
OFFICE OF THE INSPECTOR GENERAL

Illinois Department of Children and Family Services

**REPORT TO THE GOVERNOR
AND THE GENERAL ASSEMBLY**

JANUARY 2005

Denise Kane, Ph.D.
Inspector General

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**Office of the Inspector General
Illinois Department of Children and Family Services**

January 1, 2005

To Governor Blagojevich and Members of the General Assembly:

During the Revolutionary War, General Washington named the first Inspector General to assure that critical supplies reached his soldiers. Without the needed supplies, his men would be put into danger and battles put in jeopardy. Illinois citizens and our legislators expect our investigators and caseworkers to be adequately trained and properly supplied.

Recently, I have begun an educational circuit speaking to field administrators, supervisors and workers on lessons learned from errors in the field. Child welfare workers need to be equipped with the knowledge that helps us to serve children and families professionally. Ignorance is a poor excuse for a faulty investigation or an ineffective service strategy. Professional information such as pediatric studies on children's bruising or accidents, or peer reviewed research on effective substance abuse or violence treatment should flow into the field as needed supplies. Myths in the field, such as it is an invasion of privacy for an investigator to discreetly contact a parent at their workplace, have to be dispelled.

We should also look into the deployment of our workforce, especially in these times of staffing shortages. We need to explore staffing strategies that ensure services to families when school aged children and working parents are home. Staff shortages have left some units without workers or supervisors. Overstretched supervisors cover both their units and the uncovered units while workers try to shoulder the investigations of the uncovered cases. It seems archaic to have a typical 8:30 a.m. to 5:00 p.m. Monday through Friday system of investigations and services when most parents we serve work during those hours and children are in school. Child welfare could learn from the nursing profession that taught hospital administrators the importance of creative three and four-day flexible work schedules throughout the week.

Life without errors is improbable, but we can strategically learn from our errors. Timely feedback and educated adjustments can only help us in our struggles against the ravages of poverty, drugs, abuse and neglect.

Respectfully,

A handwritten signature in cursive script that reads "Denise Kane". The signature is written in black ink and is positioned above the typed name and title.

Denise Kane, Ph.D.
Inspector General

INTRODUCTION

The Inspector General was created by unanimous vote of the Illinois General Assembly in June 1993 to reform and strengthen the child welfare system. The mandate of the Office of the Inspector General (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 increase professionalism within the Department. The value and focus of the OIG is the individual life of the child.

INVESTIGATION CATEGORIES

Death and Serious Injury Investigations

The 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 04:

Table 1: Child death cases reviewed in FY 04.

Child Deaths in FY 04 Meeting Criteria for Review	140
Preliminary Investigations Conducted	23
Case Records Reviewed	91
Full Investigative Reports Submitted to DCFS	7
Investigations Pending	19

Summaries of death investigations that resulted in major recommendations are included in the Investigations section of this Report. See page 99 for a summary of all child deaths reviewed by the OIG in FY 04.

The OIG created and maintains a database of child death statistics, detailed at page 164 of this Report, that compiles critical information related to child deaths in Illinois over the last five years.

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.

Child Welfare Employee Licensure Investigations

In 2000, the General Assembly mandated that the Department of Children and Family Services institute a system for licensing child welfare

employees. The employee licensing system seeks to provide accountability, integrity and honesty from those entrusted with the care of vulnerable children and families. In an opinion recommending license revocation, the Administrative Law Judge recognized the critical role that honesty plays for child welfare professionals:

Integrity and honesty is critical to effective child welfare practice. A direct child welfare worker is not only an advocate for the clients served but also a witness and agent for the court. In order to ensure that correct decisions are made to protect the welfare and safety of a child, the child welfare system is dependent upon the veracity of information received. There must be zero tolerance for breaches of trust. A direct child welfare worker's word must be above reproach: if they say it happened, it happened and if it didn't happen then it didn't happen. Actual harm or injury to a child is not a prerequisite for immediate corrective action.

A child welfare employee license is required for both Department and private agency child welfare and licensing workers and supervisors. The Department (Office of Employee Licensure) administers and issues Child Welfare Employee Licenses (CWELs). Before employee licensing was required, a worker could be discharged from the Department or a private agency for egregious acts and then secure employment working with DCFS wards at another agency.

Referrals for CWEL 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. The committee reviews complaints to determine if the allegations meet one or more grounds for licensure action as defined in Department Rule 412.50 (89 Ill. Adm. Code 412.50). The OIG investigates and prosecutes CWEL complaints and hearings.

When a CWEL Investigation is completed, the OIG, as the Department representative, determines whether the investigation supports a

basis for possible licensure action. Allegations that could support licensure action 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 licensure action is appropriate, the licensee is provided 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 CWEL Board makes the final decision regarding licensure action. The following chart reports disposition of FY 04 investigations:

Table 2: OIG licensing investigation dispositions in FY 04.

Referred	18
Closed	18*
Investigation Outcomes	
Recommendation for No Licensure Action	11
Voluntary Relinquishment	5
Revocation	2

* Two of the eighteen closed investigations were referred prior to FY 04.

Criminal Background Investigations and Law Enforcement Liaison

The OIG provides technical assistance to the Department and private agencies in performing and assessing criminal history checks. In FY 04, the OIG performed 8,739 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 investigate the alleged act for administrative action only. The OIG assists enforcement agencies with gathering necessary documents. If a law enforcement agency elects to investigate and requests that the

administrative investigation be put on hold, the OIG will retain the case on monitor status. If a law enforcement agency declines to prosecute, the OIG will determine if administrative action is appropriate.

INVESTIGATIVE PROCESS

The OIG investigative process begins with a Request for Investigation or when the State Central Register notifies the OIG of a child's death or serious injury. Investigations may also be initiated when the OIG learns of a pending criminal or child abuse investigation against a child welfare employee. In FY 04, the OIG received 2,259 Requests for Investigation.¹ Requests for Investigation and notices of deaths or serious injury are screened to determine whether the facts suggest possible misconduct by a Department 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 the Department 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 pertain to a private agency. In rare circumstances, when the allegations are serious enough to present a risk to children, the Inspector General may request that an agency be put on "hold" or that an employee be placed on "desk duty" pending the outcome of the investigation.

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

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

Administrative Rules

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 of misconduct. Rules pertaining to employee licensure action are found at 89 Ill. Admin. Code 412.

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 defense.

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.

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 may 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. Impounded files are returned as soon as practicable. However, in death investigations the OIG forwards original files to the Department's Division of Legal Services to ensure that the Department maintains a central file.

REPORTS

OIG Reports are submitted to the Director of DCFS. 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.

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.

Recommendations

In its reports, the OIG makes recommendations for systemic reform and case specific interventions. 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 also function 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 the Department and/or to the Director and Board of the private agency. The OIG monitors implementation of recommendations for disciplinary action. Recommendations for discipline are subject to due process requirements. 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.

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.

At the beginning of this Annual 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 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.

ADDITIONAL RESPONSIBILITIES

OIG Hotline

Pursuant to statute, the OIG operates a statewide, toll-free telephone number for public access. Foster parents, guardians *ad litem*, 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 04:

Table 3: Calls to OIG hotline in FY 04.

Information and Referral	1347
Referred to SCR Hotline	175
Request for OIG Investigation	369
TOTAL Calls	1891

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 04, 398 Statements of Economic Interest were submitted to the Ethics Officer. Of the 398 submitted, 63 indicated potential conflicts of interest. The 63 were further reviewed and 24 advisory letters were sent to employees notifying them of steps to take to avoid conflicts of interest between their outside activities and their state employment.

Table 4: OIG action on statements of economic interest.

Economic Interest Statements Filed	398
Statements Indicating Possible Conflicts	63
Advisory Letters Sent to Employees	24

The OIG Ethics staff also coordinated DCFS compliance of the statewide ethics training mandated under Illinois’ State Officials and Employees Ethics Act of 2003. Over 3,250 employees were trained in FY 04.

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.

OIG Project Initiatives

Informed by OIG investigations and practice research, the OIG’s Project Initiatives assist the Department’s Division on Training in the development of 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 239 of this Report for a full discussion of the current initiatives.

¹ The number includes requests for investigation, notice of child deaths and serious injuries, notification of arrests or pending abuse investigations, OIG hotline calls, and requests for technical assistance and information.

SYSTEMIC RECOMMENDATIONS

OIG investigative reports include both systemic and case specific recommendations. The systemic reform recommendations for Fiscal Year 2004 have been categorized below to allow for analysis of the 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. *Recommendations in italics have also been made in previous years.* Recommendation categories are as follows:

State Central Register

Child Protection Investigations

- Investigative Practices
- Poisoning
- Northern Area Child Protection
- Role of DCFS Nurses
- Administrative Review of Unfounded Reports

Casework Practice

- Foster Care
- Intact Services
- Runaway Wards
- Mentally Ill Parents

Licensing

Education

Violence Prevention

Teen Parents

Substance-Abuse Involved Families

Wards Labelled as Sexually Abusive

Medical Issues

Confidentiality and Privacy

Interstate Placement of Children

Post-Adoption Services

Monitoring Private Agencies

- Personnel Practices at Private Agencies

Coordination Between Divisions

Coordination with Juvenile Court Proceedings

Personnel Practices

STATE CENTRAL REGISTER

- SCR should request a home phone number of medical, emergency room or law enforcement reporters who work weekend or night shifts.
- The operators at SCR have to be carefully trained to look for similarities and dissimilarities in the rare occasions when someone on whom they are conducting LEADS shows up with two State Identification Numbers within the state of Illinois.

CHILD PROTECTION INVESTIGATIONS

Investigative Practices

- Four OIG death investigations have found poor investigative practice in which reporters and collateral contacts were not contacted. Child Protection managers should ensure that supervisors are enforcing the policy to interview reporters and sources including those for related information.
- *The Department should require scene investigations in all investigations involving an injury to a child. (Reiterated Recommendation 2002, 2003)*

- Child Protection Management should inform field managers that, during an investigation, contacting a family at work is not a violation of privacy.
- Procedures for investigations of Cuts, Welts and Bruises should be amended to provide that when suspicious bruising is reported (indicative of fingerprints, implements or otherwise suspect based on developmental age of child or location of bruise), and investigator does not see a bruise, the reporter must be contacted prior to an initial safety determination.
- Rules and Procedures should be amended to provide that when new injuries occur, raising suspicion regarding old injuries previously believed accidental, investigators need to share new information and work collaboratively with all available professional resources, such as hospital child abuse teams or Child Advocacy Centers.
- When child protection investigators contact a local police department for a copy of a report on a specific incident they should also ask about the availability of other reports, especially in cases with domestic violence.
- The Department should issue a policy guide for child protection investigators clarifying that consideration must be given to prior unfounded as well as indicated abuse and neglect investigations, when available. When the investigations involve a licensed foster home, licensing workers must be able to extrapolate from these prior reports information relevant to the suitability of the licensed caretaker.
- An OIG Report that found that prior injuries, previously determined to be accidental, were not considered in assessing risk after new bruises to the child were noted by school personnel. The OIG death investigation should be shared with both Child Protection and the State Central Register to ensure that allegations of prior injuries are added when appropriate.
- The Department should consider establishing a policy requiring corroboration, through collateral contacts, of mitigating factors of caretakers that result in a safe CERAP (Child Endangerment Risk Assessment Protocol) determination.
- A system should be established for ensuring the uniform availability of operable thermometers to all child protection investigators.
- Child protection investigators should be trained on how to properly measure hot water temperature, as well as the temperature and corresponding exposure times at which scalding will occur in infants and children.
- The index of water temperatures and corresponding exposure times at which scalding will occur currently identified in rules and procedures for DCP investigations should be corrected to accurately illustrate the time and hot water temperature at which infants and young children will suffer partial and full-thickness scald burns and the time and temperature at which older children will suffer the same.

Poisoning

- Poisoning Allegation Procedure should include information from literature:

- Common sources of intentional poisoning of children include: ipecac, laxatives, black and red pepper, salt, water (intoxication), acetaminophen and aspirin, insulin, adult prescription drugs (e.g., barbiturates, antidepressants, diuretics), alcohol and illicit drugs, and arsenic;
- Common symptoms associated with intentional poisoning include: chronic diarrhea, vomiting, lethargy, dehydration, and seizures;
- Intentional poisoning has an extremely high mortality rate and when found, children who are intentionally poisoned should not be left with the perpetrator.
- The Department should establish guidelines for the investigation of abusive poisoning cases and suspected Factitious Disorder by Proxy cases in accordance with the published literature. Allegations should be amended to provide that in cases where intentional poisoning is suspected, the investigator should also suspect and investigate Factitious Disorder by Proxy.
- Procedures should also acquaint workers with the following necessary information to investigate Factitious Disorder by Proxy:
 - Critical to any investigation of poisoning, and especially Factitious Disorder by Proxy is a detailed determination of who provides care for the child when such care is provided;
 - Investigators must retrieve all available medical records for the affected child and siblings; an affidavit of history care, completed by the parents, will be a useful first step in attempting to get all available records;
 - While not dispositive, the typical perpetrator is a mother who has some medical background;
 - Typically, perpetrators of Factitious Disorder by Proxy appear particularly bonded with their children and are particularly adept of convincing professionals of their sincerity and abiding interest in their children;
 - Most victims of Factitious Disorder by Proxy are infants and toddlers;
 - As much as 98% of the time, the perpetrator continues victimizing the child in the hospital;
 - The most common presentation of Factitious Disorder by Proxy is apnea. Other common presenting conditions include seizures, bleeding, central nervous system depression, diarrhea, vomiting, fever (with or without sepsis or other localized infection), and rash. Probably the most common cause of death in homicidal Factitious Disorder by Proxy is suffocation, but there are many causes of death, among which are poisoning with various drugs, inflicted bacterial or fungal sepsis, hypoglycemia, and salt or potassium poisoning;
 - Factitious Disorder by Proxy is not limited to directly causing conditions (e.g., poisoning and suffocation); it may also include, over or under reporting signs or symptoms (e.g., exaggeration of symptoms), creating a false appearance of signs and symptoms (e.g., tampering of specimens) and/or coaching the victim or others to misrepresent the victim as ill. The presence of valid illness does not preclude exaggeration or falsification.
- A Factitious Disorder by Proxy investigation should include a thorough review of available medical records for all children in the family. If a child abuse team is available at the treating

hospital, they should conduct the review. If a child abuse team is not available, this review should be conducted by DCFS Nurses and should be subject to the following procedures:

- Interview medical personnel regarding symptoms. If intentionally caused, how long after administration would symptoms be expected to occur? How long would symptoms be expected to last per dose?
- Determine context of onset of symptoms. Who is present prior to onset of symptoms?
- Prepare a medical chronology of symptoms, charting the onset of symptoms and the access of possible perpetrators.
- Do siblings records contain evidence of false pediatric reporting?
- Interview treating doctor to determine whether appropriate laboratory tests have been ordered to detect the presence of poisons or emetics.
- Whenever investigators suspect intentional poisoning or Factitious Disorder by Proxy an immediate referral must be made to law enforcement and the State's Attorney.
- Whenever investigators suspect intentional poisoning or Factitious Disorder by Proxy, investigators must employ a multi-disciplinary approach that includes sharing of information and frequent contact with law enforcement and any Child Abuse Team at the hospital. If no child abuse team is available, the investigator and DCFS nurse must maintain an open dialogue throughout with treating medical professionals to ensure sharing of all information.
- The Department should consider early termination of parental rights for serious Factitious Disorder by Proxy over time. Given the knowledge that there is no known treatment for Factitious Disorder by Proxy and that studies suggest that parents so afflicted will continue abuse, the Department should appeal judicial decisions that require return home after a determination of egregious Factitious Disorder by Proxy over time.

Northern Area Child Protection

- To address deficiencies noted in an OIG death investigation, the Department should institute investigative training targeted specifically to the Northern Region. The training should be two tiered.
 - Management and supervisor investigative training should address:
 - (1) The need for individualized supervisory directives and assurances that the directives have been followed or amended prior to case closing; and
 - (2) The use of this investigation and its conclusions with previous OIG investigations on children's bruising and injuries as teaching tools to develop a system for the reviewing of evidentiary logic in future child injury cases.
 - Supervisor and investigator training should address:
 - (1) Comprehensive scene investigations
 - (2) Preparing historical timelines
 - (3) Ascertaining and verifying mechanics of injuries
 - (4) Critical analysis of operating assumptions and bias in safety decisions.

- The Department should ensure that the practice of using risk management plans in lieu of safety plans is discontinued.

Role of DCFS Nurses

- Consistent with their present job description, which includes "...conducts investigations of child abuse and neglect..." the DCFS Child Welfare Nurse Specialists should be assigned to the Division of Child Protection to conduct abuse and neglect investigations. In this capacity under DCP, the nurses would be able to utilize their medical background in obtaining and interpreting medical records and interviewing medical personnel in cases with complicated medical information. (See OIG Memo to Director McDonald, Role of the DCFS Nurses, January 30, 2003). To avoid problems presented in this case and others, however, the nurses' role should be clearly established. When a DCFS Nurse is consulted, he or she should be provided with the precise question that must be answered and the information that is sought. Imprecise referrals with vague directions to the nurses to "review records" are ineffective in utilizing nurses' expertise.
- In child abuse and neglect investigations where DCFS nurses are consulted, both the nurse and the investigator must document the questions asked, the information provided, the records reviewed and the answers given.
- DCFS Administrators should develop and train nurses in standards for providing information to DCP investigators (See recommendations in OIG Report, File # 972415, June 30, 1999). Previous OIG death and serious injuries investigations should be included in the training. Supplemental training will be necessary on bruising and other forensic issues relevant to abuse or neglect.¹

Administrative Review of Unfounded Reports

- Illinois Statutes provide that Mandated Reporters may request administrative review of investigations that are to be unfounded. The statutes further provide that when such a review is requested, the review will be conducted by outside Multidisciplinary Review Committees throughout the state. An OIG investigation found that the Department had not created any such committees. The OIG recommended that the Department initiate Multidisciplinary Review Committees in all regions.
- A Protocol must accompany the creation of such Committees to include:
 - A provision describing the appointment process for Committee Members, following the guidelines for qualifications of members set out in the statute;
 - A provision that the Committees should be expanded on an *ad hoc* basis as necessary to address any complex circumstances in the investigation under review. Mental health, pediatric, ethics, forensic and other experts should also be consulted by the committee as necessary to fully understand the facts and context of the investigation under review;
 - A provision that DCFS should provide all the records in its possession concerning cases referred to the Committee. Committee members should limit their review to the written record in the case, except for consultation provided by disinterested outside experts as appropriate. Evidence outside the written record should not otherwise be considered. Any *ex parte* communication with a Committee member should be documented and reported to the

¹ In response to recommendations in previous OIG investigations (Pediatric Palliative/ Hospice Care, File #020987, February 21, 2003; and Memorandum on the Role of DCFS Nurses, January 30, 2003), the Department agreed to review and redesign the reporting structure of the DCFS nurses by March 1, 2004. (See Report to the Governor and General Assembly, January 2004, pp. 144 and 147.) The review and redesign has not been completed.

Child Protection Manager and made a part of the record on review. An *ex parte* communication is any written or oral communication to a Committee member either 1) by or on behalf of the mandated reporter or the subject or, 2) by any person that requests or contains information or argument regarding the review of an investigation;

- A provision that any member of a Committee who has been involved in the case under review, or who has a financial or personal relationship with any of the parties whose behavior or credibility is an issue in the case, should recuse him or herself from participation in the Committee's review of the investigation in question;
- A confidentiality provision that requires that meetings be closed to the public, members sign confidentiality agreements, all records of investigations be kept confidential and returned to DCFS, and deliberations and recommendation reports of the committee be kept confidential from the general public. Exception: DCFS is required by statute to prepare an annual report to the General Assembly on the number of investigations reviewed during the previous fiscal year, the number of investigations a Committee found to be inadequate, and a summary of the Committees' comments and of corrective action taken by the Department in response;
- The Committee should produce a written finding, with identified bases of the finding, which is shared with the Child Protection Manager and becomes part of the record;
- Child Protection Managers should regularly review Multidisciplinary Reports to inform practice and training;
- Procedures for forwarding Committee recommendations to the appropriate DCFS administrators, for those administrators to record their responses to Committee recommendations, and for DCFS reporting in summary form to the General Assembly.

CASEWORK PRACTICE

Foster Care

- *The Department should require foster care caseworkers to meet with school staff and request notification when a foster child is absent from school for two consecutive days. This notification should occur even if the caretaker has notified the school that the child will be absent. Upon notification, the caseworker should make an unannounced home visit to check on the health and well-being of the child and family and offer assistance, if necessary. (Reiterated Recommendation 1998)*
- The ethical balance of notifying a foster parent of the existence of a criminal investigation or protecting children by placing a hold on a foster home should always favor the protection of children.
- Procedure 301, Appendix E, Placement Clearance Process, should be amended to create an emergency procedure, which would permit involuntary holds to be placed on a home without immediate notice to the foster parent under certain limited circumstances. Suggested language: When a foster parent is under investigation for an act which, if true, would jeopardize the health, safety or welfare of children to be placed in the home, and the Director determines 1) that providing notice to the license holder may jeopardize the investigation and, 2) that there is a reasonable basis for the investigation, the Director may place an involuntary hold on the placement for up to 120 days without notice to the foster parent.

Intact Services

- The Department should require intact family caseworkers to meet with school staff and request dates of IEP meetings and notification when a child is absent from school for two consecutive days. This notification should occur even if the caretaker has notified the school that the child will be absent. Upon notification, the caseworker should make an unannounced home visit to check on the health and well-being of the child and family and offer assistance, if necessary. Workers should attend, when possible, IEP meetings with parents and encourage parents to attend and participate.
- The Department should require intact family caseworkers to meet with medical personnel when a child in the family has a chronic medical condition.
- The Department should revise Department Procedures Part 302 – Services Delivered by DCFS to include Procedures for Assisting Fathers to File for Custody When the Parents Are Not Legally Married.
- The Department and the State’s Attorney’s Office should convene a work group to address how Orders of Protection can be used in intact family cases where there is concern about the safety of children but the case does not meet the urgent and immediate necessity hurdle to pursue custody. The Department should evaluate what specific and realistic goals for parents can be included in an Order of Protection that would help assure a child’s safety or would provide support for pursuing custody later if the parent remains non-compliant.
- *The Department should include guidelines for workers on preparing and presenting cases for court involvement in Procedures 302 – Appendix O for Intact Family Services. (Reiterated Recommendation 2001)*
- When a parent’s lack of compliance with the Department’s client service plan and/or safety plan jeopardizes the health, safety, and welfare of the child(ren) but does not rise to the level of a hotline call, workers should seek a protective order. Education and early intervention programs should be used as a safety net to monitor the child’s well being. The Department should include guidelines in Procedures 302 – Appendix O (Intact Family Service) to determine when a caretaker’s lack of cooperation places children at risk and warrants either a hotline call or seeking court involvement (such as an Order of Protection, requiring a parent to comply with the client service plan and/or the safety plan).
- At the time any family reaches an “M” (13th) sequence, a full management review should be conducted that includes reading all relevant records such as medical, mental health, school, and an assessment of the workers and supervisors to determine if there are operating biases in the case. To ensure statewide consistency, a single management review team should be developed, composed of two upper level regional administrators and representatives from DCFS Legal, to identify obstacles to screening, including operating biases of workers.
- The draft Procedures for intact families should incorporate an integrated procedural framework. The draft Procedures should also include instructions for addressing the potentiality of violence when families present issues of physical violence combined with possession of weapons.

Runaway Wards

- The Department needs to develop realistic funding mechanisms for services to wards with chronic runaway behavior.
- The administrator of case reviews should sample ACR reviews of missing and runaway wards to ascertain the relevancy and sufficiency of the assigned tasks.

Mentally Ill Parents

- The Department should consider developing and piloting specialized contracts to provide community-based integrated child welfare/mental health treatment services for older adolescents with mentally ill parents transitioning to independent living or when there exists consideration for reunifications services. Such programming should include psycho-educational and peer support components for wards who have parents whose mental illness includes major disorders such as major depression, bi-polar, and psychotic disorders with or without substance abuse disorders.

LICENSING

- Currently, private agency licensing staff are required to conduct semi-annual monitoring visits, while DCFS licensing staff are only required to conduct annual visits. The Department Procedure 402.27 and Rule 401.420 regarding foster home monitoring visits must be consistent holding all licensing workers to the same standards.
- The Department should amend Procedure 402 to require that prior to licensing monitoring visits, foster home licensing staff communicate with the caseworkers of children currently placed in the foster home. The purpose of the meeting would be to assist the licensing worker in becoming more familiar with the home, reviewing services provided the foster children in their care, and to allow caseworkers to raise any concerns about the home or the care of the children.
- Foster home licensing staff should convene meetings with all caseworkers with children currently placed in a foster home prior to the annual and monitoring home visit by the licensing worker. The purpose of the meeting is to assist the licensing worker to become more familiar with the home by gathering information about the home, reviewing services provided the foster children in their care, and for caseworkers to raise any concerns.
- The Department should send a Policy Transmittal to its Agency and Institution Licensing Division to ensure that in checking compliance with Licensing Standard 401.210, the Licensing Representative should document compliance with the personnel procedures designed to ensure that untrustworthy persons are not hired.
- Procedures 383, Licensing Enforcement, should be amended to include substantive guidelines on conducting licensing complaint investigations. Currently, the Procedures focus on the concurrent licensing investigations initiated as a result of CANTS allegations. The Procedures do not address issues such as the standard of determination, interviewing requirements, verification of self-report information, assessing credibility, or when an unfounded DCP investigation should trigger a licensing investigation. Additionally, the Department must clarify who has the responsibility for conducting the licensing complaint investigations.

- DCFS licensing enforcement procedures must provide for immediate licensing revocation proceedings with findings of egregious licensing violations.
- Quality Assurance should conduct a review of Central Office of Licensure’s current method of identifying CANTS reports on licensed foster homes and establish a schedule of reliability checks for the system of identifying foster homes with a CANTS report.
- The index of water temperatures and corresponding exposure times at which scalding will occur currently identified in rules and procedures for foster homes should be corrected to accurately illustrate the time and hot water temperature at which infants and young children will suffer partial and full-thickness scald burns and the time and temperature at which older children will suffer the same.
- Rules and Procedures for all DCFS licensed facilities should be amended to include a maximum water temperature standard (either 115° or 120° Fahrenheit), and standards for testing and correcting, as previously outlined for foster homes in Policy Guide 99.12, Hot Water Temperature in Foster Family Homes.
- A system should be established for ensuring the uniform availability of operable thermometers to all licensing workers.
- Licensing workers should be trained on how to properly measure hot water temperature, as well as the temperature and corresponding exposure times at which scalding will occur in infants and children.

EDUCATION

- *The Department should require foster care caseworkers to meet with school staff and request notification when a foster child is absent from school for two consecutive days. This notification should occur even if the caretaker has notified the school that the child will be absent. Upon notification, the caseworker should make an unannounced home visit to check on the health and well-being of the child and family and offer assistance, if necessary. (Reiterated Recommendation 1998)*
- The Department should require intact family caseworkers to meet with school staff and request dates of IEP meetings and notification when a child is absent from school for two consecutive days. This notification should occur even if the caretaker has notified the school that the child will be absent. Upon notification, the caseworker should make an unannounced home visit to check on the health and well-being of the child and family and offer assistance, if necessary. Workers should attend, when possible, IEP meetings with parents and encourage parents to attend and participate.
- A responsibility of the Educational Access Project for DCFS is to identify problematic trends for systems intervention. Project staff should examine the number, pattern and nature of education-related calls to the DCFS-Cook County Post-Adoption unit and the response of education advisors, to determine whether requests for educational assistance can be more effectively handled, i.e., allocation of time of education advisors and educational liaisons to Post-Adoption Services. The Department should ensure that educational advisors are available to review adopted and guardianship children’s records when necessary to best advocate for educational services. The Educational Access Project staff should train Post Adoption staff on available educational services and resources targeting those communities with the highest adoption rates.

VIOLENCE PREVENTION

- The Department should concentrate the efforts of its Child Family Research funding on assisting residential and foster care providers in developing evidenced-based interventions for violence prevention and response and transitional services for the return home of younger adolescent and adolescent wards.
- The Department should secure the assistance of the Northwest Center for Child Advocacy in developing a system of weekend emergency responses for alleged child-on-child sexual assault evaluations for DCFS wards that reside in Northwest suburban residential programs.
- *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 domestic violence consultation referral process. (Reiterated Recommendation from 1998 and 2002)*
- OIG death investigations involving criminal justice involved youth should be shared with members of the DCFS Justice Steering group, to assist them in their development of a handbook for workers with case management responsibility for wards involved with the Department of Corrections. It is very important that a handbook promote *pragmatic practice* and underscore the overarching requisites of *school, structured activities, employment, an intolerance toward deviance,² and pro social skills development* to reduce risk for delinquent or criminal activity. The handbook should include a synopsis of the Surgeon General's report on youth violence to recognize that different approaches are needed with any acts involving violence or weapons. In addition to resources and information, the handbook should provide practical guidelines on how to convene staffings and provide services with criminal justice involved youth, including mental health services. The mental health of incarcerated DCFS wards became a significant issue in the past year when three wards committed suicide while confined.
- The Department needs to examine the job description and relevancy of the role of the DCFS Liaison to the Department of Corrections. Currently, the Department has developed programs, advocacy, and services to incarcerated mothers of wards at the exclusion of incarcerated fathers and incarcerated wards. The Department should give consideration to the need for a comprehensive, non-fragmented approach to working with all youths involved with the adult and juvenile criminal justice system. The Department needs to make certain that resources are appropriately allocated to ensure that our youths' most pressing needs are addressed.

² Surgeon General's Report on Youth Violence, 2003.

TEEN PARENTS

- Pregnant or parenting teen wards that continue to be involved in domestic violence situations should not be allowed to remain in an independent living apartment if the ward continues to remain in a violent relationship. The umbrella program designed to oversee pregnant and parenting wards and DCFS need to develop and make available specialized crisis foster placements that can accept a teen parent and his or her children on an emergency basis while an emerging, potentially violent situation is de-escalated and the safety and well-being of the parent and child are protected. As part of a CERAP plan in a situation where a pregnant or parenting teen ward continues in a domestic violence situation, if it is necessary for the parent to attend domestic violence counseling and participate in aggression replacement treatment (involving social skill, anger management and moral reasoning programming), the parent and child/ren should remain in the specialized crisis placement or other least restrictive setting that has 24-hour supervision until the parent successfully completes the individualized violence reduction treatment program.
- DCFS Procedure 300 should be amended to provide that the decision to take protective custody of a child whose parent is receiving services from the Department (e.g., intact family, independent living, or residential programs) must include consideration of the degree of mother's cooperation with services and the extent to which services provided address the allegation.
- DCFS Rule 315, Appendix A should be amended to require a CERAP be completed when a parent who has an open DCFS case and whose children have previously been removed from his or her care has another child. The Policy and Procedures for the umbrella program designed to oversee pregnant and parenting wards should likewise be amended.
- The Department should develop guidelines and training to address issues of risk and dependency for children of teen wards especially when the pregnant or parenting teen ward has moderate, severe or profound developmental disabilities (i.e., has an IQ of 55 or below), has had three or more psychiatric hospitalizations, is under the age of fourteen, or whose previous behavior has led to the removal of other children.
- The umbrella program designed to oversee pregnant and parenting wards and all child welfare staff working with pregnant and parenting wards should utilize Rule 329, the procedure for locating and returning missing, runaway, and abducted children, as recommended in OIG, Missing Children report, 03-1553, June 16, 2003, and accepted by the Department.
- The umbrella program designed to oversee pregnant and parenting wards ('umbrella program') should coordinate agency provider input, training and dissemination of information. The umbrella program should invite supervisors and case managers from agencies that are non-regional service providers to attend a meeting to learn about the array of services available to child welfare staff working with pregnant and parenting wards. The umbrella program should invite the non-regional service providers as soon as a pregnant or parenting ward is accepted as part of the umbrella program system, and should offer the informational meetings quarterly. The umbrella program's contract and umbrella program manual should be amended to reflect this. The umbrella program will participate in or facilitate monthly meetings to aid in communication and provision of information.
- As part of its monitoring duties, the umbrella program should develop a protocol requiring that its supervisors and managers receive and review the reports of the Parenting Assessment Team to ensure that service provider agencies abide by the PAT's findings and follow PAT's case

recommendations. In addition, before the umbrella program completes a referral to PAT, umbrella program clinical staff should work with the service provider agencies to pose relevant and specific clinical questions that need to be addressed by the PAT. The DCFS Parenting Assessment Coordinator should train umbrella program clinical staff and the supervisors of workers carrying teen parent cases on the referral and follow-up procedures for the assessment process.

SUBSTANCE-ABUSE INVOLVED FAMILIES

- The Department should consider the use of graduated sanctions in cases where drug/alcohol abuse is the primary issue and the parent(s) have displayed a pattern of relapse.
- *Mothers with substance exposed infants who are referred to intact family services must receive intensive specialized intact families services that are designed to safeguard children from harm while providing effective substance abuse treatment. (Reiterated Recommendation 2003)*
- In split custody cases with a history of substance abuse and relapse, the Department should require random drug drops to assist the Department in securing necessary services for the children and family. In cases of alcoholism, random urine testing is not reliable. Breathalyzers are preferable. The OIG reiterates its prior recommendation that DCFS acquire breathalyzers and train on their use.
- The Department should consider implementing the Intact Family Recovery (IFR) model with split custody cases. The Intact Family Recovery Model is a pilot program, incubated by the Office of the Inspector General, which emphasizes accountability and expertise in working with substance-abusing families.
- *The Department should review all intact cases where a mother has more than one substance exposed infant. These cases should be reviewed to determine whether workers should obtain orders of protection for the parents to ensure that they are complying with treatment. (Reiterated Recommendation 2003).*
- In cases where the father or paramour has an ongoing relationship with the mother, the Department should require the father/paramour's cooperation in services.

WARDS LABELLED AS SEXUALLY ABUSIVE

- The Department must immediately implement the OIG's previous recommendations for the SACY program made in FY 2000 and accepted by the Department.
- The OIG, in its SACY reports (dated June 30, 1999 and June 13, 2000), previously recommended that developmentally delayed children who are victims of sexual abuse, must receive pro-social skills training. The Department should audit the Sexual Abuse Program to ensure that the OIG recommendations are implemented and that children with developmental disabilities who have been sexually abused are receiving services that emphasize development of pro-social skills.
- DCFS Clinical should ensure that providers of sexual abuse evaluations submit their final reports and recommendations to the regional coordinators within 2 weeks of completion. This requirement should be reflected in all program plans.

- The Department should create a system for tracking when sexual abuse assessments are requested and when they are returned to the regional coordinators. In order to prevent repeated assessments of the same sexual abuse allegations, the regional coordinators should gather together all previous and relevant psychological assessments for the service providers. Service providers should receive all prior assessments and requests for assessments.

MEDICAL ISSUES

- The Department needs to assess the effectiveness of its Health Works system in providing the preventive pediatric health care and anticipatory guidance for DCFS younger adolescent and adolescent wards. The Department should conduct a random audit of Health Works records for adolescent wards to gauge the depth of the failure to record critical health information for adolescents and provide anticipatory guidance.
- Department nursing staff, when asked to do a consultation on a medically complex child, should conference with other medical professionals as part of the consultation and assure the caseworker has established communication with the medical professionals involved in the child's care.
- The Department, as recommended in a previous report, should apply a targeted feeding assessment, such as the Nursing Child Assessment Satellite Training, in cases with allegations of inadequate food and/or malnutrition and failure to thrive and where there are chronically ill children whose feeding regimen may require occupational therapy adaptations.
- Wards diagnosed with Juvenile Diabetes should receive medical treatment through pediatric endocrine clinics to benefit from specialized medical care, i.e., pediatric endocrinologist, developmental ophthalmology specialist, retinal specialist, and development and implementation of individualized Diabetic Care Plans.
- Wards diagnosed with Juvenile Diabetes should have individualized Diabetic Care Plans as outlined by the American Diabetes Association. Diabetic Care Plans should be incorporated into the child's Individualized Education Program.
- The Department should require all licensed foster parents caring for medically complex children to attend medical trainings relevant to the needs of the children in their care.

CONFIDENTIALITY AND PRIVACY

- DCFS Procedures Sections 300.60 and 300.90 should be amended to ensure that follow-up workers can contact collateral sources in an open case when necessary for monitoring the child's safety.
- The Department must institute a policy for communication with the media that is more protective of wards' privacy rights. Protected information concerning a specific child should not be released to the press unless the information would not be identifiable to the child's peers.

INTERSTATE PLACEMENT OF CHILDREN

- Regional DCFS attorneys should be trained in the procedures involving Interstate Compact on the Placement of Children and should become actively involved in court proceedings where interstate placement is at issue in order for the Department to be sure that the best interests of the child are fully considered. There are times when the best interest of the child could be different from the

recommendation of the Interstate Compact Unit. It should also be made clear at the hearing what the monitoring and services will be to the child and placement family.

- When a placement is made by court order and, subsequent to the court order, the Interstate Placement approval is denied by the receiving state, DCFS Legal must inform the Court.
- When a home study is requested through Interstate Compact, the request should include asking the local child welfare worker doing the home study to check with local law enforcement authorities whether they have any history on the household in addition to the criminal background check with the State Police.

POST-ADOPTION SERVICES

- Post-adoption services should develop a training plan for all staff in the Cook County Post-Adoption Subsidy Unit. The training plan should include consumer response training. An analysis of incoming calls should assist staff in prioritizing allocation of staff time to the development of most sought after resources. The Post-Adoption Administrator should meet with the Advocacy Office for Children and Families for the purpose of developing effective linkage and communication between the two offices and to share resource databases.
- See discussion of the Education Access Project recommendation under the “EDUCATION” heading in this section.

MONITORING PRIVATE AGENCIES

- When a child’s case and foster home license transfers between agencies, the POS Division should track child and foster home files by establishing records inventory and sign-over procedures.
- Rule 434, Audits, Reviews and Investigations or the Office of Field Audits procedures should be amended:
 - To prohibit the practice of CPA firms from performing annual audits of agencies for which the CPA firm is providing accounting services;
 - To require and enforce the requirement of agencies having a comprehensive cost allocation system;
 - When an agency is almost exclusively funded by DCFS, the Department’s auditors must presume that disallowed costs are not funded by outside revenue. DCFS auditors should be prohibited from accepting an agency’s explanation for the manner in which the agency is reducing a deficit or paying back disallowed expenses. DCFS auditors must always obtain proof of the agency’s assertions;
 - Refer all agencies that have employees with salaries exceeding the Governor’s salary amount to the Director’s Office for a waiver determination. No waiver should be given to a CEO’s salary of more than the Governor’s salary when the agency is operating in a deficit or when an analysis shows that the CEO’s salary exceeds the mean salary of CEOs of private agencies with a similar budget size. Waivers should be documented and centrally maintained;

- Refer child welfare agencies operating with deficits to the Agency and Institution Licensing (A&I Licensing) unit for investigation of licensing violations (Rule 401, Licensing Standards for Child Welfare Agencies, Subpart C: Administration and Financial Management, Section 401.200). The A&I Licensing unit should be expected to determine what other licensing violations exist as a result of the agency's failure to maintain a degree of financial solvency.
- The Department should review and revise field audit procedures to streamline the auditing procedures and increase capacity to perform more audits each year.³ Valuable staff time is spent reviewing documents in order to identify disallowed expenditures. The cost to discover and recover disallowable expenditures can often exceed the amounts recovered. Field auditors should have sufficient flexibility to direct their efforts to discover and take steps to require the agency to correct obvious deficiencies in areas, such as financial controls and Board oversight in relation to the agency's finances and service delivery.
- The Office of Field Audits should routinely request complete copies of AG 990 (Federal forms 990 are required with the AG 990) for all agencies whose revenue from government sources exceeds a certain level, i.e., 97% for the following reasons:
 - The document provides assurance that the agency is in compliance with Federal and State laws;
 - The forms are a valuable source of salary data;
 - The forms provide a list of Directors of the Board, and their compensation, if any.
- The Department should issue a policy directive to private agencies to ensure that prior to a child specific placement for an employee, the private agency should conduct a review to ensure a child's case will be transferred to an objective decision-maker who:
 - is fully informed as to the reasons for the transfer;
 - will verify all critical facts underlying decision-making;
 - will conduct a thorough search for alternative placements;
 - will consult at least three other agencies regarding foster and adoptive resources, and
 - will make a placement decision.
- The Department should require Agency Performance Team staff to ensure that prior to approving a case transfer between private agencies because of conflicts of interest for the purpose of foster or adoptive placement, Agency Performance Team staff should ensure that the private agency conducted the review to ensure a child's case will be transferred to an objective decision-maker.

Personnel Practices at Private Agencies

- To address lax personnel policies at some private agencies, the Department should issue an Information Transmittal to all private agencies requiring the following personnel hiring practices:
 - Applications for employment should ask whether the employee has been convicted of or pled guilty to a crime.⁴
 - Administrators should ensure that the question is answered on the application. Employees with criminal backgrounds may leave the boxes unchecked to avoid difficult questions. Too often, employers look only to see whether the "yes" box is checked, and fail to note that the prospective employee simply failed to answer the question. With no box checked, the

³ In an audit of DCFS, the Auditor General noted that DCFS performed only five audits in one year. See Report Digest - DCFS Financial Audit of DCFS for year ended June 30, 2003. Report dated April 24, 2004, page 9.

⁴ To avoid confusion, it is important that this question use the same terminology as the question on the Department's CFS 717F form. Prospective employees can be confused when the agency's application seeks only information about felony convictions, but the Department's background check form seeks information about misdemeanors and felonies.

employer will be hard-pressed, after the fact, to show that the employee misrepresented his or her criminal history.

- Any “yes” answers must be thoroughly explored with questions and responses documented. Prospective employees with criminal backgrounds may answer yes, but then provide a substantially abbreviated explanation. For instance, an employee with dozens of convictions may reveal only one or two. Without documentation showing that the employee was questioned about the *entirety* of their history, it will be difficult to show that the employee misrepresented facts on the application. Similarly, the employer should recognize that some prospective employees will minimize the facts leading to the conviction(s). By the same token, some convictions may appear worse than the underlying facts. In another OIG investigation, review of the underlying arrest report showed that an old conviction for Contributing to the Delinquency of a Minor was the result of attending a college party at age 19, where illegal substances were consumed and some of the persons at the party were 17. Therefore, reviewing underlying law enforcement or court documents is critical to a realistic assessment of criminal background.
- When a positive criminal history is provided by the State Police, employers should review answers provided during the application and interview process – and take into consideration the employee’s honesty in assessing whether to retain the employee. However, employers should consider all facts in assessing dishonesty. A prospective employee could reasonably believe that a twenty-year-old shoplifting conviction was no longer on their record.
- Previous job history should be critically reviewed. Applicants’ presentation of prior job history should be reviewed for any gaps in employment. Most applications ask about reasons for leaving prior jobs. Explanations should be critically reviewed and documented. Discharged employees may write, “looking for better opportunity” rather than disclose their termination. Therefore, it is critical to contact prior employers and verify dates of employment and reason for leaving. As part of the application process, employers should seek consents for release of information from prospective employees to enable former employers to speak freely.
- All Department staff who review POS criminal background check assessments should be notified that when a criminal background assessment suggests that the agency does not have personnel standards that ensure that “*all persons working directly with children are of reputable and responsible character,*” staff should refer all such agencies for a licensing investigation.

COORDINATION BETWEEN DIVISIONS

- Determining who should get foster home licensing responsibility in split cases is a clinical decision that should not be made by DCFS Central Office of Licensing. When transferring or assigning child cases, the Department needs to first identify all children in the foster home and assign children's cases and licensing responsibility to receiving agencies. If on rare occasions a split cannot be avoided, the Department's Case Assignment Unit, in conjunction with Purchase of Services Monitoring, should develop an individual agreement between the agencies on the role and monitoring duties of each agency with six-month clinical reviews.
- The Department must immediately rescind any policy prohibiting Agency Performance Team's access to agency records and inform all private agencies that Agency Performance Team Liaisons should have full access to all relevant records.
- Quality Assurance should conduct a review of Central Office of Licensure's current method of identifying CANTS reports on licensed foster homes and establish a schedule of reliability checks for the system of identifying foster homes with a CANTS report.

COORDINATION WITH JUVENILE COURT PROCEEDINGS

- Change of the legal relationship between the State and the child should be on record and should not be made outside of the presence of a court reporter.
- When a placement is made by court order and, subsequent to the court order, the Interstate Placement approval is denied by the receiving state, DCFS Legal must inform the Court.
- Regional DCFS attorneys should be trained in the procedures involving Interstate Compact on the Placement of Children and should become actively involved in court proceedings where interstate placement is at issue in order for the Department to be sure that the best interests of the child are fully considered. There are times when the best interest of the child could be different from the recommendation of the Interstate Compact Unit. It should also be made clear at the hearing what the monitoring and services will be to the child and placement family.
- The Department and the Cook County State's Attorney should explore ways to develop a restorative justice model for DCFS wards.
- The Department and the State's Attorney's Office should convene a work group to address how Orders of Protection can be used in intact family cases where there is concern about the safety of children but the case does not meet the urgent and immediate necessity hurdle to pursue custody. The Department should evaluate what specific and realistic goals for parents can be included in an Order of Protection that would help assure a child's safety or would provide support for pursuing custody later if the parent remains non-compliant.

PERSONNEL PRACTICES

- The Department needs to address the ongoing problem of adequate supervision of child protection teams. Reduced supervisor staffing levels in Child Protection directly affects the quality of investigative work. The Department needs to examine supervision staffing levels and give priority to filling open positions with full-time staff.

- The Department should (1) conduct a cost benefit analysis for on-call workers to assist investigators in completing key tasks when a unit is consistently above the BH compliance level and (2) explore piloting a four day flextime work week for DCP investigators to conduct evening home visits.
- *The Department must develop a policy regarding substance abuse in the work place. (Reiterated Recommendation 1999, 2000, 2001)*
- Assessment and waiver of indicated CANTS reports for DCFS employees must be documented, with a signed determination of decision, centrally filed for future reference and assessed in accordance with Rule 385.
- The Department should ensure that DCFS Labor Relations is notified when the subject of a child protection investigation is a DCFS employee. In addition if the subject holds a Child Welfare Employee License the OIG Child Welfare Employee Licensing Division must be notified.
- The Department should require Statements of Economic Interest from all licensing representatives, supervisors and administrators.

RECOMMENDATIONS FOR DISCIPLINE

The OIG recommended discipline of Department and private agency employees for the conduct detailed below. Discipline recommendations ranged from counseling to discharge.

- In an investigation of burns and bruising to an eight month-old baby, a child protection investigator failed to read available hotline report information, including a report that the mother's boyfriend was using drugs while caring for the children, prior to his investigative interviews of the mother and her boyfriend; failed to request identification from the boyfriend resulting in an inaccurate criminal history report; and inadequately documented the investigation. The baby was killed by the boyfriend one month later.
- A child protection investigator failed to identify risk to a child's safety where the report to the hotline alleged the mother had been attacked and beaten by drug dealers in front of her home in the presence of her eight-year-old daughter as punishment for an outstanding debt. The mother had a significant criminal history of prostitution, larceny and theft, and the mother had had five other children removed. The OIG also recommended the supervisor in this case be counseled. The eight-year-old girl was subsequently raped in her home by an intruder after her mother left her home alone.
- After learning of repeated allegations of abuse in a foster home, a licensing supervisor failed to increase monitoring or conduct an assessment of the foster home, initiate or participate in staffings, or facilitate communication with the agency performance team.
- In assessing risk to teen mother's one year-old son, a child protection investigator failed to consider the mother's statements about wanting someone else to raise her son, the teen's foster parent's statements regarding the teen's drug and alcohol use, neglectful behavior toward her son, and a recent mental health assessment of the teen, which raised questions about her ability to parent.
- Two private agency caseworkers failed to read a client's case file, ignored the recommendations of a Parenting Assessment Team report that concluded the teen mother could not effectively parent her children now or in the near future, and conducted an invalid comprehensive assessment in a case in which two of the teen mother's children had been removed from her care and her third baby died of Sudden Infant Death Syndrome. The OIG also recommended that the supervisor be disciplined.
- A child protection investigator failed to secure a ward's handwritten statement of alleged abuse by residential staff before closing the investigation of abuse of a ward in a residential facility. In addition, the investigation notes contained interviews of several persons at once, without documentation allowing the reader to determine who said what. The OIG also recommended that the Department review the supervisor's conduct in this case.
- A licensing worker maintained personal business relationships with facilities for which she held licensing responsibility, and accepted a personal loan of \$4,000 from one of the facilities. In addition, the worker miscalculated the permissible licensing capacity and ignored overcrowding and licensing violations at one facility. At another facility, the worker issued a license without ensuring that the facility corrected a water temperature violation identified by the City of Chicago

Department of Public Health, which also violated the licensing rules. The worker resigned from the Department. The OIG recommended that the supervisor be counseled for inadequate supervision of this employee and signing off on documentation submitted by the employee without review.

