. A little later, staff from the hotline called her back and took her verbal report. Beta Agency staff did not complete a licensing complaint investigation nor file an Unusual Incident Report (UIR) after the hotline call.[36]

Three days later, Ms. Brady accompanied Troy to a therapy session. Ms. Brady told Ms. Sector that she had taken Troy to the DCFS office. They had met with the investigator and Troy admitted he had lied. Troy also told Ms. Sector he had lied and said he did not know why he said those things. During the therapy session, Troy continued to say that he had told a story. Ms. Brady spoke of concerns she had regarding Troy's behavior, including staring spells, regression in some developmental areas, enuresis and encopresis, and periods of lows for no apparent reason. After Ms. Brady left the session, Troy continued to say that he had told a story and he didn't know why he had done that. They discussed Troy's reports about not having food. Troy told Ms. Sector that he hadn't eaten that day but after further probing, she noted, "this seemed to not be true."

Troy had three more sessions with Ms. Sector and began with a new therapist, LaToya Paxton, on June 27, 2000. Troy and Ms. Paxton met weekly until Troy's death. Troy missed at least eleven therapy sessions from September 2000 through February of 2001. Few explanations were given for the cancellations. Troy missed six sessions from July through the end of December 2000. Notes state that, as reported by Ms. Brady, two of the missed sessions were due to transportation problems and one missed session was due to a snowstorm. In January of 2001, Troy missed most of the sessions, although Ms. Paxton saw him briefly when Ms. Brady came in to talk about changing the date of his sessions. Ms. Paxton's notes indicate that food and Troy's untruthfulness continued to be a subject of discussion during the therapy sessions. In one session Troy asked for food saying he did not have food at home. As the therapist processed this with him, he admitted he had lied and he did have food at home. In another session, Troy denied having received some candy from the secretary and later admitted he had received it. Ms. Brady continued to report that Troy hid food and expressed her concerns about his other behaviors to the therapist.

Ms. Brady had complained to the DCP investigator that she had not seen a caseworker for a while. As a result, both case management supervisors at Beta Agency visited Ms. Brady in her home on June 12, 2000.[37] In a memorandum to a former licensing supervisor at Beta Agency, dated the same day of their visit, both case management supervisors indicated they had doubts about Troy's allegations concerning

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[36]According to interview notes by a DCFS Public Administrator who conducted the Department's licensing complaint investigation of Beta Agency, the Quality Assurance Specialist of Beta Agency stated that the licensing supervisor did not have her staff complete an investigation because Beta Agency had never received the CANTS 1. The Licensing Supervisor told the DCFS Public Administrator that she could not explain why the complaint had not been investigated because the licensing supervisor at that time no longer worked at the agency.

[37]One supervisor left the Beta Agency in June of 2001; the other left in June of 2000.

the cold-water incident because of Troy's lack of verbal skills. They did, however, express concerns about Ms. Brady's lack of supervision and lack of stimulation for both children, Ms. Brady's inappropriate remarks about Troy (they said she "had compared him to a dog"), and Troy's poor school attendance.

According to notes in the licensing file, on June 20, 2000, Midge Sands, a former licensing representative with Beta Agency, conducted what she termed a "LMV [licensing monitoring visit]/investigation" at Ms. Brady's home to discuss the issues raised by the hotline call and concerns voiced by the transportation staff that Troy had been unsupervised in the parking lot while waiting to be picked up.[38] Ms. Brady denied the allegations of the hotline call, but Ms. Sands noted that she acknowledged having sent Troy downstairs by himself to be picked up by the transportation when she knew they were there, and that she had sent him by himself to the store and to take the garbage out. Ms. Brady called Ms. Sands the following day and accused her of having lied about their conversation, stating that she had never told her she allowed Troy to go to the store by himself.[39] Ms. Brady said her nephew took care of the children and her niece took Troy to therapy. Ms. Sands noted that during the visit the other foster child had tried to unlock the door to run out and that the foster parent did not do anything about it. It appears that there was some discussion about parenting classes for Ms. Brady who said she would not take the classes.

Shortly after Troy's death, Beta Agency staff interviewed Ms. Sands. According to those interview notes dated March 14, 2001, Ms. Sands stated that she was not the licensing representative but because she was one of the senior workers in the unit, Beta Agency had sent her to investigate Ms. Brady's home following the hotline call. She stated she conducted a walk through the house and did not see any indication that anyone lived in the home except Ms. Brady and the two foster children. Ms. Sands interviewed Troy who told her Ms. Brady would make him take cold showers when he was misbehaving. According to the interview notes, Ms. Sands did not believe Troy was lying – she found his story to be clear and concise and it matched the story he had reported to the therapist. Ms. Sands did not make a new hotline call. She discussed the corporal punishment policy with Ms. Brady and had her re-sign the form acknowledging that corporal punishment would not be used against a foster child in her home. Ms. Sands said she reported these concerns (she did not specify which concerns) to her supervisor and recommended that the children be removed from the home. Although the 14-day notice was sent, Ms. Sands said Ms. Brady appealed the removal and Beta Agency agreed to drop its decision to remove the children.

Megan Kohler became the new caseworker on June 22, 2000.[40] Documentation in the file indicates that Ms. Kohler made a number of unsuccessful attempts to contact Ms. Brady and visit the home: on July 13, the transportation supervisor reported to Ms. Kohler that Troy could not attend the visit with his mother because Ms. Brady had refused to allow him to go, claiming she had not been notified about the visit. Ms. Kohler called Ms. Brady but she received a recording stating the telephone had been disconnected. That same day, Ms. Kohler sent a letter via certified mail to Ms. Brady's home. The postal service was not able to deliver the letter (there is no documentation as to why the letter could not be delivered) and returned it to Ms. Kohler. Ms. Kohler called Ms. Brady again on July 19 to inform her of Troy's visit – a man answered the phone and hung up and Ms. Kohler left a message on the answering machine. On August 2, transportation staff told Ms. Kohler that Ms. Brady had not returned messages they had left notifying her of transportation arrangements for Troy. A week later, Ms. Brady called Ms. Kohler stating

[38] There is no documentation as to who from the transportation staff called and when the calls were made.
[39] Ms. Sands does not explain how Ms. Brady knew what facts she had documented in her notes about their conversation.
[40] According to CYCIS, Ms. Kohler did not become the worker until October 30, 2000; however, in a memorandum Ms. Kohler sent to the Child Welfare Administrator on August 17, 2000, she stated she had received the case on June 22, 2000.

that she had left messages for Ms. Kohler (Ms. Kohler noted that she had never received the messages) and that she had not heard from transportation regarding Troy's visit.