- A supervisor failed to provide adequate guidance to her caseworkers in addressing a teenage ward's dangerous gang-related behaviors and failed to provide discharge planning for his release from bootcamp, placing him in the same neighborhood in which he had become gang-involved with a foster parent who was not home several days of the week.
- In determining whether to take protective custody of a three-year-old boy, a child protection investigator failed to note inconsistencies in the custodial parent's version of events to the investigator and to the police and daycare provider, who had called the hotline. In addition, the investigator failed to interview the reporters. The three-year-old boy was subsequently re-abused by his father.
- In assessing the risks posed to an eight year-old boy and his nine-year-old sister, who presented with signs of both old and new bruises associated with excessive corporal punishment, a child protection investigator accepted the caregivers' story that the abuse was a one-time incident and returned the girl to a home where she had expressed fear of what might happen since she disclosed. The investigator also failed to respond to repeated attempts by the OIG for contact.
- An intact caseworker failed to identify a consistent pattern of neglect that resulted in cumulative risk to the children in their mother's care. Ultimately, a child that the mother was babysitting died of accidental strangulation after the plastic trimming from a mattress wound around her neck.
- A child protection investigator failed to interview or observe the six siblings of a 16-year-old reported to be abused by his father for signs of abuse or neglect, including a sister who was reported to have witnessed the incident, and failed to consider a pattern of violence and substance abuse in a home in which the 15-year-old son with cerebral palsy subsequently died from acute pneumonia and severe malnutrition.
- A private agency caseworker failed to investigate allegations that the foster mother's boyfriend, a convicted sex offender, was living in the home with the foster mother's 16-year-old foster son and 14-year-old foster daughter. The caseworker also failed to inform her supervisor of the allegations.
- A child protection supervisor, who assumed direct investigative responsibilities for an investigation while the assigned investigator was on medical leave, indicated a report of child abuse against the stepfather of a 16-year-old without interviewing the stepfather or mother or conducting a scene investigation. The indicated finding was reversed on appeal.
- A caseworker prepared a letter to the State's Attorney that incorrectly claimed that a mother who was involved in a private disputed custody case had been neglectful of her children.
- A residential staff person falsified his employment application and DCFS background check form concerning the existence of prior criminal convictions. The staff person also failed to seek timely medical services for a resident who sustained injuries from a fight with another resident.

- A Department employee wrote letters on Department letterhead to her husband's employer instructing the employer to discontinue garnishing her husband's wages for child support to his previous wife.
- A Department attorney failed to appear at scheduled court hearings and falsified travel vouchers claiming reimbursement for travel expenses he did not incur.

INVESTIGATIONS

This annual report covers the period of time from July 1, 2003 to June 30, 2004. The Investigations section has four parts. Part I includes cases of a child death or serious injury where the child's family was involved in the child welfare system within the preceding twelve months and OIG conducted a formal investigation. Part II contains summary information about all child deaths in Illinois (reported to the State Central Register) in FY 2004 and individual summaries for each child case. Part III is a summary of Illinois child death data from FY 2000 to FY 2004. Part IV contains general investigation summaries conducted in response to complaints filed by the state and local judiciary, foster parents, biological parents and the general public.

Investigation summaries contain sections detailing the allegation, investigation, OIG recommendations, and Department response. For some recommendations, OIG comments on the Department's responses are included in *italics* in the "OIG Recommendation / Department Response" section of each case.

DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

ALLEGATION

A father shot three of his children, killing one, before fatally shooting himself. The family had an extensive history of involvement with the Department and had both an open Intact Family Services (IFS) case and a pending child protection investigation at the time of the shootings.

INVESTIGATION

The shooting of three children in the home by their father was the culmination of an 11-year period of the family's nearly perpetual involvement with the Department. The family had been the subject of 32 hotline calls, 25 child protection investigations and 8 indicated abuse and neglect reports. During the previous 16 years, the Department opened intact family service cases for the family on four separate occasions which cumulatively totaled over 8 years in duration. Although the family demonstrated a pronounced inability to effectively address or even acknowledge the myriad problems that afflicted them, involved child welfare professionals continued to pursue family preservation as a singular goal and viewed events as individual incidents rather than evidence of chronic behavior.

Both the mother and father reported histories of their own severe physical abuse by their respective parents. The mother was diagnosed with major depressive disorder and borderline personality disorder and was known to have attempted suicide on five occasions. She had a history of substance abuse and suffered from numerous health problems, most of which stemmed from her clinical morbid obesity. The father also had issues with depression and alcohol. Both parents were prescribed multiple psychotropic drugs. Their five children, who ranged in age from 18 to 6, grew up in a chaotic, dysfunctional household characterized by frequent outbursts of violence. Despite persistent instability in the home, the two earliest intact family service cases were closed after it was determined the family had successfully met requirements.

The third intact family service case was opened following the birth of the fifth child, a boy. The mother stopped taking her anti-depressant medication in order to breast-feed the baby. By this time, the parents had divorced and the father no longer lived in the family home. The assigned intact worker developed a service plan that neglected to address the mother's need for medication or psychiatric treatment. The intact worker requested homemaker services, however the homemaker reported the mother spent the majority of time in bed and would not participate in chores or budget training sessions. In addition, the homemaker reported the mother frequently kept one of the older children home from school to take care of the baby as well as to provide company and assist with her own personal hygiene. The intact worker was directly informed of violent acts in the home perpetrated by various family members against each other, however an OIG review of case notes and State Central Register (SCR) records found no evidence these incidents were reported to the hotline. The case was closed after one year despite the fact the mother had failed to complete many of the required tasks.

One year later the fourth intact family service case was opened after police found the two oldest children, a 15 year-old girl and 14 year-old boy, intoxicated in a van. Both children were on juvenile probation at the time. When police brought the children home they found the next oldest child, a 12 year-old boy, watching the youngest sibling, then age 2, while the mother slept. The family was referred to a family preservation program through a private agency. Private agency staff immediately determined the mother was not meeting minimum parenting standards and that the children were not safe. A six-month client service plan was established, however, the private agency caseworker assigned to the case neglected to ensure that the mother adhered to the plan's requirements. The caseworker also failed to recognize the mother's ongoing substance misuse and dependence on powerful prescription narcotics, even after she was alerted to concerns about the mother's use of these drugs by involved physicians. In addition, the caseworker demonstrated poor professional judgment by failing to contact the hotline when incidents raised concerns regarding the children's safety. On one occasion, when the mother abandoned the oldest son in another state, the caseworker rationalized her decision not to contact the hotline by describing the mother's behavior as the actions of an overwhelmed parent.

The intact worker involved with the fourth open case continued the pattern of minimizing the parents' dangerous behavior and assessing incidents in a vacuum. After the second intact worker learned the oldest girl was using the youngest child's urine to pass court mandated drug tests, the mother conceded she could not control the children. The second intact worker developed a client service plan requiring the children to be supervised by an adult at all times. However, six months later when the mother was hospitalized following an apparent drug overdose, the intact worker created a safety plan that identified the 13 year-old middle child as the responsible caretaker for his two younger siblings during the afternoon and evening until their father arrived home from work. Case notes regarding the mother's hospitalization recorded a request by the fire chief to speak with the intact worker. In an interview with the OIG, the fire chief stated that one of the children told a paramedic who arrived at the home that their father was going to kill them. An OIG review of the case record found no evidence the intact worker spoke with the fire chief. In an interview with the OIG, the intact worker stated she did communicate with the fire chief but did not recall being informed of the child's statement. In her own interview with the OIG, the intact supervisor who oversaw handling of the case stated she never read the case file or visited the family home. The supervisor was unable to accurately describe the process for effectively presenting cases for screening into court. The supervisor stated she could not recall ever recommending that a family was inappropriate for intact family services once they had been involved in the program for a significant period of time.

Three months after the mother's hospitalization, the father entered the family home and fatally shot the 13 year-old boy while wounding the 18 and 12 year-old girls. The 17 year-old boy, who was in a foster home at the time of the shooting, committed suicide six months later. The 12 year-old girl, who was seriously injured, and the six year-old boy, who was not hurt, were taken into protective custody and placed in separate foster

homes.

As a result of this investigation, the OIG conducted a review of intact family service cases involving families with a high number of child protection investigations. The OIG identified 12 families with open intact family service cases who had been the subjects of at least 21 child protection investigations. The 12 families had intact family service cases open with the Department for an average of over 7 years. In instances where families have protracted involvement with the Department without any apparent progress towards resolution of persistent safety concerns, the objective of pursuing intact family as the desired goal must be seriously questioned.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. At the time any family reaches an “M” sequence (13 hotline reports), a full management review should be conducted that includes reading all relevant records such as medical, mental health, school, and an assessment of the workers and supervisors to determine if there are operating biases in the case. The full management review should begin with the 12 families. To ensure statewide consistency, a single management review team should be developed, composed of two upper level regional administrators and representatives from the Department’s Division of Legal Services, to identify obstacles to screening, including operating biases of workers. The team should specifically evaluate issues in the county where the family lived to determine if there are problems particular to that county.

A management review team completed its review. The analysis will be forwarded to the Division of Child Protection (DCP) and the Division of Field Operations. Once received, implementation efforts will begin.
Completion date: February 2005

2. The Department should consider changing the permanency goals for the six year-old boy to adoption and for the twelve year-old girl to subsidized guardianship should she continue to refuse adoption. The girl wishes to remain with her current foster parents who are reported to qualify to manage her special medical/behavioral needs.

The Department agrees. Both youth have goals of substitute care. In addition, the mother has signed specific consents for the boy to be adopted and has also agreed to a permanency goal for the girl. The girl is also receiving services through Screening Assessment and Support Services (SASS).

3. The Department should evaluate the first and second intact workers and the intact supervisor pertaining to their knowledge, skills, and ability to adequately perform their duties related to dependency, mental health and domestic violence cases.

A thorough review will be completed by March 2005.

4. The private agency should review the private agency caseworker’s ability to adequately perform her duties related to dependency, mental health and domestic violence cases. The Department should meet with private agency management after the review to determine whether the deficiencies identified in this report reflect systemic problems or to ensure adequate supervisory practices are in place.

OIG response: The OIG shared the report with the private agency. The agency developed a performance improvement plan for the caseworker.

5. The draft Procedures for Intact families should incorporate the integrated procedural framework identified in this report. The Procedures should also include instructions for addressing the potential

for violence when families present issues of physical violence combined with possession of weapons.

The Office of Child and Family Policy (OCFP) developed Procedures 302, Appendix O, Intact Families to strengthen the services and interventions provided. The Division of Child Protection is further revising Procedures 302. Administrative Case Review Critical & Chronic Feedback Reports were distributed for review.

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

An eight month-old baby girl died from a closed head injury after being shaken by her mother's boyfriend. At the time of the baby's death, the boyfriend was the subject of a pending child protection investigation regarding injuries the baby suffered one month earlier.

INVESTIGATION

One month prior to the baby's death, her mother brought her to a hospital emergency room with a second-degree burn on her cheek and bruises to her forehead and face. The mother told hospital staff the injuries had occurred the previous evening while her boyfriend was caring for the baby and her 18 month-old sister. The mother stated the boyfriend and both children were sleeping when she arrived home and she had only noticed the baby's wounds that morning. A nurse at the hospital called the hotline and related the mother's account as well as medical staff's opinion that the bruises on the baby's face were suspicious in nature. The report was accepted and a child protection investigation was initiated.

The next day an on-call investigator went to the family's home. The investigator spoke with the boyfriend who stated the baby's face had been burned when she squirmed out of his arm and fell onto a skillet as he was holding her while cooking. The boyfriend said he swabbed the burn with a moist cloth and comforted the baby before placing her in an adjoining room with her sister. The boyfriend stated that the facial bruises were caused when the older sister hit the baby in the face with a toy. The investigator did not ask to see the pan or the toy to determine if the boyfriend's explanations were plausible. The mother stated to the worker she had no concerns regarding the boyfriend's ability to care for her children but was angry the baby had been injured. The mother was unable to provide the worker with her boyfriend's last name and said she only knew him by his nickname. The worker asked the boyfriend for his last name but did not obtain identification from him, which resulted in his last name being recorded incorrectly.

The investigator told the mother she would have to secure an alternative caregiver and that the boyfriend could not reside in the home while the investigation was ongoing. The mother stated her 18 year-old friend would move into the home and watch the children while she was at work. The worker spoke to the friend who agreed to move in immediately. The worker then completed a Child Endangerment Risk Assessment Protocol (CERAP) which determined the home to be a safe environment based on the mother's agreement to have the boyfriend leave the home and the friend to assume child care responsibility. At the time, the Department office responsible for investigating cases in the region engaged in the use of risk management plans as a less restrictive substitute for safety plans regularly implemented by investigators. However, risk management plans were poorly defined and relied on compliance by families without monitoring by the Department. Furthermore, since a prerequisite of risk management plans was a determination that children were safe, the very existence of such a plan absolved investigators from monitoring responsibility.

Later on the same day as the investigator's visit to the home, the father of the two children arrived at the police station. The father made a statement to an officer that the mother's boyfriend used drugs while the mother was out of the home and supervised the children while under the influence of narcotics. The officer contacted the hotline and the father's statement was added to the Child Abuse Neglect Tracking System (CANTS) report generated by the State Central Register (SCR). The next morning, the on-call investigator spoke to a child protection investigator who then assumed responsibility for the investigation. The second investigator did not review the CANTS report and was unaware of the father's statement to police. The second investigator went to the home and encountered the boyfriend on the front porch. The second investigator conducted interviews with the mother and the boyfriend who both reiterated the information they had provided to the on-call investigator. Although the mother's friend had agreed to move in the day before, she was not present in the home. The second investigator accepted the mother's assurance the friend would arrive later that day. During the course of his interviews, the second investigator never asked the couple when

or where they met or how long they had been together. The second investigator also neglected to ask the boyfriend for identification and did not conduct a Law Enforcement Agency Database System (LEADS) check on the boyfriend until the morning of the day the baby died. The LEADS check was conducted using the boyfriend's incorrect last name and pertained only to Illinois. The mother later informed authorities she had met her boyfriend in another state only three months earlier and he moved in with her soon afterwards, shortly after her relationship with the children's father ended. It was also learned the mother's friend had never moved into the family home and the boyfriend had never moved out. One month after the baby suffered the burn and facial bruises, she died of a closed head injury after being shaken by the boyfriend.

At the time of the baby's death, the initial abuse report was pending and a third child protection investigator was assigned to the case. The third investigator made two attempts to contact the emergency room nurse who made the report but was unable to reach her at the hospital. While walking through the halls of the Department field office, the third investigator asked a Department nurse to look at a photograph of the infant taken by the follow-up worker when the baby was first injured. The Department nurse told the investigator it was possible the baby suffered the burn in the manner the boyfriend described. In an interview with the OIG, the Department nurse stated she had regarded the conversation as a casual exchange and was not provided with any other information about the incident or the family. The Department nurse stated she did not see bruises on the baby in the picture, which would have raised additional questions in her mind. The Department nurse said she did not document the conversation with the third investigator because she did not consider it to be a consultation but a brief, informal discussion. The third investigator ultimately indicated the report against the boyfriend for burns by neglect based on the boyfriend's acknowledgement he held the baby over a stove while cooking and his determination, supported in part by his interpretation of his conversation with the Department nurse, that the injuries were consistent with an accident. The third investigator indicated the report without speaking with the emergency room nurse who made the initial call to the hotline.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The on-call child protection investigator should be disciplined for his poor preparation and failure to read available CANTS report prior to his investigative interview, not requesting identification of the boyfriend for purposes of a LEADS check and his inadequate investigative documentation.

The employee was disciplined. The employee's grievance of the discipline is pending.

2. This report should be shared and reviewed with the on-call investigator as a teaching tool.

The employee was counseled.

3. To address deficiencies noted in this report, the Department should institute investigative training targeted specifically to the region responsible for handling this case. The training should be two-tiered.

Management and supervisor investigative training should address: (a) The need for individualized supervisory directives and assurances that the directives have been followed or amended prior to case closing; and (b) The use of this investigation and its conclusions with previous OIG investigations on children's bruising and injuries as teaching tools to develop a system for the reviewing of evidentiary logic in future child injury cases.

Supervisor and investigator training should address: (a) Comprehensive scene investigations; (b) Preparing historical timelines; (c) Ascertaining and verifying mechanics of injuries; (d) Critical analysis of operating assumptions and bias in safety decisions.

A workgroup has been established to revise training materials for child protection staff. The curriculum revisions will include processes for completing scene investigations, creating timelines, verifying the mechanics of injuries, and the critical analysis of operating assumptions and biases. Completion date: May 2005.

4. The Department should ensure that the practice of using risk management plans in lieu of safety plans is discontinued.

Risk management plans are no longer utilized.

5. In child abuse and neglect investigations where Department nurses are consulted, both the nurse and the investigator must document the questions asked, the information provided, the records reviewed and the answers given.

The Department will clarify the role and responsibilities of Department nurses, including the reporting structure, by June 2005.

6. Department administrators should develop and train nurses in standards for providing information to child protection investigators (See recommendations in OIG Report, File # 972415, June 30, 1999). Previous OIG death and serious injuries investigations should be included in the training. Supplemental training will be necessary on bruising and other forensic issues relevant to abuse or neglect.

The Department will clarify the role and responsibilities of Department nurses, including the reporting structure, by June 2005.

OIG response: The OIG distributed redacted reports with literature on bruises and burns to all regional nurses.

7. SCR should request a home phone number of medical, emergency room or law enforcement reporters who work weekend or night shifts.

SCR workers do request this information.

8. Administrators in the region should develop an effective communication system with local hospitals to assist investigators with contacting key medical informants in abuse and neglect investigations. In hospitals with child protection teams, the chair of the team can assist in developing a timely response. In hospitals without a child protection team, Department management should reach out to hospital administrators to have a designated contact to assist the investigator in contacting a mandated reporter and other key hospital informants. If requested by the hospital, the Department should assist in the formation of ad hoc child protection teams that can be convened on as needed basis.

The Department is working on a protocol for DCFS to have representation on all hospital child protection teams. Statewide completion date: March 2005.

9. The Department should (1) conduct a cost benefit analysis for on-call workers to assist investigators in completing key tasks when a unit is consistently above the BH compliance level and (2) explore piloting a four-day work week for child protection investigators to conduct evening home visits.

This is currently available to staff. Any staff may complete a flextime request form and submit it to their

supervisor for approval. Approvals are granted based on coverage needs.

OIG Response: The Department response only addresses the issue of flextime available to employees to accommodate the employee's personal needs. The OIG believes the Department needs to be creative to address: staff shortages; the availability of staff for weekend and evening hours for investigative interviews of working parents; follow-up investigative interviews of police and medical professionals who work evenings or weekends; and investigator availability for mandates, courtesy investigations or assistance with overloaded teams. In lieu of a troubled overtime system, structured three and four-day work weeks including weekend and evening coverage needs to be implemented to ensure parity throughout the state and the provision of effective services to children and families.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

A four year-old girl died from massive abdominal injuries resulting from physical abuse. A child protection investigation for cuts, welts and bruises and risk of physical injury to the girl had been initiated five weeks earlier and was pending at the time of her death.

INVESTIGATION

The initial abuse report was made when the four year-old girl's teacher contacted the State Central Register (SCR) and stated the girl had arrived at school a week earlier with significant swelling in both arms. The teacher recommended to the girl's mother that she take the child to see a doctor. When the girl returned to school untreated, the mother told the teacher the doctor had provided ointment for her swollen arms. The teacher and the school principal insisted to the mother that the girl revisit the doctor. When the girl returned to school once again, both of her arms were in casts. The teacher observed the girl also had a large bruise on her forehead as well as finger-sized marks on her face and cried frequently throughout the day. The hotline accepted the report for cuts, welts, and bruises and substantial risk of physical injury. Allegations of bone fractures or medical neglect were not included. SCR notified local police of the abuse report and a child protection investigator was assigned to the case.

The following day, the investigator met with the four year-old girl, her two sisters and their mother. The girl, who was interviewed in the presence of her mother, stated the injuries to her arms were the result of a fall, an account corroborated by the two sisters, ages eight and five. The four year-old denied being abused and stated she was not afraid of any members of her family. At the time of the interview the investigator did not explore the family's living arrangement or composition or question who regularly supervised the children. The mother and her husband, the girls' father, had separated a few months earlier and the mother and her daughters were living with the mother's boyfriend. The boyfriend and the father shared the same first name which caused confusion for investigators and police officers throughout the duration of the case. It is unclear from the record whether the investigator understood that references to the adult male in the household pertained to the boyfriend rather than the natural father.

The mother signed consents for the release of the girl's medical information and showed the investigator discharge papers from the hospital and an unidentified police document which determined no abuse had occurred, however the investigator did not record these forms in his case notes. The investigator focused on whether the mother had sought adequate medical attention for the wrist fractures and assumed that if the injuries had appeared suspicious to medical personnel, hospital staff would have contacted the hotline. However, hospital staff were unaware the mother had failed to promptly seek treatment for the girl. The investigator completed a Child Endangerment and Risk Assessment Protocol (CERAP) safety form, approved by his supervisor, which noted no safety concerns. Although Department Procedures require an interview with the reporter of an incident prior to completion of the initial investigation, there is no requirement that such an interview take place before submitting the CERAP. In an interview with the OIG, the investigator stated he felt confident the children were safe and moved on to other cases with the intention of interviewing the reporter later before closing the case. The investigator told the OIG he was aware of the allegation of bruises on the four year-old's face but stated he did not see any bruises when he met with the family. During the five weeks between the teacher's report to the hotline and the four year-old's death, the investigator's activity on the case consisted of a single phone call to the physician who put the girl's arms in casts and a fax of the medical release consent form to the same doctor on the same day. The investigator had yet to interview the reporter, other personnel from the children's school or any involved physicians at the time of the girl's death.

At the time of the investigation, the management of the Department's child protection division held weekly teleconferences to discuss cases involving particular risk factors that occurred within the geographic region. The Department administrator who oversaw the conference when this investigation was discussed raised

concerns that the mother of a four year-old girl with two broken arms and bruises had not immediately sought medical attention. The administrator then relayed these concerns to the child protection manager who regularly directed the teleconferences. In an interview with the OIG, the child protection manager stated she spoke with the investigator's supervisor about the need to verify with the hospital that the wrist fractures were indeed accidental. The supervisor told the child protection manager that the investigator had confirmed the determination that the fractures were accidental. However, following the girl's death, the investigator informed the child protection manager he still had not spoken to the physicians who attended to her broken arms. When confronted by the DCP manager, the supervisor could not provide an explanation for the inconsistency. Although the hospital did not report the fractured wrists to SCR as possible abuse, it is unlikely medical staff would have been aware of the mother's delay in seeking treatment or the subsequent observation by school personnel of bruises on the girl's face.

During the course of a second child protection investigation initiated following the girl's death, her five year-old sister stated that on the night the girl died, the mother's boyfriend had stomped on the girl's stomach, kicked her and punched her in the head and face while the mother was at work. The five year-old also stated the previous injury to the girl's wrists had been caused by the boyfriend grabbing and twisting her arms. As a result of the investigation into the girl's death the mother was indicated for bone fractures by neglect to the girl and substantial risk of physical injury to the girl and her two sisters. The boyfriend was indicated for internal injuries by abuse and death by abuse to the girl. The boyfriend was subsequently charged with first-degree murder. The charge is currently pending.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. A redacted version of this report as well as literature on bruising should be discussed at a weekly Division of Child Protection (DCP) Review meeting.

A workgroup is currently revising the child protection training curriculum and will incorporate information on bruising. Completion date: May 2005

2. This Report should be shared with Division of Child Protection (DCP) and State Central Register (SCR) administrators to ensure that allegations of prior injuries are added when appropriate.

In-service training for call takers at SCR is planned. Procedure 300 already has provisions for adding and investigating additional allegations if deemed appropriate. Completion date: February 2005

3. Department Rules and Procedures should be amended to provide that new injuries can raise suspicion regarding old injuries, previously believed accidental, and that when this occurs, investigators need to share new information and work collaboratively with all available professional resources, such as hospital child abuse teams or Child Advocacy Centers.

A workgroup to revise Procedures 300 was convened and will address this issue with DCFS Legal for possible liability regarding discussing previously unfounded reports with available professional resources and appropriately documenting a review and consideration of previously unfounded reports in a current investigation. Completion Date: February 2005

4. Procedures for investigations of Cuts, Welts and Bruises should be amended to provide that when suspicious bruising is reported (indicative of fingerprints, implements or otherwise suspect based on developmental age of child or location of bruise), and investigator does not see bruising, the reporter must be contacted prior to an initial safety CERAP determination.

A workgroup has been convened to revise/update Procedures 300 and will incorporate these recommendations

in the procedure for investigating an allegation of cuts, welts, and bruises (Allegation #11) if deemed appropriate. Completion date: February 2005.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION

A one year-old girl died after being smothered by her mother. The girl's parents had been the subjects of an unfounded abuse report one month prior to the girl's death.

INVESTIGATION

The parents had already been the subjects of three previous hotline reports for environmental neglect, two of which were indicated, as a result of the unsanitary and unsafe condition of their home. Despite conditions described by investigators and authorities as "unlivable," the family, which included two other children ages eight and three, was not engaged in services through the Department because of their unwillingness to cooperate. The fourth report against the parents was initiated after hospital staff contacted the hotline following the girl's admission for treatment of vomiting and diarrhea. Tests performed on the girl found she had high levels of ipecac syrup which is routinely used to induce vomiting in individuals who have ingested harmful substances. The emergency room physician suspected Factitious Disorder by Proxy, commonly known as Munchausen by Proxy, a form of abuse whereby a caregiver intentionally causes or fabricates illness in a child in order to receive medical attention. The hotline accepted the report and a child protection investigator was assigned to the case.

The child protection investigator interviewed the emergency room physician who related his suspicions to her. The physician stated it was impossible for a test for ipecac to return a result of false positive and also said the mother had told him she was essentially the girl's exclusive caretaker. The investigator then contacted the family's primary physician who informed her the girl and her mother were present in his office at that time. The investigator went to the office and spoke with the primary physician who disputed the emergency room physician's belief and stated the mother was strongly bonded to her children. The physician told the investigator he had been informed by the mother that the children's grandmother had discovered a bottle of ipecac in the eight year-old's clothes while she was doing laundry.

The investigator then interviewed the mother. The mother denied having ipecac syrup in her home. The mother stated the grandmother might have given it to the girl while she babysat but could offer no explanation as to why she might do this, other than to state the grandmother had an ongoing substance abuse problem. The investigator did not ask the mother how frequently the grandmother cared for the children or consider how this response related to her earlier statement in the emergency room that she was the children's sole caretaker. The investigator also did not address the issue of the mother's decision to allow a known substance abuser to routinely provide care for her children. The investigator then met with the other two children in the home of a family friend. The eight year-old stated she sometimes fed her sister and changed her diaper but denied giving the girl any type of medication or seeing anyone else giving the girl anything that made her ill. The girl stated she was not afraid of any of her family members. The eight year-old told the investigator she could not remember the last time the grandmother had watched the children.

The investigator forwarded a copy of the one-year-old's medical records to a Department nurse for review. The investigator did not inform the nurse of the nature of the case but asked only for a determination of medical risk. The nurse reviewed the record and told the investigator she was positive the girl had been poisoned. The nurse did not offer a judgment as to who the perpetrator might have been. An OIG review of the girl's medical records found the girl had two prior hospitalizations for similar symptoms prior to the visit that prompted the hotline call. All three instances suggested the girl had been with the mother before becoming ill and that her condition improved while being monitored. In addition, there was a reference to a phone call to the third hospital from an individual who identified herself as the mother of one of the eight year-old's classmates. The caller stated the eight year-old had told her daughter that the mother gave the one year-old an unknown substance which caused her to vomit. In an interview with the OIG, the Department

nurse stated she had seen the allegation in the case file but had not mentioned it to the investigator. In their interviews with the OIG, both the investigator and her supervisor stated they had overlooked the caller's allegation in the file. The absence of effective communication between the investigator, her supervisor and the Department nurse prevented the development of a comprehensive understanding of the one year-old's situation or an accurate assessment of who most likely poisoned her. The investigator told the OIG the nurse had concluded the girl had been given ipecac without good cause. Since that fact had already been established, the investigator saw no need for further contact with the nurse.

The investigator determined to unfind the report against the parents but to indicate the grandmother for poison/noxious substances. The investigator based her decision on her belief, shared by the family physician, that the mother was strongly bonded to the children and the grandmother's verified substance abuse problems. The investigator made this determination without interviewing either the father or the grandmother herself, who was ultimately indicated for child abuse. An OIG review of records in the investigator's field office found she was well beyond the number of cases she should have been responsible for according to Department requirements. Fifteen of her co-workers in the office also exceeded those requirements. In her interview with the OIG, the investigator stated extensions to complete investigations were not being granted during that period and time did not permit her to interview the grandmother and the father.

Three weeks after the report was indicated against the grandmother, an ambulance was dispatched to the family home following a call from the mother that the one-year-old was not breathing. The girl was pronounced dead at the hospital. After offering varying accounts to police, the mother admitted holding a blanket over the girl's face to stop her from breathing. The mother told police she did not intend to kill her child but was only trying to provoke a physical reaction. The mother also acknowledged systematically giving the girl ipecac in her bottle during feedings. The mother stated she did this because when the girl became sick she would cling to the mother, making her feel needed and offsetting her feelings of jealousy of the father's relationship with the baby. The mother pled guilty to murder and was sentenced to 30 years in prison.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. Consistent with their present job description, which includes "...conducts investigations of child abuse and neglect..." the Department Child Welfare Nurse Specialists should be assigned to the Division of Child Protection to conduct abuse and neglect investigations. In this capacity under DCP, the nurses would be able to utilize their medical background in obtaining and interpreting medical records and interviewing medical personnel in cases with complicated medical information. To avoid problems presented in this case and others, however, the nurses' role should be clearly established. When a Department nurse is consulted, he or she should be provided with the precise question that must be answered and the information that is sought. Imprecise referrals with vague directions to the nurses to "review records" are ineffective in utilizing nurses' expertise.

The Department will clarify nurse roles and responsibilities including the reporting structure by June 2005.

2. This report should be shared with the child protection investigator, her supervisor and the Department nurse.

The report will be shared with the employees.

3. The indicated report against the grandmother should be expunged.

A decision will be made by January 2005 as to whether this report can be expunged.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION

A three year-old boy died from smoke inhalation following a fire in his home. At the time of the boy's death, his family had an open case with the Department through Intact Family Services (IFS).

INVESTIGATION

The family first became involved with the Department six years earlier when the second of the mother's four children tested positive for cocaine at birth. The subsequent child protection investigation resulted in an indicated finding of substance misuse against the mother and the family was referred for intact family services. Three weeks after the baby's birth, the hotline received a call from hospital staff reporting the mother had brought her three year-old daughter to the emergency room for treatment of vaginal discomfort. Tests found the three year-old had contracted gonorrhea. The mother told hospital staff she believed her 15 year-old male cousin who served as an occasional babysitter was responsible for infecting the girl. The 15 year-old boy was examined and tested negative for gonorrhea. Although the mother told the assigned child protection investigator she had no stable housing and her children had frequent contact with numerous relatives and acquaintances, no other potential leads were pursued. The report was ultimately indicated against an unknown perpetrator.

Thirteen months after the family's initial involvement with the Department, the mother gave birth to her third child. Following the baby's birth, a decision was made to close the intact family case. The mother's caseworker determined that the children's basic needs were being met satisfactorily and the absence of a positive toxicology report on the infant supported her belief substance abuse issues had been addressed. An OIG review of hospital records found no toxicology test was performed on the mother's third child at the time of his birth. From the outset of the intact family case the mother's compliance with required drug treatment was minimal. The mother participated in an outpatient program but did not complete it successfully prior to her case being closed.

Six months after the case was closed, the hotline received a report the mother had left her two youngest children unattended in a car while she went shopping. In response to the child protection investigation, the mother acknowledged she had erred in leaving the children alone. The mother was indicated for inadequate supervision, however, based on a positive report from the former caseworker and the testimonials of three references provided by the mother that she was not using drugs, the case was not reopened for monitoring.

Seventeen months later, the mother delivered her fourth child who tested positive for cocaine at birth. The mother was again indicated for substance misuse and a second intact family case was opened. The mother was instructed to enroll in a drug treatment program or risk losing custody of her children, however seven months passed before the mother entered a program. The mother's participation in the program was sporadic and she was eventually expelled. The mother agreed to improve her compliance in another program and produced negative test results for a brief period of time, although she frequently missed sessions, particularly on days prior to or following weekends. Nonetheless, the caseworker and her supervisor requested that the mother's youngest child be discharged from Department guardianship. One month later, the hotline received a report from the mother's drug counselor that the mother had left her four children, all of whom were under the age of seven, at home alone. The children were taken into Department custody for a brief period and the mother was charged with endangering the life of a child. At the time, the oldest child reported that she sometimes cooked for her siblings and that her mother often left them alone during the day. The children were subsequently returned to their mother.

Six months later, the family's case was transferred to a new intact worker. The 14-month period of the intact worker's handling of the family case was characterized by ineffective assessments and lapses in critical judgment. The mother's inconsistent participation in mandatory drug treatment culminated in her refusal to

accept services. The mother justified her opposition in part by arguing she had to work in order to pay rent. The intact worker failed to recognize that the mother's housing subsidy had been rescinded because her home was in a state of disrepair and no longer met standards established by the state. The intact worker did not attempt to re-engage the mother in drug treatment. Following another hotline call after the youngest child was burned with an iron, the intact worker continued to minimize potential risks to the children by informing the assigned child protection investigator that although the mother was not complying with her service plan and had continually acknowledged using marijuana and crack cocaine, she appeared well groomed and was able to meet the children's basic needs.

One month after the intact worker's last documented contact with the mother, firefighters were summoned during midday to a fire at the family's home. The mother's youngest child, a three year-old boy, was killed in the fire. Officials determined the mother's five year-old son had ignited blankets in his room while playing with a lighter. The boy told officials that he attempted to alert his mother who was sleeping in another room but was unable to awaken her. During the course of the investigation, officials noted the absence of smoke detectors in the home and a general state of disarray including clothing piled several feet high and numerous space heaters, including one in the children's room that was operated without a plug by inserting exposed wires directly into an electrical outlet. It was learned gas service to the home had been disconnected for several months. In an interview with the OIG, the intact worker stated she assumed all utility bills had been current because the house was warm and illuminated when she visited. The intact worker also stated she believed there had been smoke detectors in the home and had not been concerned about the presence of fire-starting materials because the mother did not smoke cigarettes.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The OIG reiterates the following recommendations previously made in OIG Report #02-0161, issued January 2003.

- (a) Mothers with substance exposed infants who are referred to intact family services must receive intensive specialized intact families services that are designed to safe guard children from harm while providing effective substance abuse treatment;**
- (b) The Department should review all intact cases where a mother has more than one substance exposed infant. These cases should be reviewed to determine whether workers should obtain orders of protection for the parents to ensure that they are complying with treatment.**

The Department agrees. The Office of Child and Family Policy and the Division of Child Protection drafted Appendix O to Procedures 302 - Intact Family Services to address OIG recommendations; however, further revisions are needed. Appendix O is to be completed by January 30, 2005. In addition, there were revisions to the substance abuse screening tool for adolescents and a protocol was developed for referrals for assessment, treatment and/or Intact Family Recovery services. As part of the Program Improvement Plan for the Child and Family Services Review, the Department is conducting a record review of substance abuse cases to identify barriers to implementing Department policies for serving substance affected families. This is scheduled to be completed by January 2005.

The record review will lead to recommendations for changes to the existing Substance Affected Families policy as needed. This is scheduled to be completed by March 2005. The policy, with any needed revisions, will be re-issued statewide to Department and private agency staff. This is scheduled to be completed by June 2005.

2. This report should be shared and discussed as a training tool with the intact worker and her supervisor.

The Department agrees. The report was shared.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

A two year-old girl suffered serious burns and bruises as a result of abuse inflicted by her mother's boyfriend. At the time of the girl's injury, her family had an active case with Intact Family Services (IFS) which had been opened after the girl's younger sister was seriously injured by one of the mother's previous boyfriends.

INVESTIGATION

The girl's mother was herself a 16 year-old ward when she gave birth to her first child. During labor the mother threatened to harm her child after he was born and attempted to leave the hospital. After she delivered, the mother was psychiatrically hospitalized and diagnosed as bi-polar with major depressive disorder. The boy was permanently removed from his mother's custody when he was one year-old following her incarceration on felony forgery and theft charges. The mother subsequently gave birth to two more children, both girls.

Four years after the son was removed from the mother's custody, her younger daughter was brought to an emergency room with bilateral retinal hemorrhaging and abusive head trauma. The mother's boyfriend admitted to hospital staff he had shaken the four month-old because she would not stop crying after he dropped the baby on her head. The baby suffered brain damage and blindness in her left eye as a result of the abuse. The mother, who had not been in the home at the time the abuse occurred, told hospital staff she had been living with the boyfriend because she and her two children were homeless. The mother stated the boyfriend, who was the father of her older daughter, had a volatile temper and had previously threatened to harm or kill the younger daughter because her father was another man with whom the mother had been involved. Hospital staff contacted the hotline and a child protection investigation was opened.

The assigned child protection investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) which noted only the baby's abuse by a paramour as an area of concern for the children's safety. In an interview with the OIG, the investigator stated the mother told him the boyfriend had threatened to harm her before. The investigator also stated he was informed by a police detective that officers had been to the home in the past in response to domestic disturbance calls. An OIG review of police records found the boyfriend had been arrested for domestic battery against the mother three days before the baby was brought to the emergency room. The OIG also learned the mother had previously obtained an order of protection against the boyfriend. There was no evidence in the investigator's notes to suggest he discussed domestic violence issues with the mother.

The investigator initially intended to return the injured baby to her mother's custody, however hospital staff intervened. During a program designed to teach the mother techniques to meet the special needs of her daughter's condition, the mother had demonstrated an unwillingness to learn or assume responsibility for her daughter's care. At the same time, the baby's paternal grandmother had participated fully in the program and assumed duties the mother failed to fulfill, such as obtaining the girl's medicine. The baby's father had told the investigator that the mother had prevented him from seeing his daughter because of her boyfriend's attitude towards him. The father and the grandmother immediately expressed a desire to care for the baby upon her release and a commitment to meet all of her needs. At the behest of hospital staff, the investigator placed the baby with her father and grandmother. Despite unresolved issues of domestic violence, homelessness and concerns regarding the mother's interest in or ability to provide care to her children, the investigator allowed the two year-old girl to remain with her mother. The investigator referred the case to Intact Family Services (IFS) to work towards returning the four month-old to the mother. At the time, the investigator did not report to a full-time supervisor. Department staff shortages resulted in a single supervisor overseeing three child protection teams, managing the investigator's team as an acting supervisor in a temporary capacity. During the course of the OIG investigation, the child protection investigator resigned his position with the Department.

Throughout her involvement with intact family services, the mother repeatedly failed to perform required tasks regarding every aspect of her participation. She neglected to make arrangements allowing the father and grandmother to obtain medicine and treatment for the baby or redirect funds to them intended to provide for the baby's care. The mother also refused to voluntarily attest to the father's paternity of the infant or respond to his efforts to do so through the courts which further obstructed his attempts to procure services for her. The infant required developmental, occupational, physical and speech therapy sessions which required daily participation by the father and grandmother, however the mother, who was required to attend as a condition of the service plan, barely attended. In addition, while the father quit his job in order to provide additional care to his daughter, the mother made infrequent visits to the grandmother's home to see the baby and did not engage the child when she did. The mother lived in five different shelters during the eight months her case was open through intact family services. Staff at the various shelters related allegations of non-compliance with rules, theft from residents and employees and habitual lying to the assigned intact worker. At one shelter, staff reported the mother frequently left her two year-old daughter in the care of a fellow resident she did not get along with. Staff from another shelter informed the worker the mother was dating a former shelter employee who had physically abused the two year-old. The intact worker did not report the allegation or attempt to ascertain its veracity. The worker also learned the mother had provided her with an implausible explanation for her daughter's whereabouts while she claimed to be working out of town, however she did not take immediate action to ensure the girl's safety.

Despite the mother's ongoing demonstrated unwillingness to comply with the requirements of her service plan, the intact worker continued to work towards the goal of returning the infant to her mother. After eight months of unsuccessful efforts towards reunification, a clinical staffing attended by the intact worker, her supervisor, the grandmother and Department clinical staff resulted in a decision to screen the case into court. Although the Department allows for workers to procure orders of protection to motivate parents to comply with the conditions of service plans, they are infrequently utilized. Orders of protection provide workers with leverage to encourage parents to fulfill their obligations prior to children being taken into temporary custody. Implementation of an order of protection may have prompted the mother to participate in services or brought about a more timely decision to screen the case into court.

Although the intact worker was instructed to screen the case into court two days following the clinical staffing, the case was not screened for almost three weeks. In an interview with the OIG, the intact worker stated a significant period of time had passed since she had screened a case into court and she was uncertain how to proceed. The intact worker did not seek supervisory direction or discuss her apprehension with the Department's child protection division. When the family case was scheduled to be screened in, it was not accepted because the court requested additional information. Later that day, the two year-old was transported to a hospital emergency room with bruises to her thighs and buttocks and scalding burns on her feet and legs. The mother's current boyfriend, who was unknown to the intact worker, had whipped the two year-old girl after she defecated in the house. The boyfriend stated he then attempted to bathe the girl and accidentally scalded her. The girl did not receive medical attention for four days because the mother and her boyfriend were fearful of intervention by authorities. The boyfriend was subsequently found guilty of domestic battery and sentenced to 90 days imprisonment and two years conditional discharge. The mother pled guilty to contributing to the neglect of a child and was sentenced to two years conditional discharge. Six months after she was convicted, the mother gave birth to another child who was removed from her custody and placed in a foster home. The older girl was placed in a pre-adoptive foster home. The younger daughter remained in the home of her father and grandmother.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. A redacted copy of this report should be shared with the chair of the Department committee examining the involvement of fathers in child welfare services.**

The OIG shared the report.

2. The Department and the State's Attorney's office should convene a work group to address how orders of protection can be used in intact family cases where there is concern about the safety of children but the case does not meet the urgent and immediate necessity hurdle to pursue custody. The Department should evaluate what specific and realistic goals for parents can be included on an order of protection that would help assure a child's safety or would provide support for pursuing custody later if the parent remains non-compliant.

The Department has convened a workgroup to address this issue. Completion date: May 2005.

3. When a parent's lack of compliance with the Department's client service plan and/or safety plan jeopardizes the health, safety, and welfare of the child(ren) but does not rise to the level of a hotline call, workers should seek a protective order. A child's welfare includes education and early intervention programs used as a safety net to monitor the child's well being. The Department should include guidelines in Procedures 302 – Appendix O (Intact Family Service) to determine when a caretaker's lack of cooperation places children at risk and warrants either a hotline call or seeking court involvement (such as an order of protection, requiring a parent to comply with the client service plan and/or the safety plan).

The Department has convened a workgroup to address this issue. Completion date: May 2005.

4. The OIG previously recommended that the Department include guidelines for workers on preparing and presenting cases for court involvement in Procedures 302 – Appendix O for Intact Family Services. The OIG reiterates this recommendation.

The Department has convened a workgroup to address this issue. Completion date: May 2005.

5. The Department should place a "Do Not Rehire" notification in the child protection investigator's personnel file.

The investigator followed protocol when separating from employment with the Department. Accordingly, he is not coded as ineligible for re-hire on the computer screens. However, a "do not rehire" note was placed in his personnel file.

6. The Department needs to address the ongoing problem of adequate supervision of child protection teams. Reduced supervisor staffing levels in child protection directly affects the quality of investigative work. The Department needs to examine supervision staffing levels and give priority to filling open positions with full-time staff.

The Department is working with the Office of Management and Budget and the Governor's Office to fill vacant positions.

7. The Department should revise Department Procedures Part 302 – Services Delivered by the Department to include procedures for assisting fathers to file for custody when the parents are not legally married.

An Intact Family Services workgroup was convened and is currently revising/updating Procedures 302-Appendix O.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

A three year-old boy suffered scalding burns and serious injuries as a result of physical abuse. At the time of the injuries, the boy's father was the subject of a pending child abuse report.

INVESTIGATION

The pending abuse report stemmed from a domestic violence incident one month earlier. The mother, who was separated from the father, arrived at his home to pick up the three year-old and his two year-old brother following a two week visit. During an argument between the parents outside the home, the father physically assaulted the mother and left the scene. After police officers arrived, the mother noticed welts and bruises on the three year-old's face, legs and back. The mother stated to police the father had struck the children in the past. The boy was taken to an emergency room and hospital staff reported his injuries to the hotline, prompting a child protection investigation. Police who responded to the home also made a hotline report. Two days later, the hotline received a third call regarding the family from a woman who frequently provided daycare for the children reporting the injuries to the three year-old. Later that day, police located the father and he was arrested for domestic battery. The father told police that on the day before the mother came to his home he had hit the boy with a plastic belt for running into the street.

On the evening of the incident, an on-call investigator interviewed the hospital worker who made the hotline report and made an unsuccessful attempt to visit the mother and children at home. The assigned child protection investigator then assumed responsibility for the case. The investigator interviewed the mother who stated she had separated from the father because of his physically abusive behavior towards her. The mother told the investigator the father had never hit the children before, a statement that contradicted information she provided to police. When asked to provide the names of collateral contacts, the mother told the investigator she had no family or friends in the area. In an interview with the OIG, the child protection investigator stated she had never reviewed the State Central Register (SCR) narratives generated by the hotline reports made by police and the daycare provider that came in after the hospital's initial call. The investigator also was not aware of a hotline call placed by the mother 10 days after the incident requesting assistance locating services.

The investigator completed a Child Endangerment and Risk Assessment Protocol (CERAP) which judged the children to be safe based on the mother's agreement not to allow them to have unsupervised contact with their father. The investigator failed to critically evaluate available information regarding the history of domestic violence between the parents and the apparent absence of outside support for the mother. The investigator's supervisor approved the safety plan and instructed the investigator to perform additional tasks. The investigator and her supervisor prioritized the investigator's cases in anticipation of her upcoming vacation and determined additional work on the case could be delayed until after her return. A substitute investigator was not available to monitor the children and no worker was present at the father's hearing for the domestic battery charge.

One month after the incident outside the father's home and ten days after the investigator went on vacation, the parents brought the three year-old to an emergency room. The boy had severe scalding burns over 40% of his body and a cat scan showed he had a lacerated liver and bruised pancreas. After providing multiple accounts of events in the home medical staff deemed inconsistent with the boy's injuries, the father admitted placing the boy in a bathtub of hot water. The father stated he had recently punched the boy in the stomach as hard as he could as punishment for his difficulties with toilet training. The father also informed police he had been diagnosed with schizophrenia but had ceased taking his medication approximately one month earlier. The father was charged with two counts of aggravated battery to a child. He is currently awaiting trial and a psychiatric evaluation. The mother was charged with child endangerment for allowing the father to have unsupervised visitation with the children. She pled guilty and was sentenced to one year of probation.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should consider establishing a policy requiring corroboration, though collateral contacts, of mitigating factors of caretakers that result in a safe CERAP determination.

A policy regarding corroborating mitigating factors of caretakers has been established.

OIG Response: The OIG has not received this policy from the Department and therefore cannot assess whether it addresses the recommendation.

2. Prior OIG investigations have described poor investigative practice in which reporters and collateral contacts were not contacted. (See OIG#01-0694; OIG#03-0992 and OIG#02-0704). Child protection managers should ensure that supervisors are enforcing the policy to interview reporters and sources including those for related information.

A memo was sent to management staff regarding contacting all reporters and collateral contacts, including those for related information intakes.

3. The child protection investigator should be counseled for not reading all narratives including related information and interviewing all reporters.

The investigator was counseled.

4. In previous OIG report #02-0704, June 24, 2002, the OIG reaffirmed an even earlier 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 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 #97-0700.)

The Department agrees. The Policy and Procedure will be issued by January 2005. Training curriculum will be completed by January 2005 and training will begin in March 2005.

5. When an initial child protection investigation discloses intentional injuries to a child by a parent and there is a history of domestic violence in the home, a body scan must be conducted before the child(ren) can be left with the non-offending parent or caretaker. If the body scan discloses evidence of old injuries that may have been abusive, the investigator should explore the non-offending caretaker's knowledge of abuse to determine whether the non-offending caretaker can protect the child from future harm.

The Department may only request a body scan on children that have been taken into protective custody.

OIG Response: The Department can request the parent/caretaker's consent to conduct the body scan. A parent/caretaker's refusal should be a factor considered in determining whether to leave the child with that parent/caretaker.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION

A one year-old girl died of accidental suffocation while in the care of a neighbor. The caregiver was a former Department ward and the mother of three young children. The family had an extensive history of involvement with the Department and was engaged in intact family services at the time of the girl's death.

INVESTIGATION

The 22 year-old mother of the family had been involved with the Department since the age of three and, during the following 12 years, her parents were the subjects of multiple indicated reports for abuse and neglect before she and her siblings were removed from their custody. The same year she was removed from her parents, the mother gave birth to her first child. The mother lived in 12 placements during a 6-year span prior to aging out of the system, giving birth to two more children during that period.

Following the birth of the mother's third child, a girl, the family was placed in a residential facility. Facility staff reported the teen mother often used excessive corporal punishment to discipline the children and was frequently verbally abusive towards them. On multiple occasions she stated to staff that she "hated" her children and expressed a need to repress thoughts of violence towards them. While living at the facility, the mother was indicated for cuts, welts and bruises after whipping her oldest son, then age three, with a belt. The mother was the subject of 20 additional abuse and neglect reports, six of which were indicated, over the next four years.

Six months after the mother gained independence from the Department she was indicated again for cuts, welts and bruises after she punched her one year-old daughter in the face, giving her a black eye. The family was referred for Intact Family Services (IFS) and assessed as high risk. For the next three years while the family received intact services, concerns were repeatedly raised regarding mistreatment of the children, the children's education, lack of supervision, unsafe conditions in the home and the medical needs of the children and the mother.

Homemaker services were initiated to provide assistance to the mother and develop her parenting skills, however the mother refused to actively participate in maintaining the home and relied upon the homemaker to complete tasks independently. The two boys were both diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and required daily medication, however the mother's compliance with their medication schedules was inconsistent and the boys reported to school staff they would often forgo their medication or attempt to administer it themselves. The boys stated the homemaker assumed responsibility for preparing them for school on days she was present in the home while their mother remained in bed.

All three children were frequently absent from school. The mother, a diagnosed diabetic who was inconsistent with her own treatment, claimed to suffer from a sleep disorder. The mother blamed the children's sporadic school attendance on her inability to awaken in the morning and often called the children's schools to state they would be absent because she planned to sleep all day and would be unable to let them into the home when they returned in the afternoon. Although the girl had cerebral palsy which required her to participate in physical, occupational and speech therapy at her specialized school, the mother made little effort to ensure her daughter was present to receive necessary treatment. The specialized school ultimately expelled the girl after determining that her sporadic attendance and the mother's uncooperative behavior made effective treatment impossible.

The intact worker assigned to the family's case consistently relied upon the mother's self-reports and failed to critically assess her willingness or ability to provide adequate care to her children. The intact worker never obtained consents from the mother to review the children's school records to address the issue of their

absences. An OIG review of the case record found no evidence the intact worker contacted the girl's specialized school after being informed by the principal of her pending expulsion. The intact worker accepted the mother's contention that she suffered from a sleep disorder despite the presence in the case record of a previous sleep assessment that found no medical basis for such a claim and identified the mother's poor eating habits and inattention to her health as likely causes of her chronic lethargy.

The intact worker also failed to address concerns regarding the mother's supervision of her children. Involved child care workers, school personnel and local law enforcement and fire officials reported instances of finding the children unattended outside the home or being unable to enter the home because of the mother's incapacitation. On one occasion, the mother called her then six year-old son's school to ask if he was there because she did not know his whereabouts. Although both the intact worker and the homemaker were aware the mother frequently babysat her friend's one year-old daughter, neither professional recognized the additional stress the arrangement placed on the mother or the potential danger posed to the children. In addition, the homemaker and other involved professionals reported the mother's misuse of her finances, particularly Social Security Insurance (SSI) payments the mother received for her daughter's care. The mother purchased expensive clothes and amassed phone bills totaling thousands of dollars calling psychic telephone lines, however she frequently asked the homemaker to transport her to food pantries because she had no money for groceries.

After learning the mother's boyfriend was residing in the family home, the intact worker failed to conduct child abuse and neglect or criminal history background checks as required by Department policy. A Law Enforcement Agency Database System (LEADS) check conducted by the OIG found the boyfriend had a previous arrest for selling crack cocaine. Confirmation of the boyfriend's presence in the home prompted a review of the case by Department administrators. Based on the mother's habitual non-compliance with service requirements, her inability to adequately supervise the children and the boyfriend's presence in the home, the administrators contacted the State Central Register (SCR) and a child protection investigation was initiated. The children were immediately taken into protective custody but were returned home three days later after the court found no urgent and immediate necessity for the Department to take temporary custody.

The intact worker was instructed to develop a safety plan requiring an adult besides the mother to be present with the children at all times. The intact worker initially conducted a Child Endangerment Risk Assessment Protocol (CERAP) that determined the home to be safe. However, after her supervisor rejected the conclusion, the intact worker ruled the home unsafe and implemented the safety plan. Although the mother was required to permit child care workers into her home to monitor compliance with the plan, she refused to allow the assigned worker to enter her home for the first month the plan was in place. On other occasions the intact worker observed the mother to be in violation of the safety plan, although she did not report the transgressions to the monitor or her supervisor. The case returned to court, however the Department's request for temporary custody was denied, though the court ordered the mother to comply with the safety plan. Two weeks later, the mother again violated the service plan and agreed to have her children reside with her aunt until the next scheduled court date. One week later, while in the care of the mother, the friend's daughter became entangled in plastic binding loosely connected to a mattress and suffocated. At the next court hearing following the girl's death, the three children were removed from their mother's custody and placed in foster care.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should require the mother to comply with a diabetes management program. Participation in such a program should be included as a task in the client service plan.

The Client Service Plan has been updated to include diabetes management.

2. The Department should ensure the daughter with cerebral palsy is appointed a permanent SSI payee.

The application process has been initiated.

3. With the exception of necessary transportation, homemaker services should be terminated on this case. The Department should require that the mother be responsible for scheduling and maintaining appointments, budgeting, and health care. These tasks should be included in the client service plan.

These tasks have been included in the Client Service Plan.

4. If the mother is not signing consents for release of information to allow monitoring of her compliance, the Department should request a court order for the mother to provide signed consents.

The Department is working with the mother to obtain releases of information and will request a court order if necessary.

5. Department Management should conduct a thorough review of this case prior to all upcoming permanency hearings and administrative case reviews.

The Department is implementing a better system to address this issue. New cases will receive an Integrated Assessment, regular staffing by the caseworker and supervisor of placement teams, and a clinical staffing would be available regionally upon request. Should field service managers desire consultation on difficult cases, the cases can be added to the Grand Rounds agenda.

6. The intact worker should be disciplined for not following Department procedure, ignoring safety plans and relying on the mother's self report.

The employee was disciplined. The employee's grievance of the discipline is pending.

7. The Department and the State's Attorney's office should convene a work group to address the use of Orders of Protection in intact family cases where there is concern about the safety of children but the case does not meet the urgent and immediate necessity hurdle to pursue custody. The Department should evaluate what specific and realistic goals for parents can be included on an Order of Protection that would help assure a child's safety or would provide support for pursuing custody later if the parent remains non-compliant.

The Department has convened a workgroup to address this issue. Completion date: May 2005.

8. When a parent's lack of compliance with the Department's client service plan and/or safety plan jeopardizes the health, safety, and welfare of the child(ren) but does not rise to the level of a hotline call, workers should seek a protective order. A child's welfare includes education and early intervention programs used as a safety net to monitor the child's well being. The Department should include guidelines in Procedures 302 – Appendix O (Intact Family Service) to determine when a caretaker's lack of cooperation places children at risk and warrants either a hotline call or seeking court involvement (such as an Order of Protection, requiring a parent to comply with the client service plan and/or the safety plan).

An Intact Family Services workgroup was convened and is currently revising Procedures 302-Appendix O. The procedures should be completed by January 2005.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION

While at school, a 14 year-old girl secretly delivered a baby into a toilet where the infant drowned. The 14 year-old had been a Department ward until her adoption 10 months earlier.

INVESTIGATION

The 14 year-old and her siblings had been involved with the Department since they were infants and were removed from their mother's custody following multiple neglect reports when the girl was 3 years-old. The girl moved through eleven traditional and relative foster homes before being placed along with her older sister with their paternal aunt at the ages of 12 and 13. Two years later, the aunt initiated proceedings to adopt the girls. While the adoption was pending, the aunt was arrested for domestic battery against the 15 year-old. Despite the aunt's extensive history of arrests and the current charge of domestic battery, the private agency handling the case finalized the aunt's adoption of the girls.

The same month the adoption was finalized and just one month after the domestic battery arrest, the aunt was evicted from her apartment. The aunt sent her son to live with his father and abandoned the two girls. The Department continued to send adoption subsidy checks to the home which the aunt collected by returning once a month to retrieve her mail. The girls had almost no contact with the aunt and moved around, staying with various relatives until they contacted a cousin who allowed them to move into her home. The cousin, who was 32, had two young children of her own and suffered from Multiple Sclerosis (MS). The cousin made numerous, futile attempts to resolve the situation through contacts with the private agency, the Department and the hotline. Ultimately the cousin enrolled the girls in the local high school and they began attending classes.

Soon after beginning classes, the 14 year-old gave birth in a bathroom stall at school. The girl delivered the baby into the toilet where the infant drowned. The girl then retrieved the body and placed it into a trash receptacle. The 14 year-old had managed to conceal her pregnancy, even from her sister and cousin, and told no one she had given birth at school until that evening when she confided in the cousin. The cousin insisted the girl seek medical attention, however the 14 year-old stated she would run away rather than be forced to go to the hospital. The cousin relented and watched the girl throughout the night before convincing her to seek treatment the following morning.

Physicians who attended to the girl the morning after she delivered the baby found she had placenta retention and she was admitted to the hospital. The staff social worker called the hotline and a child protection investigator was assigned to the case. The investigator interviewed the social worker who stated that the cousin's delay in seeking medical attention could have resulted in more serious injury to the girl. Based on this information, the investigator indicated a report of medical neglect against the cousin. A report was indicated against the 14 year-old for child death. The aunt, whose whereabouts remained unknown, was indicated for abandonment and desertion. The State's Attorney did not bring any charges against the 14 year-old girl.

Following the baby's death, the Department ceased adoption payments to the aunt. Since the adoptive aunt could not be located, the Department assumed guardianship of the girls and they were placed in the home of another relative.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should consider unfounding the indicated finding against the cousin. If the Department accepts this recommendation, the cousin should be notified.

The Department agrees. The report will be unfounded

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION

A nine year-old girl with cerebral palsy was found dead of malnutrition in bed inside her home. The girl's family had an open case for Intact Family Services (IFS) through the Department until one month prior to her death.

INVESTIGATION

The family first became involved with the Department three years earlier after a physician contacted the hotline to report the mother had not adequately addressed the girl's seizure disorder. The girl and her mother, who also had a four year-old son, had initially been brought to the physician by a social worker from the girl's school after staff became concerned by her frequent seizures. The assigned child protection investigator interviewed the physician who stated the mother reasoned the seizures were not of particular importance because they occurred so regularly. The investigator also spoke to the school social worker who stated the mother had not consistently provided the girl with required anti-seizure medication and that the girl often arrived to school in a disheveled state. The investigator met with the mother who agreed to comply with the girl's medical treatment. The report was indicated against the mother for medical neglect and the family's case was referred to intact family services.

The assigned intact worker identified the mother's needs as increased support, such as transportation assistance and daycare, and the securing of funds to cover outstanding debts related to housing and telephone service. The intact worker assumed an active role in meeting these obligations and was directly involved in ensuring tasks were completed. A Department nurse was asked to evaluate the girl's care and home environment. The nurse noted the mother demonstrated a lack of awareness of the scope of the girl's medical issues. The nurse determined that in order for the mother to continue as the girl's primary caretaker, she required additional training and monitoring as well as identification of additional support services to provide respite and oversight. The nurse noted that although the home met minimum standards for the family's present needs, it would be unsuitable if any additional children entered the environment. The nurse also recommended an assessment of the girl's functioning in school, however school personnel were not contacted by the intact worker. After six months, the mother was deemed to have adequately complied with services and the intact case was closed. The Department nurse had no further involvement in the family's case.

Fifteen months later, the hotline received a report the mother had delivered twins, one of whom tested positive for cocaine at birth. A second child protection investigator assigned to this case interviewed the mother who stated she had used drugs occasionally during the previous year. The second investigator spoke with a number of the mother's relatives who expressed willingness to provide assistance and stated the mother's boyfriend, who had an extensive criminal history, was a negative influence in her life. The investigator also interviewed the social worker from the girl's specialized school for children with physical and mental disabilities. The social worker reported that staff had noticed the girl tended to lose weight over weekends and that, though the fluctuation was not enough to be considered dangerous, the school would monitor the trend. The case was referred to intact family services and assigned to the same intact worker that had previously worked with the family.

The intact worker completed a service plan that required the mother to submit to random drug tests, enroll in drug treatment, accept homemaker services and secure a zero-to-three evaluation for the infant twins. The mother complied with the drug tests, which she was informed of and often transported to by the intact worker, however the mother refused to participate in drug counseling and neglected to complete the twins' evaluations. The mother's failure to comply with these aspects of her service plan was not addressed by the intact worker. Ten months after the intact case was re-opened, the hotline received a report from the school social worker that the girl was hospitalized following an extended holiday weekend because she had not taken her anti-seizure medication. A third child protection investigator was assigned and interviewed the mother who stated an intruder had broken into her home and destroyed a number of items, including the girl's supply

of medication. The investigator also spoke with school staff who stated the girl had lost three to five pounds over the long weekend and that it had become their practice to weigh the girl on Fridays and Mondays to monitor her weight. Staff also expressed concerns that the girl often arrived at school dirty, lethargic and hungry. Although the investigator noted the presence of food in the family home, he did not ask the mother what the girl regularly ate or in what manner she was fed.

Four months after the hotline report the family moved to another home, necessitating the girl to register in a new school district before resuming attendance at the specialized school. The intact worker instructed the mother to register the girl, however the task was not completed and the girl did not return to school. Three months after she last attended school, the girl was found dead and emaciated in her bed at home. The nine year-old girl weighed thirty-eight pounds, twelve pounds less than the last weight recorded by her school. The mother told authorities she believed the girl had died three days before her body was found but that she did not call police because she had, "too many things on her mind to deal with that."

In an interview with the OIG, the assistant principal of the specialized school stated that staff had numerous questions regarding the mother's ability and willingness to provide adequate care for all of her children. School staff were also concerned by the mother's failure to attend any of the girl's Individual Education Program (IEP) meetings intended to identify strengths and weaknesses and focus on achievement of developmental goals. The assistant principal stated that when issues were raised with the intact worker, the worker responded with defensiveness or assurances to address problems with the mother. The assistant principal stated that school staff initiated the majority of contact with the Department and that no Department staff ever visited the school. In an interview with the OIG, the intact worker's supervisor stated that both she and the worker operated under the premise that if school staff had any concerns, they would contact the Department. The supervisor also stated that cases involving medically complex children raise unique problems because field workers generally do not possess the requisite medical knowledge to identify all pertinent issues related to a child's condition.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should require intact family caseworkers to meet with school staff and request dates of Individualized Educational Plan (IEP) meetings and notification when a child is absent from school for two consecutive days. This notification should occur even if the caretaker has notified the school that the child will be absent. Upon notification, the caseworker should make an unannounced home visit to check on the health and well-being of the child and family and offer assistance, if necessary. (See OIG report #97-0700, June 1998, where a similar recommendation was made for children returning home from foster care.) Workers should attend, when possible, IEP meetings with parents and encourage parents to attend and participate.

As the Department does not have a legal relationship with these children, the Department can only participate if the parent agrees. A workgroup has been convened to address these issues. The Department has requested copies of the IEP Workbook as a resource for staff.

OIG Response: The OIG believes that the basic casework practice of contacting and working with educational personnel is so critical that it should be made a required task of the service plan which is signed and consented to by the parent.

2. The Department nursing staff, when asked to do a consultation on a medically complex child, should confer with other medical professionals as part of the consultation and assure that the caseworker has established communication with the medical professionals involved in the child's care.

Reference to these issues will be included in the draft nurse referral policy guide which will be finalized for

submission to the Office of Child and Family Policy by January 2005.

3. The Department should require intact family caseworkers to meet with medical personnel when a child in the family has a chronic medical condition.

As the Department does not have a legal relationship with these children, the Department can only participate if the parent agrees.

OIG Response: The OIG believes that the basic casework practice of contacting medical personnel should be made a required task of the service plan which is signed and consented to by the parent.

4. The Department, as recommended in a previous report, should apply a targeted feeding assessment, such as the Nursing Child Assessment Satellite Training, in cases with allegations of inadequate food and/or malnutrition and failure to thrive and where there are chronically ill children whose feeding regimen may require occupational therapy adaptations.

DCFS Policy Guide 99.02 is in the process of being updated and will be finalized for submission to the Office of Child and Family Policy by January 2005.

OIG Response: The OIG has not received a draft of these revisions and therefore cannot comment on whether the revisions address the recommendation.

DEATH AND SERIOUS INJURY INVESTIGATION 11

ALLEGATION

A 15 year-old boy with cerebral palsy died of pneumonia complicated by malnutrition. The boy's father had been the subject of an indicated report for risk of harm one year earlier.

INVESTIGATION

The indicated report against the father stemmed from an altercation with his wife and 16 year-old son. The father, who was intoxicated, had made verbal threats against his son before knocking the mother down and pinning her to the floor. The son intervened and wrestled with his father before gaining control and holding him until local police arrived. The father was arrested and charged with domestic battery and police reported the incident to the State Central Register (SCR). The call was accepted and a child protection investigator was assigned to the case.

The investigator interviewed the mother and the 16 year-old son in the family home the following day. The mother stated the father had a drinking problem and had relapsed after a period of sobriety. Both mother and son stated their relationship with the father was only problematic when he had been drinking and expressed a desire for him to receive treatment. The son told the investigator that although the family had not had any previous contact with the Department, police had been called to the home one year earlier to respond to a similar disturbance. Despite the fact the police report related to the latest incident included the names and ages of all the children in the household, including the oldest daughter who was reported to have witnessed the altercation, the investigator never observed or interviewed the boy's six siblings, ages two to fifteen, for signs of abuse or neglect.

The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) which identified no safety factors that needed to be addressed. The investigator considered the father to be the source of potential risk and, since he was in jail at the time and the mother promised not to allow him back into the home, the investigator determined the environment to be safe. However, the investigator did not consider the temporary nature of the father's incarceration or what risk he might pose to his family upon his release. One week later, the investigator conducted a telephone interview with the father. The investigator administered a substance abuse screen that recorded the father acknowledged a drinking problem but also listed he had no observable indicators of substance abuse, despite the fact the investigator conducted the screen over the phone. After receiving approval from his supervisor, the investigator indicated the report against the father for risk of harm.

Although the mother, father and son all told the investigator that police had responded to another domestic disturbance one year earlier, the investigator did not perform a Law Enforcement Agency Database System (LEADS) check on either of the parents or attempt to obtain information regarding the episode. A LEADS check conducted by the OIG found the father had been arrested following the incident and was found guilty of battery against the mother. An OIG review of underlying documents found that at the time, the mother related a history of alcohol-related verbal and physical abuse by the father. The mother told police she had only called law enforcement once before but believed she should have on other occasions. The investigator's failure to analyze information presented by the family regarding a history of domestic violence or recognize the potential for a pattern of abusive behavior to continue prevented him from constructing a clear picture of the family dynamic. In addition, the cursory nature of the investigator's work on the case prevented the family from being engaged in services that could have identified other problems in the home.

One year after the investigation was closed, paramedics were called to the family's home after the mother found her 15 year-old son, who had cerebral palsy, lying unresponsive on the floor. The boy was estimated to weigh 20 pounds and was covered with bedsores. The house was filled with human and animal waste, rotting food, dirty clothes and broken furniture. An inspection conducted by the Department of Health deemed the home unfit for occupancy. All of the children were taken into protective custody and placed with relatives of

the father, who was no longer living in the home at the time. The children told child welfare professionals they frequently had to care for themselves because their mother drank to the point of incapacitation. Relatives and neighbors told authorities the family had become increasingly isolated and refused offers of assistance. Despite the 15 year-old's cerebral palsy, the mother had removed him from school and would not accept special education services.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The child protection investigator should be counseled for not interviewing all the household members mentioned in the police report, including six other children ages two to fifteen years.

The child protection investigator resigned from the Department.

2. When child protection investigators contact a local police department for a copy of a report on a specific incident they should also ask about the availability of other reports, especially in cases involving domestic violence.

Regional management meetings have been scheduled to address the issue of requesting if there are multiple police reports to a home of a family under investigation. Completion date: January 2005.

DEATH AND SERIOUS INJURY INVESTIGATION 12

ALLEGATION

An eight year-old girl was raped by an intruder after her mother left her home alone. A child protection investigation involving the mother was ongoing at the time the girl was raped.

INVESTIGATION

The open child protection investigation stemmed from a hotline report made by the girl's putative father. The man stated the mother had been attacked and beaten by drug dealers as punishment for an outstanding debt. The man reported the beating had taken place outside the mother's home and that the girl had witnessed the attack. The child protection investigator assigned to the case interviewed the girl who confirmed she had observed the incident and had also provided a consistent account of the event to her school's social worker. The investigator then interviewed the mother who denied any drug involvement or that an altercation had taken place. In an interview with the OIG, the investigator stated he completed a drug screen on the mother, however no documentation of a screen could be found in the case file.

A Law Enforcement Agency Database System (LEADS) check of the mother conducted by the State Central Register (SCR) at the time of the hotline call was complicated by the presence of two separate state identification numbers. An OIG review of the information accompanying each entry found only one pertained to the mother while the second was that of another woman with a similar name and birth date. The mother had a significant history of arrests and convictions on charges often indicative of drug-related behavior including domestic battery, prostitution and larceny. In addition, the mother had been extensively involved with the Department and five of her children had previously been removed from her custody after she was indicated for inadequate supervision, burns and medical neglect. Although drawing distinctions between the two similar files required detailed examination, it is vital SCR staff identify and address issues of overlapping information when they arise to ensure the availability of accurate and reliable information.

Soon after beginning work on the case, the child protection investigator went on medical leave and a second investigator assumed responsibility. The second investigator conducted his own interview with the mother who reiterated her denial of drug use or a beating at the hands of drug dealers. The second investigator conducted a drug screen which documented information that should have resulted in a referral for drug abuse treatment. However, the investigator completed the screen noting no need for a referral. In addition, the investigator did not consider the mother's criminal history or her past involvement with the Department in the context of her possible drug use. The investigator's supervisor also neglected to identify the possible connection between the mother's history and the hotline report and failed to instruct the second investigator to utilize all available information. cursory drug screens that fail to convey an accurate portrayal of a family's situation can result in children being allowed to remain in dangerous environments.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The operators at SCR have to be carefully trained to look for similarities and dissimilarities in the rare occasions when someone on whom they are conducting LEADS shows up with two state identification numbers within the state of Illinois.

The State Central Register (SCR) completed in-service training with Placement Clearance staff to note information for multiple state identification numbers in conducting LEADS checks.

2. The second investigator and his supervisor should be counseled on the correct methodology in the use of the drug screen.

The employee and the supervisor were counseled.

DEATH AND SERIOUS INJURY INVESTIGATION 13

ALLEGATION

The charred body of an 11 year-old boy who had been reported missing by his maternal grandmother was discovered in a rural area. An Illinois court had awarded custody of the boy to the grandmother, who lived in another state. Confusion among workers from both states regarding procedures related to interstate placements illustrated deficiencies in the current system.

INVESTIGATION

The boy's mother had been the subject of 14 indicated child abuse and neglect reports which led to her four youngest children moving in and out of her custody and through several placements. One of the children was ultimately adopted by his foster parents. After the mother's behavior and lifestyle stabilized, she requested that two of the children be returned to live with her in another state where she resided at the time. The private agency responsible for handling the family's case began working with the Interstate Compact for the Placement of Children (ICPC) to facilitate the placement. The ICPC is an agreement between all 50 states designed to allow for the out-of-state placement of children while ensuring the maintenance of proper child welfare standards. Each state operates ICPC offices that work in conjunction to conduct necessary evaluations, assessments and consultations as well as to achieve compliance with child welfare regulations that vary from state to state. The process of returning the two children to their mother was arduous and lasted over a year. After the two children were finally placed in her home, the 11 year-old boy was the only one of his siblings who remained in foster care.

When it was determined the boy could not be returned to his mother's custody, she recommended his maternal grandmother as a possible caretaker. Through its handling of the family's case, the private agency was aware the grandmother had a history of involvement with the Department and concerns had been raised regarding her possible dependence on alcohol. The private agency requested a home study of the grandmother, who lived in yet another state, through the ICPC. The agency requested an evaluation of the home as a relative placement, which would not require the grandmother to obtain a foster parent license. However, after learning the receiving state would only provide monetary reimbursements to licensed foster parents, a worker in the Illinois ICPC office changed the request to an evaluation for a foster home license. The worker altered the request without notifying the private agency. ICPC regulations require official communications to be conducted between the capitol cities of each state, therefore the request was directed to the receiving state's capitol before being forwarded to the regional office that encompassed the town where the grandmother lived. A child welfare worker from the regional office conducted the home study, determined the environment satisfactory and recommended the placement.

In anticipation of an approaching court date regarding the case, an attorney representing the mother contacted the out-of-state child welfare worker for information after she was unable to communicate with ICPC offices in either state. The worker faxed the attorney a copy of the home study along with a criminal background check and medical report on the grandmother. The attorney then forwarded the information to others involved in the case: an assistant state's attorney, a Department attorney, the public defender representing the children and the private agency caseworker. In interviews with the OIG, all involved stated they did not recognize that this communication bypassed official ICPC procedure requiring information to be related between offices in the two state capitols. In her interview with the OIG, the private agency caseworker stated she interpreted the grandmother's medical report showing no concerns as a refutation of possible alcohol-related issues. Although the criminal background check found the grandmother had no prior convictions, it was later learned she had been convicted three years earlier for providing her youngest son, then age 15, with anti-anxiety medication she had been prescribed. The misdemeanor offense was not recorded in the National Criminal Information Center (NCIC) database because the local police department where the incident occurred does not report misdemeanors to the NCIC.

At the court hearing, the positive home study was presented and provided the basis for the court's decision to

award custody of the boy to the grandmother while the Department retained guardianship. In an interview with the OIG, the private agency caseworker stated the agency was instructed to monitor the placement by telephone since workers would be unable to travel to the home. As the county where the case was heard does not provide court reporters for permanency hearings, transcripts of the proceedings do not exist. The grandmother was allowed to take the boy home with her following the hearing. Although the private agency director attempted to file necessary paperwork with the database to reflect the boy's change in placement, database staff refused to accept the entry.

After the court ordered the boy placed with the grandmother, the out-of-state child welfare worker who performed the home study was informed by the receiving state's ICPC office that her evaluation would not be forwarded to Illinois until the grandmother completed her course for licensure as a foster parent. The worker contacted the grandmother who stated her refusal to participate in licensure classes. The worker related the grandmother's opposition to the ICPC office. The ICPC office then denied approval of the boy's placement with the grandmother or supervision of the home by state child welfare personnel. This official denial of acceptance of the placement occurred after the boy had been living in the home for one month. The result of subsequent communication between involved attorneys and child welfare workers was the determination that the denial was based on the technicality of the grandmother's disinterest in licensure and a belief the issue could be resolved at the next court date, scheduled for five months after the placement was denied. The private agency caseworker continued to monitor the placement by telephone, speaking with the grandmother and staff from the boy's school.

Two weeks prior to the scheduled hearing, the grandmother left a voicemail message for the private agency caseworker stating the boy had not returned from a camping trip with friends. Law enforcement became involved, however the grandmother and her youngest son, who lived with her in her home, were uncooperative. Police were unable to substantiate accounts provided by the grandmother regarding her last contact with the boy or who accompanied him on the camping trip. Eight months after the boy disappeared, a farmer discovered charred human remains on his land near the area of the grandmother's home. Dental records and a DNA sample provided by the mother were used to positively identify the boy's remains. The grandmother was subsequently convicted on felony neglect charges for excessive corporal punishment and sentenced to seven years in prison.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. Change of the legal relationship between the State and the child should be on record and should not be made outside of the presence of a court reporter.

All legal staff were notified by the Chief Legal Counsel of these responsibilities.

2. When a placement is made by court order and, subsequent to the court order, the ICPC approval is denied, the Department's legal division must inform the court.

All legal staff were notified by the Chief Legal Counsel of these responsibilities.

3. When a home study is requested through Interstate Compact, the request should include asking the local child welfare worker doing the home study to check with local law enforcement authorities whether they have any history on the household in addition to the criminal background check with the state police.

Revisions to the Interstate Compact Protocol were drafted and shared with the OIG. The revisions should be completed by March 2005.

4. Regional Department attorneys should be trained in the procedures involving Interstate Compact on the Placement of Children and should become actively involved in court proceedings where interstate placement is at issue in order for the Department to be sure that the best interests of the child are fully considered. There are times when the best interest of the child could be different from the recommendation of ICPC. It should also be made clear at the hearing what the monitoring and services will be to the child and placement family.

Once the revisions of the Interstate Compact Protocol are finalized, training will be provided to all legal staff regarding procedures on interstate compact placements.

DEATH AND SERIOUS INJURY INVESTIGATION 14

ALLEGATION

A 15 year-old boy was physically abused by his foster parents. The foster parents had been the subjects of an unfounded abuse investigation 10 months earlier.

INVESTIGATION

The boy had been living with the family for three years prior to the incident and was the first child placed in the foster parents home. During the initial licensing process, the foster parents stated their preference to care for children between the ages of five and ten who did not present medical or cognitive impairments. The boy, who was placed in the home shortly before he turned 12, was developmentally delayed and had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and major depression. The boy had previously been hospitalized for suicidal ideation and had a history of aggressive and sexually reactive behavior.

Throughout the boy's placement in the home, the foster parents struggled with his cognitive and behavioral limitations. A Parenting Assessment Team (PAT) evaluation of the boy conducted when he was 13 determined he possessed the intellectual and adaptive functioning of a five year-old. Involved child welfare workers reported the foster parents held unrealistic expectations of the boy's capabilities and perceived his continued inappropriate or defiant behavior as an indictment of their abilities as caretakers. From the beginning of his residence in the home, the boy expressed anger over his removal from his mother's custody and a desire to return to live with her or in his previous placement. The boy stated to a worker he sometimes knowingly exhibited oppositional behavior as a means toward disrupting the placement.

After the boy had been in the home for almost two years, the foster mother told a private agency worker the foster parents wished to terminate the placement. The foster mother stated the boy had not progressed during his time in their home and the foster parents felt the agency was attempting to direct them towards adoption. In addition, the foster mother had grown increasingly uncomfortable with aspects of the boy's behavior she identified as being effeminate in nature and strongly disapproved of his periodic vocalization of homosexual thoughts and feelings. The foster mother also stated the boy's presence in the home was causing a strain on the couple's marriage. In her case notes, the private agency worker recorded the foster mother was venting. One week later, during a meeting at the private agency, the foster mother reported she had previously locked the boy in his bedroom at night on occasion to prevent him from wandering around the house. An OIG review of the case file found evidence the foster parents were advised of the danger of locking the boy in his room but no suggestion that the foster mother's self-report of a licensing violation was ever conveyed to agency licensing staff.

Over the ensuing six months, the boy's behavior steadily deteriorated. Staff from the boy's school reported he was increasingly anxious and agitated and demonstrated poor impulse control. He also engaged more frequently in soothing behaviors such as sitting and rocking back and forth in efforts to calm himself. The foster mother repeatedly reported the boy urinated on his bed and in locations around the house. The foster parents eventually informed the agency the boy's urination had damaged his mattress and bedroom carpeting beyond repair. The foster mother stated the boy viewed the behavior as demonstrations of his defiance of their authority. One month after the foster mother reported the ruined furniture, she told an agency worker she had left the boy at home alone while she went to work. Although leaving a developmentally delayed child home alone is a violation of Department rule and the foster mother's statement was related to agency licensing staff, no licensing investigation was conducted.

One month later, the boy's teacher contacted the State Central Register (SCR) to report the boy had arrived at school with both of his hands bruised and swollen. The boy had told the teacher the foster mother had struck him on the hands with a vacuum cleaner attachment. The report was accepted and a child protection investigator was assigned and instructed to see the boy that day. The child protection investigator went to the

family home but found no one present and left a business card in the doorway. The following day the investigator returned to the home and interviewed the boy and the foster mother separately. The boy and the foster mother stated the boy's injuries were the result of him sitting and rocking while on top of his box spring mattress support with his hands between the metal coils. Both stated the box spring was exposed because the boy had wet his bed the previous evening and it had been taken outside to dry. The investigator conducted a physical examination of the boy consisting only of asking him to roll up his shirtsleeves. The investigator did not interview the boy's teacher who made the initial hotline report, the foster father or any collateral contacts.

On the same day of the investigator's interviews, he and his supervisor met and decided to unfound the report. The decision was based on the investigator's determination the explanation for the injuries was plausible, the boy was not coached, the positive presentation of the foster mother and the absence of identifiable safety risks in the home. The investigator's failure to interview the boy's teacher, a mandated reporter outside of the home the boy disclosed allegations of abuse to, or any agency staff prevented him from developing a more accurate assessment of the situation in the home. In determining the boy had not been coached, the investigator neglected to consider that the foster parents might have been alerted to the investigation the previous day by school staff or the presence of the investigator's business card at their home.

Later on the day the decision was made to unfound the report, an anonymous caller who identified herself as a friend of the boy contacted the hotline. The caller stated the boy had told her his foster parents locked him in his room for days at a time and refused to feed him. The caller also reiterated the boy's claim of being beaten on his hands with a vacuum attachment and informed the operator the boy was a special education student who was "very afraid of the foster parents." The call was accepted as related information to the original report. In an interview with the OIG, the child protection investigator stated he had received the narrative of the related information call but conducted no further work on the case. The investigator stated that since the caller was anonymous he could not contact her and he was confident any concerns regarding the foster parents had been addressed through his investigation.

Ten months after the report was unfounded, local law enforcement received a surveillance video from an anonymous source showing the boy being physically abused by the foster parents on three separate occasions. Police obtained a warrant to search the home and were present when the family arrived. After being separated from the foster parents, the boy told police he was frequently beaten with extension cords, a wooden paddle and fists by both foster parents. Officers observed a lock on the outside of the boy's bedroom door and the foster father later told police the boy was often locked in his room for extended periods of time. The foster parents were arrested and charged with two counts of aggravated battery and one count of criminal negligence.

One week later, police interviewed a respite worker who had been in the home earlier on the day police obtained the search warrant. The respite worker acknowledged she had observed the boy had a black eye and that he told her it was the result of being punched in the face by the foster mother. The respite worker stated she was aware of her status as a mandated reporter but she believed she had 24 hours to report the abuse and intended to inform her supervisor the following day. The respite worker later admitted knowledge of two previous incidents of abuse against the boy but stated she did not report them because she, "did not want to get anyone in trouble." The respite worker was arrested and charged with failure to report child abuse. Her employment was terminated by the private agency.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The private agency, in conjunction with the Department's division of agency and institutional licensing, should review a random sample of children's case and foster home licensing records to determine whether the lack of communication present in this case between case services and foster home licensing is a systemic problem. Corrective action should be taken as necessary.**

OIG Response: The OIG shared the report with the private agency and the agency submitted a corrective action plan addressing the recommendations made in the report. The Inspector General met with agency executive and management staff and a member of the Board of Directors to discuss the report and the agency's response.

In response to recommendation #1 above, the agency commenced a quarterly Utilization Review Committee to assess the appropriateness of an individual's admission to a program, the level of services received, the need for continuing services, and staff training needs. The agency is working in collaboration with the Department's Agency and Institution Licensing Division.

2. The private agency should implement a policy whereby foster home licensing workers will convene a meeting with all the caseworkers for children in a foster home prior to the foster home's licensing compliance check. The workers should discuss the needs and behaviors of the children and foster parents in the home, including needs for training, equipment, furnishings, respite care, etc.

The agency has convened Independent Interdisciplinary Action Teams, which meet every other week, to review cases with the goal of improving communication, teamwork, coordination of service delivery, and effective delivery of services. Staff from all disciplines are represented on these teams.

3. The private agency should immediately implement the notification policy stated in Recommendation # 6, below.

Agency caseworkers are required to meet with school staff a minimum of twice per school year. Caseworkers will request notification when a foster child is absent from school for two consecutive days. Upon notification, the caseworker will make an unannounced home visit to check on the health and well being of the child and family. Additionally, for children with specialized needs, caseworkers routinely visit the foster home a minimum of twice per month.

4. The private agency should explore the development of social skill building programs and recreational programs for their developmentally delayed adolescent population.

The agency has established quarterly activity nights for their adolescent population.

5. The private agency should develop discussion groups for foster parents serving developmentally delayed teenagers entering puberty on issues of physical development and sexuality.

The agency initially presented this issue to their foster parents at a monthly meeting. The discussion groups will be on-going.

6. The Department should require foster care caseworkers to meet with school staff and request notification when a foster child is absent from school for two consecutive days. This notification should occur even if the caretaker has notified the school that the child will be absent. Upon notification, the caseworker should make an unannounced home visit to check on the health and well-being of the child and family and offer assistance, if necessary. See OIG report #97-0700, June 1998, where a similar recommendation was made for children returning home from foster care.

The Department is currently in discussion with local school districts around this and other issues.

7. The Department should require scene investigations in all investigations involving an injury to a

child. See OIG Reports #02-0704 June 2002 and #02-0881 June 2002 for similar recommendations.

The Department agrees.

8. The child protection investigator and his supervisor should receive training on the cognitive abilities of children with developmental disabilities, their risk for abuse because of their disabilities, and their susceptibility to coaching and recantation.

The Department agrees. The employees will receive training.

9. This report should be shared with the Parenting Assessment Team.

The Parenting Assessment Team that conducted the evaluation in this case has been disbanded.

DEATH AND SERIOUS INJURY INVESTIGATION 15

ALLEGATION

An 11 year-old female ward living at a residential facility claimed she was sexually assaulted by three male residents. The three boys, two age 11 and one age 12, were also Department wards. It was alleged that staff from the residential facility failed to seek medical attention for the girl or report the incident to authorities in a timely manner.

INVESTIGATION

On the day of the incident, the four youths were absent without permission from their respective housing units. The youths had been observed and periodically followed by staff members during the several hours they roamed the area. After the 11 year-old girl finally returned to her residence, she stated to a staff member she had engaged in sexual acts with the three boys. The girl showed the staff member bruises on her chest and legs and stains on her shirt. The staff member instructed the girl to take a bath and go to bed. The staff member then left telephone messages for the girl's therapist and the facility's assistant program manager informing them of the incident and completed an in-house Unusual Incident Report (UIR.) For the next two days, various facility administrators conferred regarding the incident while staff members continued to provide additional information obtained directly or indirectly from the youths involved and other residents. Although the girl's mother called the facility after being informed of the incident by her daughter, facility administrators continued to delay taking definitive action of any kind.

On the third day after the incident the girl was transported to a hospital for a medical examination. Because of the amount of time that had elapsed, medical personnel were unable to obtain potential forensic evidence for possible criminal prosecution. Despite their awareness of sexual activity by an 11 year-old resident and the allegation that she was physically compelled by other residents to engage in sexual acts against her will, upon learning of the incident facility staff did not immediately ensure the girl received medical attention or contact local law enforcement. Police were notified of the girl's allegation by hospital staff. No statement was made to police until more than two weeks after the incident occurred.

The OIG reviewed UIRs completed by facility staff regarding the incident. The OIG found that facility policy requiring each involved staff member to submit a UIR was inefficient, resulted in multiple "official" accounts of an event and risked repeated questioning of a child regarding a single incident. In addition, facility policy allowed for the production of dual UIRs, some of which were submitted to the Department while others were retained as internal records. This practice further called into question the reliability of the UIRs and created a basis for potential accusations of concealing information through the use of internal documents. Despite the sensitive nature of the incident and the young ages of the wards involved, UIRs submitted to the Department, which contained private and confidential information, were made available to the news media in the interest of public disclosure. The grandparents of the 12 year-old boy involved learned of the incident and the possibility he could be charged with rape from a television broadcast. Although the Department has allowed for the dissemination of UIRs if the names of wards are removed, the presence of specific information presents an opportunity for identification of wards by peers, siblings or other individuals. The Department must ensure clients' expectation of confidentiality is maintained.

Based on interviews conducted by specialized therapists, it was determined the sexual acts engaged in by the youths were consensual in nature. All four children expressed poorly formed concepts of the significance of sexual relations and possessed little more than rudimentary understandings of basic physical sexual functions. The girl and one of the 11 year-old boys were known to have been the victims of severe sexual abuse in the past. The 12 year-old boy had an extensive history of extreme behavioral problems and criminal activity and had been identified as a potential sexual aggressor. While the facility did conduct regular adolescent sexuality classes, girls between the ages of 11 and 15 were grouped together and sessions for boys only included those over the age of 15.

Law enforcement declined to press charges against the three boys. Although the decision absolved them of legal responsibility, it did not address the profound effect the events could have on the development of the children involved or their future attitudes toward sexual relations and the opposite gender. Throughout their involvement with the legal system, the three boys were faced with the conventions of the adult justice system. One of the 11 year-old boys expressed sadness that his actions might have harmed the girl. Restorative justice encourages alleged perpetrators to confront their actions and receive information from victims while allowing the victims themselves to address their feelings toward an incident and the participants.

The current goals for the girl and one of the 11 year-old boys are for them to be returned to their homes. Both families will require intensive support from facility staff and assistance in identifying counseling resources in their areas to help the children in their transition from the services they received from the facility. Specific needs must also be addressed in order to ensure the children and their families receive necessary services. In interviews with the OIG, a facility nurse and an assistant administrator provided conflicting information regarding the girl's medical history. An OIG review of her medical records found an absence of vital information necessary for a comprehensive approach to health. Although the boy is being returned to the care of his adoptive parent, who also has custody of one of his older brother, the Department has had limited contact with the family and has not provided assistance in their attempts to secure adequate housing. In addition, the family has not been engaged in the boy's counseling to help develop their understanding of the issues he will continue to face after returning to the home.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The OIG will meet with the new clinical director of the residential facility to review proposed changes to its clinical protocols and training to address the failure to identify the girl's initial report as possible sexual assault with an immediate referral to law enforcement and failure to respond to the confirmed information regarding sexual activity between youths of such tender ages with immediate medical and clinical interventions (through the Children's Advocacy Center).

The OIG shared the report with the residential facility. The Inspector General met with executive staff and a member of the Board of Directors to discuss the report.

Regarding clinical protocols and training needs identified in this report, the facility has instituted new programs addressing concerns noted in this report.

2. The residential facility should hire a nurse manager who has the knowledge and ability 1) to oversee a health supervision approach to adolescent health care that is consistent with the recommendations of the American Academy of Pediatrics and the United States Department of Health Services and 2) to develop an effective working relationship with child advocacy centers.

The agency noted that financial constraints may prevent the hiring of an additional nurse manger. The agency did, however, agree to have members of its nursing staff receive additional training sanctioned by the American Academy of Pediatrics and the United States Department of Health Services and develop working relationships with the child advocacy centers.

3. The Department should continue to monitor the residential facility's complete implementation of a single reporting system for UIRs. In addition, for a six-month validity and reliability trial period, the facility must institute a streamlined UIR reporting process. The facility's sophisticated computer capabilities make it uniquely able to accomplish this. During the pilot period, the facility should assign a numbering system to UIRs so that one incident is reported one time. Future clarifications or corrections would be filed under the same number so that it becomes possible to track numbers of

incidents. In addition, the facility should prohibit supervisory additions, deletions, edits or rejections of UIRs. Supervisory corrections and clarifications can be filed with the Department through supplementary clarifying or correcting reports. During the six-month trial period, both the Department and facility management should review the original and supplemental UIRs to inform them on the validity and reliability of the contents in UIR reporting categories and the need for additional training regarding UIR preparation. Further, both the Department and facility management should review and monitor the “Action Taken” section of UIRs, both to ensure that appropriate action is taken and to again inform the need for future training. During this validity and reliability trial period precautions should be taken for the potential of over-reporting by staff.

During the pilot period, facility management should particularly review incident reports to ensure that any facts suggesting the possibility of a sexual assault should be classified as such, appropriately responded to and referred immediately to the a child advocacy center.

The agency disagrees with this recommendation. Over the last year, the agency has modified and improved its UIR practices. The agency notes that any pilot program involving revamping of the UIR practices can only be effective if DCFS is a signatory to and proponent of the program and modifies its UIR system accordingly.

4. As part of its treatment intervention for youth whose anticipated discharge plan is a return to parents or relatives, the facility should adopt a multi-dimensional family approach. One of the goals of this family treatment should be to assist viable members of the child/ren’s extended family in building a caring and civil community of empathy and moral reasoning in areas of sexuality and violence. The family group sessions should take place at a facility site in the family’s geographic area to be inclusive of multiple extended family members by avoiding taxing transportation while reinforcing realistic community safety planning. Extended family visits and three-month aftercare therapeutic services should be incorporated as part of the facility’s treatment intervention to help the family transition the child into his family’s community. As part of the multi-dimensional services the children’s caretakers should receive a transitional consultation from the children’s medical provider and the children’s schools.

The agency does not disagree with the propriety of a “multi-dimensional family approach” to treatment intervention for youth who are to be transitioned to return home, but notes that such programs are have not been contracted for by DCFS with the agency. The agency is willing to discuss with DCFS representatives the particulars of such programs that might be implemented with appropriate funding.

5. Facility management should review the OIG Violence Report and develop programming that includes restorative justice and coordinates with any future reporting centers for young delinquents.

The agency will use the OIG Violence Report to strengthen already existing programs that take into account principles of restorative justice.

6. The present age grouping (girls 11-15) for the early adolescent girls’ sexuality group should be divided into several age groups. One for younger girls age 10-13, one for girls ages 14-15 and young adults ages 17 and 18 years old. Likewise the present grouping of boys (15-18) needs to be both broadened and stratified to address the developmental needs of the younger adolescent population 10-13, mid-adolescents 14, 15-16 and young adults 17 and 18 years-old.

The agency has instituted new programs that alleviate many of the “age grouping” concerns raised in this case.

7. The facility should work to improve shift summaries and communication log recordings to better reflect events in and outside the home affecting a child, significant changes in a child, clinical concerns (such as the use of inappropriate language) and absences from the home.

The agency will continue to improve shift summaries and communication logs.

8. The Department must institute a policy for communication with the media that is more protective of wards' privacy rights. Protected information concerning a specific child should not be released to the press unless the information would not be identifiable to the child's peers.

No response was provided by the Department.

9. The Department needs to assess the effectiveness of its Health Works system in providing the preventive pediatric health care and anticipatory guidance for younger adolescents and adolescent wards. The Department should conduct a random audit of Health Works records for adolescent wards to gauge the depth of the failure to use correct forms or record critical health information for adolescents and provide anticipatory guidance.

A physician may discuss sensitive issues during an exam but not necessarily note the details in the medical record. DCFS will work with the Healthworks Lead Agencies to ensure adolescent-specific issues are being addressed as appropriately as possible.

OIG Response: The OIG believes that a physician should note that anticipatory guidance was provided.

10. The Department should secure the assistance of a child advocacy center in the facility's area in developing a system of weekend emergency responses for alleged child on child sexual assault evaluations for Department wards that reside in residential programs in the region.

The Department will consider this recommendation.

11. The Department should concentrate the efforts of its Child Family Research funding on assisting residential and foster care providers in developing evidenced based interventions for violence prevention and response and transitional services for the return home of younger adolescent and adolescent wards.

The Department will pursue this recommendation pending available funding.

12. The OIG, in its SACY reports (dated June 30, 1999 and June 13, 2000) previously recommended that developmentally delayed children who are victims of sexual abuse must receive pro-social skills training, which was not evidenced in the girl's record. The Department should audit the Sexual Abuse Program to ensure that the OIG recommendations are implemented and that children with developmental disabilities who have been sexually abused are receiving services that emphasize development of pro-social skills.

Revised program standards & DCFS policies are being reviewed by the Child Welfare Advisory Committee. Completion date is March 2005.