Finally, Ms. Kohler conducted a home visit on August 10, 2000. As to her observation of the child, foster home, and foster parent, Ms. Kohler wrote, "Troy appearance was well. He was well groomed. No signs of abuse or neglect." As to the child's report, Ms. Kohler wrote, "He [Troy] was playing and he enjoys being with Ms. Brady. He ate a bowl of cereal and he was full." Her notes do not indicate whether she spoke with Troy alone or in the presence of his foster parent. She provided Ms. Brady with medical and dental forms that needed to be completed, discussed Troy's enrollment in school, discussed safety issues concerning proper supervision and positive discipline techniques, and discussed the importance of keeping in contact with her.[41] From that point on, Ms. Kohler documented monthly visits to Ms. Brady's home. The last recorded visit was January 2001. In addition, Ms. Kohler completed a CANTS check on the babysitter whom Ms. Brady stated was her nephew.

On August 2, 2000, the agency sent a letter to Ms. Brady advising her that they were going to remove the children after fourteen days. As a basis for this removal, they stated that Ms. Brady had impeded parental visits, had not provided appropriate supervision, had been uncooperative and hostile, had hung up the telephone and not answered the door, had not provided stimulation for the children, and had not provided adequate medical supervision as to braces worn by Eric, the other foster child in the home.

Ms. Brady appealed the agency's decision. On September 15, 2000, the Department held a mediation hearing. Although not specific on details of the mediation, a Beta Agency supervisor who attended the meeting told the OIG investigator that all who attended the mediation agreed the children should remain in Ms. Brady's home. Troy's Guardian *ad Litem* (GAL) attended the mediation. The GAL told the OIG investigator that Ms. Brady had always appeared to be a "caring and concerned" foster parent. She said that at the beginning she and Ms. Brady had spoken because Ms. Brady had not been receiving case management services from Beta Agency. The GAL felt Ms. Brady had a sincere interest in Troy as she attempted to obtain services for him. After Beta Agency filed the fourteen-day notice, Troy's Guardian *ad Litem* said Ms. Brady became defensive with her about the allegations of non-compliance. Although they no longer saw "eye to eye," the GAL said she felt the mediation had addressed everyone's concerns and that Troy should remain in Ms. Brady's home.

Although Ms. Kohler continued to make monthly visits after the mediation, her case notes offer little insight as to what was going on in the foster home. In early October of 2000, Ms. Kohler noted that Ms. Brady had called to report that Troy had told his teacher that he wasn't eating. From Ms. Kohler's notes, it appears that Ms. Brady told her that Troy was eating and was using this "negative behavior to get what he wants." Ms. Kohler wrote that she had observed this behavior during a parent visit. Ms. Kohler did not record any significant narrative concerning the visits she made to Ms. Brady's home in October, November (Ms. Kohler noted that in November Ms. Brady was approved for specialized care), and December of 2000. In January of 2001, Ms. Kohler wrote in the service plan that Troy "continues to do well in placement. He remains very active. Troy has not been soiling himself as much and the foster parent continues to follow the doctor's recommendations. Troy's behavior, however, is getting worse, according to the foster parent. Troy continues to be manipulative and lies." In an interview with Beta Agency Staff before she left the agency, Ms. Kohler said that her main concerns about Ms. Brady were her unavailability when she first had the case and her lack of supervision. Although she felt both these issues had been resolved, she noted that beginning in February of 2001, Ms. Brady had again begun to cancel home visits and make herself unavailable (this is not documented in the case file and Ms. Kohler does not explain the circumstances of Ms. Brady unavailability).

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[41] On August 17, Ms. Kohler submitted a memorandum to the Child Welfare Administrator outlining the events in this case. The Child Welfare Administrator left Beta Agency September 1, 2000.

On January 23, 2001, Ms. Brady called Ms. Kohler and told her that Troy had gotten into some bleach, but that she had taken him to the doctor who said he was fine.[42] At the same time, Ms. Brady asked to attend her mother's funeral. There are no notes detailing whether Troy was going to accompany her or who would care for him if he did not go.

Troy's therapist, LaToya Paxton, saw Troy briefly on January 30, 2001, when Ms. Brady brought him in for his appointment. According to Ms. Paxton's notes, she observed Troy with a bandage on his face from the burn that Ms. Brady said had been caused when he slipped and fell on a wet floor with spilled bleach. Ms. Brady said Troy had received medical treatment for the burn. Ms. Brady told Ms. Paxton that she could no longer attend the Tuesday sessions and needed a Saturday appointment.

On February 6, 2001, Ms. Brady called Ms. Kohler to report concerns about Troy's behaviors, including an incident in which he had run away that day and comments Troy had made about "things" crawling on him. According to the Unusual Incident Report, Ms. Brady reported that Troy had run away while she was checking the mailbox. He ran out of the apartment complex and ended up at the elevated train station with a woman whom the conductor assumed was his mother. The police were called (it does not state by whom) and they picked Troy up at the el station and returned him to Ms. Brady. Ms. Kohler notified Troy's therapist about the runaway incident. Case entries document that Ms. Kohler had one more contact with Ms. Brady prior to Troy's death in which she and Ms. Brady discussed an upcoming visit between Troy and his mother.