13. The Department and a second residential facility where the girl now resides need to staff the girl's case with the local Board of Education prior to her return home to ensure she has a school placement

that will help develop appropriate peer relationships. The girl should receive tutoring services. Similar planning should take place as part of a multi-dimensional intervention for younger adolescent and adolescent wards anticipating return home to their parent or relative caretaker. In addition, the Department and the second residential facility should initiate a community safety plan to provide the girl's family with preventive services. The local children's advocacy center has been willing to provide on-going therapy for the girl and her family. As the time nears for her return home, the second facility should transition the family to the advocacy center for services. The girl's treatment program must emphasize development of pro-social skills. After school and structured recreational programming must be secured for the girl to assure her safety. Similar multi-dimensional services and interventions should be sought for, the two 11 year-old boys and their families. The Department should request that the advocacy center explore the clinical and restorative benefits of the 11 year-old boys offering the girl an apology.

The girl was returned home to her mother in March 2004. Prior to her return, educational advisors from the Department worked with the local Board of Education in planning for the return. In addition, the girl was referred for SOC services in the community.

14. The Department and the Cook County State's Attorney should discuss how to set up a restorative justice model for Department wards.

No response was provided by the Department.

15. The Department's post-adoption unit should assist the adoptive parent and brother of the 11 year-old boy being returned home to find safe and adequate housing.

This case has been referred to the post-adoption services unit.

DEATH AND SERIOUS INJURY INVESTIGATION 16

ALLEGATION

A two month-old girl died of undetermined causes while she and her two brothers, ages eleven and one, were left home alone. The girl's family was involved with intact family services provided through a private agency at the time of the girl's death.

INVESTIGATION

The family had become involved with the Department one year earlier when the mother gave birth to her second child. Both the mother and her newborn son tested positive for cocaine which prompted hospital staff to call the hotline. A child protection investigation regarding the allegation resulted in an indicated finding against the mother for substance misuse. The family was referred to a private agency for intact family services.

The mother, her newborn son and her oldest son, age 11, resided with the children's maternal grandmother. The private agency worker assigned to provide services to the family informed the mother that her participation in substance abuse treatment was a prerequisite for any additional services, such as housing assistance. The worker referred the mother for a substance abuse assessment, however the mother missed the appointment and provided no explanation for her absence. After the mother missed a rescheduled appointment one month later, she explained to the worker she had been unable to attend the meeting because she had left the maternal grandmother's home and moved in with a friend. Although the worker conducted a visit at the friend's home shortly after learning of the move, the worker did not document the location of the house. The worker also failed to record the composition of the household or conduct background checks on the other inhabitants. The mother then moved back in with the maternal grandmother before moving again to the home of another friend. After the mother missed her third scheduled drug assessment, the private agency decided to close the case. In an interview with the OIG, the worker stated she closed the case because the mother was not compliant with services. The worker said she did not consider screening the case into court because she believed the children were safe with the grandmother, however the worker's notes recorded the family was not living with the grandmother at that time.

Three weeks after the case was closed the mother was the subject of a second hotline report after she left her two sons in the care of their 93 year-old paternal great-great grandmother without a care plan. During the ensuing child protection investigation, the 93 year-old told the investigator she had allowed the family to stay with her because the mother was "on drugs bad" and she felt empathy towards the children. The investigation resulted in an indicated finding of inadequate supervision against the mother and she was again referred for intact family services, this time through a different private agency.

The second private agency worker identified multiple tasks the mother needed to fulfill which included ensuring the children's medical and educational needs were met as well as addressing her ongoing substance abuse issues. The client service plan established by the worker required the mother to submit to random drug screens, however only one was completed and produced a positive result for cocaine. Throughout her involvement with the second attempt at intact family services, the mother demonstrated an inability to initiate tasks without the direct guidance and assistance of the worker. Although the worker was instructed by her supervisor to allow the mother to assume responsibility for completing service requirements, the worker disregarded the directive and continued to perform duties expected of the mother.

Two weeks after the mother's positive drug test she informed the worker she was pregnant. The mother stated she had hidden the pregnancy, continued to use drugs and had received no pre-natal care. The mother also expressed suicidal thoughts and admitted severe depression. In an interview with the OIG, the worker's supervisor stated the worker did not inform her of the mother's pregnancy until shortly before she gave birth. In addition, the supervisor stated if she had been alerted by the worker as to the mother's mental state, she would have instructed the worker to have the mother hospitalized. The worker identified an in-patient drug

treatment program that allowed children, however the mother was unable to complete the steps necessary to register. Soon afterwards the mother gave birth to the girl. Both tested positive for marijuana and cocaine.

After learning from the mother's oldest son that the mother had given birth, the worker facilitated her admission into the drug treatment program. Almost immediately the mother became involved in conflicts with staff and was threatened with expulsion. The worker intervened and persuaded the center to allow the mother to remain enrolled. When the center ultimately decided to discharge the mother, the worker and her supervisor did not conduct a home visit. The supervisor told the OIG both she and the worker assumed the family would return to reside with the grandmother in her home, which they had identified as a safe environment. However the mother and her three children went instead to the home of a male friend. Eight days after the mother was discharged, the worker attempted a visit at the grandmother's home but found no one home. The worker attempted a second visit two days later and was told the family was not there. The following day, the girl was found dead of undetermined causes while sleeping on the floor of the friend's apartment.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The OIG strongly reiterates the recommendation made in January 2003 that mothers with substance-exposed infants who are referred to intact family services must receive intensive specialized intact services designed to safeguard children from harm while providing effective substance abuse treatment. (See OIG Report # 02-0161)

When policy is revised, in-service training in Intact Family Recovery and Substance Affected Families is being planned. Completion date: February 2005

2. The Department should not assign intact family cases involving substance-exposed infants to the two private agencies involved in this case.

Intake for Substance Exposed Infant families was closed for the two private agencies.

3. A copy of the OIG's Infant Sleep Safety Report (OIG #03-2162 June 2003) should be shared with the two private agencies involved in this case and all private agencies with an intact family services contract.

Individual meetings were held with both of the private agencies.

DEATH AND SERIOUS INJURY INVESTIGATION 17

ALLEGATION

A nine year-old girl suffered significant injuries after being whipped with a belt by her aunt. A child protection investigator failed to adequately assess the risks posed to the girl and her eight year-old brother by their family and allowed them to remain in their home.

INVESTIGATION

After being informed of the girl's injuries by other students, staff from the girl's school observed multiple bruises and an open wound on her back. The girl stated her aunt had whipped her with a metal-studded belt that morning. School staff contacted the hotline and local police before the girl and her brother were transported to the hospital. Physicians examined the children and found that in addition to the girl's fresh injuries, both children had numerous welts, bruises, belt imprints and scabs in various stages of healing. The examining physician recorded in his notes that both children stated they had previously lived with their grandmother but had resided with their aunt for the past year. Both children separately told the doctor they had been instructed not to tell anyone about the beating because, "The Bible says it's OK."

The child protection investigator assigned to the case arrived at the hospital and spoke with the school social worker. The social worker stated the girl told her she routinely received corporal punishment but it had never before been so severe. The investigator interviewed the girl who said she was afraid of her aunt and wanted to stay with her grandmother or other relatives. The girl was also fearful that she would be punished for allowing the abuse to be discovered. The investigator also spoke with the aunt and grandmother who were present at the hospital. Both denied the aunt had employed corporal punishment prior to this incident. The aunt and the grandmother agreed the aunt would not serve as the children's primary caretaker. An OIG review of the investigator's case notes found no documentation he inquired as to the grandmother's possible use of corporal punishment or established a clear definition of a "primary caretaker."

In an interview with the OIG, the investigator stated he read the attending physician's report while he was at the hospital. The investigator said he was aware of the discovery of old injuries on both children and observed them himself but was unable to determine the perpetrator of the previous abuse at the time. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP). Despite the aunt's acknowledgement she had abused the girl, the failure of any family member to either intervene or ensure the girl received medical treatment and the girl's statement directly to the investigator that she was afraid of her aunt and feared retribution for the public disclosure of her abuse, the investigator determined it would be safe for the children to remain in the home. In his interview with the OIG, the investigator stated he believed it was unnecessary to develop a written safety plan because of the family's agreement not to allow the aunt to be the children's primary caretaker. The investigator stated he interpreted that to mean the aunt would not be left alone with the children, however he could not recall if such a provision was conveyed to the grandmother. There was no indication in the investigator's notes he obtained an agreement from the family not to use corporal punishment. The investigator determined the children would be safe and allowed them to leave the hospital in the grandmother's custody.

Later the same day, the investigator placed a call to the girl while the family was out to dinner. The investigator spoke with the girl and asked her if she felt safe. The girl responded that she did, although she did so while in the presence of her family members, including the aunt who inflicted the abuse. Three days after the abuse occurred, staff at the children's school learned the grandmother had continued to allow the aunt to have unsupervised contact with the girl. The investigator's failure to properly utilize the CERAP or develop a formal safety plan prevented a thorough assessment of the grandmother's ability or desire to guarantee the children's safety.

During the course of the OIG investigation, the child protection investigator did not provide necessary

documents to the OIG and did not respond to repeated phone calls and e-mails requesting an interview. Department rule requires full cooperation and compliance with OIG investigations.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The child protection investigator should be disciplined for his failure to correctly assess risk through the Child Endangerment Risk Assessment Protocol (CERAP), as required by

Department Rule 300. The investigator should be disciplined for his failure to cooperate with an OIG investigation in accordance with Department Rule 430.

The employee was disciplined. The employee's grievance of the discipline is pending.

2. The investigator should be closely supervised on investigations, including proper usage of the CERAP and formal safety plans.

The investigator is currently closely supervised and evaluated quarterly. The supervision includes the correct utilization of CERAP and safety plans.

3. Management staff of the Division of Child Protection should conduct a review of all investigations performed by the investigator involving allegations of cuts, welts and bruises or other physical abuse.

Management is conducting reviews of the investigator's previous cases involving all allegations of physical abuse. Completion date: January 2005

DEATH AND SERIOUS INJURY INVESTIGATION 18

ALLEGATION

A two year-old boy was severely injured after he was mauled by a dog owned by his mother's boyfriend. The boy's 16 year-old mother was a Department ward with an open case through an umbrella program designed to oversee pregnant and parenting wards at the time of the attack.

INVESTIGATION

The girl had been a ward since the age of eight when her own mother, who had a history of Department involvement, died of a heroin overdose. The girl's case was assigned to a private agency and she moved through a number of placements, with varying degrees of success, before being placed in a foster home when she was 13 where her behavior stabilized. One year later, the girl learned she was pregnant. The girl began parenting classes and, following the baby's birth, initially made a positive adjustment to parenting. After less than nine months, however, the foster parent reported the teen mother had stopped coming home from school to take care of the baby and was complaining about the limits child rearing placed on her time. The situation in the home worsened until the foster parent requested the teen mother's removal. The private agency caseworker complied and moved the mother and her baby into another non-relative home.

In interviews with the OIG, both the private agency caseworker and her supervisor stated they had never dealt with a pregnant or parenting ward before and were unaware of the extent of services the umbrella program designed to oversee pregnant and parenting wards could provide. The caseworker and the foster parent raised several concerns about the mother with the assigned umbrella program clinical worker at their first staffing, however the clinical worker attributed the mother's erratic behavior to her age and lack of parenting experience. The clinical worker did not consider counseling the mother on options available to her other than being the primary caretaker for her baby or make an effort to explore the potential to involve her extended family or the baby's father. The caseworker told the OIG that the umbrella program did not provide her with the direction she needed to ensure the mother and her baby received appropriate, comprehensive services.

Three months after the staffing, the mother took her one-year old baby and ran away for four days after the foster parent denied her request to go out for the evening. Police located the mother and baby and transported them to the Emergency Reception Center (ERC). During a mental health exam conducted at the ERC, the mother stated she smoked marijuana every chance she had and expressed her wish that her son had never been born. A hotline call prompted by the mother's disappearance initiated a child protection investigation. The assigned child protection investigator interviewed the mother and observed her with the baby while both were still at the ERC. The mother denied she had any substance abuse issues and told the investigator she wanted to give the baby to her father or another relative. The investigator also met with the foster parent who stated the mother frequently expressed her desire to have someone else take care of her son and often neglected her responsibilities towards him. The foster parent further stated the mother often returned home from school under the influence of drugs or alcohol. Despite obvious concerns regarding the mother's investment in raising her son, the investigator determined there was insufficient evidence to support the allegation of risk of harm and unfounded the report against the mother. In an interview with the OIG, the investigator stated she believed the young mother was simply frustrated and inexperienced and that her expressed remorse and promises to try harder were satisfactory indicators of positive behavior in the future. The investigator stated she was not aware of the mental health assessment performed at the ERC and had not requested any available documentation from the center because the mother had been there for a short period of time.

The mother's case was subsequently transferred to another private agency and the mother and her baby were placed in a specialized foster home. Five weeks after being placed in the new home, the mother took her baby and ran away again. The mother's whereabouts were unknown for one month until a child welfare worker from another state contacted the second private agency. The child welfare worker informed the agency the

mother had dropped the child off with his maternal grandfather and requested available information about the family and the baby's guardianship status. Private agency staff dealt with the matter casually. A cursory review of the case file resulted in the report being misinterpreted to mean the mother had given the baby to his biological father. In addition, agency staff failed to return communication to the out-of-state worker. Agency staff's lax response to developments in the case demonstrated disregard for the baby's safety. The mother's first caseworker, who was a source of support to the mother, obtained other information independently which suggested the mother was living with a known drug dealer and that the maternal grandfather she had left her son with was a felon with previous convictions for violent crimes. The first caseworker forwarded this information to the umbrella program clinical worker, however the clinical worker failed to convey it to other involved workers in a timely manner. The reluctance or inability of child welfare professionals to communicate openly and quickly prevented any meaningful services being provided to the family and placed the baby at risk. The umbrella program's practice of focusing solely on the ward and its unfamiliarity with missing child protocols regarding non-ward children created a situation that compromised the baby's safety.

After three months on run, the mother returned along with her baby. Following her return, the mother's case was transferred to yet another private agency and assigned to a new worker. The mother was placed in an unlicensed relative foster home but after that placement became untenable, the mother secretly moved into the home of her new boyfriend. It was in that home her son suffered the dog attack.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The umbrella program funded to oversee services to pregnant and parenting wards should coordinate providers' input, training, and dissemination of information. The umbrella

program should invite supervisors and case managers from agencies that are non-regional service providers to attend a meeting to learn about the array of services available to child welfare staff working with pregnant and parenting wards. The umbrella program should invite the non-regional service providers as soon as a pregnant or parenting ward is accepted as part of the umbrella program system, and should offer the informational meetings quarterly. The umbrella program contract and umbrella program manual should be amended to reflect this. The umbrella program will participate in or facilitate monthly meetings to aid in communication and provision of information.

OIG Response: The OIG shared the report with the umbrella program funded to oversee services to pregnant and parenting wards. The program submitted a response to the recommendations made in the report. The Inspector General met with program executive staff and a member of the Board of Directors to discuss the report.

The umbrella program hosts a quarterly Affiliated Service Provider Roundtable to communicate service issues and resources to specialty providers. The program will recommend to DCFS that these quarterly meetings be mandatory for all DCFS pregnant and parenting ward providers. The program also hosts a monthly Resource Committee meeting to provide caseworkers direct exposure to resource providers such as health clinics, parenting programs, counseling resources, substance abuse programs, educational resources, and domestic violence programs.

The umbrella program acknowledged that this case identified a problem in communication and follow-up by program personnel. The involved employees were disciplined.

The umbrella program has provided additional training to providers about substance affected families, HIV/AIDS, domestic violence, crisis intervention, and screening cases for DCFS custody. The program has been working with DCFS on the development of a training program to be offered to all pregnant and parenting providers.

2. The umbrella program and all child welfare staff working with pregnant and parenting wards should utilize Rule 329, the procedure for locating and returning missing, runaway, and abducted children, as recommended in the OIG Missing Children report, 03-1553, June 16, 2003, and accepted by the Department.

Rule 329 is used by all Department staff, including the umbrella program and caseworkers involved with pregnant and parenting teens.

The umbrella program has revised its program plan to address this recommendation.

3. The child protection investigator should be counseled on the child abuse/neglect matrix and the need to carefully weigh all the factors presented when evaluating risk.

The investigator is currently on family responsibility leave. Counseling is scheduled for February 2005.

DEATH AND SERIOUS INJURY INVESTIGATION 19

ALLEGATION

A three month-old boy died of Sudden Infant Death Syndrome (SIDS). The boy's mother was a 20 year-old ward whose two older children had been removed from her care. The family had an open case with through an umbrella program designed to oversee pregnant and parenting wards.

INVESTIGATION

The girl had been taken into Department custody and placed with her maternal grandmother when she was 11 years old. When the grandmother died shortly thereafter, the girl moved through numerous placements which were often disrupted by her behavioral problems. The girl, who had disclosed a history of physical and sexual abuse, was diagnosed with major depressive disorder, borderline personality disorder, oppositional defiant disorder and chronic post-traumatic disorder. At 17, the mother gave birth to her first child while residing in a group home. The family's case was transferred to the umbrella program and assigned to a private agency to provide services. The teen mother and her baby were moved into a transitional living facility for pregnant and parenting teens when the boy was six months old.

One month before the family moved, the teen mother was treated for chlamydia and it was learned she was pregnant with her second child. An OIG review of records from the transitional living facility found the mother ran away from the facility five times in the first five months of her placement. Staff noted the mother returned each time with bruises to her face and body and reported she had been fighting with her boyfriend, the father of both children. It was also recorded that the mother's frequent absences prevented her from receiving pre-natal care. Following the second baby's birth, the mother was the subject of two indicated reports for risk of harm to her children. After she violated an order of protection forbidding her from running away from the facility she was indicated for a third time and the children were removed from her care and placed with their paternal grandmother.

Six months later, the Parenting Assessment Team (PAT) completed an evaluation of the mother. The PAT concluded the mother was unable to effectively care for her children and did not possess the skills to do so in the near future. The assessment determined the mother's children would be at high risk if they were returned to her care and stated that although she demonstrated greater functioning in highly structured environments, her volatile resistance to established limits made compliance with such a program unlikely. The PAT recommended placing the mother in a structured living environment and cautioned that even her acceptance of services would not enable her to adequately care for children in the near future. Three months after the PAT report was completed, the mother gave birth to her third child and was placed with the infant in an independent living program that identified itself as being unstructured. Prior to giving birth, the mother had consistently refused to participate in domestic violence or anger management counseling or parenting skills classes. The mother's caseworker recorded in her notes the mother received no pre-natal care, continued to smoke during her pregnancy and infrequently visited her two children at the paternal grandmother's home. At the time the mother delivered her third child, none of the involved child welfare professionals contacted the hotline to report the baby's birth. In interviews with the OIG, the mother's first and second independent living caseworkers as well as their supervisor expressed their beliefs that responsibility for contacting the hotline belonged to other individuals or organizations. The supervisor stated it was appropriate to allow the baby to remain in the mother's care because she was complying with services at the time, a statement directly contradicted by the PAT evaluation and service plans rated "unsatisfactory" just prior to the birth. The second caseworker stated she had not read the case file because she did not want to "pre-judge" the mother. Neither of the two workers nor the supervisor mentioned considering the PAT's conclusion the mother was unable to care for children. Although the mother was identified as being "high risk," a Child Endangerment Risk Assessment Protocol (CERAP) was not conducted to identify potential safety concerns for the newborn.

Two months after the mother and her baby moved into their new apartment, a private agency worker conducted a home visit. The worker asked to see the baby and was informed by the mother he was sleeping. The worker observed the baby sleeping face down on a bed near a wall. When the worker told the mother such a sleeping position put the infant at increased risk for SIDS, the mother became belligerent. The worker related the episode to both the first and second independent living caseworkers. In interviews with the OIG, neither independent living caseworker could recall speaking with the worker about the baby's sleep habits, even after they were shown the corresponding case notes. Both independent living caseworkers stated they were aware the mother did not possess a crib but stated it was her responsibility to acquire one. One month later, the mother found the baby lying unresponsive on her bed. The infant was transported to the hospital where he was pronounced dead. The medical examiner determined the cause of death to be SIDS.

Although domestic violence had been an ongoing issue between the mother and father, the frequency of incidents increased following the baby's death. The mother was eventually evicted from her apartment by building management for repeated disturbances and property damage stemming from physical and verbal altercations between the couple. Management agreed to allow the mother to relocate to another of their buildings on the condition she did not disclose the location to the father and that he was barred from the property. Following the move, the second independent living caseworker continually documented injuries she observed on the mother and the presence of the father in the home. The caseworker accepted the mother's explanations for her injuries and failed to critically assess the likelihood of domestic violence in the home. Six months after the baby's death, the mother was arrested after she attacked the father with a knife in front of their two children. Authorities were unable to clearly establish why the children were present in the mother's apartment.

Although the paternal grandmother reported the father did not live in her home, he provided the grandmother's address as his residence during the investigation into the baby's death. Involved child welfare professionals suspected the grandmother's boyfriend also lived in the home. A criminal background check of the boyfriend conducted by the OIG found he had previous convictions for vehicular felony and theft. In addition, the grandmother had been convicted of felony aggravated financial identity theft. The conviction barred her from retaining her foster care license but did not prohibit her from serving as a relative caregiver. Three months after the infant's death, the grandmother was indicated for inadequate supervision after the mother's two year-old son was found alone outside the grandmother's home. A decision was made to develop a safety plan and maintain the placement.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. Department Procedure 315, Permanency Planning, Appendix A, should be amended to require a CERAP be completed when a parent who has an open Department case and whose children have previously been removed from his or her care has another child. The policies and procedures of the umbrella program funded to oversee pregnant and parenting wards should likewise be amended.

Revisions to Procedure 315 will be completed by March 2005.

OIG Response: The OIG shared the report with the umbrella program funded to oversee pregnant and parenting wards. The program submitted a detailed corrective action plan addresses the recommendations made in the report. The Inspector General met with the program's executive staff and a member of the Board of Directors to discuss the report.

The program agreed to update policies and procedures to mandate a CERAP be completed when a parent with an open DCFS case and whose children have previously been removed has another child. The program will also have its clinical staff review such cases prior to the birth.

2. Department Procedure 300, Reports of Child Abuse and Neglect, should be amended to provide that the decision to take protective custody of a child whose parent is receiving services from the Department (e.g., intact family, independent living, or residential programs) must include consideration of the degree of mother's cooperation with services and the extent to which services provided address the allegation.

The Child Endangerment Risk Assessment Protocol (CERAP) Advisory Council is currently reviewing the CERAP Protocol. The OIG recommendations will be shared with the group at their next meeting in January 2005.

3. Pregnant or parenting teen wards that continue to be involved in domestic violence situations should not be allowed to remain in an independent living apartment if the ward continues to remain in a violent relationship. The umbrella program and the Department need to develop and make available specialized crisis foster placements that can accept a teen parent and his or her children on an emergency basis while an emerging, potentially violent situation is de-escalated and the safety and well-being of the parent and child are protected. As part of a CERAP plan in a situation where a pregnant or parenting teen ward continues in a domestic violence situation, if it is necessary for the parent to attend domestic violence counseling and participate in aggression replacement treatment (involving social skill, anger management and moral reasoning programming), the parent and child/ren should remain in the specialized crisis placement or other least restrictive setting that has 24-hour supervision until the parent successfully completes the individualized violence reduction treatment program.

A workgroup was convened to revise Procedures 300. The workgroup will incorporate this recommendation if deemed appropriate. Completion date: February 2005. In addition, the Department is modifying and updating Independent Living Only (ILO) / Transitional Living Program (TLP) contracts to reflect level of need for special populations that includes pregnant and parenting clients. The Department is developing specialized contract providers for specialized populations.

The program agrees that there is a problem with wards remaining in independent living apartments in domestic violence situations. The program continues to advocate for new types of emergency foster care and other more structured placement options. In the meantime, the program agrees to work with all independent living providers to review their procedures as to domestic violation situations.

4. The Department should develop guidelines and training to address issues of risk and dependency for children of teen wards. In developing such guidelines, the Department should focus on cases in which the pregnant or parenting teen ward has moderate, severe or profound developmental disabilities (i.e., has an IQ of 55 or below), has had three or more psychiatric hospitalizations, is under the age of fourteen, or whose previous behavior has led to the removal of other children.

The Department's Legal Division, Division of Child Protection, Division of Clinical Services and the umbrella program along with the State's Attorney's office have all met regarding this issue. From these meetings, coordinated trainings were developed on screening cases for court, including format and documentation of information needed. The Division of Clinical Services will begin a pilot assessment of 100 high-risk pregnant and parenting teens clients for the Integrated Assessment. In addition, the Division of Child Protection has assigned two child protection managers as liaisons with the umbrella program, both Cook and downstate, to address issues on hotline reports, Emergency Reception Center (ERC) admittance and screening documentation for clients of the umbrella program.

5. As part of its monitoring duties, the umbrella program should develop a protocol requiring that its

supervisors and managers receive and review the reports of the Parenting Assessment Team (PAT) to ensure that service provider agencies abide by the PAT's findings and follow PAT's case recommendations. In addition, before the umbrella program completes a referral to PAT, umbrella program clinical staff should work with the service provider agencies to pose relevant and specific clinical questions that need to be addressed by the PAT. The Department's parenting assessment coordinator should train umbrella program clinical staff and the supervisors of workers carrying teen parent cases on the referral and follow-up procedures for the assessment process.

The Department, the umbrella program and PAT provider agencies have met and developed a protocol for referral and follow-up on PAT cases to ensure recommendations are implemented.

Program management staff have met with the Department's PAT Clinical Administrator to establish communication protocols for pregnant and parenting ward PATs. In addition, the program has notified its caseworkers of the availability of Parenting Capacity Evaluations for clients without mental illness.

6. In accordance with the independent living program personnel policies, the following employees should be disciplined: (a) The first independent living caseworker for ignoring the recommendations of the PAT report which stated that the mother could not effectively parent her children now or in the near future and for conducting an invalid comprehensive assessment of the mother; (b) The second independent living caseworker for failing to read the mother's file and for ignoring the recommendations of the PAT report which stated that the mother could not effectively parent her children now or in the near future; and (c) The independent living supervisor for inadequately supervising the first and second caseworkers.

The OIG shared the report with the private agency. The Inspector General met with agency executive staff and a member of the Board of Directors to discuss the report and the concerns about the involved employees. Corrective action was taken with regard to the involved employees.

7. If the paternal grandmother pursues adoption of the two children, the caseworkers for the children must disclose to the court the OIG's concerns about this placement.

The OIG shared the report and the specific concerns about the placement with the private agency. The agency notified the court of the concerns about the children's placement with the paternal grandmother. The court shares the OIG concerns about this pre-adoptive placement. The agency is exploring other potential placements for the children.

DEATH AND SERIOUS INJURY INVESTIGATION 20

ALLEGATION

A 17 year-old male ward was shot and killed three weeks after being released from a Department of Corrections boot camp. The ward had been returned to the foster home he lived in prior to his incarceration.

INVESTIGATION

The boy was the fourth of eight children born to his mother who had an extensive history of substance use and was the subject of 17 abuse and neglect reports. The boy, who was taken into custody by the Department when he was four years-old, was moved 24 times between 12 foster homes, 3 residential institutions and 1 group home. The boy was diagnosed with oppositional defiant disorder and significant issues with anger management, aggression and low self-esteem. When the boy was 14, an assessment conducted by a private agency concluded the boy was at high risk for gang involvement, substance misuse and criminal activity. At 16, after being discharged from a group home for chronic absences and failure to participate in services, the boy was placed in a private agency foster home where he had lived two years earlier. The original placement had ended after the foster father requested the boy's removal because of uncontrollable behavior, however he agreed to the subsequent placement arrangement because of the boy's strong desire to live with him. The Department maintained case management responsibility while the private agency was responsible for the foster home.

The boy initially responded well to the placement, however five months after his return to the home, the foster father reported to the caseworker that the boy's behavior had deteriorated. After the boy stopped attending school and quit his part time job, the caseworker referred the boy and his foster father for family counseling. The 62-year-old foster father told counselors he had persistent health problems and was considering moving to another state. The foster father also stated his suspicions of the boy's involvement with gang activity prevalent in the area where they lived. The boy told counselors he would not accompany the foster father if he moved out of state. Despite the foster father's stated concerns regarding his own health and the boy's associations with neighborhood gangs and the foster father's intent to move, the caseworker completed a client service plan which stated the boy was in a safe and stable placement.

Two months later the boy, who had one previous arrest for possession of a controlled substance, requested entry into drug treatment. The boy was placed at an in-patient facility, however after one week he ran from the facility and returned to the foster father's home. At the same time, management of the boy's case was transferred to a second caseworker. The second caseworker did not learn of the boy's whereabouts until one month later when he contacted the foster father. The foster father told the second caseworker he was unhappy with the boy's return to his home. The foster father stated the boy was using drugs and associating with gang members. An OIG review of the case record found no evidence the second caseworker had visited the home after speaking with the foster father. In an OIG interview, the caseworker stated he had never read the boy's case file.

Three weeks after the conversation between the caseworker and the foster father, the boy was arrested one block from his foster home after officers observed him attempting to sell drugs. While in custody, the boy acknowledged that a loaded semi-automatic pistol found at the scene belonged to him and that he provided security for members of his street gang. The boy pled guilty to aggravated unlawful use of a weapon and was sentenced to four months in a boot camp to be followed by eight months probation.

While in boot camp, the boy actively participated in programs and obtained his General Equivalency Degree (GED). In interviews with the OIG, boot camp staff stated the boy expressed a desire to alter the course of his life and attend college. The OIG found no evidence the caseworker or other involved professionals participated in any discharge planning meetings with the boy while he was in boot camp. In his case notes, the caseworker recorded that the boy told him he would accept living in another state with his foster father

and that he feared a return to the foster father's current neighborhood would result in a resumption of gang activity. Prior to the boy's release from boot camp, the caseworker failed to identify alternative placement options or pursue the possibility of moving the boy directly from incarceration to the college he wished to attend. In an interview with the OIG, the caseworker stated the decision to return the boy to the foster home was made by the boy and agreed to by the foster father and the caseworker's supervisor. In his interview with the OIG, the supervisor stated the boy was returned to the foster home upon his release because he would have run away from any other placement.

Both the caseworker and his supervisor were unaware the Department employed a liaison to the Department of Corrections. An OIG review of the job description of the Department liaison to the Department of Corrections found the involved programs are geared towards the incarcerated mothers of wards. These programs ignored the need to provide services to the jailed fathers of wards or wards who are incarcerated.

While the boy was in boot camp the foster father purchased a home in another state and divided his time between the two residences. An OIG review of the case record found the caseworker's supervisor had recorded a conversation between herself and the foster father in which he stated he did not want the boy placed with him because the boy would be unsupervised for days at a time while the foster father went to his home in another state. In an interview with the OIG, the supervisor stated she was unaware of the foster father's dual residence. After being shown the case entry, the supervisor stated she did not recall the conversation. Three weeks after his release from boot camp and while his foster father was at the out of state residence, the boy was confronted on the street by a rival gang member. The boy was fatally shot twice in the back.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. This report should be shared with the caseworker's supervisor and she should be counseled on her failure to provide adequate guidance to address the boy's dangerous behaviors and issues (i.e., discharge planning, lack of supervision in the foster home, needed supports to foster parent and the boy) relevant to her supervision of the boy's case.

The employee was counseled.

2. This report and two related OIG reports should be shared with members of the Department's justice steering group to assist them in their development of a handbook for workers with case management responsibility for wards involved with the Department of Corrections. It is very important that a handbook promote pragmatic practice and underscore the overarching requisites of school, structured activities, employment, an intolerance toward deviance, and pro social skills development to reduce risk for delinquent or criminal activity. The handbook should include a synopsis of the Surgeon General's report on youth violence to recognize that different approaches are needed with any acts involving violence or weapons. In addition to resources and information, the handbook should provide practical guidelines on how to convene staffings and provide services with criminal justice involved youth, including mental health services. The mental health of incarcerated DCFS wards became a significant issue in the past year when three wards committed suicide while confined.

The reports have been shared with the DCFS Justice Steering Group. The guidebooks are still in development.

3. The Department needs to examine the job description and relevancy of the role of the Department liaison to the Department of Corrections. Currently the Department has developed programs, advocacy, and services to incarcerated mothers of wards at the exclusion of incarcerated fathers and incarcerated wards. The Department should give consideration to the need for a comprehensive, non-

fragmented approach to working with all youths involved with the adult and juvenile criminal justice system. The Department needs to make certain that resources are appropriately allocated to ensure that our youths' most pressing needs are addressed.

The relationship between DCFS and the Department of Corrections is an ongoing discussion between the two agencies. Legislation may be introduced during the next session clarifying this relationship.

OIG Response: This response does not address the recommendation that the Department ensure that services are available to incarcerated fathers and incarcerated wards as well as incarcerated mothers of wards.

DEATH AND SERIOUS INJURY INVESTIGATION 21

ALLEGATION

A six-week old girl died of congenital heart disease. At the time of the infant's death, her family had an open case with the Department through Intact Family Services (IFS.)

INVESTIGATION

The infant's mother initially became involved with the Department 20 months earlier following a hotline report she had left her two children, then ages two years and six months, home alone while she traveled to another city to visit the children's father. The Department took custody of the children and placed them with their maternal grandmother. The mother was indicated for inadequate supervision and the case was referred to intact family services. The assigned intact worker identified the mother's ongoing alcohol abuse and incidents of domestic violence between she and the father as the primary issues to address through services. Despite concerns of violence and substance abuse, the intact worker did not conduct a Law Enforcement Agency Database System (LEADS) check on either of the parents. A LEADS check conducted by the OIG found the father had multiple convictions for assault, invasion of privacy and drug offenses.

The intact worker developed a service plan requiring the mother to participate in alcohol abuse counseling, attend domestic violence training and cooperate with monitoring efforts. The mother's compliance with services was sporadic. Although she successfully completed alcohol treatment through an independent program, she was dismissed from the program's halfway house for repeated rules violations. The father was never engaged in services. In an interview with the OIG, the intact worker stated the father was disinterested and attempting to communicate with him was like "talking to a wall."

Five months after the initial hotline report, the mother delivered her third child. The intact worker made a hotline call to report the baby's birth, however the call was not accepted because the mother was engaged in services. For one month following the baby's birth the intact worker attempted unsuccessfully to see the mother. The mother did not have a telephone, preventing the intact worker from coordinating visits, and did not respond to the worker's requests for correspondence. When the worker encountered the mother outside her home following another attempted visit, the mother stated she had missed her two most recent substance abuse sessions.

Two weeks later the mother's sister contacted the hotline to report she had entered the mother's apartment and found the mother and father too intoxicated to care for the baby. A child protection investigation was initiated and the assigned investigator interviewed the intact worker who stated the mother's compliance with services had been unsatisfactory. The investigator and his supervisor completed a Child Endangerment Risk Assessment Protocol (CERAP) which determined the home to be safe based on signed agreements from the mother and father pledging to remain sober while caring for the baby. The mother and father were indicated for inadequate supervision. As a result of information regarding the mother's insufficient compliance with services presented during a status hearing, the court determined the baby was at risk in the mother's custody and ordered the baby removed from the home.

The mother's participation with services initially improved following the baby's removal, however after three months she tested positive for alcohol. The mother then entered an extended care facility. Two weeks after the mother entered the facility, the intact worker learned the mother, who was five months pregnant, had again tested positive. While at the facility, the mother failed to adhere to program rules and was ultimately dismissed from the facility. Two months after her expulsion, the mother delivered her fourth child. The intact worker attempted to report the birth to the hotline but the call was not accepted. Following the baby's birth the mother disengaged from services and had infrequent contact with the intact worker, however six weeks after the infant was born, the mother attended a child and family conference with the intact worker.

Three days after the conference, the mother checked on the infant in the morning and found her unresponsive. The infant was transported to the hospital where she was pronounced dead. The infant's death was reported to the hotline and a child protection investigation was initiated. The assigned investigator interviewed hospital staff who stated the baby arrived at the hospital with a diaper rash so severe it was bleeding. Hospital staff also stated the mother smelled of alcohol when she arrived in the emergency room with the infant. The next day, the investigator went to the home of the mother's sister to conduct interviews. Upon her arrival, the investigator observed the mother and father as well as several other individuals consuming alcohol. Despite acknowledgements from the mother and father they had been drinking, the investigator conducted her only interviews with each of them. The report was ultimately indicated against the mother for inadequate supervision and wounds by neglect. Her parental rights for her other three children have been terminated.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should consider the use of graduated sanctions in cases where drug/alcohol abuse is the primary issue and the parent(s) have displayed a pattern of relapse.

The Department is revising Procedure 302, Appendix O, Services to Intact Families and will strengthen the sections for servicing families with substance misuse. Completion date: February 2005

2. In cases where the father or paramour has an ongoing relationship with the mother, the Department should require the father/paramour's cooperation in services.

The Department has developed a plan for working with fathers as part of the Department's Program Improvement Plan. This plan is in the final draft stage.

3. In split custody cases with a history of substance abuse and relapse, the Department should require random drug drops to assist the Department in securing necessary services for the children and family. In cases of alcoholism, random urine testing is not reliable. Breathalyzers are preferable. The OIG reiterates its prior recommendation that DCFS acquire breathalyzers and train on their use.

The Department is convening a group of child welfare and substance abuse providers to discuss alcohol and drug testing procedures for DCFS involved families.

4. The Department should consider implementing the Intact Family Recovery (IFR) model with split custody cases.

No response was provided by the Department.

5. A redacted copy of this report should be shared with the intact worker and her supervisor to address the proper use of the LEADS protocol.

The report was shared with the employees.

6. A redacted copy of this report should be shared and reviewed with the child protection investigator who conducted the death investigation to discuss the problems associated with interviewing a subject who is intoxicated.

The report will be shared with the investigator.

DEATH AND SERIOUS INJURY INVESTIGATION 22

ALLEGATION

The OIG reviewed the case management, monitoring and investigation of foster parents who were the subjects of seven unfounded abuse and neglect reports prior to the foster mother being indicated for risk of harm.

INVESTIGATION

The foster parents were originally licensed almost four years earlier to accept two children in placement, although over time their capacity was increased to five. From the time of initial licensing until the foster mother was indicated for abuse, 21 children were placed in the home. The first child protection investigation was initiated two years after licensure when a 16 year-old girl reported she had been the object of sexual advances by the foster father. The girl ran away after six weeks in the placement and reported to her grandmother and her caseworker the foster father had accosted her on multiple occasions and offered her money in exchange for sexual favors. Following child protection and police investigations the report was unfounded and no criminal charges were filed.

Two months later, a seven year-old boy was placed with the foster parents in respite care and returned to their home in a pre-adoptive placement after his previous foster mother's health problems forced her to request his removal. The boy's two brothers, who had lived with him in the previous home, were accepted as pre-adoptive placements by relatives of the foster parents. Six months after the boy was placed, staff from his school called the State Central Register (SCR) to report the boy had returned after being absent for four days with a black eye and a burn mark on his forehead. The assigned child protection investigator interviewed the foster mother and the boy who both stated he had injured his eye by walking into a door at shopping center. The foster mother and the boy said the burn was caused when the foster mother, attempting to alleviate the eye injury, held a towel under excessively hot water and gave it to the boy to press against his face.

The investigator interviewed the boy's pediatrician who stated that although the presence of two injuries at once was cause for suspicion, the explanation provided was plausible. The investigator did not conduct a scene investigation or speak with store management to learn if they had been notified of an accident on company property involving a child. The investigator ultimately decided to unfound the report. A third investigation of the family was opened later the same month, however it was unfounded and expunged and details were not available for review.

A fourth investigation was opened one month later when the caseworker called the hotline after being informed by the boy's teacher he had burns on his hands. The teacher also contacted the hotline and reported the boy also had a burn on his arm and stated he had been warned by the foster parents, "never to pull up his sleeves." The teacher expressed concern the boy had already presented three black eyes, a bloody lip and two other burns during the current school year. A second child protection investigator was assigned to the case and interviewed the foster parents and the boy who all denied any abuse occurred and stated the boy had burned himself playing with candles. While the investigation was still pending, the foster mother contacted the second investigator and stated the boy disclosed to his therapist he had set fires during his previous placement. The foster mother also stated the boy reported "hearing voices."

After the second investigator conferred with her supervisor, a decision was reached to unfound the report. The second investigator did not interview the teacher who made the second hotline report or document that she addressed the issue of a second burn on the boy's arm. The investigator neglected to interview the boy's therapist to confirm the foster mother's report of firesetting and hallucinations. In an interview with the OIG, the therapist denied the boy ever made any statements suggesting a history of firestarting. The second investigator's supervisor and the field office administrator both approved the investigator's decision without recognizing the inadequacy of the work performed.

The boy's therapist, school staff and some involved child welfare professionals noted concerns regarding the foster mother's demeanor towards him. Following a meeting between the therapist, the boy's teacher, his caseworker and the foster mother, the therapist documented the foster mother displayed "emotional volatility" and demonstrated a, "desire to punish [the boy] harshly and regularly." School staff reported to the caseworker that the foster mother continually made references to the boy's poor behavior in school, however, they felt he was a well-behaved and potentially gifted student. The increasingly hostile relationship between the foster mother and the private agency prompted the agency to notify the foster parents the boy would be removed. The foster parents appealed the decision and a clinical consultation was held. A clinical coordinator participated in the staffing, however she did not review any of the case records or contact the boy's therapist or school personnel. The clinical coordinator accepted the information offered by private agency workers without verification or the context provided by supporting documentation. The clinical coordinator concluded the boy was depressed, possibly self-injurious and in need of psychological evaluation. The clinical coordinator recommended maintaining the placement and offering additional support to the foster parents.

Three weeks after the consultation was held, the boy's teacher contacted the hotline to report he had arrived at school with cuts and bruises on his face, neck and arm. Because the boy had received numerous injuries during a short period of time the assigned investigator scheduled a Victim Sensitive Interview (VSI.) During the interview the boy did not disclose any abuse but stated the foster parents had instructed him not to talk about anything that occurred inside the home. The investigator determined there was insufficient evidence to support the allegation and unfounded the report. Six weeks later the principal of the boy's school contacted the hotline to report the boy had a bump on his forehead and that the swelling had increased over the previous two days, however the foster parents had not sought medical attention. A third child protection investigator was assigned and interviewed the foster parents and the boy. All three stated that the boy, then 10 years-old, had been injured in an altercation with a 5 year-old at school. The third investigator spoke with an investigator assigned to previous cases involving the family who stated the boy was not abused but accident-prone. The third investigator decided to unfound the case. The third investigator's supervisor, who had been involved in earlier abuse reports regarding the boy, documented the investigator had interviewed the five year-old and that the child had acknowledged striking the boy. In an interview with the OIG, the third investigator stated he never spoke with the alleged five year-old assailant.

One month after the previous hotline report, the boy was located by police after he ran away from the foster home. The officer who found the boy reported his body was covered with apparent belt lash marks. The officer contacted the hotline and the third investigator was assigned to the case. The boy refused to acknowledge any abuse and provided contradictory explanations for his injuries to his caseworker. The investigator interviewed the foster mother who stated the boy had injured himself while running away and that other scars were the result of abuse prior to his placement in their home. The boy's pediatrician observed numerous marks and bruises on the boy of various ages and stages of healing. The pediatrician told the caseworker the boy's injuries were inconsistent with the explanations provided and made an additional hotline call to report his fresh wounds. Over the next two weeks the boy ran away from the home two more times before he was removed by the private agency and placed with another foster family.

During a psychological evaluation conducted one week after his removal, the boy reported being whipped with extension cords and belts by the foster parents. The third investigator and his supervisor subsequently determined to unfound the report based on the denials by the foster parents and the boy that abuse occurred and the explanations provided for the boy's old and new injuries. In interviews with the OIG, neither the third investigator, his supervisor or the field office administrator could provide an explanation for the reconciliation of the information provided by the foster family and the pediatrician's conclusion the injuries could not have occurred as described.

Three weeks after the boy was removed, a Department foster parent support specialist contacted a Department licensing worker and requested that three siblings, two girls ages seven and six and a five year-old boy, be placed in the foster parents' home. In interviews with the OIG, licensing employees stated it was common practice in the region to defer to the foster parent support specialist on placement issues despite the fact Department rule prohibits foster parent support specialists from involvement in placement decisions. In an interview with the OIG, the foster parent support specialist stated she had a close personal relationship with the foster father dating back to her childhood and that she and the foster mother were good friends who communicated daily. The agency agreed to the placement of the siblings in the home. One month after the siblings were placed, a homemaker and the children's biological parents observed healing injuries on the five year-old boy. The children reported severe abuse by the foster parents including being punched, burned with hot water, struck with belts and held under water. A medical examination of the six year-old girl found she had contracted anal warts. When questioned the girl reported she had been sexually abused by the foster father. A subsequent child protection investigation resulted in indicated findings of risk of physical injury against the foster mother and sexually transmitted disease against an unknown perpetrator.

Throughout the Department's involvement with the foster family, monitoring of their home was insufficient or non-existent. Although the inclusion of foster parents on the Child Abuse and Neglect Tracking System (CANTS) database of pending investigations requires the initiation of a licensing review of the home, the multiple unfounded reports against the foster parents triggered no such response. Despite being aware of the abuse and neglect allegations against the foster parents, neither the licensing worker or her supervisor deemed it necessary to reassess the viability of the home, increase supervision or implement protective measures. In an interview with the OIG, the licensing supervisor stated he believed licensing reviews related to CANTS were only to be initiated following an indicated report.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should issue a policy guide clarifying for child protection investigators that consideration must be given to prior unfounded as well as indicated abuse and neglect investigations, when available. When the investigations involve a licensed foster home, licensing workers must be able to extrapolate from these prior reports information relevant to the suitability of the licensed caretaker.

This is current practice as per Procedure 300. There is a checkbox on the person tab labeled "Prior History Reviewed." Staff was trained that a check this box indicates that all prior investigations have been reviewed. This is being clarified in the revision of Procedure 300. Completion date: February 2005. The Department will also look at the availability of web-based training.

2. Procedures 383, Licensing Enforcement, should be amended to include substantive guidelines on conducting licensing complaint investigations. Currently, the Procedures focus on the concurrent licensing investigations initiated as a result of CANTS allegations. The Procedures do not address issues such as the standard of determination, interviewing requirements, verification of self-report information, assessing credibility, or when an unfounded child protection investigation should trigger a licensing investigation. Additionally, the Department must clarify who has the responsibility for conducting the licensing complaint investigations.

Procedure 383, Licensing Enforcement revisions will be completed by March 2005.

3. Currently, private agency licensing staff are required to conduct semi-annual monitoring visits, while Department licensing staff are only required to conduct annual visits. The Department Procedure 402.27 and Rule 401.420 regarding foster home monitoring visits must be consistent holding all licensing workers to the same standards.

Department's Rules are being amended to incorporate the OIG recommendation requiring DCFS & POS to conduct monitoring visits at the same intervals. Completion date: March 2005.

4. As previously recommended in the OIG case # 031162, July 23,2003, the Department should amend Procedure 402 to require that prior to licensing monitoring visits, foster home licensing staff communicate with the caseworkers of children currently placed in the foster home. The purpose of the meeting would be to assist the licensing worker in becoming more familiar with the home, reviewing services provided the foster children in their care, and to allow caseworkers to raise any concerns about the home or the care of the children.

A utilization review is being conducted to determine which homes do not have children and therefore, do not require a review. Procedure 402, Licensing Standards for Foster Family Homes, was reviewed and revisions are being developed. Completion date: March 2005

5. Quality Assurance should conduct a review of Central Office of Licensure's current method of identifying CANTS reports on licensed foster homes and establish a schedule of reliability checks for the system of identifying foster homes with a CANTS report.

Quality Assurance will convene a work group comprised of Quality Assurance and Licensing Staff to develop the procedures for reliability checks for the purposes of identifying foster homes with a CANTS report. Implementation date: April 2005.

6. The licensing supervisor should be counseled for failing to adequately supervise the licensing worker. He neglected to act when made aware of potential problems in the foster home. The licensing supervisor did not instruct the licensing worker to increase monitoring of the foster home or to conduct an assessment of the foster home in light of the various allegations. He neglected to initiate or participate in staffings pertaining to this foster home with child protection staff and the multi-worker assessment staffing, or to facilitate a meeting when the Agency Performance Team monitor did not. The failings noted in this report should be reflected in his next performance evaluation.

The employee will be counseled. Completion date: January 2005

7. The Department should consider not renewing the contract for foster parent support specialist for: (1) disregarding an essential part of the program plan that reads "FPSS ARE STRICTLY PROHIBITED FROM PARTICIPATION IN PLACEMENT DECISIONS" (emphasis in the original program plan); and (2) her unethical behavior for having direct involvement in a case in which she had a personal bias.

The foster parent support specialist currently has a reduced contract. The Department will evaluate renewal for fiscal year 2006.

8. This report should be reviewed and discussed with the following staff: the second child protection investigator, the third child protection investigator, their child protection supervisor and the field office administrator. The discussions should be reflected in their next performance evaluations.

This will be completed in January 2005.

9. The report should be shared with the Department clinical coordinator's supervisor and reviewed with clinical coordinator to address deficiencies in conducting the clinical staffing: specifically, her

failure to review the case record and failure to contact the child's therapist or review the therapist's record. The discussion should be reflected in her next performance evaluation.

The supervisor reviewed the report with the worker and tasks were added to her evaluation.

10. A redacted version of this report should be used as a training tool with child protection investigators, licensing workers and supervisors.

Child protection training is currently under revision and applicable sections of this report will be incorporated in training modules. Completion date: May 2005

11. A copy of this report should be shared with the seven year-old boy's current caseworker and therapist.

The report has been shared

12. The seven year-old boy's therapist should develop a therapeutic intervention to address the Department's failure to protect him and the possibility of the boy visiting with his siblings.

This has been completed. The boy's siblings have been adopted and the Department will explore visitation.

13. The OIG will request a review of this case with local law enforcement to explore whether the foster parents can be charged criminally with the abuse and neglect of the seven year-old boy.

OIG response: The case has been referred to local law enforcement for review.

DEATH AND SERIOUS INJURY INVESTIGATION 23

ALLEGATION

A seven month-old boy was found dead of dehydration in his crib inside his family home. The medical examiner ruled the death was the result of natural causes. The boy's family had an open case for intact services through the Department at the time of his death.

INVESTIGATION

The family's initial involvement with the Department occurred five years earlier when police responded to a report the mother, a licensed nurse, was too intoxicated to care for her two children. Upon arriving in the home, police found the mother was inebriated and unable to provide them with information regarding the last time her two daughters, ages three and one, had eaten. The day before, the father had been arrested at the family home following an allegation by the mother he had punched her in the leg. The mother was subsequently indicated for inadequate supervision and a case was opened for Intact Family Services (IFS.)

Both parents had extensive histories of alcohol abuse and the mother's habitual heavy drinking was the central source of instability in the home. The father had also been diagnosed with bi-polar disorder. The unstable nature of the parents' relationship resulted in repeated domestic disturbances as well as counseling sessions which often deteriorated into screaming matches between the mother and father in the children's presence. The family had frequent contact with law enforcement related to the mother's practice of making erroneous emergency calls and chronic drunk driving. Throughout the family's involvement with intact family services, the mother's repeated episodes of dangerous and negligent alcohol-fueled behavior were viewed by involved workers as isolated incidents rather than a pattern of conduct sustained over time.

The intact family service case was closed after eight months following a period of moderate compliance with services. The intact worker determined the parents' involvement with outpatient alcohol treatment programs addressed the issue that initiated Department involvement. The intact worker also concluded that the parents' histories of addiction and recovery made them more attuned to the possibility of relapse and more likely to resume treatment if it occurred. The parents expressed a desire to improve their relationship and, by extension, the home environment. A Child Endangerment Risk Assessment Protocol (CERAP) was completed rating the home as safe. Six months after the case was closed, a park district employee called police to report the mother smelled of alcohol and drove erratically as she dropped her four year-old daughter off at pre-school. The mother was indicated for inadequate supervision and risk of harm, however a case was not opened because the mother voluntarily entered alcohol treatment.

Two years later, the father called police to report he and the children had been physically attacked by the mother, who was intoxicated. Responding officers observed a red mark on one of the girl's cheeks and both children stated they were afraid of their mother. Another child protection investigation was initiated and the mother again entered substance abuse treatment voluntarily. After completing treatment, the mother told the assigned child protection investigator she had resumed drinking during a stressful period. The investigator completed a Family Assessment Factor Worksheet which noted the mother appeared unaware of how her alcohol abuse affected her parenting ability. The mother was indicated for cuts, welts and bruises and risk of injury and the case was referred for intact family services.

The family's second involvement with intact services began with the parent's refusal to sign the client service plan because the mother refused to attend domestic violence counseling and the father would not participate in individual therapy. Throughout the second intact case, the parents remained selectively compliant with services but suffered no repercussions for their actions. Although intact family service cases are voluntary, families enter such programs as a result of involvement with the Department. Based on the reasons for involvement and the potential consequences of non-compliance, parents can be compelled to cooperate with services through the utilization of graduated sanctions. By progressively increasing the restrictions or

responsibilities placed on a family, child welfare workers can seek to obtain a degree of leverage with parents resistant to necessary services.

One year after the second intact family service case was opened, police found the mother intoxicated inside her car, stuck in a ditch. The mother's five year-old daughter had been in the car at the time of the accident and, after being unable to wake her mother, exited the car and walked across the road for assistance. The girl also told police her baby brother had been left home alone. Police went to the home and found a three month-old boy. The intact worker was unaware the mother was pregnant or had delivered a baby. When the intact worker visited the family home three days after the accident, the parents acknowledged they had hidden the pregnancy and later the baby from her and stated they derived enjoyment from their deception. The intact worker took no direct action but continued to attempt to provide services and work towards family preservation. Four months after the car accident, the father discovered the baby boy, then seven months-old, dead in his crib. The father moved out of the house and separated from his wife shortly afterward. The parents are currently involved in divorce proceedings. Eight months after the boy's death, police responded to a request for a well child check at the family home. Officers found the mother half-naked and incoherent. The father was also present in the home. After being informed by the father of the presence of two guns in the home officers initiated a search. The mother told police she did not know where the gun was but that she had removed from its storage location in order to "go and find" her son from a previous relationship. The Department assumed guardianship of the children and placed the children with their father. The Department also implemented a safety plan prohibiting the mother from having unsupervised contact with the children and providing for their removal and placement in foster care if the father violated the plan.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department's clinical division should immediately refer this family to a Parenting Assessment Team. The father's bipolar diagnosis and the mother's extensive substance abuse

warrants the intensive assessment. Further, the Department needs guidance for future service planning and placement of the children.

The DCFS Parenting Assessment Team Administrator has referred this family for an evaluation. The mother has refused to sign consents. The Department will follow-up to ensure that by February 2005 consents will be obtained or attempt to get a court order for access to the needed documents. The father has signed consents for assessment scheduled for January 2005.

The Department is currently revising Procedures 302, Appendix O, Services to Intact Families and will strengthen the sections for servicing families with substance misuse. Completion date: February 2005.

OIG Response: The OIG believes the Department needs to either get a court order for the release of needed records or make a safety decision presuming negative information is contained in the records.

2. The child protection investigator of the current investigation needs to attach a memo to the indicated report informing the State Central Register (SCR) of the need to alert the Department of Professional Regulations of the indicated report on the mother. The mother holds an active license as a registered nurse.

Memos have been sent to the Department of Professional Regulation.

3. The Department's Division of Legal Services should file a motion to intervene in the domestic relations proceedings as the children's legal guardian.

The Attorney General's Office has declined to represent the Department in this matter.

OIG Response: The OIG agrees to contact the Attorney General to advocate for the importance of this representation.

4. The follow-up worker should contact all service providers and pertinent parties to assure that they have been informed that the Department has guardianship of the children. The worker should have regular contact with the therapist and the school. The therapist and the treating psychiatrist should be provided with the Department history and pertinent records such as the social history. Any social addendums or progress reports should also be shared with the children's therapist and the older daughter's psychiatrists.

The school and therapist are aware that the Department has guardianship and are not to release the children to the mother. The worker has had regular contact with service providers.

5. Department management should assure that the case is closely monitored as the parents have a history of deceiving the Department and not disclosing information to service providers. During the two-month safety plan period, at least half of the visits should be unannounced; the children should be interviewed outside of the presence of their parents and all self-report should be corroborated. The corroboration should be documented. The Department should establish strict guidelines the mother must adhere to before she is allowed unsupervised contact.

The assigned worker has weekly contact with the father and children and has access to experts in the field of substance abuse for consultation.

OIG Response: In addition to being available for consultation, the OIG believes it would be prudent to have experts in the field of substance abuse review the case.

6. The follow-up worker should determine if the mother has contact with her adult son and if so alert his father of his mother's comments to police about "using the gun to find her son."

The OIG notified the father.

7. The OIG reiterates a previous recommendation that the Department consider the use of graduated sanctions in cases where drug/alcohol abuse is the primary issue and the parent(s) have displayed a pattern of relapse. (See OIG# 03-0505, January 26, 2004).

The Department agrees. The Office of Child and Family Policy and the Division of Child Protection drafted Appendix O to Procedures 302 - Intact Family Services to address OIG recommendations; however, further revisions are needed. Appendix O is to be completed by January 30, 2005. In addition, there were revisions to the substance abuse screening tool for adolescents and a protocol was developed for referrals for assessment, treatment and/or Intact Family Recovery services. As part of the Program Improvement Plan for the Child and Family Services Review, the Department is conducting a record review of Alcohol and Other Drug Abuse (AODA) cases to identify barriers to implementing Department policies for serving substance affected families. This is scheduled to be completed by January 2005.

The record review will lead to recommendations for changes to the existing Substance Affected Families policy as needed. This is scheduled to be completed by March 2005. The policy, with any needed revisions, will be re-issued statewide to DCFS and private agency staff. This is scheduled to be completed by June 2005.

8. The OIG previously recommended that the Department's clinical division should immediately refer this family to a Parenting Assessment Team. According to a private agency Parenting Assessment Team, the referral has been made but the team has not yet received the parents' consents from the worker, stalling the assessment from going any further. The worker has received the signed consent from the father but the mother and her attorney have not yet cooperated. The supervisor should assure that the court is informed of the mother's failure to cooperate and should request a court order for the mother to comply with a Parenting Assessment Team evaluation.

The court has been advised of the mother's lack of cooperation. The mother has refused to sign the consents based on her attorney's advice. The father has signed consents and has PAT appointments in January 2005.

OIG Response: The OIG believes the Department needs to either get a court order for the release of needed records or make a safety decision presuming negative information is contained in the records.

DEATH AND SERIOUS INJURY INVESTIGATION 24

ALLEGATION

The OIG conducted an examination of the identification and prevention of intentional poisoning of children by their caregivers.

INVESTIGATION

Factitious Disorder by Proxy, often known as Munchausen Syndrome by Proxy, is a bizarre and relatively rare form of child abuse in which an adult persistently fabricates illness in a child. The adult may rely upon the simulation of a medical condition by making false reports of a child's symptoms or actively attempt to produce illness or the appearance of illness in a child through physical manipulation such as suffocation or the surreptitious administering of medicine, drugs or other substances. While the overall incidence of such cases is low, they present unique challenges to the child welfare system.

Of the 2,380,028 human poison exposure cases reported in the United States in 2002, 51.6% involved children under the age of six. Despite comprising more than half the total number of cases, children younger than six accounted for only 2% of poisoning fatalities. In Illinois that year, 119 cases of suspected abusive poisoning were reported to the child abuse hotline of which 17 were indicated for poisoning by abuse. As standards for the packaging and handling of poisonous substances have risen, it is possible more reported cases of poisoning among children are the result of abuse.

Children exposed to a perpetrator of Factitious Disorder by Proxy are at great risk because of the high rate of recidivism by offenders. Children are taken to multiple health care providers to reduce the likelihood of recognition by physicians and abuse often continues after children have begun receiving care in order to prolong involvement with the medical apparatus. Very young children are primarily targeted and are particularly susceptible as a result of their inability to defend themselves physically or verbalize the abuse. Because of the planning and deliberation required to systematically harm a child and the inherent deception involved, caretakers who commit Factitious Disorder by Proxy are difficult to engage in therapy.

In order to identify potential cases of Factitious Disorder by Proxy, investigators should obtain all available medical records for the involved child and their siblings. An accurate understanding of a child's previous medical involvement will assist in identifying the recurrence of particular maladies or the prevalence of similar illnesses among family members. Medical histories also offer the presenting statements of parents to medical personnel at the time of admission. Broadcast subpoenas can be utilized to request any and all available records from hospitals in a geographic area.

Allegations of Factitious Disorder by Proxy are often difficult to prove because perpetrators portray themselves as the loving parents of afflicted children. It is also difficult for relatives and friends to accept the notion of sustained, premeditated and essentially public abuse to a child. By working in conjunction with medical personnel, law enforcement and child welfare professionals, investigators can assemble information from disparate sources to develop a comprehensive understanding of a child's past history and current condition to increase the likelihood of reaching an accurate assessment of their actual health.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department procedure for investigation of an allegation of poisoning should include information from literature, specifically: (a) common sources of intentional poisoning of children include: ipecac, laxatives, black and red pepper, salt, water (intoxication), acetaminophen and aspirin, insulin, adult prescription drugs (e.g., barbiturates, antidepressants, diuretics), alcohol and illicit drugs, and arsenic; (b) common symptoms associated with intentional poisoning include: chronic diarrhea, vomiting, lethargy, dehydration, and seizures; and (c) intentional

poisoning has an extremely high mortality rate and when found, children who are intentionally poisoned should not be left with the perpetrator.

A workgroup was convened to revise/update Procedures 300. A protocol for conducting investigations when Factitious Disorder by Proxy is suspected is being drafted. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

2. The Department should establish guidelines for the investigation of abusive poisoning cases and suspected Factitious Disorder by Proxy cases in accordance with the published literature. Allegations should be amended to provide that in cases where intentional poisoning is suspected, the investigator should also suspect and investigate Factitious Disorder by Proxy.

A workgroup was convened to revise/update Procedures 300. A protocol for conducting investigations when Factitious Disorder by Proxy is suspected is being drafted. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

3. Department Procedures should also acquaint workers with the following necessary information to investigate Factitious Disorder by Proxy: (a) critical to any investigation of poisoning, and especially Factitious Disorder by Proxy is a detailed determination of who provides care for the child and when such care is provided; (b) investigators must retrieve all available medical records for the affected child and siblings; an affidavit of history care, completed by the parents, will be a useful first step in attempting to get all available records; (c) while not dispositive, the typical perpetrator is a mother who has some medical background; (d) typically, perpetrators of Factitious Disorder by Proxy appear particularly bonded with their children and are particularly adept at convincing professionals of their sincerity and abiding interest in their children; (e) most victims of Factitious Disorder by Proxy are infants and toddlers; (f) as much as 98% of the time, the perpetrator continues victimizing the child in the hospital; (g) the most common presentation of Factitious Disorder by Proxy is apnea. Other common presenting conditions include, seizures, bleeding, central nervous system depression, diarrhea, vomiting, fever (with or without sepsis or other localized infection), and rash. Probably the most common cause of death in homicidal Factitious Disorder by Proxy is suffocation, but there are many causes of death, among which are poisoning with various drugs, inflicted bacterial or fungal sepsis, hypoglycemia, and salt or potassium poisoning; (h) Factitious Disorder by Proxy is not limited to directly causing conditions (e.g., poisoning and suffocation); it may also include, over or under reporting signs or symptoms (e.g., exaggeration of symptoms), creating a false appearance of signs and symptoms (e.g., tampering of specimens) and/or coaching the victim or others to misrepresent the victim as ill. The presence of valid illness does not preclude exaggeration or falsification.

A workgroup was convened to revise/update Procedures 300. A protocol for conducting investigations when Factitious Disorder by Proxy is suspected is being drafted. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

4. A Factitious Disorder by Proxy investigation should include a thorough review of available medical records for all children in the family. If a child abuse team is available at the treating hospital, they should conduct the review. If a child abuse team is not available, this review should be conducted by Department nurses and should be subject to the following procedures: (a) interview medical personnel regarding symptoms. If intentionally caused, how long after administration would symptoms be expected to occur? How long would symptoms be expected to last per dose? (b) determine context of onset of symptoms. Who is present prior to onset of symptoms? (c) prepare a medical chronology of symptoms, charting the onset of symptoms and the access of possible perpetrators; (d) do siblings' records contain evidence of false pediatric reporting? (e) interview treating doctor to determine

whether appropriate laboratory tests have been ordered to detect the presence of poisons or emetics.

A workgroup was convened to revise/update Procedures 300. A protocol for conducting investigations when Factitious Disorder by Proxy is suspected is being drafted. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

5. Whenever investigators suspect intentional poisoning or Factitious Disorder by Proxy an immediate referral must be made to law enforcement and the State's Attorney.

A workgroup was convened to revise/update Procedures 300. A protocol for conducting investigations when Factitious Disorder by Proxy is suspected is being drafted. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

6. Whenever investigators suspect intentional poisoning or Factitious Disorder by Proxy, investigators must employ a multi-disciplinary approach that includes sharing of information and frequent contact with law enforcement and any Child Abuse Team at the hospital. If no child abuse team is available, the investigator and Department nurse must maintain an open dialogue throughout with treating medical professionals to ensure sharing of all information.

A workgroup was convened to revise/update Procedures 300. A protocol for conducting investigations when Factitious Disorder by Proxy is suspected is being drafted. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

7. The Department should consider early termination of parental rights for serious Factitious Disorder by Proxy over time. Given the knowledge that there is no known treatment for Factitious Disorder by Proxy and that studies suggest that parents so afflicted will continue abuse, the Department should appeal judicial decisions that require return home after a determination of egregious Factitious Disorder by Proxy over time.

The Department will review each case individually and respond accordingly.

CHILD DEATH REPORT (FY 2004)

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.

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 of DCFS.

In Fiscal Year 2004, the OIG received notification from SCR of 140 child deaths meeting criteria for review. In 23 cases preliminary investigations were conducted. In 91 cases records were reviewed. In 7 cases reports were sent to the Director. Nineteen full investigations were completed. Summaries of death investigations that resulted in major recommendations are included in the Investigations section of the annual report.

Summary

Following is a statistical summary of the 140 child deaths received by the OIG in FY 04 as well as summaries of the individual cases. The first part of the summary presents child deaths by age and manner of death (Table 5), case status and manner of death (Table 6), county and manner of death (Table 7), and substance exposure status and manner of death (Table 8). The second part presents a summary of deaths classified in five manners: homicide, suicide, accident, undetermined, and natural. Manner of death is determined by the Medical Examiner, Coroner, or Coroner's Jury.

Key for Case Status at the time of OIG investigation:

Ward.....	Deceased is a ward
Unfounded DCP.....	Family involved in an unfounded DCP investigation within one year of the death
Pending DCP.....	Family involved in a pending DCP investigation at time of death
Indicated DCP	Family involved in an indicated DCP investigation within one year of the death
Child of Ward.....	Deceased is a ward's child, but not a ward themselves
Open Intact.....	Currently open intact family case
Closed Intact.....	Closed intact family case within one year of the death
Open Placement.....	Death of newborn (and never went home) whose mother has children in foster care
Closed Placement.....	Death of newborn (and never went home) whose mother had children in foster care who have achieved permanency within one year of the death
Split Custody.....	Death of a child who is at home where mother's other children are in foster care (or out of home pursuant to DCFS safety plan)
Others.....	Including Open or Closed Preventive Service, Open or Closed Return Home, Homicide by a Ward, Adopted, Former Ward, Interstate Compact Monitoring, Subsidized Guardianship, Child of Former Ward, Extended Family Support

Table 5: CHILD DEATHS BY AGE AND MANNER OF DEATH

Child Age		Homicide	Suicide	Undetermined	Accident	Natural	TOTAL
MONTHS OF AGE	At birth	3	0	0	2	11	16
	0 to 3	2	0	10	1	22	35
	4 to 6	1	0	0	2	6	9
	7 to 11	4	0	0	3	5	12
	12 to 24	3	0	1	0	6	10
YEAR OF AGE	2	1	0	1	4	4	10
	3	2	0	0	4	2	8
	4	0	0	2	1	2	5
	5	1	0	0	0	0	1
	6	0	0	0	0	1	1
	7	0	0	0	1	1	2
	8	0	0	0	2	3	5
	9	0	0	0	1	0	1
	10	0	0	0	2	1	3
	11	0	0	0	0	1	1
	12	0	1	0	0	1	2
	13	1	0	0	0	1	2
	15	0	1	0	1	0	2
	16	0	0	0	1	2	3
	17	3	0	0	1	1	5
18 or older	4	1	0	1	1	7	
TOTAL		25	3	14	27	71	140

Table 6: CHILD DEATHS BY CASE STATUS AND MANNER OF DEATH

Reason for OIG investigation		Homicide	Suicide	Undtmn	Accident	Natural	TOTAL
Ward		8	2	2	3	16	31
Placement	Open	1	0	0	0	9	10
	Closed	1	0	0	0	1	2
Intact Family	Open	1	1	4	1	8	15
	Closed	4	0	1	5	3	13
Split custody		2	0	1	2	3	8
DCP	Indicated	0	0	0	3	3	6
	Unfounded	2	0	3	8	16	29
	Pending	2	0	2	1	6	11
Others	Adopted	0	0	0	1	0	1
	Former ward	0	0	0	1	0	1
	Child of former ward	1	0	0	1	1	3
	Child of Ward	0	0	0	1	1	2
	Extended family support	1	0	0	0	1	2
	Open Preventive Service	0	0	0	0	3	3
	Closed Preventive Service	0	0	1	0	0	1
TOTAL	Interstate	1	0	0	0	0	1
		25	3	14	27	71	140

Table 7: CHILD DEATHS BY COUNTY AND MANNER OF DEATH

County*	Homicide	Suicide	Undetermined	Accident	Natural	TOTAL
Bond	0	0	1	0	0	1
Champaign	0	1	0	0	1	2
Clinton	0	0	0	1	0	1
Cook	15	0	9	16	38	78
DuPage	0	0	1	0	2	3
Edgar	1	0	0	0	0	1
Fulton	1	0	0	0	0	1
Jefferson	0	0	0	0	1	1
Kane	1	0	0	0	2	3
Kankakee	0	0	0	0	3	3
Kendall	1	0	0	0	0	1
Lake	0	0	0	1	0	1
Lee	0	0	0	0	1	1
Livingston	0	0	0	0	1	1
McHenry	0	0	0	0	2	2
McLean	1	0	0	0	1	2
Macon	0	0	1	1	2	4
Macoupin	1	0	0	0	2	3
Morgan	1	0	0	0	0	1
Ogle	0	0	0	0	2	2
Peoria	0	0	0	0	3	3
Richland	0	0	1	0	0	1
St. Clair	0	0	0	1	1	2
Sangamon	0	0	0	0	2	2
Stephenson	1	0	0	1	0	2
Tazewell	0	0	0	0	1	1
Union	0	0	0	0	1	1
Will	0	1	0	2	0	3
Williamson	0	0	0	1	0	1
Winnebago	1	1	1	0	4	7
TOTAL	24	3	14	24	70	135**

* Counties in Illinois unless otherwise noted.

** Five children died in counties outside Illinois.

Table 8: CHILD DEATHS BY SUBSTANCE EXPOSURE STATUS AND MANNER OF DEATH

Substance exposure	Homicide	Suicide	Undetermined	Accident	Natural	TOTAL
Child exposed at birth	1	0	2	2	19	24
Mother has history of substance abuse	5	1	5	4	33	48

FY 2004 DEATH BREAKDOWN BY MANNER OF DEATH

Homicide

There was a total of 25 deaths classified homicide in manner.

Cause of death	Number
Gunshot wounds	7
Blunt head trauma	9
Multiple injuries due to blunt trauma/assault	3
Abdominal injury due to blunt trauma	1
Drowning after delivery into toilet	2
Stab wound to chest	1
Suffocation	1
Sepsis and massive brain Hemorrhage	1
TOTAL	25

Perpetrator information

Perpetrator	Number of deaths
Mother's Boyfriend	5
Mothers	5
Father	3
Mother and Father (alleged)	1
Stepfather	1
Foster Mother	1
Foster Father	1
Boyfriend of Victim	1
Unrelated Peer	3
Unsolved	4

Perpetrator sex	Perpetrator age range
Male: 16	17 to 34
Female: 8	14 to 42

In 25 death cases, 15 individuals have been criminally charged. One case was ruled as self defense. In one case, the state attorney declined charges. In four cases, charges are expected. Four cases remain unresolved.

Criminal charge status	Number of individuals
Convicted	3
Awaiting trial	12

Suicide

Three deaths were classified as suicide in manner

- A 13-year-old ward hanged himself. The case is in Champaign county
- A 14-year-old hanged herself. The case is in Winnebago county

- A 19-year-old died of asphyxia due to putting a plastic bag over his head. The case is in Will County.

Undetermined

A death is classified as undetermined in manner when there is insufficient information to classify the death as homicide, suicide, 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 four possible manners of death. In nearly all cases involving infants and children the decision rests between homicide and two other possible manners: accident and natural.

There was a total of 14 deaths classified undetermined in manner.

- 12 children also had an undetermined cause of death
- 1 child died of Cerebral Injuries
- 1 child died of Bronchopneumonia due to prematurity with significant issue of maternal drug use

Accident

There was a total of 27 deaths classified accident in manner.

Cause of death	Number
Asphyxia/sleep related deaths	4
Fire related deaths	6
Drowning	4
Motor vehicle related deaths	8
Other causes	5
TOTAL	27

Natural

There were a total of 71 deaths classified natural in manner.

Cause of death	Number
Sudden Infant Death Syndrome (SIDS)	16
Complications from premature birth	13
Complications of multiple medical problems	11
Cardiac disease or complications from heart problems	7
Pneumonia or respiratory complications	7
Progressive illness	6
Complications from gastro-intestinal disease	4
Complications from dehydration	3
Leukemia	2
TOTAL	71

Homicide¹

Case No. 1	DOB 07/03/86	DOD 07/27/03	Homicide
Age at death:	17 years		
Substance exposed:	No		
Cause of death:	Gunshot wound to the head involving skull and brain		
Perpetrator:	Unknown, remains unsolved		
County:	Cook		
<u>Narrative:</u> Seventeen-year-old male was shot in the back of the head at 11:00 pm			
<u>Prior History:</u> In July 2001 three maternal cousins, who are wards of the state of Minnesota, were placed in the home of the deceased's parents. One cousin was removed in February 2002 because of behavior problems while the other two children remain in placement. The home is being monitored by an agency contracted by the Department to oversee interstate compact placements. The OIG conducted a preliminary review of this child's death.			

Case No. 2	DOB 5/19/2001	DOD 8/29/03	Homicide
Age at death:	2 years		
Substance exposed:	No, although mother has a history of drug and alcohol abuse		
Cause of death:	Closed head injury		
Perpetrator:	Stepfather		
County:	Morgan		
<u>Narrative:</u> Twenty-three-year-old mother left her children in the care of her 22-year-old husband. When she returned the mother found the child unresponsive in bed. The husband was arrested and charged with first-degree murder and indicated for death by abuse. The mother was charged with child endangerment and was indicated for death by neglect and substantial risk of physical injury because she allowed her husband to care for the child knowing he had previously abused the child. They are both awaiting trial. The child's siblings, ages 6 years and 1 month, were taken into custody.			
<u>Prior History:</u> In March 2002 the Department opened an intact family case after the husband (then boyfriend) was indicated for cuts/welts/bruises after physically abusing the deceased. The children were informally placed with relatives on a voluntary basis until the boyfriend moved from the home in May 2002. The mother participated in services and the Department closed the case in October 2002. A second investigation began shortly after the case was closed when the mother was seen with her boyfriend. During the course of the investigation she went to her boyfriend's family in Chicago and a referral was made for DCFS services. Before those services began the mother decided to move back to Morgan County away from her boyfriend. A preventive services case was open from February to May 2003 to assist the mother with the relocation. The mother was pregnant but denied that her former boyfriend was the father and denied any contact with him. The mother and boyfriend married in the summer of 2003 but the mother and extended family hid the information from the Department. The mother maintained that her boyfriend had moved to Chicago and she did not have contact with him. After the child's death the siblings were placed in traditional foster care while relative placements were being explored. In January 2004 a judge granted guardianship of the siblings to the maternal grandfather. There has been no further contact with the family. The OIG reviewed records in this case.			

Case No. 3	DOB 12/27/99	DOD 9/11/03	Homicide
Age at death:	3 ½ years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to assault		
Perpetrator:	Mother's boyfriend (alleged)		
County:	Cook (death), Lake County, IN		

Narrative: Twenty-three-year-old mother reported finding her 3-1/2-year-old daughter unresponsive in a fetal position on the bathroom floor. She contacted 911 and the minor was transported to the hospital and then taken by helicopter to a Chicago hospital. Abdominal surgery was performed and it was revealed that the minor suffered massive abdominal trauma. The Indiana Child Protective Services was notified about the child's death, as this is where the injuries occurred, and they were going to conduct an investigation. No one has been charged though the boyfriend is considered the prime suspect.

Prior History: In March 2003 a hospital physician contacted the hotline when the 3-year-old child was brought into the ER with bruises all over her right upper buttocks and bruises on her scalp. Her 23-year-old mother had no explanation for the injuries, and denied that her 17-year-old live-in boyfriend was allowed to discipline the child. Mother was indicated based on her admission of smacking the child a few times and hitting her with a belt as discipline. It was never determined who or what caused these injuries to the minor. In June 2003, the case was referred to the Extended Family Support Program to assist maternal grandmother in obtaining guardianship of her granddaughter. This plan was appropriate because at the time of the referral, mother had moved out of state with her 17-year-old boyfriend and allowed the minor to remain with maternal grandmother, whom she had been with since birth. In July 2003, mother removed the minor and took her out of state to live with her and her boyfriend. The OIG conducted a records review in this case.

Case No. 4	DOB 10/16/01	DOD 9/30/03	Homicide
Age at death:	Two years		
Substance exposed:	No		
Cause of death:	Subdural hematoma due to blunt head trauma		
Perpetrator:	Foster Mother		
County:	Cook		
<u>Narrative:</u> Two-year-old ward reportedly found by 41-year-old foster mother unresponsive and having a seizure. The child suffered a subdural hematoma, retinal hemorrhaging, and cerebral edema and was pronounced dead the next day. At the time of the death, there was a pending investigation on the foster mother for allegations of burns and cuts, welts, bruises to the child. The foster mother was charged with the child's murder and remains in jail awaiting trial. The child's 6-year-old sibling and a 4-year-old unrelated foster child were removed from the foster home.			
<u>Prior History:</u> The biological mother of the deceased minor became a ward of the state in February 1999, prior to the death of the child. Her mother locked her and her other child out of the home. The mother received independent living services from a private agency. In February 2003 the hotline received a call regarding the safety of the child and her sibling. The mother reported that she could no longer care for her children and might hurt them. The mother was indicated for substantial risk of physical injury and her 2 children were placed in a traditional foster home. The sibling remains in foster care with a goal of return home. The OIG conducted a full investigation. A report was sent to the director on December 1, 2004.			

Case No. 5	DOB 10/1/03	DOD 10/1/03	Homicide
Age at death:	0 days		
Substance exposed:	No		
Cause of death:	Drowning after being delivered head first in toilet		
Perpetrator:	Mother		
County:	Cook		

Narrative: The baby was born to a 14-year-old mother at a Public High School who delivered the baby into the toilet. Thinking the baby was dead the mother placed the body into the trash. The mother had not revealed her pregnancy or the birth to anyone. The mother and her 15-year-old sister were staying with a relative after their adoptive mother had abandoned them. Later that night she told the relative about the birth and she was taken to the hospital. School maintenance workers found the body. The State's Attorney declined to prosecute.

Prior History: The mother and her siblings became known to DCFS in September 1989. They were removed from the parents because of neglect. They returned home, but were permanently removed in August 1991 on an allegation of neglect. The mother was in 11 foster homes between August 1991 until December 2000, when she was placed with a relative who subsequently adopted the mother and her sister in December 2002. After the death the children were brought back into the system and placed with relatives in a different county. The OIG conducted an investigation and a report is pending.

Case No. 6	DOB 2/20/86	DOD 10/10/03	Homicide
Age at death:	17 ½ years		
Substance exposed:	Unknown, mother has a history of substance abuse		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unsolved, thought to be a gang related shooting		
County:	Cook		
<u>Narrative:</u> Seventeen-year-old ward was walking in his Chicago neighborhood when an assailant approached and asked, "what are you about?" When the ward ran, the assailant chased and shot him twice in the back. He died the next day in the hospital.			
<u>Prior History:</u> The ward was the fourth of eight siblings. His family had a long history of involvement with DCFS. His mother was the subject of at least 17 investigations of abuse and neglect arising from her drug use. Since the age of 4, the ward was moved approximately 24 times among foster care, group home, and residential placements. Less than once month before his death the ward had been released from the Cook County Department of Corrections boot camp. He was returned to a foster home in the neighborhood where he was known to be involved in gang activity. The OIG submitted a report of this child's death to the Director on June 1, 2004.			

Case No. 7	DOB 8/19/02	DOD 10/18/03	Homicide
Age at death:	14 months		
Substance exposed:	No		
Cause of death:	Multiple injuries due to blunt trauma		
Perpetrator:	Mother's boyfriend		
County:	Cook		
<u>Narrative:</u> Fourteen-month-old child was severely beaten and burned by his mother's 30-year-old boyfriend while the 23-year-old mother was at work. The child died in the hospital two days later. The boyfriend is currently being held in Cook County Jail awaiting trial for murder. The boyfriend was indicated for death, head injuries, burns, and bone fractures to the deceased. The mother was indicated for substantial risk of physical injury to her surviving child now age 6 was placed in foster care following the brother's death.			
<u>Prior History:</u> The deceased was the third child of two sisters to die in a 4 ½ year time span. The Department first became involved with this family in May 1999 when the deceased's 22-month-old cousin died from opiate intoxication. The mother of the child was indicated for death by neglect and environmental neglect of her four surviving children, all of whom were placed in foster care following their sibling's death. In November 2001, the deceased's 11-month-old sibling died from an overdose of cough syrup. The mother was indicated for death by neglect. Her 3-year-old child was allowed to stay in her care and an intact family case was opened. The mother completed services and the case was closed in April 2003. The OIG is conducting a full investigation of this case. A report to the Director is expected.			

Case No. 8	DOB 10/20/03	DOD 10/21/03	Homicide
Age at death:	1 day		
Substance exposed:	No		
Cause of death:	Escherichia coli sepsis and massive brain hemorrhage		
Perpetrator:	Biological father		
County:	Edgar (case) Indianapolis, IN (death)		
<p><u>Narrative:</u> Twenty-three-year-old mother gave birth to an infant at 28 weeks gestation. The infant died the following day. Later, the mother confessed to her parents that while pregnant her twenty-six-year-old husband had inserted bailing wire into her vagina so they would have a retarded child and collect social security money. He had also tried this unsuccessfully with their two older children. Seven months after the child's death, police and DCFS investigated. The father was convicted of involuntary manslaughter of a family member and was sentenced to 14 years. The mother was not charged. Both parents were indicated for death by abuse and substantial risk of physical injury to three surviving children (the oldest has a different father). The children are in the private guardianship of their maternal grandparents and DCFS has a case open on the family.</p>			
<p><u>Prior History:</u> There were two prior investigations involving this family. The first, in October 2002, was for medical neglect of her 4-month-old for failing to treat what was thought to be an infection on his chin. The mother took the child to the doctor and was given hydrocortisone cream for chapped skin. The investigation was unfounded, but an intact family case was opened to help mother with her parenting skills. In January 2003 the mother was indicated for inadequate supervision of her three children after leaving the children, ages 8 months and 1 and 3 years, alone in a cold car for 45 minutes to an hour while she visited her ex-boyfriend. The Department stepped up services and a case remained open on the mother until May 2003. The OIG reviewed records in this case.</p>			

Case No. 9	DOB 9/15/00	DOD 10/25/03	Homicide
Age at death:	3 years		
Substance exposed:	No		
Cause of death:	Abdominal Hemorrhage due to blunt force trauma due to assault		
Perpetrator:	Foster father		
County:	Peoria		
<p><u>Narrative:</u> Police were called to the 3-year-old child's foster home. When they arrived, they found the child unresponsive on the kitchen floor. The child was taken to the hospital where bleeding to the brain, internal bleeding, and numerous bruises to her ribcage were found. The injuries, according to the physician, were from abuse and varied in age. The child died the following day. The foster father claimed he was going outside to smoke a cigarette when he heard the child's shallow breathing and went back into the home and called police. The child and her 7 and 9-year-old brothers were in the relative foster home of their 29-year-old maternal aunt, her 29-year-old boyfriend (the foster father) and the couple's 4-year-old child. The foster father confessed to police that he caused the injuries that led to the child's death. He told police that he dropped on his knees onto the child's abdominal area. He was convicted of involuntary manslaughter and sentenced to eight years. DCFS indicated the foster father for death by abuse, internal injuries, cuts/bruises/welts, and substantial risk of physical injury. The maternal aunt was indicated for substantial risk of physical injury.</p>			
<p><u>Prior History:</u> The children entered foster care and were placed with their aunt and her boyfriend in September 2003, however, the children had been staying in the home since June 2003. The parents have a history with DCFS dating to 1998. The parents are substance abusers who were unable to successfully complete treatment. The siblings of the deceased are still in foster care, in a non-relative placement. The maternal aunt has custody of her child. The OIG reviewed records in this case.</p>			

Case No. 10	DOB 2/20/90	DOD 10/26/03	Homicide
Age at death:	13 years		
Substance exposed:	No		
Cause of death:	Gunshot wound to head		
Perpetrator:	Unrelated peer		
County:	Winnebago		
<u>Narrative:</u> Thirteen-year-old ward was out at 8:30 p.m. walking in his neighborhood with friends when a car drove by and fired gunshots at the group. The ward was shot in the head. He died the following day in the hospital after being removed from life support. Family members were present and donated his organs. Two men have been charged with murder.			
<u>Prior History:</u> DCFS has been involved with this family since 1996 when the mother was indicated for neglect of her children. The children entered foster care in 1999. The surviving siblings are not placed together. The 16-year-old has a goal of guardianship, the 10-year-old has a goal of adoption, and the 8-year-old has been adopted. The OIG conducted a preliminary review of this ward's death.			

Case No. 11	DOB 8/10/03	DOD 11/1/03	Homicide
Age at death:	2 ½ months		
Substance exposed:	No		
Cause of death:	Blunt trauma due to child abuse		
Perpetrator:	Mother's boyfriend		
County:	Cook		
<u>Narrative:</u> Two-and-a-half-month-old infant was living with her 19-year-old mother and the mother's 20-year-old boyfriend. The mother left the baby in the care of her boyfriend while she went to the store. The boyfriend confessed to police that the baby was crying and he shook her. He has been charged with murder and is awaiting trial.			
<u>Prior History:</u> The mother was a ward from January 1994 until April 2003. From 1994 to 1998 she was placed in foster homes. In 1998 behavior problems necessitated residential placement, including some time in juvenile detention centers. In October 2002 the mother entered an independent living program. In December 2002 the mother told her caseworker that she was pregnant and her case was transferred to the teen parent service network. The teen lived in a self-selected placement although workers attempted to find more appropriate placements for the mother to consider. In April 2003 the mother informed her caseworker that she had gotten married. The teenager was emancipated because of the marriage. The boyfriend who killed the baby was not the mother's husband. The mother had no other children. The OIG reviewed records in this case.			

Case No. 12	DOB 2/19/98	DOD 11/7/03	Homicide
Age at death:	5 ½ years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to blunt trauma due to child abuse		
Perpetrator:	Mother's boyfriend		
County:	Cook		
<u>Narrative:</u> Twenty-four-year-old mother reported finding her 5-1/2-year-old son unresponsive during a nap. She contacted 911 and the boy was transported to the hospital where bruises were found. At autopsy the child was discovered to have been beaten. The mother and her boyfriend were indicated for death by abuse, internal injuries, cuts/ bruises/welts, and substantial risk of physical injury. The mother was found not guilty in the child's murder, but was convicted of child endangerment. The boyfriend is awaiting trial for murder. Two surviving siblings, one born after the 5-year-old died, are together in foster care with a relative.			

Prior History: At the time of his death, there was a pending DCP investigation for substantial risk of physical injury to the deceased by his mother. The report was made 24 days earlier after the mother psychiatrically hospitalized her son for behavioral issues and then took him out of the hospital against medical advice. The OIG is conducting a full investigation of this child's death. A report to the Director is expected.

Case No. 13	DOB 07/16/83	DOD 11/25/03	Homicide
Age at death:	20 years		
Substance exposed:	No		
Cause of death:	Exsanguination due to perforating gunshot wound to chest		
Perpetrator:	Unrelated Peer		
County:	Milwaukee, WI (death) Cook (case Management)		
<u>Narrative:</u> Twenty-year-old ward was shot in the chest by an unknown assailant when he answered a knock at his mother's door. The ward was on run from a self-selected, independent living placement following his release from Cook County Boot Camp. A missing person's report had been filed. After his death, his mother reported that she had picked him up in Illinois two days earlier to live with her so he could straighten out his life. She believed the boyfriend of a girl he befriended was responsible for the shooting. A seventeen-year-old and twenty-year-old man has been charged with the murder and is awaiting trial.			
<u>Prior History:</u> The ward and his siblings were taken into DCFS custody on three separate occasions for allegations of neglect. In October 1998 they were removed from their mother for the final time and placed in foster care after a hotline report that the mother left her children for two days and failed to return. The OIG conducted a preliminary review of this ward's death.			

Case No. 14	DOB 3/31/87	DOD 12/5/03	Homicide
Age at death:	16 years		
Substance exposed:	No, although the mother has a history of substance abuse		
Cause of death:	Stab wound to the chest		
Perpetrator:	Unrelated peer		
County:	Cook		
<u>Narrative:</u> Sixteen-year-old ward was at a house party when the resident of the home came home and ordered everyone to leave. The resident's boyfriend had organized the party without her permission. The ward went into the bathroom, came back out with a knife, and stabbed the resident in the arm and continued swinging at her. The resident grabbed another knife and stabbed the ward in the chest. The resident was not charged as the act was considered self-defense.			
<u>Prior History:</u> The deceased had been a ward of the state since February 1994, when she was 6 years old. The mother had a second substance-exposed infant and all the children came into care for substantial risk of physical injury. The deceased was initially placed in the home of a relative and was sexually abused. She was then placed with a different relative. In 1996 she was moved to a traditional foster home for behavioral issues. The ward started running away in 2000 and was placed in various homes between runs. She was also involved in delinquent behavior. At the time of her death the ward had been on run for several months. The ward has 5 siblings, 2 of whom are with their father and 3 of whom have been adopted. Problems with running behavior in wards have been addressed in previous OIG reports. The OIG reviewed records in this case.			

Case No. 15	DOB: 5-10-87	DOD: 1-5-04	Homicide
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		

Perpetrator:	Unknown, remains unsolved
County:	Cook
<u>Narrative:</u> Sixteen-year-old and two other youths were chased by another male teen who shot the minor three times. When the police arrived the victim was in and out of consciousness. The child was transported to the hospital and pronounced dead on arrival.	
<u>Prior History:</u> The family came to the attention of the Department in March 2000 when the 30-year-old mother was indicated for cuts/bruises/welts to the deceased's 10-year-old sibling. The sibling entered foster care where he remains. He is currently placed in a psychiatric facility. The deceased child had no involvement with DCFS. The OIG conducted a preliminary review in this case.	

Case No. 16	DOB 4/22/03	DOD 1/8/04	Homicide
Age at death:	8 ½ months		
Substance exposed:	No		
Cause of death:	Neurogenic shock due to a closed head injury		
Perpetrator:	Mother's boyfriend		
County:	Stephenson		
<u>Narrative:</u> Eight-and-a-half-month-old infant died after being shaken by her mother's 21-year-old boyfriend who was babysitting. The boyfriend was indicated for the child's death. The 21-year-old mother was indicated for head injuries by neglect and substantial risk of physical injury because she left her children in the care of her boyfriend despite an agreement with DCFS not to do so. Her 19-month-old daughter was removed from her custody and is in foster care with a relative. The boyfriend was convicted of involuntary manslaughter and sentenced to eleven years.			
<u>Prior History:</u> At the time of the child's death there was a DCP investigation pending for burns and cuts/bruises/welts. The boyfriend said a burn on the child's face occurred when she fell into a hot pan while he was cooking and that a bruise on the child's cheek occurred when the sibling hit her with a toy. The mother had agreed to not allow the boyfriend to babysit while the investigation was pending. A report was sent to the Director on June 2, 2004.			

Case No. 17	DOB 12/02/02	DOD 1/30/04	Homicide
Age at death:	13 months		
Substance exposed:	No		
Cause of death:	Cerebral injuries due to blunt head trauma		
Perpetrator:	Mother		
County:	Cook		
<u>Narrative:</u> Thirteen-month-old child was found in her crib unresponsive and having vomited by her mother's 40-year-old boyfriend. The child was taken by ambulance to the hospital. The child was diagnosed with a subdural hematoma and had multiple new and old rib fractures. She died the following day. A 7-year-old sibling was taken into foster care and placed with a relative. The 26-year-old mother, who was pregnant with her fifth child, was indicated for the infant's death, head injuries, and bone fractures. She was charged with first degree murder and is awaiting trial.			

Prior History: In February 2000 the mother took her 18-month-old child to the emergency room for leg pain. The child had a distal fracture of the right fibula. The mother, who was pregnant with her third child, admitted to twisting the child's leg and was indicated for bone fractures. She was also arrested and convicted of battery. The child was placed in foster care. The child's older sibling, then 3 years old, lived with her father. In August 2000, while incarcerated, the mother gave birth and was indicated for substantial risk of physical injury to the newborn. The newborn was placed in foster care. The mother participated minimally in services. In August 2002 she and the fathers signed specific consents for the two children in foster care to be adopted by their foster parents. One child was adopted in September 2002 and the other was adopted in January 2003. The agency assigned to the family closed the case in January 2003. The supervisor who approved case closure did not know the mother was pregnant or that her oldest child, 7 years old, was living with her. The caseworker is no longer with the agency. The OIG is conducting a full investigation in this case.

Case No. 18	DOB 6/28/03	DOD 3/3/04	Homicide
Age at death:	8 months		
Substance exposed:	No		
Cause of death:	Subdural hematoma and cerebral injuries due to blunt force trauma		
Perpetrator:	Biological father		
County:	Kane		
Narrative: Eight-month-old baby was shaken by his 23-year-old father. The baby was being cared for by his father in the family's basement apartment. The baby's 19-year-old mother was in the upstairs apartment washing bottles. When she returned she found the baby unresponsive. The baby was hospitalized and died two days later. The father was charged with murder and is awaiting trial. He was indicated for abuse allegations of death, head injuries, internal injuries, bone fractures, and cuts/bruises/welts, and burns by neglect. He was also indicated for substantial risk of physical injury to the baby's 18-month-old brother. The mother was indicated for cuts/bruises/welts by abuse and burns by neglect to the baby and substantial risk of physical injury to the sibling. The sibling entered foster care and is placed with a relative. The mother has supervised visits.			
Prior History: Two months prior to the baby's death, the father was investigated for cuts/bruises/welts to the baby. An anonymous reporter stated she had seen several bruises on the baby's cheeks, palms of his hands, legs and buttocks. The reporter also indicated that the mother stated the injuries were caused by the father biting the baby and that the baby had a bruise on his cheek at that time. The DCP investigator observed a mark on the baby's cheek that the mother described as heat rash. The mother stated that the rash was being treated with ointment prescribed by the baby's pediatrician. The DCP investigator did not interview the pediatrician. The report was unfounded three days before the baby's death. The OIG conducted a full investigation of this child's death. A report was submitted to the Director on October 28, 2004.			

Case No. 19	DOB 10/16/02	DOD 3/15/04	Homicide
Age at death:	17 months		
Substance exposed:	No		
Cause of death:	Anoxic encephalopathy due to subdural hematoma due to blunt head trauma		
Perpetrator:	Biological father (alleged)		
County:	Cook		
Narrative: Seventeen-month-old ward died from injuries inflicted fifteen months earlier when at the age of 2 months he was allegedly shaken by his 24-year-old father. He was indicated for the child's death, as was the 32-year-old mother although she was not home when the child suffered the injuries that led to his death.			

Prior History: On an afternoon in December 2002 the father contacted 911 because his 2-month-old son was having trouble breathing. The infant was rushed to the hospital where it was discovered that he had head and eye injuries consistent with shaken baby syndrome. The father was the caretaker for the infant while the mother was at work. The father admitted the baby was a little irritable and he shook him, but not enough to cause the damage the infant suffered. He was charged with aggravated child abuse. The mother could not believe the father injured the child. Family members described the father as affectionate and good with the infant. Both the father and mother were indicated for head injuries by abuse. The infant lived, but remained in a vegetative state. He entered foster care and lived in a nursing care facility until his death. His mother was a frequent visitor. The OIG reviewed records in this case.