Ms. Paxton met with Troy for the last time on February 8, 2001. She noted that he seemed stable and that he claimed not to remember anything about having run away and knew nothing about "things" crawling on him (he did, however, talk about a monster). Ms. Paxton consulted with a doctor and they recommended that Troy have an EEG to rule out a possible seizure disorder. Ms. Paxton arranged an appointment for the next day for an EEG and arranged for Troy to be seen for a psychiatric evaluation following the EEG. The following week, Ms. Paxton learned that Troy had not attended the psychiatric evaluation. After she called Ms. Brady to find out what had happened, Ms. Brady left a message saying she had taken Troy to a hospital to get a medical work up and set up a psychiatric evaluation.[43] Ms. Paxton left a message for Ms. Brady to bring Troy to therapy the following Saturday, but Troy did not attend the appointment. A few days later, Ms. Brady called back saying she had not received the message in time to bring Troy to the session.

On February 21, 2001, Ms. Brady called Ms. Paxton to report that Troy had had a psychotic episode that evening. Ms. Paxton contacted the emergency services telephone number of the agency and called the SASS hotline to report her concerns. A SASS worker contacted Ms. Brady who described Troy's psychotic symptoms as "talking out loud and looks up in the sky" and talking about bugs crawling on him. Ms. Brady said Troy was stable at the time and not currently exhibiting the psychotic symptoms that he had exhibited earlier or other disturbing behaviors (such as catatonic, disorganized speech current hallucination or a danger to self or others). The SASS worker also contacted the therapist who said she had never witnessed Troy in a psychotic state and that she had not seen him for two weeks. Because Troy

[42] Medical records document a call Ms. Brady made on January 22, 2001, to a medical group about Troy's burn. According to the clinic note, she spoke with a doctor who suggested that she take Troy to the emergency department as soon as possible. There is no documentation of an emergency room visit in the records the OIG received from the hospital medical records department. There is, however, a note from a doctor from the hospital in Troy's school records file indicating that he had seen Troy for a bleach burn on his face and that he would return to school on February 5, 2001. The OIG spoke with that doctor who confirmed that he had seen Troy for the bleach burn and had written a note excusing him from school.

[43] Medical records from show that Troy had an EEG February 14, for "staring spells."

was asleep and not currently exhibiting any symptoms, they decided to do the assessment the following day.

The next day, February 22, 2001, another SASS worker spoke with Ms. Brady in the morning. Ms. Brady described Troy's behaviors to include urinating/defecating on himself, staring "into space," hitting/scratching child in foster home, hitting the air and saying "something" is pinching him, gorging food, sleeping poorly, displaying attention-seeking behavior in school, lying, stealing, and threatening to kill another student. Betsy Rowan went to Ms. Brady's home to complete an assessment. Ms. Rowan told the OIG investigator that she found Ms. Brady "mild mannered and pleasant." Ms. Rowan described Troy as "stable, seemingly depressed mood and appropriate, somewhat withdrawn affect." He did not exhibit any of the behaviors described by Ms. Brady although he did acknowledge that a monster pinched and hit him at times. Ms. Brady repeated some of her earlier concerns regarding Troy's behavior. She told Ms. Rowan that she had taken Troy a few days earlier for an EEG. They discussed Troy's background and his family. For a few minutes Ms. Brady was away and Ms. Rowan questioned Troy about his home. He indicated he liked his foster home. Although Ms. Rowan and Ms. Brady discussed hospitalization, Ms. Rowan did not recommend it because Troy did not fit the criteria for hospitalization, as he did not present as a danger to himself or others at the time. Ms. Rowan did recommend that Troy receive a psychiatric evaluation and she discussed with Ms. Brady the possibility of a 90-day diagnostic placement. She noted that Ms. Brady, who had expressed dissatisfaction with services due to changes in caseworkers, was pleased about the possibility of more services. Ms. Rowan said that Ms. Brady did not seemed "overwhelmed" by Troy's behaviors, but that she was concerned about them.

Troy's School History

According to school records, Ms. Brady enrolled Troy in a pre kindergarten program on September 29, 1999. Troy began school on October 7. School records document that Troy attended only thirteen days of school during the 1999-2000 school year. Troy enrolled for kindergarten in September of 2000. According to school records, Troy was absent thirty-four days from September 2000 through February 23, 2001.[44] Brady wrote a few notes explaining some of the absences, but most of the absences were unexcused. According to Troy's teacher, Ms. Brady attributed some of these absences to Troy's asthma. Troy's teacher told the OIG investigator that no one from the Department had ever contacted her regarding Troy's progress in school. Troy's last service plan, signed by Ms. Kohler and her supervisor and evaluated in January 2001 just one month before Troy died, reports that he attended school regularly. The OIG investigator did not find the Education Report Form (CFS 407) or the Education Profile (Assessment – Form CFS 407-4) in the case file reviewed by the investigator.

Troy's teacher described Troy as a "sweet" child who often appeared sad and withdrawn but who did not present any significant behavioral problems. Although some people who knew Troy found his speech difficult to understand, Troy's teacher said Troy had only a "slight" stutter and she had no problem understanding him. She recalled that he was always hungry and often would eat two or three lunches. When she questioned his foster mother about this, Ms. Brady replied that he was "greedy." She noted this obsession with being hungry occurred at the beginning of the school year and then decreased somewhat in October only to continue the pattern a few weeks later. After she spoke again with Ms. Brady regarding this problem, she noted that Troy stopped asking for food in December. She also had noticed Troy's bandage on his face and said that she accepted Ms. Brady's explanation regarding "spilled" bleach and said she had brought a doctor's statement to school regarding the incident.[45]

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[44] After Troy returned to school after Christmas vacation in January of 2001, he attended January 8-19, was absent January 22 through February 2, returned to school on February 5,6, and 7, was absent February 8, returned February 9, and was absent again until February 15.

[45] As noted earlier, documentation of this visit is contained in Troy's school records.

DCP Investigation

A DCP investigator investigated the hotline call made by the therapist, Alexa Sector, on May 16, 2000. The following morning, May 17, the DCP investigator spoke with Ms. Sector who confirmed the substance of her hotline call. According to the DCP investigator's notes, Ms. Sector did not view Troy as being in danger. She said he had a history of abuse and fabrication, noted that Ms. Brady had been working with Troy which is why she found the story somewhat questionable and explained that she had done a safety contract with the family before Troy left her office. The DCP investigator went to Ms. Brady's home to interview Troy on the afternoon of May 17. No one was home, and the DCP investigator left a note asking Ms. Brady to bring Troy to the DCP office on the following day, May 18, at 10:00 a.m. Ms. Brady called back and changed the interview to the afternoon of May 19.

On May 19, 2000, three days after the therapist had called the hotline, Ms. Brady brought Troy to the DCP investigator's office. According to the investigation interview notes, the DCP investigator first interviewed Troy alone. Troy recanted his allegations. He told her that nobody had hit him and that he had lied. He said he gets in the bathtub by himself and turns on the water. The DCP investigator decided to have her supervisor interview him with her. According to the notes, Troy denied all his prior allegations and said no one had told him to say it didn't happen. He said Ms. Brady had told him to tell the truth, to not steal, and that he could get what he wanted out of the refrigerator. The DCP investigator also interviewed Ms. Brady who denied the allegations and who indicated that she had not seen a caseworker for some time. In a subsequent conversation with a Beta Agency case management supervisor, the case management supervisor explained that although no worker was currently assigned to the case, that she had been planning to visit the home. The DCP investigator reminded her that it was the supervisor's responsibility to monitor the home. On May 25, she spoke again with the Beta Agency case management supervisor who said a worker had been out to the home and Troy was doing all right.

A month later, the DCP investigator spoke with Ms. Brady's nephew. The DCP investigator did not talk to the second collateral who was listed. The DCP investigator spoke with Ms. Brady again who reported that licensing staff had visited her home and that they were trying to remove the children. Apparently Ms. Brady had spoken with the Advocacy Office who, she claimed, was trying to get Ms. Brady and the children out of the agency. In a last conversation the DCP investigator had with licensing staff representative Midge Sands, Ms. Sands indicated there were other problems in Ms. Brady's home but she declined to give details. The DCP investigator unfounded the report on July 14, 2000, based on Troy's recantation.[46]

Ms. Brady – Foster Parent History

Licensing

Ms. Brady was initially licensed by a private agency, Alpha Services, in May of 1995.[47] In 1998, Ms. Brady transferred her license to a new agency, Delta Services. There is nothing in the licensing file explaining the reason for the transfer, nor was staff at Alpha Services able to provide any information regarding the transfer. The agency did not keep a copy of the file. In April of 1998, staff from Delta Services placed two month old Eric Carver in Ms. Brady's home. Shortly thereafter, the agency closed and Eric's case and Ms. Brady's licensing file were transferred to Beta Agency. According to Beta Agency staff, they received little of the original licensing file. There are only a few scattered notes and

[46] There are notes in the case file reporting that Troy had said that the water is initially cold when he showers and then warms up. There is, however, nothing in the DCP interview notes confirming this explanation by Troy.
[47] This date is taken from the foster parent licensing record recorded on CYCIS. Two documents in the file report that Ms. Brady completed foster care training in 1993.

licensing monitoring records from Alpha Services and no documentation of any concerns about the foster home. One of the licensing monitoring records from Alpha Services dated January 10, 1997, refers to the sleeping arrangements of the children and states that Ms. Brady's daughter lived in one of the bedrooms.

According to licensing case notes, a licensing representative with Beta Agency visited Ms. Brady on July 6, 1998. The licensing representative observed the apartment and Ms. Brady told her that she and Eric were the only ones living in the apartment. There is no documentation indicating that the licensing representative reviewed the licensing file and attempted to resolve the discrepancy regarding Ms. Brady's daughter. The licensing representative visited Ms. Brady's home again on July 23 and they discussed the licensing standards. Ms. Brady completed a new foster parent application for Beta Agency. At the same time, Ms. Brady completed the Foster Family Home Information sheet in which she reported only one person, her foster child Eric Carver, as living in her home. She said her sister took care of Eric when she was working. Ms. Brady stated she was a "nurse" and documented her salary and the name of the person for whom she worked. A copy of a cancelled check is in the licensing file. A medical form in the file does not report any medical problems. An authorization for a background check is also in the file.

The licensing representative made a third visit to the home on September 22, 1998, at which time she and Ms. Brady discussed the licensing renewal process. Beta Agency renewed Ms. Brady's foster care license in May of 1999. Documentation for the licensing renewal, including a renewal application, the foster home information sheet, authorization for a background check, and evidence of completion of foster parent renewal training, is not contained in the licensing file. There are no further notes until the next license-monitoring visit completed in October of 1999.

According to the licensing file, monitoring visits occurred in September of 1998, October of 1999, March of 2000, and June of 2000. One monitoring note, dated June 6, 2000, states that the licensing representative, Midge Sands, told Ms. Brady that she would recommend parenting classes for Ms. Brady, but Ms. Brady stated she would not take the classes. Although the record does not document why the licensing representative recommended parenting classes, presumably it was in response to the DCP allegation of the cold-water shower incident and Troy's complaint of having been hit by Ms. Brady. In January of 2001, the licensing representative scheduled a monitoring visit for January 24, 2001. According to a licensing case note, Ms. Sands visited Ms. Brady on January 25 for their "prescheduled" visit and Ms. Brady was not at home. Because Ms. Sands left Beta Agency a few days after Troy's death, no one was able to interview her regarding her monitoring of this home. The monitoring reports show that Ms. Brady's home was in compliance except for one time when she did not have adequate sleeping arrangements. This was remedied upon the next visit.

On June 20, 2000, the licensing representative, Midge Sands, went to Ms. Brady's home to discuss issues raised by the hotline call and the issues raised by the transportation staff concerning lack of supervision. On August 2, 2000, Beta Agency sent a letter to Ms. Brady detailing licensing violations that included the following 1) impeding parental visits; 2) lack of appropriate supervision – incident in the parking lot, going to the store alone, childcare by person who has not been cleared: 3) being uncooperative – hostile, hanging up the telephone, not answering the door; 4) lack of stimulation of the children who watch TV all the time; 5) inadequate medical supervision – Eric's braces cause pain. Although there was a subsequent mediation on these issues, there is nothing in the licensing file documenting the resolution of these issues and no licensing complaint investigation of these concerns. There are no other notes in the licensing file.