Case No. 20	DOB 6/19/87	DOD 4/14/04	Homicide
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Gunshot wound of the head		
Perpetrator:	Boyfriend		
County:	Cook		
Narrative: Sixteen-year-old was killed by her boyfriend when he accidentally shot her in the head as he played with a loaded gun. The boyfriend has been charged and is awaiting trial. The incident occurred in his home.			
Prior History: Aunt of the deceased obtained guardianship of her nieces and nephews in May 1996. Their mother died in June 1996. At the time of this girl's death, there was a pending DCP investigation involving her mother and her 16-year-old cousin. The hotline was called with an allegation of medical neglect. Investigation revealed that the 16-year-old cousin was mentally ill with three psychiatric hospitalizations in the last year. Following each hospitalization, doctors ordered outpatient therapy and medication management. The aunt did not follow through with recommendations. The report was indicated and the cousin was taken into custody. Her siblings remain with their aunt.			

Case No. 21	DOB 12/12/03	DOD 4/20/04	Homicide
Age at death:	4 months		
Substance exposed:	Yes, cocaine, marijuana		
Cause of death:	Closed head injuries due to blunt force trauma		
Perpetrator:	Parents (alleged)		
County:	Kane		
Narrative: Four-month-old infant was transported by ambulance to the hospital where he was pronounced dead. His 23-year-old mother and 25-year-old father called 911 after allegedly finding the infant unresponsive in his crib face down. Hospital personnel observed bruising to the infant's forehead, back of his head, and his right temple and a CAT scan revealed a subdural hematoma. The hotline was contacted and a DCP investigation of the infant's death, head injuries, and cuts, welts and bruises from abuse is pending. Police also investigated. To date, no one has been charged with this infant's death.			
Prior History: DCFS became involved with this family when the infant was born substance-exposed. The mother was indicated for substance misuse, and an intact family case was opened. The mother engaged in substance abuse treatment, but continued to use cocaine. The mother had bipolar disorder and took medication for it. She lived on and off with the infant's father who also used drugs. They had a history of domestic violence. The mother was released from 48 days of inpatient substance abuse treatment a week before the infant's death. In a telephone conversation the morning of the infant's death, the mother told her caseworker that the father was no longer living with her and wanted nothing to do with her and the infant. The OIG is conducting a full investigation of this child's death.			

Case No. 22	DOB 10/13/85	DOD 4/24/04	Homicide
Age at death:	18 years		
Substance exposed:	No		
Cause of death:	Gun shot wound		
Perpetrator:	Unsolved		
County:	Cook		
<u>Narrative:</u> Eighteen-year-old ward was shot and killed while attempting to rob a home in his grandmother's apartment complex.			
<u>Prior History:</u> The deceased had been a ward of DCFS since September 2001 when his grandmother, who had cared for him since he was three years old, contacted the Department stating she could no longer care for him because of his behavior problems. The ward was placed in group homes until he was incarcerated in Cook County Jail in October 2003 on a charge of armed robbery. In March 2004, the ward was released to a self-selected authorized placement. He was due back in court in June 2004 for assignment to boot camp and a six-month probationary home monitoring program. The OIG conducted a preliminary review of this ward's death.			

Case No. 23	DOB 4/28/04	DOD 4/28/04	Homicide
Age at death:	0		
Substance exposed:	Unknown		
Cause of death:	Postpartum Neglect with positional asphyxia due to vaginal delivery into toilet		
Perpetrator:	Mother		
County:	Madison		
<u>Narrative:</u> Twenty-six-year-old developmentally delayed mother gave birth to a baby in the toilet. The baby was born alive. The mother reportedly saw the baby kick her legs, but left her in the toilet. Paramedics found the baby with her head face up at the bottom of the bowl amid human waste. The mother has been charged with first-degree murder. She was found not fit to stand trial and is being held in a psychiatric facility.			
<u>Prior History:</u> The mother has two living children. An 8-year-old child has been in foster care since 1998 when his mother was indicated for cuts/bruises/welts to him. A second child born in 1999 remained at home with his mother. After the death of the newborn he was placed in foster care. The OIG is conducting a full investigation of this case.			

Case No. 24	DOB 10/11/03	DOD 5/2/04	Homicide
Age at death:	6 months		
Substance exposed:	No		
Cause of death:	Closed head injuries due to blunt force trauma due to an assault		
Perpetrator:	Mother (indicated)		
County:	Peoria		
<u>Narrative:</u> Six-month-old died from severe head injuries caused by abuse. The twenty-eight-year-old mother was indicated for the child's death as she was the likely caregiver present when the injuries occurred, her stories as to how the injuries occurred changed and were inconsistent with the extent of the injuries, she attempted to blame the injuries on her four-year-old daughter, and she admitted her children were "driving her crazy" that day. The deceased's siblings, ages 2, 5, and 7, were removed from their mother's care. The 2 and 5-year-old girls are placed together, while the 7-year-old boy is in another foster home. The mother has not been charged.			

Prior History: Prior to the infant's birth, there was an investigation for inadequate supervision. In June 2003, the police and DCFS were called about the mother's children being on the roof of their apartment building. Investigation revealed that a 6-year-old and his 10-year-old neighbor had climbed out a window onto the roof for five to ten minutes without the knowledge of the adults in the home. The OIG reviewed records in this case.

Case No. 25	DOB 3/7/04	DOD 5/8/04	Homicide
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Suffocation		
Perpetrator:	Mother		
County:	Cook		
Narrative: Twenty-five-year-old mother told police she put her 2-month-old infant in a drawer with a pillow on top of her and closed the drawer to try to stop the baby's crying. The mother went to sleep and later found the infant unresponsive. The mother has been charged with first-degree murder and is in jail awaiting trial. DCFS indicated the mother for death by neglect and substantial risk of physical injury to the siblings.			
Prior History: In July 2002 the mother was indicated for cuts/welts/bruises when she hit her 2-year-old in the face leaving a black eye. The mother called the police to report the incident. She expressed remorse, stating she was five months pregnant, she had just lost her job, and she was frustrated with the child. The child was informally placed with her grandmother and an intact family case was opened. The mother was ordered by the criminal court to attend parenting classes. The intact family case was closed in September 2003. A second investigation was conducted in February 2004 after an adoption agency contacted the hotline stating that the mother (who was pregnant with her third child, the deceased) described neglect and spoke negatively about her children during an appointment the mother had set up to discuss giving her baby up for adoption. The mother denied the allegations saying that she often put her 1-year-old child in a playpen because she was close to delivery and could not carry him around. The children were observed to be doing well. The reporter noted that she had not seen the children and the investigation was unfounded. The OIG is conducting a full investigation of this case.			

Suicide

Case No. 26	DOB 10/29/90	DOD 8/15/03	Suicide
Age at death:	12-1/2 years		
Substance exposed:	Unknown		
Cause of death:	Anoxic encephalopathy due to hanging		
County:	Champaign		
Narrative: During his second admission to an in-patient psychiatric unit, the 12-year-old in temporary custody of the Department attempted suicide, hanging himself with a bed sheet. He died four days later from complications stemming from asphyxiation. During his first admission less than a month earlier, the boy had made a suicide attempt. On the day of his fatal suicide attempt, the boy was informed that his foster mother was not taking him back into her home. The boy had been angry with his biological mother because he felt she chose her boyfriend over him and his brother. Although the child had voiced feelings of hopelessness and despair he was not closely monitored for suicide risk.			
Prior History: The family has a history with DCFS dating to 1993. The deceased and his two siblings were in foster care from May 1994 to September 1995. He and his younger sibling reentered foster care in June 2004 (the older sibling reached majority) because of domestic violence and drug and alcohol problems. The OIG is conducting a full investigation of this child's death.			

Case No. 27	DOB 5/19/85	DOD 2/17/04	Suicide
Age at death:	18-1/2		
Substance exposed:	Unknown		
Cause of death:	Asphyxia due to plastic bag over his head		
County:	Will (death) Cook (case management)		
<u>Narrative:</u> A corrections officer found the eighteen-year-old ward hanging by a sheet from a light fixture in his cell. His feet were tied with torn bed sheets and his hands were tied with a torn sheet behind his back in a slipknot. He was alone in his cell when the incident occurred. Earlier that morning, the ward had eaten breakfast with his cellmate who was transferring to another institution that day. After the ward's death, the cellmate was interviewed. He said he knew the ward because they were from the same neighborhood. He did not know the ward planned to commit suicide, but he remembered the ward looking up at the light fixture and saying it was going to be the fourth summer in a row that he was in jail. The ward was in his bunk when the cellmate said goodbye. The internal investigations division of the Illinois Department of Corrections investigated the ward's death and there was a coroner's inquest to determine manner.			
<u>Prior History:</u> The ward entered foster care in September 1993 when the police found the 8-year-old child wandering the streets without supervision with bruises. The 30-year-old mother, who admitted to hitting the child, was arrested for battery. During the ten years the ward was in custody he experienced numerous placements, including foster homes, group homes, and private institutions. He was frequently on run. His mother was not involved, and she was in and out of jail. In April 2001 the ward was arrested and charged as an adult with armed robbery. He was detained in the Cook County Juvenile Temporary Detention Center until his 17 th birthday when he was transferred to Cook County Jail. The ward pleaded guilty and served time in the Illinois Department of Corrections. The ward was out of prison for only two months when he was arrested and detained in December 2003 for aggravated possession of a stolen vehicle. He was detained in Cook County Jail and was transferred to the Illinois Department of Corrections eight days before his death. The ward did not have a history of mental health problems. His caseworker last saw him in Cook County Jail in December. The Department was not notified of the ward's death. In March 2004 the caseworker contacted the Illinois Department of Corrections trying to locate the ward. At that time she was told of his death a month earlier. The OIG reviewed records in this case.			

Case No. 28	DOB 1/6/90	DOD 3/10/04	Suicide
Age at death:	14 years		
Substance exposed:	No		
Cause of death:	Asphyxiation due to hanging		
County:	Winnebago		
<u>Narrative:</u> Fourteen-year-old child was found by her fifty-year-old mother hanging in the basement of their home. The child left a suicide note stating that she loved her mother and the family dog and would see them in heaven. The note blamed students at school for her suicide. The child had a history of major depression and suicidal ideation and had been previously psychiatrically hospitalized.			

Prior History: This family has a history with DCFS dating to 1999 when the mother was indicated for inadequate supervision because she was too intoxicated to care for her daughter. Between March 2002 and November 2003 there were five reports as a result of mother's substance abuse. The child also experienced mental health issues during this time. An intact family case was opened in November 2003. In early October 2003, the local mental health center seeing the child recommended psychiatric hospitalization, however, both mother and child refused. A SASS (Screening Assessment and Support Services) worker was assigned to the girl in October 2003. In late October 2003, the child was hospitalized for major depression until November 2003 when she was discharged at mother's request. In late November 2003 the child was assessed again because she told her school counselor that she was having ideas of killing herself. The mental health center recommended psychiatric hospitalization, but her mother refused to consent. The mother died in April 2004 from a massive gastrointestinal bleed. The OIG is conducting a full investigation of this child's death.

Undetermined

Case No. 29	DOB 5/2/01	DOD 7/4/03	Undetermined
Age at death:	26 months		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Macon		
Narrative: Twenty-six-month old child's family's house was destroyed in a fire. The child's 29-year-old father, 55-year-old paternal grandmother and 8-month-old sister were home at the time of the fire. The child's 21-year-old mother was not present. At autopsy it was discovered that the child died before the fire and not as a result of the fire. The grandmother admitted to the police that, in the early morning, she and the child fell asleep with a thick comforter over them both. When she awoke, she noticed that the comforter and her right breast were covering the child's face and he was not breathing. The grandmother admitted to purposely setting the fire because she knew her grandson had died, his death was her fault, and she wanted to "get the problem away from her." Once the fire started she attempted to get herself and the child out of the house, but fell onto the floor. The child's father got everyone out of the home. The grandmother was arrested and charged with aggravated arson. DCFS indicated the grandmother for death and substantial risk of physical injury. An intact family case was opened to assist the mother and father. It was closed at the end of January 2004.			
Prior History: This family came to the attention of DCFS in March 2003. An anonymous reporter contacted the hotline stating that the deceased was observed running around the house naked and going potty on the floor, and the parents did nothing about it. The reporter said there was human feces and urine on the floor and the parents made no effort to clean it up. A report was taken for investigation of environmental neglect. A DCP investigator visited the home and did not see or smell feces or urine anywhere in the home. She found the report to be a false one as the children and home were neat and clean and, the children appeared to be very well fed and loved. The OIG reviewed records in this case.			

Case No. 30	DOB 8/3/2003	DOD 9/28/2003	Undetermined
Age at death:	6 weeks		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Cook		
Narrative: Twenty-eight year old mother woke up in the early morning to find her 6- week-old infant on her chest not breathing. The baby was taken to the hospital where she was pronounced dead.			

Prior History: The infant lived with her mother and two siblings ages 3 and 9 years. Two days prior to the death the hotline initiated an investigation for environmental neglect and substantial risk of physical injury after it was reported that the family home was infested with roaches, there was garbage on the floors and the mother was drunk and not watching the children. The following day a DCP investigator made an unannounced visit to the home. The home and the 3 children were noted to be clean and appropriate and no roaches were seen. The mother admitted that she sometimes has a roach in the apartment and she occasionally drinks beer, but denied infestation or intoxication. The mother told the investigator that the father and paternal relatives had threatened to call the Department if she did not give them the 3 year dd. The 3-year-old child's paternal grandmother told the investigator that they had raised the child for two years, with the mother visiting weekends before the mother took her back. The investigator advised the relatives that the father could go to court to gain joint custody. The investigator instructed the mother to contact the landlord regarding the roaches and the mother agreed to a drug and alcohol assessment. The community agency administering the assessment was informed of the death of the infant and the investigator asked that they assess the mother's need for grief counseling. The report was unfounded. There has been no further contact with the Department. The OIG reviewed records in this case.

Case No. 31	DOB 10/29/02	DOD 11/11/03	Undetermined
Age at death:	12 months		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Cook		

Narrative: Twelve-month-old child was found unresponsive by her 17-year-old father. The 16-year-old mother dropped the child off at her father's house while the mother went to the beauty shop. The father reported that he had put the child down for a nap. When the child fell asleep, he put her on her stomach and swaddled her with a blanket under her body, as he reported that she slept better in that position. The father left the room and when he returned later he observed vomit coming out of the child's nose and mouth and, there were stains on the sheet. Paramedics were called and the child was transported to the hospital where she was pronounced dead. At autopsy the child was discovered to have adult-sized bite marks on her cheek and arm. A DCP investigation of the child's death was unfounded.

Prior History: In March 2003, the hotline was contacted when the child, then four months old, was brought to the hospital by her mother and grandmother with a swollen left leg. The leg was x-rayed, and it was discovered the child had a fractured femur. A skeletal survey did not reveal any other injuries. The hotline report was unfounded in May 2003. Paternal family members reported that another child, 2 to 3 years old, may have caused the injury by falling over the car seat where the baby was sitting (which would have pinned the baby's thigh between the child and the car seat frame). The mother had sought medical attention immediately after the child was returned to her from the father, and she noticed the infant's leg was swollen. She thought the child might be having a reaction to recent immunizations. Prior to being seen at the hospital where the fracture was identified, other doctors saw the child but did not take x-rays, and the fracture went undetected. Medical experts consulted found the child's injury to be consistent with the family's explanation for it. The OIG reviewed records in this case.

Case No. 32	DOB 10/19/03	DOD 11/13/03	Undetermined
Age at death:	25 days		
Substance exposed:	Yes, positive for cocaine and opiates		
Cause of death:	Bronchopneumonia, prematurity due to maternal drug use		
County:	Cook		

Narrative: Three week old baby was sleeping in bed between his 8-year-old sibling and 36-year-old mother who awoke to find the infant cold and unresponsive. The mother was indicated for death by neglect on the baby and substantial risk of physical injury on the 8-year-old child.

Prior History: The Department had one prior contact with the mother before the substance exposed birth of the deceased child prompted the second investigation. In November 1997 the mother was indicated for sexual exploitation on her then 11 year old and substantial risk of sexual injury on her then 15-year-old and 1-year-old children. The mother explained that she was taking explicit photos of herself to send to her husband in prison and the 11-year-old came into the room and could be seen in one of the pictures. The prison contacted the Department when the photos arrived. In October 2003 the mother gave birth at 36 weeks gestation to the deceased minor. The mother entered methadone treatment and an intact family case was opened. The mother was residing with her adult daughter who allowed the mother to remain in the residence if she participated in substance abuse treatment. Following the death the Department opened an extended family service case to assist the adult daughter in getting guardianship of her minor sister. The mother has no children in her care. The OIG reviewed records in this case.

Case No. 33	DOB 6/26/99	DOD 11/18/03	Undetermined
Age at death:	4 years old		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Bond		
<p>Narrative: An ambulance was requested for a 4-year-old boy who reportedly had a seizure and fell and hit his head. The paramedics reported that the 4-year-old was in cardiac arrest when they arrived at the home. The child was transported to the hospital where he was pronounced dead. The 27-year-old mentally ill mother and a DCFS-provided homemaker were present at the time of the incident. The mother and homemaker both reportedly observed the child initially staring off, then his body stiffened and relaxed, and he fell asleep. The mother allegedly took him to a bedroom and laid him on the bed. When the mother and homemaker returned to check on him, he was unresponsive and had vomit around his mouth. The homemaker performed CPR and sent an older sibling to a neighbor's telephone for help. The father was not at home at the time of the incident. An investigation of the child's death was initiated because of the family's prior involvement with the Department, the mother's mental illness, and the October 2001 similar death of another child in the family. That child's death was also undetermined. Police and DCFS investigations of the child's death are still pending.</p>			
<p>Prior History: In September 2002 the hotline was contacted with allegations of cuts/bruises/welts and substantial risk of physical injury. The reporter stated that mother told her that there was an incident over the weekend during which she hit her 8-year-old, but did not remember doing so. The child had a bruise on his right eye. The mother was indicated as she admitted that the incident occurred. The Department did not provide services to the family at this time because it was learned during the investigation that the mother was already receiving mental health services. Almost a year later, in August 2003, the hotline was contacted with allegations of substantial risk of physical injury to the deceased because he had been brought to the hospital for injuries twice within a week. The mother brought the child into the emergency room reporting that he slipped, hit his head, and was unconscious. Five days later the mother arrived at the emergency department with the child reporting that he had been lying on the couch, tensed up, stopped breathing, and lost consciousness. The father was not in the home at the time of either incident. Following an investigation, the report was unfounded, as there was no evidence of abuse to the children. However, an intact family case was opened in September 2003 with the family's agreement. In November 2003, while the intact family case was open, the hotline was contacted with allegations of substantial risk of physical injury to the deceased. The reporter stated that the child was brought to the hospital after both parents allegedly found him lying unresponsive in bed. While at the hospital the father told the doctor that the child made statements indicating that mother put a bag over his mouth. This investigation was still pending when seven days later, the hotline was contacted regarding the child's death. The OIG reviewed records in this case.</p>			

Case No. 34	DOB 6/24/01	DOD 12/16/03	Undetermined
Age at death:	2 ½ years old		
Substance exposed:	No		
Cause of death:	Cerebral injuries		
County:	DuPage (residence) Cook (death)		
Narrative: Two-and-a-half-year-old was at his babysitter's home putting his boots on when he fell over backwards and appeared to be having difficulty breathing. The babysitter called 911 and the child was transported to the hospital where he died. The child was found to have a non-acute (old) head injury. In the week prior to his death, the child had complained of headaches, and his 42-year-old mother took him to the doctor the day before he died for the headaches and cold-like symptoms. The child's parents were divorced and the mother, father, babysitter, grandmother, and siblings had access to the child. Everyone except the mother cooperated in the investigation. Without the mother's cooperation (she was the primary caregiver), a timeline and explanation for the injuries could not be established and the death was classified undetermined.			
Prior History: Seven months prior to the child's death the mother contacted the hotline to report that the child was returned home filthy, wet, and covered in diarrhea following a visit with his 44-year-old father. The report was unfounded as the father and the child's older siblings, ages 9 and 12, independently reported the father did not clean the child up following a baseball game because he was in a hurry to return them to their mother on time. The parents were going through a bitter divorce and custody battle. The OIG reviewed records in this case.			

Case No. 35	DOB 11/28/03	DOD 2/7/04	Undetermined
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Lake County Indiana		
Narrative: Two-month-old ward was found unresponsive by his foster sibling. The foster sibling called her mother who was out of the home. The foster mother called 911 and returned home. The ward was transported to the hospital by ambulance and was pronounced dead. The hospital was in Indiana and the ward was autopsied in Lake County Indiana. According to the autopsy report, the ward's death was classified undetermined because record, witness, and scene of occurrence information were in Illinois and outside the investigational jurisdiction of the Lake County Coroner's office.			
Prior History: The infant entered foster care right after his birth based on his mother's history with DCFS. The ward's three siblings were removed from the mother because she left them on numerous occasions with family and friends without a care plan. The ward was placed in the foster home where his 10-year-old sister resided. The 10-year-old is in the guardianship of the foster mother, who is a paternal cousin. The other two siblings are placed together in a pre-adoptive home. The OIG is conducting a full investigation of this child's death.			

Case No. 36	DOB 1/20/04	DOD 2/16/04	Undetermined
Age at death:	Four weeks		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Cook		
Narrative: Four week old, living with his 22-year-old mother in a shelter, was found unresponsive face up in bed. The investigator and the medical examiner's office attempted to locate the mother over the next 6 months to offer services and conduct a scene investigation. At autopsy no signs of trauma were noted, but because a scene investigation could not be done the death was signed out as undetermined.			

Prior History: An investigation for substantial risk of physical injury to the deceased was pending when the child died. After the baby's birth, a nurse noticed the mother seemed hesitant to feed the baby and questioned her. The mother told hospital staff that she had 2 children in custody in Indiana. The State Central Register contacted Indiana and found that in December 2001 the mother was indicated for lack of food, clothing and abandonment and had a history of depression. Two children, ages 2 and 3 years, were in foster care. The mother was in the process of having her parental rights terminated. The Department initiated an investigation for substantial risk of physical injury on the baby. The mother told the investigator that she had epilepsy and takes anti-seizure medication. Her older children were removed from her when she was involved in a violent relationship. In Indiana the mother took parenting classes and visited her children weekly until she moved to Chicago a year ago. She has had no contact with the children since then. Shelter staff told the investigator that the mother was involved in counseling, parenting and computer classes, and they were in the process of setting up psychological and psychiatric evaluations. The shelter was assisting with formula and diapers and a crib for the baby. The investigator released the baby to the mother and was in the process of referring the case to the intact family unit. The OIG reviewed records in this case.

Case No. 37	DOB 6/6/02	DOD Approximately 2/04	Undetermined
Age at death:	Approximately 21 months old		
Substance exposed:	No		
Cause of death:	Undetermined (pending)		
County:	Richland		
Narrative: An approximately 21-month-old child and his 38-year-old mother were found dead in their trailer. The mother's body was found on her bed and the child's body was found under the mother's bed. Both bodies were decomposing and their causes of death are still undetermined and being investigated.			
Prior History: This family first came to the attention of DCFS shortly after the deceased's birth when a preventive services case was opened. The case was closed in September 2003. In May 2003 an investigation of substantial risk of physical injury was initiated because of reports that the mother was refusing to take her medication for bipolar disorder and schizophrenia and was experiencing delusions. The investigation was unfounded. Another investigation of substantial risk of physical injury was initiated in December 2003 when a hospital reported that the mother brought the child into the hospital requesting a neurological consult because she thought someone was trying to clone her child. The maternal aunt called the hotline the same day to report that her sister would not let her take care of the child because she believed the aunt was a witch. This investigation was still pending when the mother and child were found dead. It was subsequently unfounded. The OIG is conducting a full investigation of this child's death.			

Case No. 38	DOB 2/22/04	DOD 3/2/04	Undetermined
Age at death:	7 days		
Substance exposed:	No		
Cause of death:	Undetermined (pending)		
County:	Cook		
Narrative: Nine-day-old infant was found unresponsive by her maternal grandmother who was babysitting her overnight for the first time. The infant was transported by ambulance to the hospital where she was pronounced dead.			
Prior History: The 49-year-old grandmother and 26-year-old mother, who live together, had preventive services cases open from June 2002 to May 2003. The mother has an 8-year-old daughter. The grandmother has eight children ranging in age from 3 to 28. The OIG conducted a preliminary review of this child's death.			

Case No. 39	DOB 2/14/04	DOD 4/9/04	Undetermined
Age at death:	1 ½ months		
Substance exposed:	No, but mother has a history of substance abuse		
Cause of death:	Undetermined		
County:	Cook		
<u>Narrative:</u> A 13-year-old cousin found the infant ward unresponsive in an adult bed in the late morning. The baby was placed with a maternal relative who had fed the child in the early morning and then left the baby in bed sleeping. The 52-year-old foster mother had gone to the store leaving her teenage child and another aunt who lived in the same building to care for the baby. The foster mother said the baby had her own crib, but she had the baby in bed with her the night before.			
<u>Prior History:</u> The deceased baby's 38-year-old biological mother has an extensive history with the Department. The baby was the mother's tenth child, none of whom are in her care. From November 1994 through May 1996 the mother was investigated 3 times and had indications for medical neglect, environmental neglect, inadequate food and substantial risk of physical injury. The mother's 4 children, ages 12, 8, 4 and 1 were taken into care as was the baby born in June 1996. In February 1998, January 1999, August 2000 and June 2002 the mother gave birth to substance exposed infants who were also taken into custody. The deceased baby did not test positive for substances but was taken into care for substantial risk of physical injury, as the mother had not participated in any services. The baby's oldest sibling has aged out of the system. The 16-year-old sibling remains in an adoptive home. Three siblings, ages 12, 9 and 8 have been adopted. Three siblings, ages 6, 5 and 4 are in the process of being adopted. One sibling, age 2, remains in a home of relative with a return home goal. The OIG reviewed records in this case.			

Case No. 40	DOB 2/16/04	DOD 4/14/04	Undetermined
Age at death:	2 months		
Substance exposed:	Unknown, mother admitted to using during her pregnancy		
Cause of death:	Undetermined		
County:	Cook		
<u>Narrative:</u> Twenty-seven-year-old mother found her 2month-old infant unresponsive in bed with her and the infant's 53-year-old father. The mother called 911 and the infant was transported to the hospital where he was pronounced dead.			
<u>Prior History:</u> This family came to the attention of DCFS in November 2001 when the mother left her two children, ages 3 and 6, with her brother to raise. The uncle beat the 3-year-old child, who required hospitalization, and the two children were placed in foster care. During the investigation, the mother and her third child, age 1, were located, and the 1-year-old was placed in foster care. The mother had a history of substance abuse and sporadically attended drug treatment. She complied minimally with services offered by the private agency overseeing her case and in December 2003 her children's placements became pre-adoptive. Two months later the mother gave birth to the deceased. The private agency was monitoring the mother's care of the infant. The OIG is conducting a full investigation of this child's death.			

Case No. 41	DOB 3/15/04	DOD 6/19/04	Undetermined
Age at death:	3 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Undetermined, possible suffocation		
County:	Cook		

Narrative: Residential substance abuse treatment staff heard the deceased infant's sibling crying and entered the room. The staff discovered mother getting out of her twin bed where she had been lying with the deceased to attend to the sibling. When she returned to the infant, she found him unresponsive. There was a crib for the infant in the room and toddler beds for his two siblings. The infant's cause and manner of death were undetermined because the mother did not participate in a scene investigation and suffocation could not be ruled out as a cause of death.

Prior History: This family came to the attention of DCFS with the substance-exposed birth of the deceased. The twenty-year-old mother of three, ages 0, 1 and 2 years, was indicated for substance misuse. The mother said she began using drugs on the 1st anniversary of the 9/11 tragedy in which her mother was killed. The child protection investigator helped the mother and her children enter substance abuse treatment at the residential treatment center and an intact family case was opened. Following the infant's death, the mother returned to the residential facility and completed substance abuse treatment and parenting classes. The mother subsequently moved without informing her caseworker and the agency diligently attempted to locate her and her children without success. The OIG reviewed records in this case.

Case No. 42	DOB 3/7/04	DOD 6/21/04	Undetermined
Age at death:	3-1/2 months		
Substance exposed:	No		
Cause of death:	Undetermined (pending)		
County:	Winnebago		
Narrative: Twenty-two-year-old mother called 911 requesting medical assistance for her 3-1/2- month-old son who was not breathing. The infant was transported by ambulance to the hospital where he was pronounced dead. The maternal grandmother, who cared for the infant while the mother was at work, stated that her daughter brought the child to her home and told her that the infant had been vomiting. When the maternal grandmother took off the blanket covering the infant's car seat, she saw that the baby was pale and unresponsive. She attempted CPR while the mother called 911. The infant had been sick with an ear infection and was seen at the emergency room the day before his death. He was prescribed an antibiotic that mother had already given him. Initial reports showed possible SIDS, but an x-ray later showed a spiral fracture to the right femur and bruising to the left side of the forehead and ear. The hotline was called with allegations of death by abuse, bone fractures, and cuts/bruises/welts to the deceased and substantial risk of physical injury to a sibling. The DCFS investigation is currently pending as is a police investigation.			

Prior History: There are prior indicated reports of neglect involving the 22-year-old mother both as a child victim and as a mother. In October 2002 the hotline was contacted with an allegation of environmental neglect to mother's two children, ages 1 and 3. The report alleged that the home was extremely dirty with garbage, papers, broken glass, and kid feces everywhere. During the investigation, the boyfriend (father of younger child) told the investigator that they were being evicted from the home, as the home was being foreclosed on later that month. The mother and her 23-year-old boyfriend were indicated as the home was hazardous to the children. The children stayed with relatives while the mother and boyfriend were given a chance to clean the home. The investigator indicated that the case would be referred to a family educator. Twelve days after the initial hotline call, the paternal grandmother brought the 1-year-old to the emergency room with a fever. The paternal grandmother reported that there was no electricity in the family's home. The child was examined and it was determined that he had an ear infection and pneumonia. The hotline was contacted with allegations of inadequate shelter and substantial risk of physical injury. The report was indicated and a preventive services case was opened in November 2002. The family was Norman certified. At the onset of the case, the 1-year-old child was living with his paternal grandmother and the 3-year-old child remained with the mother and her boyfriend. A short time later the mother and her boyfriend separated. He moved in with his mother and 1-year-old child and complied with DCFS services. He was granted custody of his son through domestic relations court. DCFS had no contact with mother and the older child, despite conducting a diligent search. The case was closed in October 2003. At the time of this child's death, the oldest child was residing with maternal grandmother. The maternal grandmother had prior indicated reports of neglect including one in which the alleged victim was a grandson. The maternal grandmother also had an extensive history of unresolved drug abuse issues and a criminal history of endangering the life of a child in 1995. Subsequent to this child's death, a petition was filed on both surviving siblings. The juvenile court ordered that the younger child remain with his father and that the older child be placed in DCFS custody. The OIG reviewed records in this case.

Accident

Case No. 43	DOB 7/29/95	DOD 7/3/03	Accident
Age at death:	7 ½ years		
Substance exposed:	No, but mother has subsequent history of drug abuse		
Cause of death:	Multiple injuries sustained while he was a pedestrian struck by an automobile on a porch		
County:	Cook		
Narrative: Seven-and-a-half-year-old child was with a group of people standing on a porch when a drunk driver jumped the curve, hit the porch and continued through the living room of the house. Numerous people were injured and the child died.			
Prior History: The deceased was the subject of an intact family case from February 2001 to July 2002. The case was opened after his mother's thirty-year-old boyfriend beat him. The boyfriend was indicated for cuts/bruises/welts to the child and his twenty-seven-year-old mother was indicated for substantial risk of physical injury. The mother gave birth to another child in May 2001. At the time of case closing, mother had successfully participated in services, including drug treatment. The children appeared well cared for and were developing age appropriately. Mother had three older children who were adopted by their foster parent in 1999. There have been no further reports involving this family. The OIG conducted a preliminary review of this child's death.			

Case No. 44	DOB 9/9/93	DOD 8/18/03	Accident
Age at death:	9-1/2 years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to automobile striking pedestrian		
County:	Cook		
<u>Narrative:</u> Nine-and-a-half-year-old child darted out into the street and was struck by the 17-year-old driver of a sports utility vehicle. An ambulance took the child to the hospital where he was pronounced dead.			
<u>Prior History:</u> The Department's first contact with the family was in August 1998 when the 22-year-old mother was indicated for cuts/bruises/welts to her 6-year-old son. The next contact was in October 2002 when the 26-year-old mother was indicated for inadequate supervision of her 10-year-old son. The mother allowed the boy, who is trainable mentally handicapped, to go across a busy street to a park where he fractured his wrist. The family was referred to a community-based agency for services. Another investigation was initiated in May 2003 when the agency worker arrived at the home to find three children, ages 7 months and 2 and 4 years home alone (the other three children, ages 8, 9, and 10 were in school). The investigation was indicated and the agency involved with the family agreed to continue to provide services to the family. Since the child's death, there have been three more reports made to the hotline; two were indicated and one was unfounded. An intact family case was opened with the Department in January 2004 following the first of the indicated reports. The case is currently being evaluated for screening for a temporary custody hearing. The OIG reviewed records in this case.			

Case No. 45	DOB 4/27/00	DOD 9/14/03	Accident
Age at death:	3 years		
Substance exposed:	No, but mother has a history of drug abuse, cocaine		
Cause of death:	Cervical injuries due to automobile striking pedestrian		
County:	Cook		
<u>Narrative:</u> Three-year-old ward was hit by a car when he darted across the street to meet his father. His foster parent-grandfather was with him at the time. The driver of the car was ticketed for failing to yield to a pedestrian.			
<u>Prior History:</u> The family has a history with DCFS dating to July 1999 when then 21-year-old mother gave birth to a substance-exposed infant, the deceased's only sibling. The children entered foster care in September 2002 because of the parents' continued drug use. The children were placed with their paternal grandparents where the surviving sibling remains. The OIG conducted a preliminary review of this child's death.			

Case No. 46	DOB 1/10/00	DOD 9/21/03	Accident
Age at death:	3 1/2 years		
Substance exposed:	No		
Cause of death:	Inhalation of smoke and soot due to house fire		
County:	Cook		
<u>Narrative:</u> Three-and-a-half-year-old child of a former ward died in a fire in the house of a paternal relative. The 21-year-old mother and a 2-month-old sibling were not in the home at the time of the fire.			
<u>Prior History:</u> The deceased's mother was a ward from October 1994 until shortly before the fire when she reached the age of 21 and aged out of the system. The mother was placed in the home of a relative for most of her time as a ward. In January 2000 she entered the teen parent service network while pregnant with the deceased. She spent some time on run and eventually entered into an independent living program. The Department has had no further contact with the mother or sibling. The OIG reviewed records in this case.			

Case No. 47	DOB 4/18/03	DOD 9/22/03	Accident
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Overlaying in an adult bed with mother and older sibling		
County:	Cook		
<u>Narrative:</u> Five-month-old infant was found in the morning unresponsive lying face down on pillows by his 21-year-old mother. The infant had been sleeping in a full-sized pull-out bed on top of pillows between his mother and 2-year-old sister. The mother had taken night-time cold medicine.			
<u>Prior History:</u> An A-sequence report was made twelve days prior to the infant's death. A shelter where the mother was staying reported that mother neglected her two children by leaving them in dirty diapers for hours, using dirty baby bottles, propping the infant's bottle, leaving the children unsupervised in the shelter, failing to fill the 2-year-old's medication for an ear infection, and tying a pacifier on a string around the infant's neck. A report was taken for investigation of medical neglect, inadequate supervision, and environmental neglect. Shelter personnel reported that the mother was depressed and it was affecting her parenting. They scheduled an appointment for her with a psychiatrist. While the investigation was pending, the mother and her children went to stay with the mother's adoptive mother, her maternal great-grandmother. Following the infant's death, the mother was indicated for medical neglect of her 2-year-old and an intact family case was opened. The case remains open. The OIG reviewed records in this case.			

Case No. 48	DOB 1/6/03	DOD 10/8/03	Accident
Age at death:	9 months		
Substance exposed:	No		
Cause of death:	Respiratory arrest due to asphyxia due to aspiration of a food bolus with drowning as a contributing factor		
County:	Lake		
<u>Narrative:</u> Nine-month-old infant was found submerged in bath water by her 22-year-old mother. The mother was bathing the infant and her 1-1/2 year old son. The mother pulled the stopper to let the water out and removed her son from the bath and took him into another room. When she returned, she found the infant face down in the water. At autopsy a piece of food was located in the infant's trachea. The mother said she had given the infant a plum to chew on just prior to bathing her. The mother was indicated for death by neglect and an intact family case was opened until July 2004.			
<u>Prior History:</u> There were two prior DCP investigations involving this family. In June 2002 the hotline was called following a domestic dispute between the mother and the 22-year-old father. Both mother and father were indicated for substantial risk of physical injury as mother and father had a violent relationship and the child was exposed to the violence. The mother obtained an order of protection. In February 2003 an anonymous reporter contacted the hotline with an allegation of substantial risk of physical injury to the children by their mother. The report was unfounded as there was no evidence of maltreatment by the mother and the report appeared to have been made as a form of harassment following the father's arrest for violation of an order of protection on mother. The OIG reviewed records in this case.			

Case No. 49	DOB 4/15/00	DOD 10/21/03	Accident
Age at death:	3-1/2 years		
Substance exposed:	No		
Cause of death:	Asphyxia due to mechanical pressure to the chest, neck and back		
County:	Williamson		

Narrative: Three-and-a-half-year-old child was found pinned under a chest of drawers by his 25-year-old mother. It is believed the child was climbing on the chest to reach his 10-month-old sister in her crib. The mother said she heard a noise but thought it was her son throwing a toy. The mother went outside to talk to a neighbor and when she returned to check on the children, found the child under the dresser. The mother was not indicated for anything related to the child's death. She voluntarily agreed to participate in services and an intact family case was opened.

Prior History: There were two prior DCP investigations involving this family. The first, in July 2002, was unfounded for substantial risk of physical injury. The allegation was that the mother and her paramour placed the deceased at risk by keeping two large snakes in the home. The snakes were observed to be contained in an aquarium and the larger snake was voluntarily removed from the home. The second investigation, in April 2003, was unfounded for cuts, welts, and bruises. The reporter said she babysat for the deceased and four days earlier observed several dark purple and blue bruises all over the front and back of the child's legs. A child protection investigator saw the child the following day and observed several small bruises on his legs that were consistent with play. No other marks were observed. The child, his mother, and his speech therapist all denied abuse in the home. The OIG reviewed records in this case.

Case No. 50	DOB 7/18/03	DOD 11/1/03	Accident
Age at death:	3 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Brochopneumonia due to anoxic encephalopathy due to maternal drug use		
County:	Cook		
Narrative: Thirty-three year old mother pregnant with twins had an emergency c-section at 33 weeks gestation, after she allegedly jumped in front of a car while using alcohol and cocaine. This twin, who had severe medical problems, tested positive for cocaine and the mother was indicated for substance misuse. The other twin was stillborn. The baby was taken into custody and died one day after being released from the hospital to a residential care facility.			
Prior History: The twins were the youngest of four children. DCFS first had contact with the family in August 1997 when the mother gave birth to a baby who tested positive for cocaine. An intact family case was open until the baby was taken into custody 18 months later. The mother did not comply with services and a relative adopted the child in November 2001. In October 2000 the mother gave birth to another child who remained in her custody. There was an unfounded report for inadequate supervision of the child when the investigation found the mother had made an adequate care plan. Following the birth of the twins the mother agreed to residential substance abuse treatment with the 3-year-old. In October 2003 the mother relapsed and the child was taken into custody. The child remains in care with a goal of return home. The mother's oldest child, a teenager, resides with her father. The OIG reviewed records in this case.			

Case No. 51	DOB 1/17/00	DOD 11/10/03	Accident
Age at death:	3 ½ years		
Substance exposed:	Yes		
Cause of death:	Cranio-cerebral injuries due to garbage dumpster accident		
County:	Cook		
Narrative: Three-and-a-half-year-old child was playing with his siblings, ages 6 and 8, on a dumpster located behind the building in which they resided. The door of the dumpster accidentally swung open and struck the child in the head. The child's father, who was in front of the building, was told of the accident. He picked the child up, ran to his car, and rushed him to the hospital.			

Prior History: The family has a history with the Department dating to 1993. The 36-year-old mother has given birth to 9 children. Three of her four youngest children were born substance exposed; the first in 1993, the second in 1995, and the third, the deceased, in 2000. Intact family cases were opened after the birth of each substance-exposed child. The intact family case was screened with the State's Attorney's Office in 2002 and went to a temporary custody Hearing, however, temporary custody was not granted. Instead, the father was granted custody of the minor children. The mother was asked to leave the home, and she was required to have supervised visitation. The OIG reviewed records in this case.

Case No. 52	DOB 10/23/85	DOD 11/17/03	Accident
Age at death:	18 years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to car accident		
County:	Polk County, Missouri		
Narrative: Eighteen-year-old girl who had been released from guardianship less than one month earlier was killed in a car accident. The girl was in a vehicle with an ex-boyfriend, who was the father of her child born in October 2000 (both parents' rights had been terminated and their child was adopted in October 2003). They were struck head on by a semi-truck and killed instantly.			
Prior History: The maternal grandmother was given guardianship of the deceased after the death of the mother in April 1998. Her father was incarcerated for raping her. The grandmother had little control over the girl and DCFS provided services for seven months during 1998-1999. During 1999 and 2000 the girl was in the guardianship of Juvenile Court Services because of delinquency. In January 2001 guardianship was given back to the grandmother. Three months later, the grandmother put the girl out of the home, and she and her daughter were placed in foster care. The ward had been on run for six months when her case was closed on her 18 th birthday. She had expressed a desire to be released from guardianship numerous times. The agency servicing her case had reported her missing. The OIG conducted a preliminary review of this child's death.			

Case No. 53	DOB 12/14/03	DOD 12/26/03	Accident
Age at death:	12 days		
Substance exposed:	No		
Cause of death:	Overlaying		
County:	Cook		
Narrative: Twenty-seven year old mother was awakened by the 20-year-old father and found her baby unresponsive beneath her. The child was pronounced dead at the hospital. DCFS indicated the mother for death by neglect after she admitted she was sleeping in bed with the baby and had chosen not to use a bassinet.			
Prior History: The deceased was the youngest of the mother's four children. The mother is a former ward; she aged out of the system in 1996. From February 2002 until March 2003 an intact family case was open on the mother. In February 2002 the mother brought her 8 and 7 year old sons to the hospital stating that the 7-year-old said he had seen the mother's boyfriend sexually molesting the 8-year-old, who is autistic. The boyfriend admitted to some sexual contact. He was arrested but the states attorney declined to pursue the matter. The boyfriend told the investigator that he had been sexually abused as a child and he wanted to get counseling; he was indicated for sexual molestation and substantial risk of sexual injury. The intact family case was opened to monitor that the mother was not allowing the boyfriend to be the caretaker for the children and that the children and the boyfriend were linked to services. During the death investigation, relatives said the boyfriend (who was the father of the deceased and the 3-year-old) did not live in the home, and was only visiting for the holidays. The OIG reviewed records in this case.			

Case No. 54	DOB 9/25/89	DOD 1/1/04	Accident
Age at death:	14 years		
Substance exposed:	No		
Cause of death:	Anoxic encephalopathy due to drowning		
County:	Cook		
<u>Narrative:</u> Fourteen-year-old child died at home while in the care of an in-home nurse. The child was a near drowning victim when at 2 years old he fell into a hole being dug for a swimming pool. The child suffered from anoxic brain damage and was totally dependent. He received nearly around the clock care from a nursing agency.			
<u>Prior History:</u> In June 2003 the hotline was contacted with an allegation of substantial risk of physical injury to the child by his 42-year-old mother. The reporter alleged that the child had recently been hospitalized for pneumonia and was supposed to be on oxygen. The reporter stated that a nurse arrived at the home to find that the child's oxygen had been removed by the mother against doctor's orders. Investigation revealed that the mother had removed the oxygen because her son was breathing fine and the oxygen tank was running low with no back up so she took him off temporarily to conserve it in case of an emergency. The child's physician was in support of the mother's decision. The OIG reviewed records in this case.			

Case No. 55	DOB 10/30/87	DOD 1/8/04	Accident
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Drowning		
County:	St. Clair		
<u>Narrative:</u> Sixteen-year-old ward fell into a rain-swollen stream. Friends of the teenager attempted to throw logs and branches for the ward to grab hold. The ward continued to be carried downstream and disappeared under the water. Her body was found in a lake downstream 4 days later.			
<u>Prior History:</u> The family first came to the attention of the Department in July 2003 when the girl reported that her mother's boyfriend hit her in the face with a shoe and molested her on two separate occasions. The girl reported the molestation to her mother, who did nothing about the allegations. The girl participated in a victim sensitive interview that confirmed the allegations of molestation. She was placed in foster care. The mother was indicated for sexual molestation for her failure to protect her child once the molestation was reported and substantial risk of physical injury. The mother's paramour was indicated for sexual molestation and substantial risk of physical injury. The paramour was arrested for sexual assault, but the ward died before the case went to trial. The OIG reviewed records in this case.			

Case No. 56, 57	DOB 9/8/01 6/7/99	DOD 1/13/04 1/13/04	Accident
Age at death:	2 years 4 ½ years		
Substance exposed:	No, but mother has a history of substance abuse		
Cause of death:	Extensive burn of entire body and smoke inhalation		
County:	Lake County, Indiana		
<u>Narrative:</u> Two children, living with their 42-year-old mother, 74-year-old grandmother and 21-year-old sibling in Gary, Indiana, died from injuries due to a house fire. The adult sibling was hospitalized for injuries.			

Prior History: The family first came to the attention of the Department in April 2001 when the 11-year-old child, who is autistic and non-verbal was found wandering in the street. The 50-year-old father was indicated for inadequate supervision and an intact family case was opened. In June 2001 police found the autistic child on the railroad tracks near the family's home. The mother was indicated for inadequate supervision and the child was taken into custody. The parents participated in services and the child was returned home in February 2002. DCFS continued to monitor the home. In February 2003 the child came back into care when the intact family worker found the parents had left the autistic child with a relative who could not care for the special needs child. The child was placed in a specialized foster home where he remains today. The mother, who moved to Indiana in May 2003, regularly visited the child in care. The caseworker attempted to assist the mother with housing, but the mother let Section 8 vouchers expire. The caseworker visited the family home in Indiana several times. The caseworker noted concerns in the home and contacted Indiana child protection authorities to initiate an investigation. It was pending at the time of the fire. The foster child in Illinois has a goal of guardianship. The OIG conducted a preliminary review of this case.

Case No. 58	DOB 5/8/03	DOD 1/20/04	Accident
Age at death:	8 months		
Substance exposed:	No		
Cause of death:	Bronchopneumonia due to intrauterine cerebral injuries from traffic accident		
County:	Cook		
Narrative: Eight-month-old infant died after being taken to a regular doctor appointment. While at the clinic he experienced trouble breathing and was taken to the emergency room where he died.			
Prior History: Twenty-seven-year-old mother gave birth by caesarean section to a premature infant weighing three pounds after she was in a car accident. The mother was not wearing a seat belt and was ejected from the automobile. A 14-month-old daughter was in the back seat of the car and according to the father was belted in, but was not in a car seat. The child was not injured. The mother was indicated for not having the child in a car seat. The finding was overturned on appeal when the Department failed to send a representative to the hearing. The OIG reviewed records in this case.			

Case No. 59	DOB 4/29/93	DOD 1/22/04	Accident
Age at death:	10 ½ years		
Substance exposed:	No		
Cause of death:	Carbon monoxide intoxication due to inhalation of smoke and soot due to mattress fire		
County:	Cook		
Narrative: Ten-and-a-half-year-old child died in a house fire. Her 62-year-old adoptive mother, twin sister and 13-year-old brother survived. Her sister suffered burns over 10% of her body. The fire was believed to have been caused by faulty electrical wiring on a space heater. The fire began in the middle of the night. There was a working smoke detector in the home, but it failed to alert the occupants.			
Prior History: The deceased and her siblings entered foster care in 1994 because of severe neglect by their mother. The foster parent adopted them in February 2001. In November 2003 the hotline was contacted two days in a row with reports that the adoptive mother had suffered a stroke and was ill and unable to care for the children or home which was described as cluttered, dirty, and roach infested. The reports were consolidated into one investigation of environmental neglect. An investigator visited the home and found that while cluttered, it was not dirty or roach infested. An adult son was interviewed at the home. He reported that he was in the home daily to help his mother. The investigation was unfounded. Following the child's death, the OIG referred the family to DCFS's post-adoption unit for services. The OIG reviewed records in this case.			