Other Foster Placements

Eric Carver

Staff from Delta Services placed Eric Carver in Ms. Brady's home on April 1, 1998, nine months before Troy was placed in her home. After the agency closed, Eric's case was transferred to Beta Agency in June of 1998. Eric remained in Ms. Brady's home until Troy's death. He was three years old at the time of Troy's death.

Beta Agency staff failed to document monthly home visits to monitor Eric. There are no visits recorded for the following months: August of 1998 through January of 1999; March, April, July, August, September, November, and December of 1999; and January, February, March, April, and July of 2000.

There is some documentation in the file indicating similar issues regarding Ms. Brady's unavailability. Letters from the file written in December 1998 and January 1999 indicate that a new worker was having a difficult time getting hold of Ms. Brady. There is also one note from Eric's caseworker in April of 2000 stating that she had had a difficult time contacting Ms. Brady who is "often unavailable" and who caused two visits to be cancelled. Eric's case manager from January 2000 through March of 2001, told the OIG investigator that Eric appeared "very bonded" to Ms. Brady. The case manager said she initially did not find Ms. Brady to be cooperative, but that she became more accommodating after the mediation in August of 2000.

Eric's occupational therapist noted that Ms. Brady seldom accompanied Eric to his session and that two older girls, "possibly Ms. Brady's daughters," brought him to the sessions. After Troy's death, the occupational therapist told Beta Agency staff that if they had known of the prior pending DCP report, they would have observed the caretaker and Troy more carefully. The therapist recalled that Ms. Brady and Troy were present at one of Eric's therapy sessions and she observed a burn mark on under Troy's eye. When she questioned Ms. Brady about the burn, Ms. Brady explained that she had taken Troy to the doctor who had prescribed medication. The therapist said she did not call the hotline, as she had no reason to doubt Ms. Brady's explanation that Troy had fallen on some spilled bleach.

Jansen Stein

Alpha Services placed Jansen Stein in Ms. Brady's home in April of 1996. The OIG investigator spoke with Jansen's grandmother about Ms. Brady. Ms. Stein said she had had serious concerns about the care her grandson received in Ms. Brady's home and that she had expressed these concerns often to staff at Alpha Services. According to Ms. Stein, her grandson regressed while in Ms. Brady's home. One of Jansen's case managers at Alpha Services agreed. According to the case manager, who was Jansen's caseworker from August of 1996 through August of 1997, Ms. Brady was uncooperative with the agency, uncooperative with Jansen's occupational therapy, unavailable for home visits, would not facilitate sibling and relative visits, and failed to provide a positive environment for the child. She recalled that Ms. Brady would not let children eat when they were bad. The Alpha Services case manager indicated that workers at the agency knew that they shouldn't put anyone else in her home. The case manager indicated she spoke with licensing staff about Ms. Brady and thought it was possible that Ms. Brady transferred her license because of increased concerns about her home. There is nothing in Ms. Brady's licensing file documenting a licensing violation from Alpha Services.

DCP and Police Investigations of Troy's Death

The DCP investigator assigned to the death investigation indicated Ms. Brady in March of 2001, for Troy's death and risk of harm to Eric and Ms. Brady's two daughters. During the investigation, the DCP

investigator learned that Ms. Brady had three children: a nineteen-year-old son, seventeen-year-old and sixteen-year-old daughters. The girls, whom Ms. Brady claimed were her nieces, have always lived in the home. The son, who acknowledged that he had been in the home, said he had not lived there for the past six months. The DCP investigator learned that Ms. Brady had been receiving public aid for the girls.[48] According to the investigator, the girls were aware of their mother's scheme and had been coached by her to present themselves as her nieces and to deny any knowledge of their father.

The local police department investigated the case. Although Ms. Brady initially denied any active involvement in Troy's death, she later confessed to having placed him in the bathtub, physically making him remain in the bathtub, running 4-5 inches of cold water into the bathtub, and holding him down until he fell limp. Ms. Brady told the police of the events leading up to Troy's death. According to the police investigation notes, Ms. Brady said that Troy had been acting up all day and giving her a hard time. When Ms. Rowan came to her home [for a prearranged interview] Ms. Brady said she asked her to hospitalize Troy but Ms. Rowan told her it was not necessary at that time. After Ms. Rowan left, Ms. Brady told the police that Troy became upset because he thought she was trying to get rid of him. As she tried to feed him, he threw food around the room and over himself. Ms. Brady tried to put Troy in the bathtub. According to Ms. Brady, she had to force him into the tub because he was struggling with her and did not want to get in. There ensued more of a struggle as he tried to get out and she kept forcing him back in. Finally Ms. Brady plugged the drain with a sock, pushed the shower button to release cold water, and turned the water up to get him to stop struggling. As he continued to struggle, Ms. Brady said she 'just lost it' and continued to hold Troy down in the tub for about 45 minutes to an hour until he became limp. The state's attorney's office has charged her with first-degree murder and she is currently in jail awaiting trial.

Licensing Investigation

Agencies and Institutions Licensing completed a licensing complaint investigation of Beta Agency on June 8, 2001. The Department found that Beta Agency had violated the following licensing standards:

1) 401.250 C - Beta Agency did not complete an Unusual Incident Report (UIR) when the therapist reported Troy's allegations about Ms. Brady to the hotline and a child protection investigation was completed;
2) 401.420 (a) - A Beta Agency Supervisor was in charge of Troy's case for 45 days, in violation of the Department rule requiring that child welfare workers be assigned a child's case and that supervisors may not be assigned a case for more than 30 days;
3) 401.420 (b) - Beta Agency workers failed to see Troy at least once every month as required by Department Rules;
4) 401.420 (d) - Beta Agency staff failed to revise Troy's service plan to address issues regarding Ms. Brady's foster home that had been documented in the 14 day notice after having made the "critical decision" not to remove Troy from Ms. Brady's home;
5) 401.420 (h) - Beta Agency failed to conduct an "admission study" and failed to document the circumstances surrounding the withdrawal of the 14 day notice;
6) 401.440 (e) - Neither Troy nor Eric had updated dental examinations in the file;
7) 401.440 (f) – Troy's immunizations were not current;[49]

[48]The OIG investigator spoke with an employee of the Illinois Department of Human Services who stated that according to the Department's records, Ms. Brady and her daughters had received some sort of public assistance (cash, medical, or food stamps), from September 1993 through March 1, 2001.

[49]On the last ACR feedback report, dated January 11, 2001, the reviewer wrote that Troy's dental and medical were both up-to-date.

8) 401.460 (a) – the foster home was not licensed in accordance to the standards set out in Rule 402. Beta Agency did not complete an assessment at renewal, it did not have the three references required by licensing rules, and the foster parent had not completed the required amount of foster parent training; and
9) 383.7 (b) - Beta Agency failed to complete a licensing complaint investigation following the allegations Troy made in May of 2000.

Agencies and Institutions Licensing also reviewed other children's case files and foster home files from Beta Agency. It was noted that Beta Agency had not completed admission studies, had failed to send Unusual Incident Reports within the appropriate time frames, and had failed to send to the Department complaint investigations with the appropriate disposition letters attached. Agencies and Institutions Licensing interviewed the licensing supervisor at Beta Agency at the time of Troy's death, but not at the time Ms. Brady's license was renewed.[50] The former licensing supervisor was unable to explain why Beta Agency had renewed Ms. Brady's license without having received the references, evidence of renewal foster training, or an assessment of the foster parent. According to Agencies and Institutions Licensing's interview notes, the former supervisor did not know that copies of complaints are to be sent to DCFS Licensing. Agencies and Institutions Licensing reviewed outstanding complaints and told the former licensing supervisor that wrong terminology was being used in the letters they send to report outcome of the investigations to the foster parents. The former supervisor agreed to make the necessary corrections.

Agencies and Institutions Licensing told the OIG investigator that they will be working with Beta Agency on the development, implementation, and monitoring of a correction plan for the agency.

ANALYSIS

Mediation

Although Beta Agency had documented significant concerns about Ms. Brady's care of the two young children in her home, it accepted Ms. Brady's promise to cooperate in the future without any concrete plan for assuring future compliance with the terms of the mediation agreement. Case managers had documented in case notes Ms. Brady's lack of cooperation and unavailability during June and July of 2000, the lack of supervision noted by transportation staff when they picked Troy up for visits, lack of stimulation for the children, and Ms. Brady's failure to ensure Troy's school attendance, all of which suggested that Troy was simply being "warehoused" by Ms. Brady. After Beta Agency issued the fourteen-day notice to Ms. Brady for removal of the children from her home, Ms. Brady appealed the matter, a mediation was held, and all parties agreed that the children would remain in Ms. Brady's home. Presumably, the basis for the agreement was that Ms. Brady would cooperate, make herself available, supervise Troy more carefully, ensure that Troy went to school, and provide a more stimulating environment for the children. In spite of the fact that Beta Agency's concerns had been serious enough to serve notice for removal of the children from Ms. Brady's home, subsequent to the mediation it failed to ensure that Ms. Brady was in fact doing what she had promised to do. Although the worker made her monthly visits to the home, she documented little about Troy's quality of life in Ms. Brady's home and never addressed the issue of lack of stimulation in the home and, most importantly, never monitored Troy's school attendance.

Children who come into foster care are already compromised and should not be compromised further by foster parents who place them in unsafe situations and who ignore their educational needs. Mediation of

[50] The licensing supervisor at that time left Beta Agency in July of 2001 and is currently a licensing supervisor at Alpha Services.

issues affecting foster parents' care of children in their home may not be appropriate for those issues that significantly endanger or compromise the quality of care a child receives. Mediation does not, however, require any side to concede issues they deem important or critical. Prior to mediation, there are two questions that Beta Agency should have dealt with in its analysis of Ms. Brady as a foster parent: 1) whether there was sufficient evidence to show a violation; and 2) if there was sufficient evidence, whether it would be in Troy's best interests to remove him from Ms. Brady's home. If Beta Agency felt it did not have sufficient evidence, of if it believed that Ms. Brady would change her ways, the could, at a minimum, have agreed to settle in exchange for measurable promises with increased monitoring. With a good licensing investigation, Beta Agency should not have had to give up on critical issues such as Troy's safety and his educational needs, especially in light of the fact that Ms. Brady had already indicated that she was willing to compromise on such issues.

Failure to Monitor Troy's Educational Needs

The failure to monitor Troy's school attendance and academic progress was especially egregious. All of the professionals involved – the Beta Agency case manager, the ACR Reviewer, and the GAL – ignored Troy's educational needs. Beta Agency staff was already aware of Troy's poor school attendance for the 1999-2000 school year. Although Ms. Brady had agreed to enroll Troy for the 2000-2001 school year, there was no follow-up to ensure that he was in fact going to school. Apparently relying on Ms. Brady's reporting, Megan Kohler, Troy's case manager, stated in the service plan that Troy was attending school regularly. In fact, Troy was absent thirty-four days, a little over a third of the school days. School personnel said they never received a call from any child welfare personnel regarding Troy's attendance or his progress in school.[51] In addition, Ms. Kohler never met with school personnel to review instructions on how to complete the Education Report as required by Department rule 314.80 a) 1), and she did not ensure that school personnel completed the Education Report required by Department Rule 314.80 b).[52]

Department Rules and Procedures specifically address the ACR reviewer's obligations for "ensuring [that] the child's or youth's educational needs are met and a record of those services is maintained..." During each ACR, the reviewer is supposed to review the Education Report Form, the Education Profile, school or preschool records and the Scholastic Summary (education plan) of the Client Service Plan. The Department held an Administrative Case Review (ACR) on Troy's case in January of 2001, just a month before Troy died. There is nothing in the ACR monthly feedback report documenting that the reviewer ever questioned the caseworker about Troy's educational needs or reviewed any of the required documentation. Nor is there any documentation in Troy's case file indicating that the worker had obtained any of these reports.