Case No. 60	DOB 1/8/04	DOD 2/27/04	Accident
Age at death:	7 weeks		
Substance exposed:	No		
Cause of death:	Asphyxia due to placement on a plastic bag		
County:	Will		
<u>Narrative:</u> Seven-week-old infant was found unresponsive in the morning face down on the floor on a plastic bag. The family had recently moved and the infant was sleeping on the floor. The infant reportedly did not like to sleep on her back.			
<u>Prior History:</u> In March 2003 a report was made to the hotline alleging physical abuse to the deceased's 10-month-old and 3-year-old siblings. The investigation was unfounded because the children had no injuries and everyone interviewed stated the children were not abused. The OIG reviewed records in this case.			

Case No. 61	DOB 12/11/01	DOD 3/17/04	Accident
Age at death:	27 months		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Macon		
<u>Narrative:</u> The twenty-six-year-old mother of the deceased called 911 to report that her child had drowned. The mother told investigators that she and the toddler were lying on the couch taking a nap and when the mother awoke she found the toddler naked in the bathtub face down. She believed the child attempted to take a bath by herself. No definite supportive evidence for drowning could be demonstrated at autopsy. A coroner's jury ruled the death an accident. DCFS indicated the mother for death by neglect. The mother has two surviving children, ages 8 and 4. Neither child was living with the mother at the time. The oldest boy was living with the grandmother and the other boy was living with the mother's friend. Following the child's death, a case was opened on the mother. The 8-year-old is now in the guardianship of his grandmother and the 4-year-old is in the guardianship of his aunt. The mother is pregnant and is participating in services.			
<u>Prior History:</u> The mother had two preventive services cases opened. The first case was open in 1997 for housing assistance for her and her son. The second case was open from July 2002 to April 2003. The mother requested services to help her with her three children, including getting her oldest who was born with serious physical disabilities to his doctor appointments. While the case was open, her second child went to live with his mother's friend. Later, the oldest child went to live with his grandmother. The OIG reviewed records in this case.			

Case No. 62, 63	DOB 5/21/01 DOB 7/08/93	DOD 4/1/04 DOD 4/1/04	Accident
Age at death:	2 ½ years 10 ½ years		
Substance exposed:	No		
Cause of death:	Carbon Monoxide intoxication due to house fire		
County:	Cook		
<u>Narrative:</u> Two-and-a-half and ten-and-a-half-year-old children were sleeping in a bedroom heated by a metal space heater. The heater was placed close to a bed and ignited the bedding causing a house fire. The children died. Two adults were injured in the fire.			

Prior History: In November 2003 a DCP investigation was initiated on the 26-year-old mother for environmental neglect of her children ages 10, 7, 5, 4, 2 and 1. The investigator went to the home and found it to be clean and appropriate. The older children were interviewed and no problems were noted. The mother and other relatives explained that the mother had been caring for an elderly mentally ill woman for many years. Recently the woman's relatives came to take the woman to their home. The mother and the relatives of the woman got into a disagreement about the care of the woman. The family stated the relatives of the woman threatened to call the hotline on the mother. The mother's childcare provider was interviewed and stated that the children were always clean and appropriate. The investigation was unfounded. The OIG reviewed records in this case.

Case No. 64	DOB 7/24/03	DOD 4/2/04	Accident
Age at death:	8 months		
Substance exposed:	No		
Cause of death:	Hyperthermia		
County:	Cook		
Narrative: Twenty-year-old mother found her 8-month-old infant unresponsive. The mother reported that she fed the infant and put her in a baby chair in her crib. Both the mother and infant fell back asleep. Approximately three hours later the mother checked on the infant and found her unresponsive. The mother called 911 and attempted CPR while waiting for the ambulance. The infant was transported to the hospital where she was pronounced dead on arrival. An autopsy revealed that the child was dehydrated and it was determined that her crib was too close to the radiator, and it was excessively hot in the apartment.			
Prior History: At the time of the infant's death, the mother was a ward. Guardianship of the mother was granted to DCFS in 1989. Three months after the infant died the mother's case was closed when she reached majority. At the time of the infant's death the mother was involved in a teen-parenting program. In January 2003 the mother's caseworker contacted the hotline with an allegation of medical neglect. The caseworker stated that the mother failed to show up for medical appointments for her baby and was not using the apnea monitor as prescribed. The report was unfounded. In September 2003 another caseworker contacted the hotline with an allegation of substantial risk of physical injury. The caseworker reported that she went to the mother's residence and could hear mother screaming and someone being slapped. The report was indicated. It was determined that despite an active order of protection against her boyfriend, there was an incident of domestic violence between the mother and her boyfriend while their 1-year-old child was laying on the bed. In November 2003, the caseworker contacted the hotline again to report inadequate supervision. The caseworker stated that mother was outside while her two children were upstairs sleeping and unsupervised. The report was unfounded as mother told the investigator that she went downstairs for a few minutes to meet her sister who was coming to babysit, and her caseworker happened to drive by at that time. Since the death of this child there have been two more unfounded reports, a May 2004 report of substantial risk of physical injury to the 20-month-old surviving sibling and a July 2004 report of death by neglect of the deceased. The OIG is conducting a full investigation of this case.			

Case No. 65	DOB 12/21/01	DOD 4/4/04	Accident
Age at death:	27 months		
Substance exposed:	No		
Cause of death:	Acute peritonitis due to small bowel perforation due to abdominal blunt force injury		
County:	Stephenson		

Narrative: Twenty-seven-month-old child died while being cared for by his 20-year-old mother's 32-year-old friend at her home. The babysitter said that the deceased and her 4-year-old daughter were playing outside at the playground and had climbed to the top of a slide and collided with another child who was climbing the wrong way up the slide. She witnessed the children fall from her kitchen window, approximately 60 feet away. The slide was 8-10 feet high and the playground was covered with wood chips. The babysitter said the child only cried for a minute and had a bruise on his head, but otherwise appeared okay. Later that evening, the child vomited, complained of a stomachache, and became lethargic. That night the mother stopped by and the babysitter told her she should take the child to a doctor, but the mother refused without seeing him because she did not want to upset him. Eventually the child became unresponsive and died. Had medical treatment been sought, he may have survived. Six weeks after the child's death, the OIG referred the case to the Illinois State Police Child Homicide Task Force to reach out to local police to assist in the investigation. The police declined ISP assistance. The manner of death was ruled undetermined by a coroner's jury and no one was charged in the child's death. The babysitter was indicated for death by neglect for failing to supervise the child and failing to seek medical attention for him; for inadequate supervision of the deceased and her own child for allowing them to play at the playground alone; and for substantial risk of physical injury because of her use of marijuana and crack cocaine while caring for the deceased. The mother was indicated for medical neglect and substantial risk of physical injury. While the investigation was still pending, intact family cases were opened on both women. The mother of the deceased has one surviving son who is 1 ½ years old. Her case remains open. The babysitter has three children, ages 1 ½, 2 ½, and 5. The children were with her parents pursuant to a safety plan when she and her husband (who was not present the weekend of the death) abducted the children in August 2004. The children were recovered in Pennsylvania in November 2004 and are currently placed there in foster care.

Prior History: The babysitter had no prior history with DCFS. The mother of the deceased had an intact family case open from July 2003 through October 2003 when it was closed because of her lack of cooperation. The case was opened following an investigation for substantial risk of physical injury to the deceased's sibling based on an incident where the 21-year-old father choked the mother while she was holding their 2-month-old infant. The father did not live in the home and the mother obtained an order of protection against him. The OIG reviewed records in this case and referred the child's death to the Illinois State Police Child Homicide Task Force.

Case No. 66	DOB 11/25/96	DOD 5/11/04	Accident
Age at death:	7 ½ years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to auto striking pedestrian		
County:	Cook		
Narrative: Seven-year-old child was struck by a vehicle while running to an ice cream truck in the street. He died two days later in the hospital.			

Prior History: The deceased had not been the subject of any child's Department involvement, but the 30-year-old mother had been investigated for allegations relating to the 13-year-old sister who had been living with her father and recently came to the mother because the father could not control her behavior. In October 2003 the 13-year-old had engaged in a relationship with an older man whom she met through the internet. The man was arrested after police responded to a domestic call and discovered the relationship. Allegations against the mother were unfounded after the investigator determined the mother had no knowledge of the relationship. In November 2003 the mother was investigated for substantial risk of physical injury when the 13-year-old was admitted to a psychiatric facility and reported that her mother hit her. The mother denied hitting the child, explaining that her daughter was angry with her for admitting the child to the hospital because of her behavior, which included running away, and stealing her grandfather's car. In December 2003 the girl went to school with scratches on her face saying her mother had caused them. The mother related that her daughter got scratched during a physical altercation initiated by the 13-year-old. The mother went to take the phone away from her daughter who was calling men and setting up dates. The investigator observed bruises on the mother's arms. The child was psychiatrically hospitalized during the course of the investigation, and the mother was in the process of applying for an Illinois Care Grant. The 7 and 3-year-old children were seen during each of the investigations and no concerns were noted. The OIG reviewed records in this case.

Case No. 67	DOB 9/23/95	DOD 5/20/04	Accident
Age at death:	8 ½ years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to automobile striking pedestrian		
County:	Cook		
Narrative:	Eight-year-old former ward and eleven-year-old child were running across the street when they were hit by a police squad car responding to a call. The 8-year-old died. He had been adopted by his foster mother a month prior to his death. His brother was adopted by her a month afterward.		
Prior History:	The child and his four siblings entered foster care in May 1998 following a beating to the child by one of his sibling's fathers. Two of the siblings were released to their father's custody and two were adopted by foster parents. A January 2004 report of substantial risk of physical injury of the deceased by his foster mother's adult daughter was unfounded. The daughter, who lived in the home with her two children, was accused of mistreating her 1-year-old daughter and presenting a risk to the other children in the home. The report was unfounded because there were no indications of maltreatment, but evidence that the report was made to harass the mother (the report was retained for harassment). The OIG reviewed records in this case.		

Case No. 68	DOB 1/14/95	DOD 6/15/04	Accident
Age at death:	9 years		
Substance exposed:	No		
Cause of death:	Anoxic encephalopathy due to drowning		
County:	Will		
Narrative:	Nine-year-old child went swimming with his church day camp at a lake with no lifeguards on duty. The child had no life jacket. While playing tag with a sibling in the water, the child went under and the sibling tried to pull him up out of the water. The child was transported to the hospital where he was pronounced dead six days later.		

Prior History: The family first came to the attention of the Department in May 1998. The father sexually penetrated his two children ages 5 and 3-years-old. The father was arrested for aggravated criminal sexual assault and indicated for sexual penetration of his children. An intact family case was opened with the 21-year-old mother and her two children. The intact family case was closed 6 months later after services were completed. In October 2002 school personnel reported the 7-year-old came to school with red marks on his face, neck and shoulder. The mother was indicated for cuts/bruises/welts to the 7-year-old child. The mother was reported to have developmental delays and a second intact family case was opened. The family completed intact family services in August 2003 and DCFS closed the case. The OIG reviewed records in this case.

Case No. 69	DOB 11/15/88	DOD 6/27/04	Accident
Age at death:	15 ½ years		
Substance exposed:	No		
Cause of death:	Blunt head trauma due to impact between car and bicyclist		
County:	Clinton		
Narrative: Fifteen-year-old girl was riding her bike in the middle of a highway at approximately 10:30 p.m. and was hit by a car. The bike had no reflectors. A friend was riding his bike along the side of the highway and witnessed the accident.			
Prior History: The girl's family has an extensive history of indicated investigations of environmental neglect dating to 1991. The family had five children who were often observed to be dirty and smelly. The home was dirty and unsanitary. An intact family case was open from December 1995 to December 1996. Six years after the intact family case was closed, the hotline was contacted with an allegation of environmental neglect to three remaining siblings in the home, ages 12, 14, and 16. The home was found to be filthy with 11 dogs going to the bathroom in the house and roaches in the house. In November 2003 the 46 and 54-year-old parents were indicated for environmental neglect and an intact family case was reopened. The case remained open at the time of the girl's death. The OIG reviewed records in this case.			

Natural

Case No. 70	DOB 12/23/02	DOD 7/5/03	Natural
Age at death:	7 months		
Substance exposed:	No, though mother has a history of alcoholism		
Cause of death:	Dehydration		
County:	DuPage		
Narrative: The seven-month-old child was put down for a nap in the morning. The father checked on the child at noon and again at 4:00 p.m. when he found the child blue and not breathing. The father drove the child to the hospital where physicians pronounced the infant dead.			

Prior History: The family first came to the attention of the Department in August 1998 when then 38-year-old mother was found intoxicated and unable to care for her 2 children then ages 3 and 1 year. The mother was indicated for inadequate supervision and an intact family case was opened until April 1999 when services were completed. In November 1999 the mother brought her 4-year-old child at day care while intoxicated. She was indicated for inadequate supervision and substantial risk of physical injury. A case was not opened because the father was in the home and considered an appropriate caregiver. In March 2002 police responded to the home found the mom intoxicated and the father reported she had hit the children. The mother was indicated for cuts/bruises/welts, and inadequate supervision, and a second intact family case was opened. In March 2003 the mother drove while intoxicated with the 5-year-old in the car and was involved in an accident. The 5-year-old told police they left her 3-month-old sibling home alone. Because the parents hid the baby from caseworkers, the Department had no previous knowledge of the infant that the mother gave birth to in December 2002. The mother was indicated for substantial risk of physical injury, inadequate supervision, and cuts/bruises/welts by neglect. The mother entered substance abuse treatment. The parents separated in the fall of 2003 and the children remained with their mother. The Department took guardianship of both children in January 2004. In March 2004 a seventh investigation revealed that the mother was intoxicated and unable to care for the children. The mother was indicated for risk of physical injury and inadequate supervision and the children were placed with their father. The OIG conducted a full investigation of this case. An interim report was sent to the director on April 1, 2004. A final report was submitted to the director on June 28, 2004.

Case No. 71	DOB 9/23/91	DOD 7/5/03	Natural
Age at death:	11 ½ years		
Substance exposed:	Yes, cocaine and heroin		
Cause of death:	Cerebral palsy due to quadriplegia		
County:	Cook		
Narrative: Eleven-year-old medically complex ward died in his residential care facility.			
Prior History: DCFS became involved with this family in September 1991 when this child was born substance-exposed. The child was sent home with his mother and an intact family case was opened. The deceased entered foster care in March 1992. His three older siblings followed in January 1993. The siblings were adopted in 1997 by a relative. The OIG conducted a preliminary review of this child's death.			

Case No. 72	DOB 12/28/95	DOD 7/15/03	Natural
Age at death:	7 ½ years		
Substance exposed:	No		
Cause of death:	Pulmonary hypertension		
County:	Cook		
Narrative: Seven-year-old child died of pulmonary hypertension. She had felt ill for a week, but her parents didn't feel she was sick enough for medical treatment.			
Prior History: In May 2003 the hotline was called with allegations of inadequate food and environmental neglect of the deceased and her three siblings. The investigation was unfounded. The investigator found plenty of food in the home, which was neat with no observable environmental hazards. The children appeared well cared for and healthy. Previous involvement with DCFS included an unfounded neglect investigation in 2001 and an open case for three months in 1997. The OIG reviewed records in this case.			

Case No. 73	DOB 7/18/03	DOD 7/18/03	Natural
Age at death:	0 days		
Substance exposed:	Yes, cocaine		
Cause of death:	Intrauterine asphyxia due to maternal cocaine use		
County:	Cook		
<u>Narrative:</u> Thirty-three-year-old mother pregnant with twins had an emergency c-section at 33 weeks gestation, after she allegedly jumped in front of a car while using alcohol and cocaine. This twin was stillborn. The mother was indicated for substance misuse as she and the surviving twin tested positive for cocaine. The surviving twin, who was taken into custody, had complex medical problems and died in November 2003.			
<u>Prior History:</u> The twins were the youngest of 4 children. DCFS first had contact with the family in August 1997 when the mother gave birth to a baby who tested positive for cocaine. An intact family case was open until the baby was taken into custody 18 months later. The mother did not comply with services and a relative adopted the child in November 2001. In October 2000 the mother gave birth to another child who remained in her custody. There was an unfounded report for inadequate supervision of the child but the investigation found the mother had made an adequate care plan. Following the birth of the twins the mother agreed to residential substance abuse treatment with the 3 year old. In October 2003 the mother relapsed and the child was taken into custody. The child remains in care with a goal of return home. The mother's oldest child, a teenager, resides with her father. The OIG reviewed records in this case.			

Case No. 74	DOB 2/21/97	DOD 7/19/03	Natural
Age at death:	6 years		
Substance exposed:	No		
Cause of death:	Acute lymphocytic leukemia		
County:	Cook		
<u>Narrative:</u> Six-year-old child died of undiagnosed leukemia after being seen at a local urgent care center twice and the local emergency room once over the past five months for acute complaints of bilateral joint pain, frequent illness, and follow-up on a diagnosis of pneumonia.			
<u>Prior History:</u> There was one prior unfounded DCP investigation involving this family. In May 2003 an anonymous reporter contacted the hotline alleging abuse and neglect to the children in the home. Among the allegations, the reporter said that a 4-year-old child in the family had an untreated broken leg and that the deceased was so sick for the past month she could not play and had to be carried up and down the stairs. DCFS, as well as the Chicago Police Department, initiated an investigation that evening. Both children were examined by medical personnel. Xrays were taken of the 4-year-old child's leg and no fractures were found. The deceased was found to have an ear infection and was treated with intravenous and oral antibiotics. The OIG reviewed records in this case.			

Case No. 75	DOB 10/22/02	DOD 7/20/03	Natural
Age at death:	9 months		
Substance exposed:	No		
Cause of death:	Bilateral bronchopneumonia due to hypomotility and neural developmental delay due to Zellweger-like syndrome		
County:	Cook		
<u>Narrative:</u> Nine-month-old ward died while hospitalized.			

Prior History: The baby's 20-year-old mother had been a ward since April 1992. Between November 2002 and June 2003 the mother was indicated on three reports involving medical neglect to the deceased. In June 2003 the child was hospitalized and the mother failed to meet with hospital staff to participate in after-care planning for the child. Custody of the child was taken, and the child never left the hospital prior to her death. In May 2003 the mother was indicated for cuts/welts/bruises to the deceased's sibling. He entered foster care in August 2003. He is placed with a relative. A third child born in November 2003 entered foster care in January 2004. She is medically complex and resides in a nursing care facility. The mother's wardship ended in May 2004. The OIG is conducting a full investigation of this case.

Case No. 76	DOB 7/2/02	DOD 7/29/03	Natural
Age at death:	1 year		
Substance exposed:	No		
Cause of death:	Multiple anomalies		
County:	Cook		
Narrative: One-year-old ward died after being found unresponsive in the middle of the night by his foster mother.			
Prior History: An A sequence report was indicated against the infant's 41-year-old mother for substantial risk of physical injury/ environment injurious when it was determined that she was mentally ill, homeless, and unable to care for the medically complex infant. The infant was placed in his foster home after spending 3 months in the hospital following his premature birth. The OIG conducted a preliminary review of this child's death.			

Case No. 77	DOB 10/28/02	DOD 8/5/03	Natural
Age at death:	9 months		
Substance exposed:	No, although mom has a history of marijuana use		
Cause of death:	Hypoxic encephalopathy due to prematurity		
County:	Cook		
Narrative: Nine-month-old ward with multiple medical problems died after experiencing respiratory distress at her residential care facility. The baby was born at 29 weeks gestation, required a feeding tube, was blind, deaf and neurologically impaired.			
Prior History: The Department took custody of the infant in February 2003 when the hospital reported that the infant was ready for discharge but the 21-year-old parents had not come to the hospital to receive training on how to care for the child. At the time of the investigation the parents did not have an apartment. The mother, a former ward, was living with relatives. The relatives were considered for placement but they were not equipped to handle the special needs of the child. The mother related that she did not feel as though she could care for the child and the Department took custody. The OIG reviewed records in this case.			

Case No. 78	DOB 11/05/98	DOD 8/23/03	Natural
Age at death:	4 ½ years		
Substance exposed:	No		
Cause of death:	Perforated bowel due to pneumatosis intestinalis due to infection		
County:	Winnebago		
Narrative: Four-year-old child was taken to the hospital due to acute stomach and bowel problems. The child was then transferred via air to another hospital approximately sixty miles away. During the flight the child went into cardiac arrest. The child was admitted to pediatric intensive care unit and died there later that day.			

Prior History: The family has a history with the Department dating back twenty-one-years. In September 1982 the 19-year-old mother was indicated for neglect of a sibling to the deceased child and an intact family case was opened until October 1983. A second intact family case was open from October 1986 to June 1987 following an indication of abuse. In 1989 the mother was indicated in January for inadequate supervision and in August for substantial risk of physical injury, and cuts/bruises/welts against the deceased child's two siblings. The un-named father (not the father of the deceased child) was indicated for substantial risk of physical injury to one of the deceased child's siblings. The siblings entered foster care. A third child was born in June 1990. The mother was indicated for substantial risk of physical injury but the child remained with her. The two other children were returned home in June 1991. In July 1993 the mother and an unknown perpetrator were indicated for substantial risk of physical injury and cuts/bruises/welts to the deceased child's four siblings and an unrelated child. In December 1993 the mother was indicated for failure to thrive and substantial risk of physical injury. An intact family case was opened. In June 1994 the mother was indicated for substantial risk of physical injury to a child of a boyfriend. The intact family case remained open until September 1997. The Department had contact with the family in March 2003 when the mother was indicated for cuts/bruises/welts and substantial risk of physical injury. In July 2003 the deceased child's mother and father were indicated for inadequate supervision. The investigation was pending at the time of the death. The OIG reviewed records in this case.

Case No. 79	DOB 11/14/86	DOD 08/25/03	Natural
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Aspiration pneumonia due to anoxic encephalopathy due to bronchial asthma		
County:	Cook		
Narrative: Sixteen-year-old medically complex child began experiencing difficulty breathing. The family transported the child to the hospital where she was pronounced dead. The child had suffered brain damage from lack of oxygen after an asthma attack at the age of 1 ½ and had been in a vegetative state since that time. The child had home nursing care.			
Prior History: The deceased child's mother adopted a 5-year-old grandchild in 1999. In 2001 the child began experiencing behavior problems and was placed on psychotropic medication. In September 2002 the grandchild was psychiatrically hospitalized for behavior problems at home including fire setting, running away and aggression. When the hospital determined the child was ready for discharge the adoptive parent refused to pick the child up stating that she could no longer handle the child's behavior. Further, the hospital reported that the adoptive parent had not given the child his medication when at home. The grandmother was indicated for abandonment and medical neglect, and the child was taken back into custody and currently has a goal of substitute care pending court decision on termination of parental rights. He has been in the same foster home since coming back into custody two years ago. The OIG reviewed records in this case.			

Case No. 80	DOB 11/12/01	DOD 9/4/03	Natural
Age at death:	21 months		
Substance exposed:	Yes, alcohol		
Cause of death:	Multiple congenital cardiac anomalies		
County:	Kane		
Narrative: Twenty-one-month-old ward died after becoming unresponsive in his foster home where he was being cared for by a nurse and his foster mother, also a nurse.			

Prior History: After a long hospital stay and six months in a residential care facility, the ward was placed with his foster parents who were both trained on how to care for him. The ward also had sixteen hours daily of nursing services. The ward's mother and putative father relinquished their parental rights in January 2003. The child's foster parents planned to adopt him and were granted permission by the juvenile court to bury him. The child's mother has a history with DCFS dating to 1991. Three surviving siblings live with their fathers; a fourth was adopted and a fifth is in a pre-adoptive foster care placement. The OIG conducted a preliminary review of this child's death.

Case No. 81	DOB 7/2/03	DOD 9/13/03	Natural
Age at death:	2 months		
Substance exposed:	No, however, mother has a history of heroin addiction		
Cause of death:	Sudden Infant Death Syndrome		
County:	Kankakee		
Narrative:	Two-month-old infant was found unresponsive by her thirty-eight-year-old mother.		
Prior History:	DCFS first became involved with this family in October 1998 when the mother repeatedly slapped her 2-year-old daughter's face in a doctor's waiting room. The mother was indicated for substantial risk of physical injury and a case was open from March to November 1999 for Family First services. In August 2003 a report of head injuries to the deceased was unfounded. The mother brought the infant to a hospital reporting that the infant's 6-year-old sister accidentally dropped her. The infant had a hematoma on her head. There were no other signs of abuse or neglect to the infant. The 6-year-old told the investigator she dropped the infant and the doctor found the injury consistent with the family's explanation. An intact family case was opened when the infant died. It was closed in October 2004. The OIG reviewed records in this case.		

Case No. 82	DOB 10/06/03	DOD 10/08/03	Natural
Age at death:	2 days		
Substance exposed:	Yes, cocaine		
Cause of death:	Intraventricular hemorrhage		
County:	Cook		
Narrative:	Infant born at 26 weeks gestation and diagnosed with severe cardiac hemorrhaging was placed on a ventilator for respiratory distress. The infant was the mother's fourth substance-exposed infant. The infant never left the hospital and the mother gave permission to remove the infant from the ventilator two days after the birth.		
Prior History:	The 37-year-old mother has an extensive history with DCFS, including 18 child protection investigations in the past 13 years. The family first came to the attention of the Department when the mother gave birth to a substance-exposed infant in June 1991. The Department opened an intact family case until March 1992. In May 1992 the mother was indicated for medical neglect of her 1 year-old child and a second intact family case was opened. In November 1996 the mother was indicated for inadequate supervision of her 3 children, ages 5, 2 and 9 months. The case was closed in August 1997. The mother gave birth to a second substance-exposed infant in March 2001 and a third intact family case was opened. In December 2002 the mother gave birth to her third substance-exposed infant. The child was placed in a traditional foster home because of medical needs. The mother's 2 oldest children live with a maternal aunt. One child remains in the care of the mother with the maternal grandmother as the main caregiver. The OIG reviewed records in this case.		

Case No. 83	DOB 10/20/03	DOD 10/20/03	Natural
Age at death:	0 days		
Substance exposed:	Yes, stillborn but mother tested positive for cocaine		
Cause of death:	Placental Abruption		
County:	Cook		
<u>Narrative:</u> Thirty-year-old mother gave birth to a stillborn baby at 33 weeks gestation. Mother tested positive for cocaine.			
<u>Prior History:</u> The mother had older children, ages 10, 7, 3 and 1 year, in care at the time of their sibling's death. In September 2000 the mother gave birth to her third child, a baby who tested positive for cocaine. An intact family case was open until May 2001. In January 2002 the mother gave birth to another substance-exposed infant prompting the opening of a second intact family case. In August 2003 the intact family worker called the hotline after mother did not enter substance abuse treatment and would not allow the worker to see the children. The children entered foster care. The mother continued to be non-compliant with services after the removal of her children. The siblings remain in foster care and have goals of substitute care pending court decision on termination of parental rights. The OIG reviewed records in this case.			

Case No. 84	DOB 8/3/03	DOD 10/31/03	Natural
Age at death:	2 ½ months		
Substance exposed:	No, though mother has a history of substance abuse		
Cause of death:	Fatty deposition of cardiac cells- severe due to carnitine deficiency		
County:	Stephenson		
<u>Narrative:</u> Two and a half month old baby, born at 27 weeks gestation, had been discharged from the hospital two weeks earlier with monitors. Baby's heart monitor went off and the 19-year-old mother and 23 year old father called the paramedics. The baby was airlifted to a hospital in Wisconsin where she later died.			
<u>Prior History:</u> The mother has 2 older children with a different father than the deceased minor who were removed from her care. In April 2001 the mother and the then 21-year-old father were indicated for medical neglect on their then 4-month-old baby for not using an apnea monitor, but no follow up case was opened. The couple's second child was born in October 2001 and a month later the couple was investigated for medical neglect a second time. The investigation was unfounded but the Department opened an intact case to assist the family. Two investigations in January and March 2002 for inadequate supervision and medical neglect were indicated and the mother was referred for mental health services. In September 2002 the couple separated and the mother moved in with the father of the deceased minor. In December 2002 the mother and her boyfriend were indicated for environmental neglect and were not cooperating with services including drug testing. In March 2003 the Department was given guardianship of the children and they were placed with their biological father where they remain today. In July 2004 the mother gave birth to a baby testing positive for cocaine who was placed in a traditional foster home. The OIG reviewed records in this case.			

Case No. 85	DOB 11/11/03	DOD 11/12/03	Natural
Age at death:	1 day		
Substance exposed:	Yes, cocaine and barbiturates		
Cause of death:	Asphyxia due to placental abruption with prenatal cocaine use		
County:	Kankakee		
<u>Narrative:</u> Baby born at 34 weeks gestation, testing positive for cocaine and barbiturates, died 1 day after birth. The 31-year-old mother, who has 4 older children, was indicated for substance misuse.			

Prior History: At the time of the baby's death the Department had a pending investigation. Two weeks prior the mother had called the hotline to report that she and her children, ages 7, 11, 12 and 13 years were living in a friend's garage and the children did not have any coats. The Department investigated an allegation of inadequate shelter. The investigation found that 2 of the children had been living with the grandmother for sometime. The two other children told the investigator that they had been staying in the house of their aunt, not the garage. All of the children had coats. The youngest child needed a new coat and the principal of the school had arranged for her to receive a coat donated by Sears. The caseworker was linking the mother with services when the deceased minor was born. The mother previously had a intact case open from October 1991 through November 1993 after the mother was indicated for cuts/bruises/welts, and inadequate supervision on the two oldest children. The third child, born in November 1992, was placed with the grandmother until the case was closed. The OIG reviewed records in this case.

Case No. 86	DOB 10/25/03	DOD 11/20/03	Natural
Age at death:	3 weeks		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Narrative: Three-week-old infant was found unresponsive by his thirty-seven-year-old mother with whom he may have been sleeping.			
Prior History: The OIG conducted a preliminary review of this case because the family was involved in an Extended Family Support Program (prior to this infant's birth), from June 2003 to July 2003, following a call from a relative who stated that she had been caring for the mother's two children, as mother was homeless and running the streets. The relative wished to continue caring for the children and expressed interest in obtaining guardianship of them. The agency assigned to the case made numerous attempts to meet with the relative without response, and the case was closed in July 2003. The OIG conducted a preliminary review of this child's death.			

Case No. 87	DOB 5/18/00	DOD 11/28/03	Natural
Age at death:	3 ½ years		
Substance exposed:	No		
Cause of death:	Hydrocephalus due to seizure disorder		
County:	Cook		
Narrative: Three-and-a-half-year-old medically complex child was found unresponsive in the morning by his maternal grandmother. He was transported to the hospital where he was pronounced dead. The child had hydrocephalus, seizure disorder, and was blind and hearing-impaired. There are two surviving siblings, ages 5 and 7.			
Prior History: The mother was indicated for medical neglect of the deceased in October 2000 and August 2001 for failure to follow through on his medical care. An intact family case was opened in January 2001. The mother and her three children moved in with the maternal grandmother who agreed to assist mother with the care of the deceased. The intact family case was closed in July 2004. The OIG conducted a preliminary review of this child's death.			

Case No. 88	DOB 10/26/03	DOD 11/29/03	Natural
Age at death:	34 days		
Substance exposed:	No		
Cause of death:	Sepsis		
County:	Peoria		

Narrative: Infant twins were born at 24 weeks gestation weighing less than two pounds each. Both infants were placed on a ventilator. After a month in the hospital, the mother gave permission to remove one infant from life support. The other twin survived and was taken into custody.

Prior History: The family first came to the attention of the Department in June 2003 when the 19-year-old mother's 21-year-old boyfriend was caring for her 3 month old infant. The boyfriend admitted to hitting the child causing a bruised liver and black eye. The boyfriend was indicated for cuts/bruises/welts. The infant and an eighteen-month-old sibling were placed in the home of the maternal grandmother. The family again came to the attention of the Department in October 2003 when the mother gave birth to the twins. The mother was indicated for risk of physical injury. At the time of the second hotline call, the paramour was awaiting trial on assault charges for the first hotline call. The mother did not cooperate with services. The surviving twin was placed in a traditional foster home. All three children have goals of return home. The OIG reviewed records in this case.

Case No. 89	DOB 10/10/03	DOD 12/17/03	Natural
Age at death:	2 months		
Substance exposed:	Yes, cocaine		
Cause of death:	E. Coli Septicemia due to Gastroenteritis		
County:	Cook		
Narrative: Two-month-old infant was found unresponsive by his 32-year-old mother. The infant had been sleeping on her chest at a friend's home.			
Prior History: DCFS became involved with this family when the infant was born substance-exposed and premature. The mother was indicated for substance misuse and an intact family case was opened. The infant remained in the hospital for six weeks. He was discharged to the care of his mother. The mother agreed to live with her own mother and the maternal grandmother agreed to supervise the mother's care of the infant. At the time of the infant's death, the mother had missed two substance abuse assessment appointments. The OIG reviewed records in this case.			

Case No. 90	DOB 11/4/03	DOD 12/19/03	Natural
Age at death:	1 ½ months		
Substance exposed:	No, though mother has a history of substance abuse.		
Cause of death:	SIDS		
County:	McHenry		
Narrative: Six-week-old baby was discovered unresponsive by his 18-year-old mother who was sleeping with the baby in her arms.			
Prior History: In April 2002 the mother gave birth to a baby testing positive for cocaine. The mother and the 21 year old father, both drug users, agreed to voluntary placement of the baby with relatives and an intact family case was opened under a court order of protection. The mother participated in substance abuse treatment in a residential setting that eventually allowed the baby to reside with the mother. The mother was compliant with services completing the outpatient portion of her treatment in October 2003. In November 2003 the case was closed shortly after the birth of the deceased baby. The OIG reviewed records in this case.			

Case No. 91	DOB 4/19/88	DOD 12/27/03	Natural
Age at death:	15 ½ years		
Substance exposed:	No		
Cause of death:	Reactive airway disease		
County:	Cook		
Narrative: Fifteen-year-old medically complex ward died in his residential care facility. His death was expected and a do not resuscitate (DNR) order was in place.			

Prior History: DCFS became involved with this family in July 1994 when the hotline was contacted with allegations of inadequate food, medical neglect, failure to thrive and malnutrition (non-organic) to the deceased. The 22-year-old mother was indicated on all the allegations and for substantial risk of physical injury to her two other children, ages 8 months and 4 years. The deceased lived in his residential care facility for nine years. The facility had had no contact with his family for eight of those years. The mother saw the child shortly before he died. She has custody of his two siblings. The OIG conducted a preliminary review of this child's death.

Case No. 92	DOB 8/14/03	DOD 12/29/03	Natural
Age at death:	4 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Union		
Narrative: Four-month-old baby was found unresponsive by his seventeen-year-old mother. The infant was reportedly found lying on his stomach with nothing around his face.			
Prior History: In October 2003 the hotline was contacted with an allegation of inadequate supervision. A local health department worker alleged that a woman contacted her stating she needed formula for a baby. The woman stated that the mother dropped her two-month-old son off at her home and was supposed to return in one to two days, but she did not have enough formula or the resources to purchase it. The report was unfounded after the investigator went to the woman's home and found the mother there. The woman was the mother's maternal aunt. The mother and baby were temporarily living with the aunt, and there was some formula in the home. The aunt denied telling anyone the mother dropped the baby off and felt there was a misunderstanding as she was just seeking the mother's WIC allotment of formula. The OIG reviewed records in this case.			

Case No. 93	DOB 12/29/03	DOD 12/30/03	Natural
Age at death:	1 day		
Substance exposed:	Yes, cocaine		
Cause of death:	Extreme prematurity secondary to maternal placental abruption		
County:	Tazewell		
Narrative: Baby was born at twenty-six weeks gestation and died the following day. The 23-year-old mother used crack cocaine for several hours the night before the baby's birth.			
Prior History: The mother, who was abused, and has problems with mental illness and substance abuse, has an extensive history with child protective services. In 1995, when the mother was in another state, she suffered postpartum depression following the birth of her first child. She attempted to smother the baby, who was removed from her care and subsequently adopted. In November 1999 the mother was indicated in Illinois for substantial risk of physical injury on her 8-month-old baby, following a suicide attempt and erratic behavior. The baby was removed from her care and adopted by the paternal grandparents. In May 2003 the mother gave birth to a substance-exposed infant and an intact family case was opened with a private agency. The agency provided intensive services to the mother, baby and 1 ½ year old child, including substance abuse treatment, therapy and supportive services. In December 2003 the agency, for contractual reasons, was transferring the case back to the Department for continued monitoring. During the transition the mother was evicted from her apartment, eluded caseworkers, and moved in with a known drug user. The private agency caseworker called the hotline to report the baby had a rash that had not been treated and the mother had tested positive for cocaine. The investigation was unfounded. Three weeks later the mother gave birth. Following the newborn's death the siblings were taken into custody and placed in a foster home. The OIG conducted a full investigation of the child's death. A report was sent to the director on October 7, 2004.			

Case No. 94	DOB 12/4/03	DOD 1/4/04	Natural
Age at death:	1 month		
Substance exposed:	Yes, cocaine and heroin		
Cause of death:	Bronchopneumonia		
County:	Cook		
<u>Narrative:</u> One-month-old substance-exposed infant was found unresponsive by her thirty-five-year-old mother while they were sleeping overnight at a friend's home. The child died from bronchopneumonia which is often difficult to detect in infants.			
<u>Prior History:</u> The mother became involved with DCFS when she gave birth to the deceased. The mother was indicated for substance misuse and an intact family recovery case was opened (intensive intact family services). The maternal grandmother had signed a safety plan stating she would supervise the mother's care of the infant until the mother was enrolled in substance abuse treatment. The mother had missed two substance abuse treatment intake appointments; a third appointment had been scheduled for the day after the infant's death. The OIG reviewed records in this case. The OIG referred concerns about the case to the DCFS coordinator for Intact Family Recovery Services.			

Case No. 95	DOB 5/23/03	DOD 1/5/04	Natural
Age at death:	7 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Effingham		
<u>Narrative:</u> Seven-month-old infant was found unresponsive face up in his playpen-bed when checked by his 22-year-old mother. The infant lived with his mother, 22-year-old father and 2-year-old sister.			
<u>Prior History:</u> In December 2003 a report of cuts/bruises/welts to the infant was unfounded. The infant was brought to the emergency room by his mother after experiencing difficulty breathing. When examined by a nurse the infant was found to have marks on his chin, chest, back, and tops of his feet that appeared to be bruises. The doctor who examined the child did not believe any of the marks were caused by abuse and stated that three other doctors who also saw the child had no concerns about abuse. One of these doctors was interviewed and agreed. At the time of the infant's death, per the family's request for help, DCFS was assisting the family with two months rent as the father's work hours had been temporarily cut. The OIG reviewed records in this case.			

Case No. 96	DOB 1/7/04	DOD 1/7/04	Natural
Age at death:	0 days		
Substance exposed:	No		
Cause of death:	Extreme prematurity incompatible with life		
County:	Tazewell		
<u>Narrative:</u> Baby was born at 21 weeks gestation and died the same day. The 23-year-old mother had been in the hospital for two weeks because of a high risk pregnancy.			

Prior History: The Department's first contact with the family was in March 2003 when the maternal uncle was indicated for sexual penetration of the mother's 4-year-old child. The mother immediately sought medical attention and agreed to not allow contact with the uncle again. In April 2003 the mother and her boyfriend were indicated for substantial risk physical injury on their 5-month-old child because of domestic violence incidents, with both parents as violence perpetrators in the home. Also, the boyfriend was found to be an unfit parent of his children by another woman. An intact family case was opened. The 4-year-old was no longer in the house as she was residing with her father. In August 2003 the parents of the baby were again indicated for substantial risk of physical injury because of continuing, escalating incidents of violence between the parents in front of the baby. The baby was placed in foster care. The parents have been referred for anger management and psychiatric services but have minimally participated. The OIG reviewed records in this case.

Case No. 97	DOB 10/18/03	DOD 1/10/04	Natural
Age at death:	2 ½ months		
Substance exposed:	Yes, mother said she used cocaine during the pregnancy		
Cause of death:	Viral pneumonia		
County:	Peoria		
Narrative: Baby was found unresponsive in the back seat of the car during a trip the 29-year-old mother and maternal uncle were making from Tennessee to Illinois. The baby, the mother's tenth child, was supposed to be on an apnea monitor but the mother had left the monitor in Tennessee. The baby was born in Tennessee at 33 weeks and had heart problems. The mother had a previous substance exposed baby die in May 2000.			
Prior History: The mother has an extensive history with the Department. In April 1997 through October 1999 the Department had a preventative services case open. In January 2000 the mother gave birth to a substance-exposed infant in Tennessee and Illinois was contacted when the mother moved back to Illinois. The baby died in May 2000 and the Department opened an intact family case because of substantial risk of physical injury due to the mother's drug lifestyle. In September 2000, 5 children, ages 12, 10, 9, 8 and 2, were removed from her care. A seventh child, born in July 2001, was removed shortly after birth. The maternal grandmother has since adopted these children. In May 2002 the mother gave birth to twins in Tennessee who were placed with her father. She signed guardianship of the children over to her father who now lives in Illinois with the children. In June 2004 the mother gave birth to a premature substance exposed baby. The baby was placed with a relative who had undergone training to care for the baby's special needs. The mother has not participated in services. The OIG reviewed records in this case.			

Case No. 98	DOB 8/13/03	DOD 1/11/04	Natural
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Winnebago		
Narrative: Twenty-five year old mother found her 5-month-old baby cold and unresponsive when she went to check on the baby in the morning.			

Prior History: In May 2001 the Department opened an intact family case following an investigation for substantial risk of physical injury. Although the report was unfounded, the mother of three needed treatment for depression following the birth of her youngest child and assistance with managing her 7-year-old son's mental health needs. In February 2002 the mother was indicated for environmental neglect. The mother was cooperative with services and the intact family case remained open. In December 2002 the mother was indicated for inadequate supervision when she left her 10-year-old son alone. The child was taken into custody, but returned to his mother with an order of protection. The intact family case remains open. There have been no further child protection investigations. The OIG reviewed records in this case.

Case No. 99	DOB 7/21/95	DOD 1/14/04	Natural
Age at death:	8 ½ years		
Substance exposed:	No		
Cause of death:	Acute lymphocytic leukemia		
County:	Macon		
Narrative: Eight-year-old child had been suffering from leukemia and was receiving home hospice care at the time of his death. The child had been diagnosed in late September 2003 and spent the next months in a hospital. The mother had taken leave from work to be with the child.			
Prior History: The family had a preventive services case open at the time of the child's death. Previous involvement included preventive services cases from July 1996 to February 1996 and January 1997 to February 1997. The case open at the time of the death was initiated after the child was diagnosed. The Department provided supportive services, referred the siblings for counseling and gave Norman funds to assist with utility bills. The case was closed in February 2004. The OIG conducted a preliminary review of this child's death.			

Case No. 100	DOB 12/25/02	DOD 1/20/04	Natural
Age at death:	12 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Dehydration due to acute febrile illness with prematurity as a contributing factor		
County:	Cook		
Narrative: Twelve-month-old ward was brought to the emergency room by ambulance after he had trouble breathing and did not respond to a nebulizer treatment administered by his foster parent/maternal grandmother. The ward was born prematurely and had respiratory and gastrointestinal problems. The ward was hospitalized eight days prior to his death for treatment of RSV. He was released to his foster parent the evening before his death. The ward had diarrhea while in the hospital and continued to have it when he was released from the hospital.			
Prior History: An intact family case was opened following the child's substance-exposed birth. The child and his 10-year-old sister entered foster care in February 2003 following the continued drug use and beating of their mother by drug dealers or the child's father. At the time of the ward's death, there was a pending investigation against the foster mother for failure to thrive because the ward was not gaining weight. The investigation was unfounded after it was learned that the grandmother was told by medical personnel to decrease the amount of food given to the child through his gtube. Everyone involved in the child's care agreed that the grandmother loved this child very much and took good care of him. The sibling is now in the guardianship of the grandmother. The OIG reviewed records in this case.			

Case No. 101	DOB 8/8/03	DOD 1/29/04	Natural
Age at death:	5 months		
Substance exposed:	No, though mother has a history of substance abuse		
Cause of death:	Respiratory failure, influenza, prematurity		

County:	Cook
Narrative: Five month old medically complex baby, who suffered from Down's syndrome, pulmonary hypertension, cerebral palsy and congenital heart disease was living with her mother and other relatives. The baby began to experience respiratory distress and was transported to the hospital where she later died.	
Prior History: The 39 year old mother has 2 older children that were born substance exposed in July 1999 and April 2000. Both children were taken into custody. The mother's parental rights were terminated and the children were adopted in 2003. The deceased child was born at 27 weeks gestation and did not test positive for drugs. However, the hospital called the hotline because of the mother's prior history and the baby's special needs. The mother was indicated for substantial risk of physical injury because of her history and her admitting to using drugs while pregnant. The mother entered a methadone drug treatment program, and was visiting the baby regularly at the hospital. The mother also moved in with relatives who were supportive and offered to help with the care of the baby. The investigator told the hospital that when the baby was ready for discharge the baby could be released to the mother. The OIG reviewed records in this case.	

Case No. 102, 103	DOB 1/31/04 2/3/04	DOD 1/31/04 2/3/04	Natural
Ages at death:	0		
Substance exposed:	Not tested, but mother tested positive for cocaine and opiates		
Cause of death:	Stillborn & extreme prematurity		
County:	Ogle		
Narrative: Thirty-five-year-old substance-abusing mother gave birth to a stillborn twin daughter. Three days later she gave birth to a son who died two hours later. The babies were born at 22 weeks gestation. The mother has given birth to seven children; three of whom died at birth.			
Prior History: The mother has a history with DCFS dating to 2000. Since that time she has been indicated for neglect numerous times as a result of her drug abuse. Between 2001 and 2003 the mother's four children, now 22 months, 3, 9, and 16 years, entered foster care. Three of the siblings are placed in the same foster home; the oldest child is in a residential treatment facility. The mother has engaged in drug treatment, but continues to relapse. The OIG reviewed records in this case.			

Case No. 104	DOB 6/19/02	DOD 2/7/04	Natural
Age at death:	19 months		
Substance exposed:	No		
Cause of death:	Myocarditis with allergic drug reaction a contributing factor		
County:	Cook		
Narrative: Twenty-two-year-old mother applied orajel to her 19-month-old son's gums because he was teething. His mouth began to swell and the mother and 24-year-old father decided to take the child to the hospital by foot. While walking, the child stopped breathing and the family entered a store and called 911. The child was transported to the hospital where he was pronounced dead.			
Prior History: In July 2003 the hotline was contacted with allegations of failure to thrive and medical neglect to a 1-month-old sibling. The infant had been born prematurely and was sick with a metabolic disorder. He required hospitalization. The infant entered foster care because the mother was noncompliant with the infant's medical care. The State's Attorney's Office did not accept the deceased for court involvement, and he remained at home with his mother. DCFS monitored the child at home, and he appeared to be cared for adequately. The sibling remains in foster care; he is placed in a specialized foster home. The OIG reviewed records in this case.			

Case No. 105	DOB 8/31/01	DOD 2/10/04	Natural
Age at death:	2 ½ years		
Substance exposed:	No		
Cause of death:	Peritonitis due to a ruptured duodenum		
County:	Winnebago		
<u>Narrative:</u> Two-and-a-half-year-old ward died after being brought to the emergency department by his 31-year-old maternal uncle and aunt who were his foster parents. In the two days prior to his death, the ward experienced diarrhea and vomiting. His foster parents brought him to the doctor and he was diagnosed with viral gastroenteritis. The doctor recommended fluids and rest and sent the child home. The following morning the child experienced difficulty breathing and was brought to the emergency department by his foster parents. He arrived at the hospital unresponsive and was unable to be resuscitated. Police and DCP investigations of the child's death were unfounded.			
<u>Prior History:</u> The ward entered foster care in October 2001 after his mother and grandmother were indicated for substantial risk of physical injury to him. His sister had entered foster care seven months earlier. Both children were placed with their maternal uncle in August 2003. He wanted to adopt them. However, in the month prior to the ward's death, the uncle requested the sibling be removed because of her behavior problems. The 10-year-old sibling was removed from her uncle's home in April 2004. She is currently placed in a psychiatric hospital. The OIG reviewed records in this case.			