Troy's main developmental task was to attend school. The failure to monitor his progress in school reflects the low priority that education often receives among the services we provide to our children. The fact that it involves early childhood education should not diminish its importance. Children who are wards generally come into foster care under circumstances that put them at risk of developing disabilities as well as social and emotional problems. It is critical that workers understand the importance of early childhood education. It must begin early; it must be consistent; and it must be ongoing.

Troy/Services

There is contradictory information as to Troy's behaviors. As reported by Ms. Brady, Troy was a very difficult child who exhibited troublesome behaviors shortly after he came into care. Ms. Brady described these behaviors to the case manager only a few months after Troy came to her home and later to the

[51] Troy's therapists never contacted his teacher either.
[52] These are actions for which the OIG might have recommended discipline.

mental health worker who assessed Troy. The behaviors included aggressiveness, stealing, lying, nightmares, walking out of the apartment, talking to himself, encopresis and enuresis. Apparently these behaviors did not diminish while Troy was in Ms. Brady's home. After the first hotline call in May of 2000, Ms. Brady discussed with Troy's therapist her concerns regarding Troy's on-going behaviors. In January of 2001, after Troy ran away, Ms. Brady told the case manager that Troy "constantly" ran away and that he was hallucinating. This incident was followed shortly by the therapist's call to SASS after Ms. Brady reported that Troy had had a psychotic episode. In addition to these behaviors, others reported that Troy had significant stuttering and was difficult to understand.

Other professionals who worked with Troy corroborated few of Troy's serious behaviors as reported by Ms. Brady. In completing a Certification of Mental Health Special Needs for Troy's Level of Care Assessment, Troy's therapist, LaToya Paxton, wrote that in therapy he was sometimes "hyperactive" and had difficulty with "regulating his behavior that is age appropriate." Troy's teacher expressed surprise when the OIG investigator described behaviors reported by Ms. Brady to her. According to the teacher, Troy had never exhibited any of these behaviors in the classroom; on the contrary, she found Troy to be a sweet child who was not a problem in the classroom. She also indicated that she had no problem in understanding Troy's speech. The teacher's main concerns were Troy's poor attendance and his constant comments about being hungry.

Troy's therapist never spoke with Troy's teachers to determine whether his behaviors were specific to the foster home setting or whether they occurred across other life settings. In order to effectively treat a child's behaviors, the therapist needs to know the context in which theses behaviors occur. Treatment may differ depending on whether these behaviors occur only in the foster home or only in school or in both settings. Professionals who rely solely on the foster parent's self-reporting without taking into account how the child behaves across multiple settings cannot ensure an accurate assessment of the child.

There is no evidence that Beta Agency staff offered services directed toward Troy's reported aggression, encopresis or enuresis during the two years the agency had Troy's case.[53] Beginning in May of 2000, questions began to arise about Ms. Brady's home. At that time, Troy credibly disclosed to his therapist that he was punished by having to stand in a cold shower. The hotline was called but the allegation was ultimately unfounded after Troy recanted and all professionals involved supported the foster mother. Professionals corroborated Ms. Brady's allegation that Troy "lies."[54] At the same time, separate licensing issues arose concerning the foster home. A transportation worker alleged that when she went to pick up then five year old Troy in the parking lot, she found him alone. This was of concern since Ms. Brady lived in a particularly dangerous area.[55]

Caseworkers documented a lack of stimulation in the home.[56] There are a number of activities in Chicago that a little five or six-year-old child can participate in, including sports, library activities, or art projects, to name just a few. Other than the weekly therapy Troy received and one conversation a case manager had with Ms. Brady in August of 2001, in which they discussed positive discipline techniques, there is nothing to indicate that they discussed with Ms. Brady other services or options that she might have

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[53] For a discussion on encopresis and approaches to treatment, refer to a forthcoming OIG report.

[54] Ms. Paxton, Troy's therapist, reported an incident in which Troy lied about not having received candy from her secretary.

[55] Ms. Brady's apartment complex retained a security guard who informed the SASS worker that it was not safe for her to be in the apartment complex.

[56] During the SASS assessment, the examiner asked Troy if he could have three wishes come true what they would be. Troy responded: 1) a toy, 2), a game, and 3) a book. According to the examiner's notes, Ms. Brady replied, "he has all that stuff here."

offered to Troy to enhance the quality of his care in her home. Instead, workers allowed Troy to be "warehoused" in Ms. Brady's home, a situation that was only exacerbated by his poor school attendance.

Other services were missing. Troy had been diagnosed with asthma, yet there is nothing in the file indicating that staff ever put in place an "asthma plan" to ensure that Troy's medical needs would be attended to. Although speech therapy had been recommended and service plans note that Ms. Brady was to cooperate with such therapy, there is nothing documenting that this service was ever put in place. And finally, even though Troy's treating therapist and Eric's occupational therapist both worked at the same hospital, it appears as if there was no collaboration between them as to services and progress of these children who resided in the same foster home. This lack of coordination between these service providers demonstrates that that particular hospital is not using an ecological approach in its treatment of families.

Licensing Issues

Transfer of Licensing Files

Although Ms. Brady had already been a licensed foster parent for three years, when her licensing file was transferred to Beta Agency, the file contained only a few scattered notes from Alpha Services, the agency that had initially licensed Ms. Brady in 1995. It is unclear what happened with the original licensing file. Staff from Alpha Services told OIG staff that when Ms. Brady transferred to another supervising agency in June of 1998, it forwarded the entire licensing file to the Department and did not retain a copy of the original licensing file. Somewhere between the transfer of the file from Alpha Services to Delta Services and from Delta Services to Beta Agency, most of the documentation from the original licensing file was lost. As a result, Beta Agency had little information about Ms. Brady's history as a foster parent.

Agencies that receive transferred licensing files must obtain all available information about the licensee. When an agency receives a licensing file with minimal documentation about the foster parent, it has an ethical obligation to obtain information through interviews with prior workers from the agencies that had licensed the foster parent. As conversations with a former worker at Alpha Services indicated, agency staff had serious concerns about Ms. Brady as a foster parent. This was significant information about a problematic foster parent and the questionable quality of care she provided that should have been shared with the new agency.

One of the few documents from Alpha Services contained in the Beta Agency licensing file is a monitoring note that refers to Ms. Brady's "daughter" as living in Ms. Brady's home. There was, however, no follow up by Beta Agency licensing staff about this "daughter" or Ms. Brady's personal family history. Since Ms. Brady always presented these girls as her nieces and did not include them as members of the household on the application she submitted to Beta Agency, such information from the previous agency would have alerted Beta Agency to Ms. Brady's fabrication about her family history.

Beta Agency Failure to Comply With Licensing Standards

Beta Agency and the Department allowed children to be placed in the home of a foster parent about whom they knew virtually nothing. Ms. Brady was assigned to Beta Agency with no documentation of her previous three years as a foster parent. Licensing staff did not know why she had left the first agency or the kind of care she had provided for other foster children. They knew little or nothing about her background, her family composition, her family history, her education, her parenting experience, her parenting style, her support systems, her training, her outside interests, and her motivation for becoming a foster parent. When Beta Agency renewed Ms. Brady's license, it did not complete an assessment of Ms. Brady that might have given them important information.

Although a "home assessment" or "home study" of a foster home is required for licensing, these assessments differ in both content and form among agencies. Rule 402.12 c) 1-5 offers some guidance as to what information should be contained in the assessment. An introductory paragraph to Procedure 402 refers also to the "home study/social study" of the foster family and states as follows: "Neither the Procedures nor the Foster Family Home License Compliance Record are a substitute for the home study/social study of the foster family. Such a study is not part of the licensing record and should not be appended to it. Likewise the home study/social study of the foster family is not a substitute for the licensing study which shall be recorded on form CFS-590."

The Quality Assurance Officer for Beta Agency told the DCP investigator that although Beta Agency recommended Ms. Brady for re-licensing, it was not a requirement that they go back and do a full home assessment. When foster parents wish to renew their foster care licenses, licensing rules require that the supervising agency conduct a license study to determine whether the foster home is still in compliance with licensing standards (Rule 402.5). The foster parent submits a new Application for Family Home License and the licensing representative reviews it for completeness and accuracy (Procedure 402.5 b). The supervising agency must then do a re-licensing study. As part of the re-licensing study, procedures state that the supervising agency "shall do random surveys of parents or legal guardians of the children cared for by the foster family home to assess the quality of care provided by the home" (Procedure 402.5 d). Although the Rules are not clear as to whether a home assessment should be done upon re-licensing, in a situation in which a foster parent with minimal documentation and no home assessment transfers to another agency, the agency has an ethical obligation to complete a comprehensive and quality driven home assessment to ensure that the foster parent can not only provide a safe environment for the child but is capable of meeting the child's needs. There is nothing in the Beta Agency licensing file indicating that licensing staff completed any assessment of Ms. Brady's ability to be a foster parent or the quality of care provided by Ms. Brady.

In addition to its failure to conduct a comprehensive assessment of this foster parent, Beta Agency failed to comply with numerous licensing standards: it did not obtain required references; it did not ensure that Ms. Brady had completed her renewal foster parent training; it did not complete a licensing complaint investigation of the allegations made by Troy in May of 2000; it did not complete a licensing complaint investigation of concerns raised by Beta Agency staff regarding Ms. Brady (lack of cooperation, unavailability, lack of supervision, lack of stimulation for the children, inappropriate remarks Ms. Brady made about Troy, and Troy's poor school attendance); it did not complete Unusual Incident Reports for the incident in which Troy complained of cold-water punishment, the incident in which he ran away, and the time he was left unsupervised in the parking lot; it allowed supervisors to carry cases for more than the allowable 30 day period, and it failed to ensure that caseworkers made monthly home visits. Finally, although licensing staff made regular monitoring visits to Ms. Brady's home, the lack of thoroughness of these visits is evidenced by the failure of licensing staff to observe that two teenage girls, and perhaps a son, lived in Ms. Brady's home.

DCP Investigation of Troy's Death

Although the investigator had technically met the 24-hour mandate, she allowed two days to go by before she interviewed Troy. Department rules regarding contact with the child on a Priority I report state that the investigator should "consider relevant factors" on the Family Assessment Factor Worksheet to help the investigator determine whether the child should be seen the following day after failing to meet with the child within the initial 24 hours. The therapist had told the investigator that Troy had a history of abuse and fabrication and that she had found his story somewhat questionable. Although it is reasonable for an investigator to consider the reporter's (in this case, the therapist's) information when deciding whether to see the child sooner, unfortunately this probably allowed Ms. Brady sufficient time to pressure

Troy into recanting his story. If the DCP investigator had gone to Troy's school to interview him, Troy might not have recanted his allegations about a cold-water shower being used as punishment.

RECOMMENDATIONS

1. The OIG has had other cases in which a foster parent's or parent's public aid status would have been important information for the licensing entity or the worker to consider in their assessment of the suitability of the person as a caretaker. The Department should require that a public aid check be completed when licensing a foster parent or in a DCP investigation of the parent or caretaker.

2. *This recommendation addresses personnel issues.*

3. Prior to mediation, the Department should require that a full school report on the child or children who are the subject of the mediation be prepared and made available to all parties and the mediator.

4. The Department must ensure that wards are receiving quality mental health services. In contracting with any entity providing mental health services to wards, the Department must require that the mental health providers use an ecological approach and contact the appropriate school personnel to obtain information about the child in the school setting.

5. *This recommendation addresses personnel issues.*