Case No. 106	DOB 8/18/02	DOD 2/13/04	Natural
Age at death:	18 months		
Substance exposed:	No		
Cause of death:	Congenital Anomalies due to Charge Syndrome		
County:	Cook		
<u>Narrative:</u> The 18-month-old lived with her 17-year-old mother and maternal grandparents. The 18-year-old father lived with his parents, but often visited. The medically complex child required 12 hours of nursing care a day. On the day the baby died a home health nurse came in the early morning and found the child unresponsive. The nurse attempted resuscitation but the child was pronounced dead at the hospital.			
<u>Prior History:</u> In August 2003 the father was indicated for inadequate supervision. The father had taken the child from mother's house to his parent's home for a visit. The father stopped at a store on the way back to the mother's house. Police found the baby alone in the car with the windows closed. The father told investigators that he had left the baby in the car with a friend who stated that she was in the car with the baby but got out to talk to someone and walked a few feet away. The father was indicated for inadequate supervision. The mother agreed to not allow the father to care for the child unsupervised. The Department had an intact case open with the family from August to December 2003 and offered the family services. Both sets of grandparents had been trained to care for the child and were supportive. The home health nurses told investigators the parents interacted appropriately with the child. The OIG reviewed records in this case.			

Case No. 107	DOB 7/8/03	DOD 2/15/04	Natural
Age at death:	7 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Dehydration due to bronchopneumonia		
County:	Cook		
<u>Narrative:</u> Seven month old baby was brought by her 28 year old maternal aunt (who was also her guardian) to the hospital because of severe diarrhea and coughing. The aunt said the baby had been coughing very hard the day before but stopped coughing that afternoon. The baby went into shock and died at the hospital.			

Prior History: Involvement with the Department commenced in July 2003 when the 31-year-old mother was indicated for substance misuse when she and the baby tested positive for cocaine at the birth of the deceased minor. The baby was born at 26 weeks gestation and remained in the hospital for over 2 months. The mother initially agreed to attend drug treatment and an intact family case was opened. After the baby was released from the hospital she went to live at the drug treatment center with the mother. The maternal aunt agreed to care for the sibling while the mother went into treatment. In October 2003 the mother left the treatment center with the baby. The treatment center called the hotline. The report was unfounded because the mother went from the treatment center to her sister's house, and was caring for the baby there with the help of the aunt. The mother chose to enter a different treatment center and signed guardianship of the baby over to her sister. The intact family worker ensured that the aunt had resources and arranged for the baby's healthcare needs. The intact family case was closed in early February 2004. The OIG reviewed records in this case.

Case No. 108	DOB 7/7/95	DOD 2/16/04	Natural
Age at death:	8 years		
Substance exposed:	No		
Cause of death:	Multiple medical problems		
County:	Cook		
Narrative: Eight-year-old ward had been hospitalized after losing consciousness following a blood transfusion. After 12 days in the hospital the child went into cardiac arrest and could not be revived.			
Prior History: The Department became involved with the family in November 1997 after the hotline was called when the then 16 year old mother had not completed training on caring for her child, who had been diagnosed with spinal muscular atrophy, chronic respiratory failure, scoliosis and sickle cell anemia. The mother was indicated for medical neglect and the child was taken into custody. The child was ventilator dependent, used a wheelchair and required a g-tube for feeding. The case was later re-evaluated as a dependency case because of the mother's young age and child's severe medical problems. Child was placed in a specialized foster home, received school and home nursing care and weekly occupational and physical therapy. The OIG conducted a preliminary review of this child's death.			

Case No. 109	DOB 9/5/91	DOD 2/16/04	Natural
Age at death:	12 years		
Substance exposed:	No		
Cause of death:	Sickle Cell Anemia		
County:	Kankakee		
Narrative: Twelve-year-old child died of complications related to his sickle cell anemia. The child was bedridden and needed a tracheotomy after suffering a stroke in October 2002.			

Prior History: Thirty-year-old mother had intermittent contact with the Department since July 2000 when she was indicated for medical neglect and inadequate supervision. An intact family case was opened and the mother went to parenting classes and was linked with resources for childcare and respite health care. The intact family case was closed in July 2002. A second medical neglect allegation was reported in June 2003. The deceased had been re-admitted to the hospital with a deep bedsore on his ankle after being home for only 6 days. The child had been released with home nursing care and special equipment, and hospital staff felt that if the child was turned and cared for properly the bedsore would not have re-opened. The mother explained that she first saw the sore yesterday when the nurse changed the bandage for the first time as mandated by orders from the hospital. The home health nurses, the case manager from the Division of Specialized Care for Children, and the child's pediatrician all related that the mother had taken good care of the child and the re-opening of the sore was not because of lack of care from the mother. Further, the doctor, nurses and case manager noted that because of a shortage of home health nurses the family was not receiving all the hours of care they were supposed to and the mother was getting less respite. The investigation was unfounded. The OIG reviewed records in this case.

Case No. 110	DOB 1/27/94	DOD 2/22/04	Natural
Age at death:	10 years		
Substance exposed:	No, although mother has a history of substance abuse		
Cause of death:	Cerebral Palsy and Seizure Disorder		
County:	Cook		
Narrative: Ten-year-old medically complex ward began experiencing respiratory distress at his residential care facility and was brought to the hospital where he was pronounced dead.			
Prior History: The Department's first contact with the family was in February 1994 when the 27-year-old maternal uncle was indicated for sexual penetration of the deceased's 10 and 12-year-old sisters. In September 1994 the uncle was indicated for substantial risk of physical injury on all four children, as was the 29-year-old mother when the uncle was found to be living in the home with the children. The mother was also alleged to have a substance abuse problem. In October 1994 the Department took custody of the children and they were placed with a relative. In September 1995 the deceased became ill and was placed at a residential care facility for two months before returning to the relative. In April 1996 the deceased again required nursing care and was placed in the care facility where he remained until his death. The siblings remained with relatives. While wards the two oldest siblings were involved with the teen parent network and have reached majority age. The third sibling remains with a relative who now has guardianship. The OIG conducted a preliminary review of this case.			

Case No. 111	DOB 12/6/03	DOD 2/26/04	Natural
Age at death:	2 ½ months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Narrative: Two-and-a-half-month-old infant was found unresponsive in the morning by his nineteen-year-old mother who is a ward. The mother had a bassinet, but the infant slept with the mother that night because he did not like the bassinet. The infant was put to sleep on his stomach, however, when mother awoke she found the infant on his back. The mother had received prenatal care.			
Prior History: The mother of the deceased has been a ward since 1992. The mother was living with her baby in a licensed foster home. The mother attended parenting classes and teen mom group meetings. She also attended school consistently and was an honor roll student. The OIG conducted a preliminary review of this child's death.			

Case No. 112	DOB 12/9/03	DOD 3/7/04	Natural
Age at death:	3 months		
Substance exposed:	Yes		
Cause of death:	SIDS		
County:	Cook		
<u>Narrative:</u> Three-month old ward found unresponsive, by his foster mother's boyfriend, laying on his back in an adult bed in the morning. The foster mother's boyfriend was caring for the child while she was at work. DCP unfounded an investigation of the child's death.			
<u>Prior History:</u> The deceased baby was the 27-year-old mother's sixth child, her second born substance exposed. The 5 other children, ages 10, 9, 8, 5 and 1 ½ years at the time of the death, are wards of the state. The 4 oldest children were taken into custody in July 1998 after the mother was twice indicated for inadequate supervision and substantial risk of physical injury and gave birth to a substance exposed baby. Those children were placed with their maternal grandmother and have a goal of adoption. The mother's parental rights were terminated in April 2004. The fifth child was born testing positive for opiates in July 2002 and was placed in a traditional foster home. His foster parent adopted the child in February 2004. The deceased baby came into care shortly after birth and was placed in the foster home in which he died. The Department has had no further contact with the mother. The OIG reviewed records in this case.			

Case No. 113	DOB 1/5/89	DOD 3/11/04	Natural
Age at death:	15 years		
Substance exposed:	No, although mother has a history of alcohol abuse		
Cause of death:	Acute pneumonia with contributing factor of severe malnutrition		
County:	McHenry		
<u>Narrative:</u> Fifteen-year-old, who suffered from cerebral palsy and was severely disabled, was found unresponsive by his 44-year-old mother. Paramedics found the child who weighed 23 pounds lying on a carpet stained with urine and feces, wearing only a diaper. He had not been in school or seen a doctor for over two years. The child's six siblings, ranging in age from 2 to 17 years, were taken into custody. The parents, who were separated because of domestic violence, were both indicated for the child's death, medical neglect, and substantial risk of physical injury. The mother was also indicted for malnutrition, inadequate food and clothing to the deceased minor and environmental neglect and inadequate supervision to all the children.			
<u>Prior History:</u> In January 2003 police responded to a fight between the 47-year-old father and his 16-year-old son. The police noted that the father was drunk and the police had been called to the home for previous domestic disputes and reported the incident to the hotline. The DCP investigator interviewed the father, who was arrested and did not return to the home, by phone. Other children in the home were not listed on the hotline report, however, the police report, which was in the investigative file, had the names and ages of the 6 other children. The investigator did not see the other children in the household. The investigation was indicated for substantial risk of physical injury and referrals for domestic violence services were provided. The Department had no further contact with the family. The six siblings are in foster care with relatives. The mother has been charged with involuntary manslaughter, criminal neglect of a disabled person, and endangering the life of a child. She is awaiting trial. The OIG conducted a full investigation of this case. A report was sent to the director on June 30, 2004.			

Case No. 114	DOB 3/4/04	DOD 3/16/04	Natural
Age at death:	12 days		
Substance exposed:	Yes, cocaine		
Cause of death:	Trisomy 18		
County:	Cook		
<u>Narrative:</u> Twelve-day-old infant born substance-exposed died from the chromosomal abnormality Trisomy 18. He never left the hospital.			
<u>Prior History:</u> At the time of his death, the Department was investigating the infant's substance-exposed birth. Three of the 37-year-old mother's four surviving children (the fourth is an adult) have been in subsidized guardianship with their maternal grandmother since May 2002. The OIG reviewed records in this case.			

Case No. 115	DOB 2/17/04	DOD 3/19/04	Natural
Age at death:	1 month		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
<u>Narrative:</u> One-month-old infant was put down for a nap on his stomach in a bassinette by his thirty-four-year-old father. The infant was found unresponsive two hours later. The infant lived at home with his father, 29-year-old mother, and four siblings, ages 5, 6, 9, and 11.			
<u>Prior History:</u> Prior to the birth of the deceased, in May 2003 there was an unfounded DCP investigation for cuts/bruises/welts to an 8-year-old sibling. The child's school contacted the hotline to report that the boy had a torn shirt and marks under his left arm from being thrown by his mother's boyfriend (the father of the deceased). The boy and the boyfriend separately described an incident where the boyfriend grabbed the boy out of a tent and threw him down, catching his shirt on a nail tearing it and scraping the boy's arm. The boy was supposed to be getting ready for school. The boy and his 5 and 9-year-old siblings denied abuse in the home. The boy was having trouble adjusting to his parents' divorce and his mom's new boyfriend, and the school provided the mother with a counseling referral. The OIG reviewed records in this case.			

Case No. 116	DOB 4/27/01	DOD 3/19/04	Natural
Age at death:	2 ½ years		
Substance exposed:	No		
Cause of death:	Sepsis due to pneumonia		
County:	Cook		
<u>Narrative:</u> Two-and-a-half-year-old medically complex ward had a small infection that quickly resulted in acute respiratory distress. The child was transferred from the residential care facility in which he lived to the hospital. The infection spread quickly and the child died several hours later.			

Prior History: In July 2001 the deceased child, then 2 months, and his two siblings, ages 4 and 3 years, were taken into custody after the deceased was severely injured. The 25-year-old father violently shook the child leaving him in a persistent vegetative state. The father was indicated for head injuries and the 24-year-old mother was indicated for substantial risk of physical injury. The father was charged with assault but was never prosecuted. The baby was placed in a specialized foster home for a brief period until his needs required placement in the residential care facility. His siblings were placed in foster care with a relative until September 2003 when they were returned to their mother who had completed services through the Department. The child's death certificate was signed out at the hospital as a natural death. If the hospital had notified the medical examiner's office of the death with a history of shaken baby syndrome the medical examiner would have required an autopsy and could have signed the death out as a homicide due to the shaking injury, placing the child at extreme risk for infection. The OIG facilitated a meeting between the hospital and the medical examiner's office to assure notification of child deaths in the future. The OIG conducted a preliminary review of this child's death.

Case No. 117	DOB 3/26/04	DOD 3/26/04	Natural
Age at death:	0 days		
Substance exposed:	Yes, cocaine		
Cause of death:	Extreme prematurity incompatible with life		
County:	Kane		
Narrative: Baby born at 22 weeks gestation lived approximately 3 hours after birth. The 23-year-old mother had received no prenatal care and both mother and baby tested positive for cocaine.			
Prior History: The mother, a former ward with mental health issues, has a history with the Department both as a child and a parent. The deceased baby is the mother's fourth child. The oldest child, born when the mother was 16 was removed from the mother in June 1999 after the mother left the child without a care plan while she was out using drugs. The baby was adopted by the foster parent with whom the mother and the baby had been placed since October 1996. The next contact came in October 2002 when the Department indicated the mother and her 30-year-old boyfriend for substantial risk of physical injury after police were called to the house for a domestic disturbance. The mother said the father was drunk and hit her. When the police arrived the mother chose not to file a report and was arrested on an outstanding warrant. The children ages 1 year and 3 months were home at the time. The family was offered services but could not be located, despite a diligent search as the family moved during the investigation. In October 2003 when the mother was arrested for solicitation and told police she had left her children ages 1 and 2 years alone in a motel room. The children were placed with the father and the paternal aunt where they remain. The Department has had no further contact with the mother. The OIG reviewed records in this case.			

Case No. 118	DOB 6/23/03	DOD 4/2/04	Natural
Age at death:	9 months		
Substance exposed:	No		
Cause of death:	Myocarditis		
County:	Livingston		
Narrative: Nine-month-old infant's apnea monitor went off; CPR was attempted and 911 was called. The infant was pronounced dead at the hospital. The child died from myocarditis, which is inflammation of the muscle tissue of the heart. Endocardial fibroelastosis was listed as a significant condition contributing to the child's death.			

Prior History: There were five unfounded reports from September 2002 to September 2003 on the 24-year-old mother with regard to her 4-year-old son, who was the subject of a custody dispute between his parents and subsequently went to live with his father. There was one prior October 2003 report unfounded for medical neglect to the deceased who was born prematurely and had a history of medical problems, including apnea. There was a pending report of substantial risk of physical injury to the deceased by her mother at the time of the infant's death. A week earlier the infant had been hospitalized for an apneic episode and medical personnel were concerned about the mother's mental health and ability to care for the child. The mother and father were in the process of separating and the mother was depressed. Her family stepped in to help care for the deceased and her 2-year-old sister. Following the infant's death, the mother gave temporary custody and guardianship of her 2-year-old to her mother. The OIG reviewed records in this case.

Case No. 119	DOB 2/27/04	DOD 4/2/04	Natural
Age at death:	1 month		
Substance exposed:	Yes, cocaine		
Cause of death:	Congenital heart disease		
County:	Cook		
Narrative: One-month-old ward was in the car with his foster mother-aunt and cousin when he began having trouble breathing. She rushed him to the hospital where he was pronounced dead.			
Prior History: The ward entered foster care at birth. He was born full-term, but weighing only 3 pounds, 11 ounces. His mother admitted to using cocaine and alcohol during her pregnancy. The mother had given birth to another substance-exposed infant one year earlier. That child was placed at birth with the maternal grandmother who had adopted three of the mother's older children. The OIG reviewed records in this case.			

Case No. 120	DOB 10/25/95	DOD 4/3/04	Natural
Age at death:	8 ½ years		
Substance exposed:	Unknown		
Cause of death:	Acquired immune deficiency syndrome (AIDS)		
County:	Cook		
Narrative: Eight and a-half-year-old child who suffered from AIDS, died at home with her adoptive parents. The child had been adopted five years earlier by her grandparents with whom she was placed at ten days old.			
Prior History: In December 2003 the adoptive parents were unfounded report for medical neglect. The parents took the child to the emergency room because she had been suffering from a high fever. When the emergency room doctor began asking questions about the child's medical condition and medications the parents got upset and left the hospital against medical advice. The mother told the investigator that they monitor the child very closely. Earlier that night they had called their primary care physician and was told by a doctor on call that if the fever did not break the child should be taken to the hospital. The mother said she did not wait for the fever to break and instead went to the hospital immediately. She related that when the doctor began asking her questions about the child's medications she felt the staff was insinuating that they had not been giving them to her. She noticed that the child's fever had broken so they left the hospital. The child saw her regular physician the next day. The doctor who called in the report and the investigator spoke with the child's primary care physician who spoke positively about the family. The doctor confirmed that the child had been seen and that the parents were attentive. The doctor felt the parents were emotional because the child was nearing the end stage of the disease. The OIG reviewed records in this case.			

Case No. 121	DOB 12/19/03	DOD 4/4/04	Natural
Age at death:	3 ½ months		
Substance exposed:	Yes, positive for opiates		
Cause of death:	SIDS		
County:	Cook		
<u>Narrative:</u> 3 ½ month old ward, born one month prematurely and testing positive for opiates, was found unresponsive in his crib by his foster mother when she checked on him in the morning.			
<u>Prior History:</u> Thirty-one-year-old mother, tested positive for opiates and PCP, gave birth to the deceased minor who tested positive for cocaine. The mother left the hospital against medical advice and never came back to pick up the baby. The Department attempted to locate the mother, who gave a false address, phone number and emergency contact to the hospital, but was unsuccessful. The baby was placed in a traditional foster care home. The Department has had no further contact with the mother. The OIG reviewed records in this case.			

Case No. 122	DOB 11/13/03	DOD 4/13/04	Natural
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Madison		
<u>Narrative:</u> Five-month-old infant was found unresponsive by her 27-year-old father with her face against a pillow. The parents, the deceased, and her 21-month-old sibling were visiting family members and had been sleeping on the floor, with the children surrounded by pillows. Positional asphyxia was considered, however, no scene photos confirmed a position of the infant, which would result in positional asphyxia.			
<u>Prior History:</u> In December 2003 there was an unfounded investigation for medical neglect of the deceased. The 21-year-old mother brought the infant to the hospital stating she had a fever. Hospital personnel did not find a fever, but told the mother they wanted to do a spinal tap. The mother took the baby out of the hospital against medical advice and said she would follow-up at another hospital. Investigation revealed that the mother took the child the following day to another hospital and no fever was detected. The OIG reviewed records in this case.			

Case No. 123	DOB 1/10/02	DOD 4/15/04	Natural
Age at death:	27 months		
Substance exposed:	No		
Cause of death:	Bowel obstruction due to intussusception		
County:	Cook		
<u>Narrative:</u> Twenty-seven-month old child exhibiting flu-like symptoms was brought to the hospital by his 21-year-old mother and 20-year-old father. He died the following morning from bowel obstruction due to intussusception (infolding of one part of the intestine into another).			
<u>Prior History:</u> In February 2004 the hotline was called by a hospital alleging medical neglect of the deceased's younger sister who was born prematurely in May 2003 and required follow-up for various health issues. The hospital was concerned because the mother had failed to bring the baby in for medical appointments. Investigation revealed that the mother was bringing the baby to another hospital for care and was following through with her appointments. The investigation was unfounded, but the Department opened a preventive services case to ensure that the child received medical attention and her mother was capable of providing for her medical needs. The mother and her two children lived with her parents, and the father was involved with the family. The case was closed in June 2004. The OIG reviewed records in this case.			

Case No. 124	DOB 1/2/04	DOD 4/16/04	Natural
Age at death:	3 months		
Substance exposed:	yes, cocaine		
Cause of death:	Cor pulmonale due to Bronchopulmonary dysplasia due to prematurity		
County:	Cook		
<u>Narrative:</u> Three-month-old baby brought to hospital by 20-year-old aunt who noticed the baby was unresponsive. The aunt said the 34-year-old mother had dropped the baby off a few hours earlier and left. The aunt thought the baby was sleeping until she checked him and found him to be cold. The baby was pronounced dead at the hospital.			
<u>Prior History:</u> The deceased baby was the mother's fourth child, her third substance exposed. The mother's oldest child, now age 18, was raised by a relative. The mother first came to the attention of the Department in November 1993 when she gave birth to a substance exposed infant. In June 1994 the mother was indicated for failure to thrive on her then 7-month-old baby and an intact case was opened until June 1995. In April 2001 the mother gave birth to a second substance exposed baby and an intact case was opened until July 2002. The next contact came with the birth of the deceased infant. The baby was born prematurely, at 26 weeks gestation and remained in the hospital for almost 3 months after the birth. The mother was indicated for substance misuse, agreed to enter inpatient treatment and an intact case was opened. Upon discharge from the hospital the baby was placed with the mother at the treatment center. Within 2 weeks the mother left the treatment center. The intact family worker assisted the mother in locating a shelter for herself and her children. The mother took her children to the aunt's the day the child died. The siblings, ages 3 and 11 years, and the mother currently reside with relatives. The intact family case remains open. The OIG is conducting a full investigation of this case.			

Case No. 125	DOB 2/5/01	DOD 4/19/04	Natural
Age at death:	3 years		
Substance exposed:	No		
Cause of death:	Multisystem organ failure due to Trisomy 18 chromosome disorder		
County:	Cook		
<u>Narrative:</u> Medically complex child died at hospital. Child had recently been operated on for narrow pulmonary outflow on the right side of the heart.			
<u>Prior History:</u> There had been several calls to the hotline for medical neglect on the child. All of the investigations were unfounded. The child's medical treatment often required that the minor receive blood products or blood transfusions. The parents, for religious reasons, could not consent to such procedures so doctors took protective custody in order to perform the procedures. The investigators would then allow protective custody to lapse. There was no concern of abuse or neglect. The OIG conducted a preliminary review of this child's death.			

Case No. 126	DOB 2/26/04	DOD 4/28/04	Natural
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Mesenteric fibrosis lung disease due to prematurity		
County:	St. Clair		
<u>Narrative:</u> Two-month-old infant died from medical complications. The infant was born prematurely at 30 weeks and had numerous medical problems. He never went home after birth. The infant had surgery for renal problems and thrombosis. The twenty-year-old mother had a history of hypertension, but reportedly had adequate prenatal care and no history of drug use.			

Prior History: In May 2003 the mother was indicated for head injuries by abuse to another child. The nine-month-old child was diagnosed with a left parietal skull fracture and a subdural hematoma. The mother told the doctor that the infant fell off the bed. The doctor reported the injuries to the hotline because mother's explanation was not consistent with the injuries. The investigator never determined how the infant was injured or by whom, but rather indicated the case for head injuries because the mother failed to return for a follow-up appointment with the neurologist. The family declined intact family services. The OIG is conducting a full investigation of this case.

Case No. 127	DOB 7/19/90	DOD 5/11/04	Natural
Age at death:	13 years		
Substance exposed:	No		
Cause of death:	Respiratory failure due to multiple medical problems		
County:	Cook		
Narrative: Thirteen-year-old ward went into respiratory distress at his residential care facility and was transferred to the hospital. The child had a longstanding Do Not Resuscitate order because of the chronic lung disease and multiple medical problems.			
Prior History: The child was a quadriplegic and suffered from severe spastic cerebral palsy and asthma. The Department opened an intact case on the family in May 1992 after the then 18-year-old mother was indicated for medical neglect. Two months later, when the child was 2 years old, the child came into custody. The child was initially placed with the grandmother. In March 1994 the child's condition grew worse and he was placed at the residential facility where he remained until his death. The child's grandmother remained involved with him at the residential facility. The child's 2 siblings, now ages 13 and 8 years, were never taken into custody. The OIG conducted a preliminary review of this child's death.			

Case No. 128	DOB 3/6/04	DOD 5/15/04	Natural
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Dehydration		
County:	DuPage		
Narrative: Two-month-old infant was found unresponsive by her 21-year-old mother and 22-year-old father who were sleeping in bed with her. At autopsy the child was found to be dehydrated. A DCP investigation of the infant's death was unfounded, but a Family First case was opened to provide services to the developmentally delayed parents and their surviving 1-1/2-year-old daughter.			
Prior History: There were two prior unfounded DCP investigations involving this family. The first investigation was in August 2003 when a report was made alleging medical neglect because the parents failed to obtain a follow-up x-ray for an accidental head injury to their 8-month-old daughter. The investigation was unfounded when it was determined that the parents showed up for the x-ray but were turned away. The x-ray was completed and there were no injuries. The second investigation was in April 2004 when a community social worker visiting the family found the home filthy. The report was unfounded after the parents cleaned the home. The reporter and prior investigator both stated they had not witnessed the home to be dirty previously. The OIG reviewed records in this case.			

Case No. 129	DOB 2/24/04	DOD 5/19/04	Natural
Age at death:	2 ½ months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Tazewell		

Narrative: Two-and-a-half-month-old was found unresponsive by her 22-year-old father. The infant was lying on her side. Factors present thought to contribute to SIDS included: excessively warm home, smoking mother, and low socioeconomic status.

Prior History: In the week prior to this infant's death, there were two DCP investigations unfounded against the family; one against the mother and father and the other against the paternal grandmother. The investigations revealed conflict between the mother and grandmother that resulted in the hotline reports against each other. The deceased and her 1-year-old sister appeared well cared for. The OIG reviewed records in this case.

Case No. 130	DOB 3/9/04	DOD 5/26/04	Natural
Age at death:	2 ½ months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Sangamon		
Narrative: Two-and-a-half-month-old infant was found unresponsive by her twenty-six-year-old mother and forty-year-old father during a nap.			
Prior History: There was a pending DCP investigation for inadequate supervision of two of the deceased's siblings. This investigation was ultimately unfounded, as were investigations involving the family in 9/03, 2/04 and 3/04. While there were concerns about the family's lifestyle, no abuse or neglect of the children was substantiated. The family declined DCFS services, which were offered following the infant's death. There have been no further reports involving this family. The OIG reviewed records in this case.			

Case No. 131	DOB 1/28/00	DOD 5/28/04	Natural
Age at death:	4 years		
Substance exposed:	No		
Cause of death:	Hypoxic Encephalopathy due to aspiration pneumonia due to seizure disorder		
County:	Lee(residence) Winnebago (death)		
Narrative: Four-year-old ward had flu-like symptoms for a week and had been seen by a doctor. He awoke late at night screamed and his foster father found he had vomited. The child became unresponsive and was rushed to the hospital.			

Prior History: The child and his then 8-month-old sibling came into care in October 2002 after their 22-year-old mother was indicated for substantial risk of physical injury. The mother was mentally ill, had left them without a care plan and had exposed them to dangerous situations. The siblings were placed together in traditional foster care. In April 2003, 6 months after placement, the 39-year-old foster mother brought the child to the hospital for seizures and reported a fall from a bed and a fall in the bathroom onto a tiled floor. The child had a subdural hematoma and retinal hemorrhages that were suspicious for shaking but a doctor said were consistent with the stories. In May 2003 the foster mother was investigated for substantial risk of physical injury when a therapist reported that foster mother was treating the child roughly. The investigation was unfounded when the doctor found no injuries and the therapist said she mainly had heard the child crying and had not seen abusive behavior. In August 2003 the child was again brought to the hospital with a subdural hematoma and bruises to the ear. A doctor opined that the injuries were consistent with shaking. Further, the investigation found witnesses that stated they had seen the foster mother flick the child in the head and roughly pulling on the child. The foster mother was indicated for head injuries and substantial risk of physical injury and the child and the sibling were removed. In May 2004 the child was brought to the hospital with bruises and reports of seizure-like behavior and died shortly after admission. During the course of the death investigation the biological mother reported that during the Summer of 2002, before her children came into care, a boyfriend had picked up her son and violently shook him. Her child seemed dazed, but then went to sleep and seemed okay the next day so she never told anyone of the incident. The pathologist found old head injuries and stated the bruises were consistent with having seizures and falling. The child died because of choking on his own stomach contents during seizure activity. The OIG is conducting a full investigation of this child's death.

Case No. 132	DOB 5/14/03	DOD 5/28/04	Natural
Age at death:	1 year		
Substance exposed:	No		
Cause of death:	Myocarditis		
County:	Cook		
Narrative: One-year-old girl was found unresponsive by her 19-year-old mother during a nap.			
Prior History: There was a DCP investigation unfounded 2 days prior to the girl's death. The investigation alleged that the mother's 2-year-old daughter had genital warts for which she was treated. The investigation was unfounded because there was no evidence of sexual abuse, the mother also had genital warts, and it was likely the girl contracted the warts from her mother during birth. The OIG reviewed records in this case.			

Case No. 133	DOB 3/29/04	DOD 5/28/04	Natural
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Narrative: Two-month-old infant was found unresponsive in the morning by his primary caretaker. The 31-year-old caretaker and her boyfriend called 911 and the infant was transferred to the hospital where he was pronounced dead. The caretaker was a family friend with whom the infant's 22-year-old mother made a care plan.			

Prior History: The caretaker is a licensed foster parent. In September 2003 the hotline was contacted with an allegation of cuts/bruises/welts to a 10-year-old foster child in the home by the foster mother's 43-year-old boyfriend, who did not live in the home at the time of the infant's death. The report was unfounded and the child was moved to a relative placement. The infant's mother was the subject of three DCP investigations between January 2003 and April 2004 for inadequate supervision. It was alleged that the mother was leaving her children, ages 2 and 3, with inappropriate caretakers. The first investigation was indicated and the subsequent ones were unfounded. A child welfare services (voluntary) case was opened shortly after the infant's birth. The mother was requesting assistance because she had just given birth and had no home. The OIG is conducting a full investigation of this case.

Case No. 134	DOB 5/15/04	DOD 6/4/04	Natural
Age at death:	3 weeks		
Substance exposed:	Yes, cocaine and alcohol		
Cause of death:	Complications of premature birth possibly due to intrauterine cocaine exposure		
County:	Macon (case management) Sangamon (death)		
Narrative: Three-week-old infant born prematurely at twenty-three-weeks gestation, weighing only a little over a pound, died in the hospital. Both she and her mother tested positive for cocaine at the time of her delivery.			
Prior History: There was an intact family case open at the time of the infant's death. In March 2004 the 40-year-old parents were indicated for substantial risk of physical injury to their 2-year-old child because of domestic violence and alcohol abuse. An intact family case was opened. A month and a half later, the mother gave birth to the substance-exposed infant and DCP initiated an investigation for substance misuse. Following the infant's death, the mother was indicated for substance misuse, death by neglect, and substantial risk of physical injury to her surviving 2-year-old child because of her continued drug and alcohol abuse. The father was also indicated for substantial risk of physical injury to the 2-year-old child who was removed from his parents and placed in foster care. The OIG is conducting a full investigation of this case.			

Case No. 135	DOB 12/23/01	DOD 6/6/04	Natural
Age at death:	2 ½ years		
Substance exposed:	No		
Cause of death:	Multiple medical problems, cerebral palsy		
County:	Cook		
Narrative: Two-year-old medically complex child was found unresponsive by his 27-year-old mother. He was transported to the hospital where he was pronounced dead. The child had cerebral palsy and was fed by g-tube.			
Prior History: In August 2003 DCFS was contacted with a report of inadequate supervision. An early intervention therapist reported that she called the home and a 12-year-old cousin was babysitting the child. The reporter believed the 12-year-old could not care for the child because of his severe disabilities. The report was unfounded as the parents reported the father was at home sleeping at the time (he worked nights) and another service provider and family member reported that the child was always appropriately supervised. The OIG reviewed records in this case.			

Case No. 136	DOB 5/5/04	DOD 6/12/04	Natural
Age at death:	1 month		
Substance exposed:	No		
Cause of death:	SIDS		
County:	Champaign		
<u>Narrative:</u> A 38-day-old baby last seen alive when put to bed the night before the infant was found unresponsive in the morning.			
<u>Prior History:</u> In September 2003 the 23-year-old mother was investigated for an allegation of inadequate supervision on her then 4-year-old child. The school bus had come to drop off the 4-year-old after the Head Start program but no one came to meet him. The bus took the child back to school and the principal took the child to the police department. The investigation was unfounded after the mother came to the police station and explained that she was home but was tending to her other children ages 2 years and 10 months. The mother stated that in the past the driver would have the children come to the door and make sure the child got in the house. The mother eventually went to the school where a maintenance worker told her the principal had taken the child. The DCP investigator interviewed the principal who told the investigator they have a policy of taking the child to the police to emphasize the importance of having a care plan for the child's safety when the child is brought home. The principal said she did not feel as though DCFS needed to be involved. The investigator unfounded the case. The OIG reviewed records in this case.			

Case No. 137	DOB 6/13/04	DOD 6/13/04	Natural
Age at death:	0 days		
Substance exposed:	No		
Cause of death:	Prematurity		
County:	McLean		
<u>Narrative:</u> Baby born at 27 weeks gestation to a 27-year-old mother who had not received any prenatal care. The baby lived for about 30 minutes after birth.			
<u>Prior History:</u> The Department became involved with the family in February 2002 when the hotline received a report that the mother was living with the then 28 year old father of her 2 youngest children who is an indicated perpetrator of sexual abuse to other children. The father was indicated for risk for sexual abuse. An intact family case was opened and the mother agreed to not allow her children then ages 6, 3 and 1 to have unsupervised contact with the father. In June 2002 the children were taken into custody after the mother was found to have violated the safety plan several times. The oldest child was placed with her father and the 2 youngest went into foster care. In June 2003, the mother gave birth, prematurely, to her fourth child who was taken into custody, despite the parents attempt to hide the child from the Department. In April 2004 the court began the process of terminating the parent's parental rights because of the father's refusal to participate in services and the mother's denial of the father's sexual abuse past. The oldest child remains with her father and the three other siblings remain in foster care. The parents are in the process of having their rights terminated. The OIG reviewed records in this case.			

Case No. 138	DOB 2/27/04	DOD 6/19/04	Natural
Age at death:	3 ½ months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
<u>Narrative:</u> Three-and-a-half-month-old infant born prematurely at twenty-seven weeks gestation was found unresponsive in his crib by his twenty-year-old mother. The mother reported that she last saw him alive at 4:30 a.m. when she fed him. The infant had respiratory problems for which he was prescribed albuterol.			
<u>Prior History:</u> In March 2003 DCFS was contacted with a report of inadequate clothing. A nurse reported that mother had come to a clinic with her two small sons, both of whom were inappropriately dressed for the weather. The report was unfounded as the investigator interviewed the mother and observed adequate clothing. Four months later, in July 2003, DCFS was contacted with allegations of environmental neglect and inadequate food. The twenty-six-year-old father was the reporter. He stated that mother was not bathing or feeding the children and the house was littered with garbage, old food and dirty diapers. The case was unfounded as the investigator found the home clean with ample food, and the children appeared healthy and well-cared for. The OIG reviewed records in this case.			

Case No. 139	DOB 4/26/04	DOD 6/23/04	Natural
Age at death:	1 ½ months		
Substance exposed:	Yes, cocaine		
Cause of death:	Edwards Syndrome (Trisomy 18 genetic disorder)		
County:	Madison		
<u>Narrative:</u> One-and-a-half-month-old infant died at home from a genetic disorder. His death was expected and the family received hospice and nursing care services.			
<u>Prior History:</u> DCFS became involved with this family when the infant was born substance-exposed. The 34-year-old mother was indicated for substance misuse and an intact family case was opened. The infant was the mother's fourth child. Her 7 and 10-year-old children live with their father and she sees them often. A 3-year-old lives with her and the child's father. The family appeared well-functioning and stable. The mother explained her use of cocaine as due to the stress of learning her child's medical condition. The intact family worker planned for the mother to undergo a substance abuse assessment. The intact family case remains open. The OIG reviewed records in this case.			

Case No. 140	DOB 3/23/04	DOD 6/30/04	Natural
Age at death:	3 months		
Substance exposed:	No, though mother has a history of substance abuse		
Cause of death:	Acute Pneumonia		
County:	Winnebago		
<u>Narrative:</u> Three-month-old infant was sleeping in bed with his 26-year-old mother who awoke to find the baby cold. Infant, who weighed 2 ½ pounds at birth, and his twin were born at 33 weeks gestation. The mother suffers from epilepsy and mental illness.			

Prior History: The mother, who has 2 older children, has had sporadic contact with the Department since July 1996 when she gave birth to a baby testing positive for marijuana. It was also reported that the mother had a baby die of SIDS two years prior. The case was indicated for substantial risk of physical injury and an intact family case monitored the family until November 1996. In April 2002 the mother was indicated for inadequate supervision on her then 5 year old and 19 month old, when she admitted to leaving them alone for 20-30 minutes at a time. The mother was referred to a family educator and parenting classes. In January 2003 the mother was indicated for inadequate supervision when she left her children, ages 2 and 6 years, in the car for 2 hours while she went into the county jail to bail out her boyfriend. Mother was arrested on child endangerment charges. The grandparents became involved with the children and the family was referred for community services. Three months later the Department investigated the mother for substantial risk of physical injury when a probation officer found the mother had marijuana on a dresser in reach of the children. The case was unfounded when the investigator determined the children had not accessed the marijuana and were doing well in school and at home. Mother went into drug treatment during the course of the investigation. In December 2003 an investigation was unfounded for inadequate supervision when she did not answer the door upon the 6 year old coming home from school. Mother, who was pregnant with twins, reported it happened when she and the younger child were napping. In April, June and July, there were 3 investigations for substantial risk of physical injury on the newborn twins because of the mother's history and the medical problems of the infants. The investigations were unfounded. The OIG reviewed records in this case.

¹ Medical Examiner or Coroner's Office ruling on manner of death.

CHILD DEATH SUMMARY (FY 2000 – 2004)

This year marks the fifth year that the OIG began to systemically collect data on deaths referred to the office by the State Central Register. The State Central Register informs the OIG of those child deaths that have had any type of DCFS involvement in the previous year. The information has been organized into the major categories of age of the child, manner of death and DCFS status at the time the OIG received the death information. Manner of death is determined by the Medical Examiner, Coroner, or Coroner's Jury. The intersection of categories gives a context for further investigation into the deaths. Interventions need to target all three areas.

Over the five years the number of deaths has increased. That does not necessarily mean that the actual number of deaths of children involved with DCFS has increased or that the number of child deaths in the state of Illinois has increased. Child Death Review Teams throughout the state have been working to increase the reporting of child deaths to the State Central Register by other agencies, especially hospitals and coroners throughout the state. Better reporting certainly would increase the number of deaths referred to the OIG by the State Central Register. Yet, certain categories should not be affected by better reporting such as death of wards, open intact family cases and pending DCP reports where the Department is actively involved with the child. The number of deaths of wards has been steady throughout the five years despite the decrease in the number of children in care. One explanation is that the most medically vulnerable and emotionally troubled children may have remained in care.

The OIG recognizes the limitations of the data but presents it with the hope that it can assist the Department in its efforts to support the well-being of the children and families it serves.

Table 9: Death Breakdown by Case Status, 2000-2004

Year	2000		2001		2002		2003		2004		TOTAL	
Case Status	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Ward	29	31%	43	41%	20	22%	29	23%	31	22%	152	27%
Unfounded DCP	7	7%	14	13%	7	7%	20	15%	29	21%	77	14%
Pending DCP	10	11%	6	6%	8	9%	15	12%	11	8%	50	9%
Child of Ward	5	5%	4	4%	6	6%	12	10%	2	1%	29	5%
Indicated DCP	8	8%	14	14%	9	10%	12	10%	6	4%	49	9%
Open Intact	9	9%	12	12%	20	21%	19	15%	15	11%	75	13.4%
Closed Intact	5	5%	2	2%	8	9%	7	5%	13	9%	35	6.2%
Open Placement	3	3%	4	4%	5	5%	2	1.5%	10	7%	24	4.3%
Closed Placement	3	3%	1	1%	4	4%	2	1.5%	2	1%	12	2.1%
Split Custody	10	11%	0	0	4	3%	1	1%	8	6%	23	4%
Others	7	7%	3	3%	3	4%	8	6%	13	10%	34	6%
Total Deaths / Percent	96	100%	103	100%	94	100%	127	100%	140	100%	560	100%

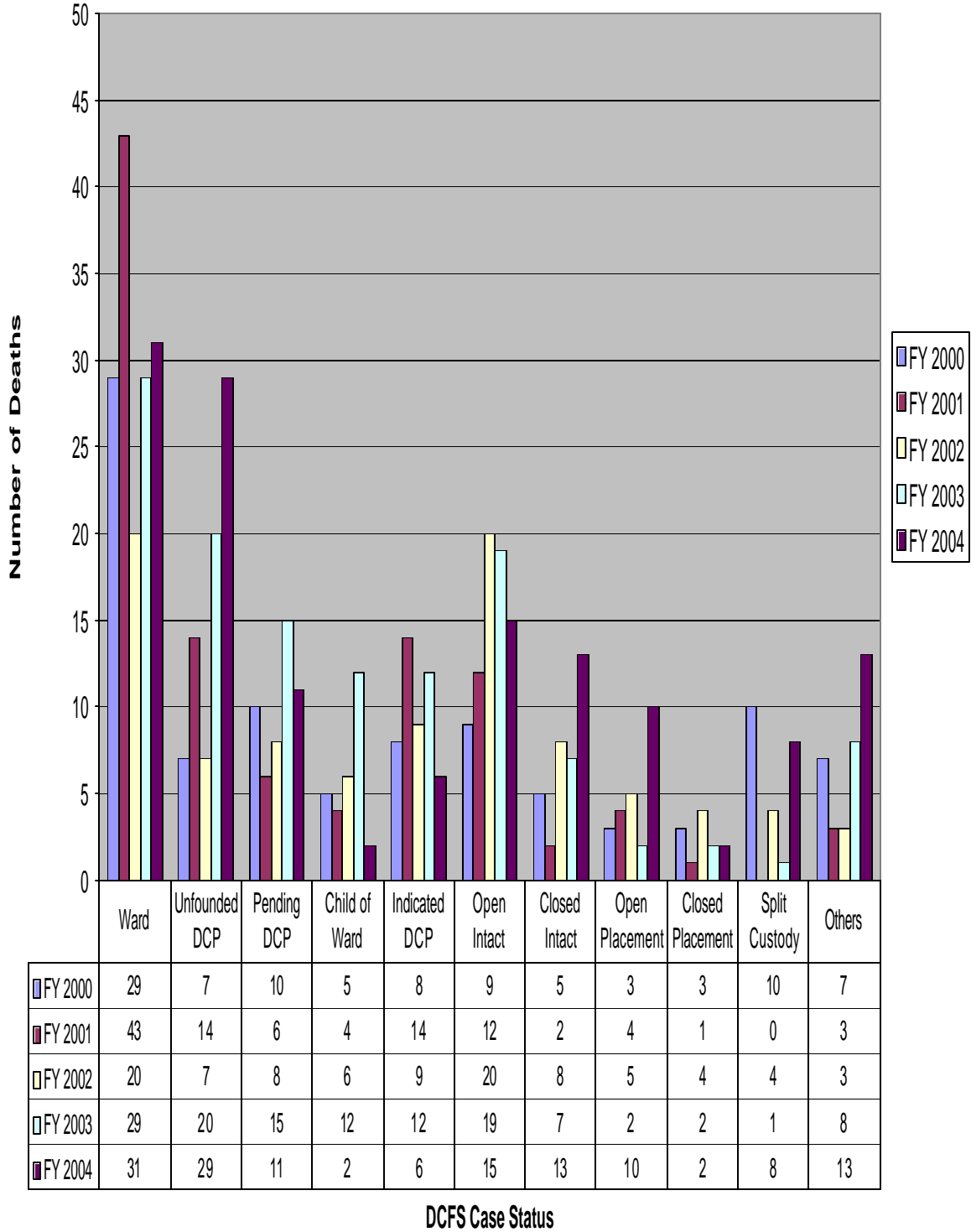
No. = Number of deaths

% = The percentage of deaths with a particular status out of all deaths in that fiscal year.

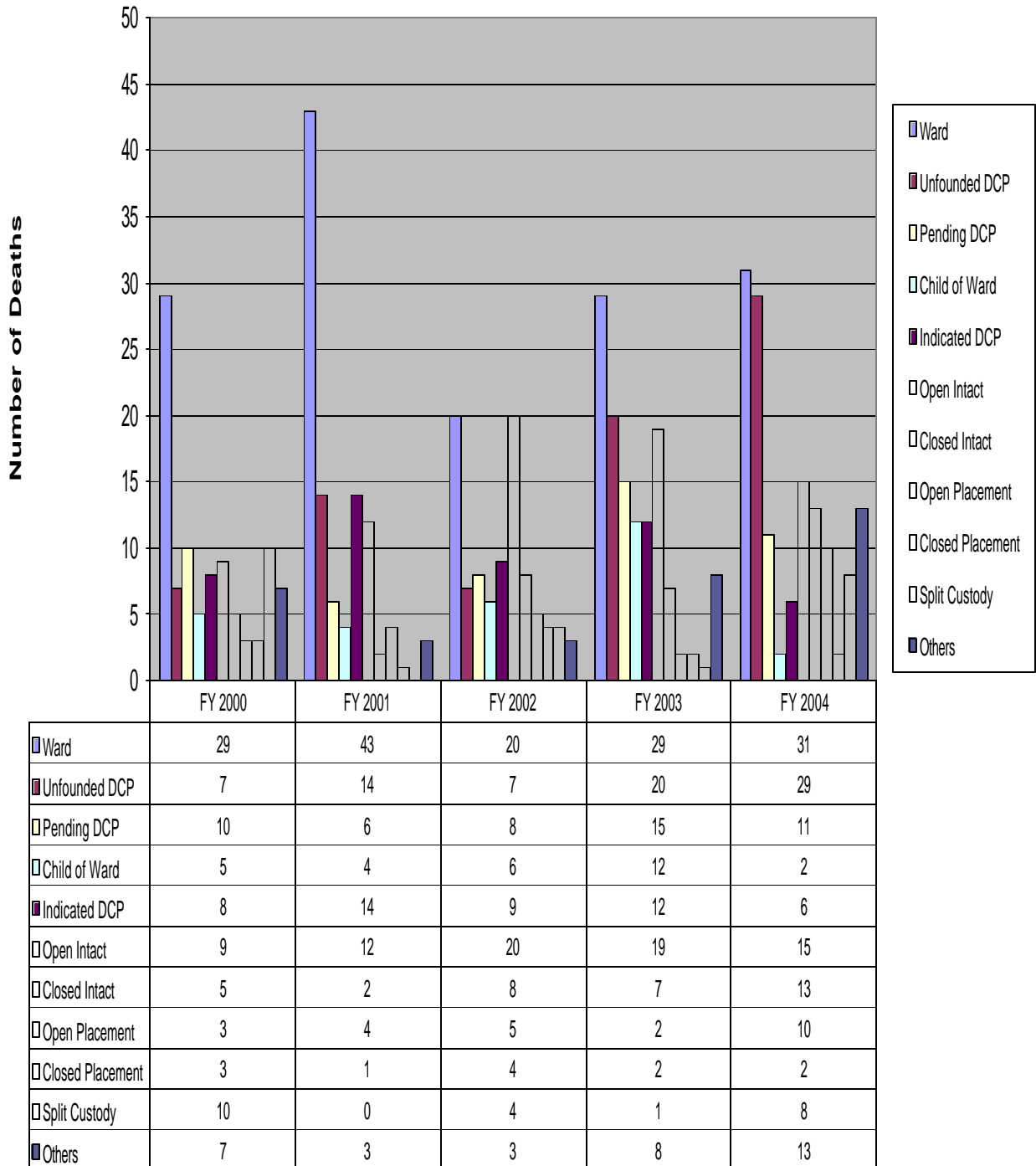
Key for Case Status at the time of OIG investigation:

- Ward.....Deceased is a ward
- Unfounded DCP.....Family involved in an unfounded DCP investigation within one year of the death
- Pending DCP.....Family involved in a pending DCP investigation at time of death
- Indicated DCPFamily involved in an indicated DCP investigation within one year of the death
- Child of Ward.....Deceased is a ward’s child, but not a ward themselves
- Open Intact.....Currently open intact family case
- Closed Intact..... Closed intact family case within one year of the death
- Open Placement..... Death of newborn (and never went home) whose mother has children in foster care
- Closed Placement.....Death of newborn (and never went home) whose mother had children in foster care who have achieved permanency within one year of the death
- Split Custody.....Death of a child who is at home where mother’s other children are in foster care (or out of home pursuant to DCFS safety plan)
- Others.....Including Open or Closed Preventive Service, Open or Closed Return Home, Homicide by a Ward, Adopted, Former Ward, Interstate Compact Monitoring, Subsidized Guardianship, Child of Former Ward, Extended Family Support

Child Death Summary by DCFS Case Status, FY 2000 - FY 2004



Child Death Summary by DCFS Case Status, FY 2000 - FY 2004



DCFS Case Status by Year

FY2000 - FY 2004 Average Death Distribution by DCFS Case Status

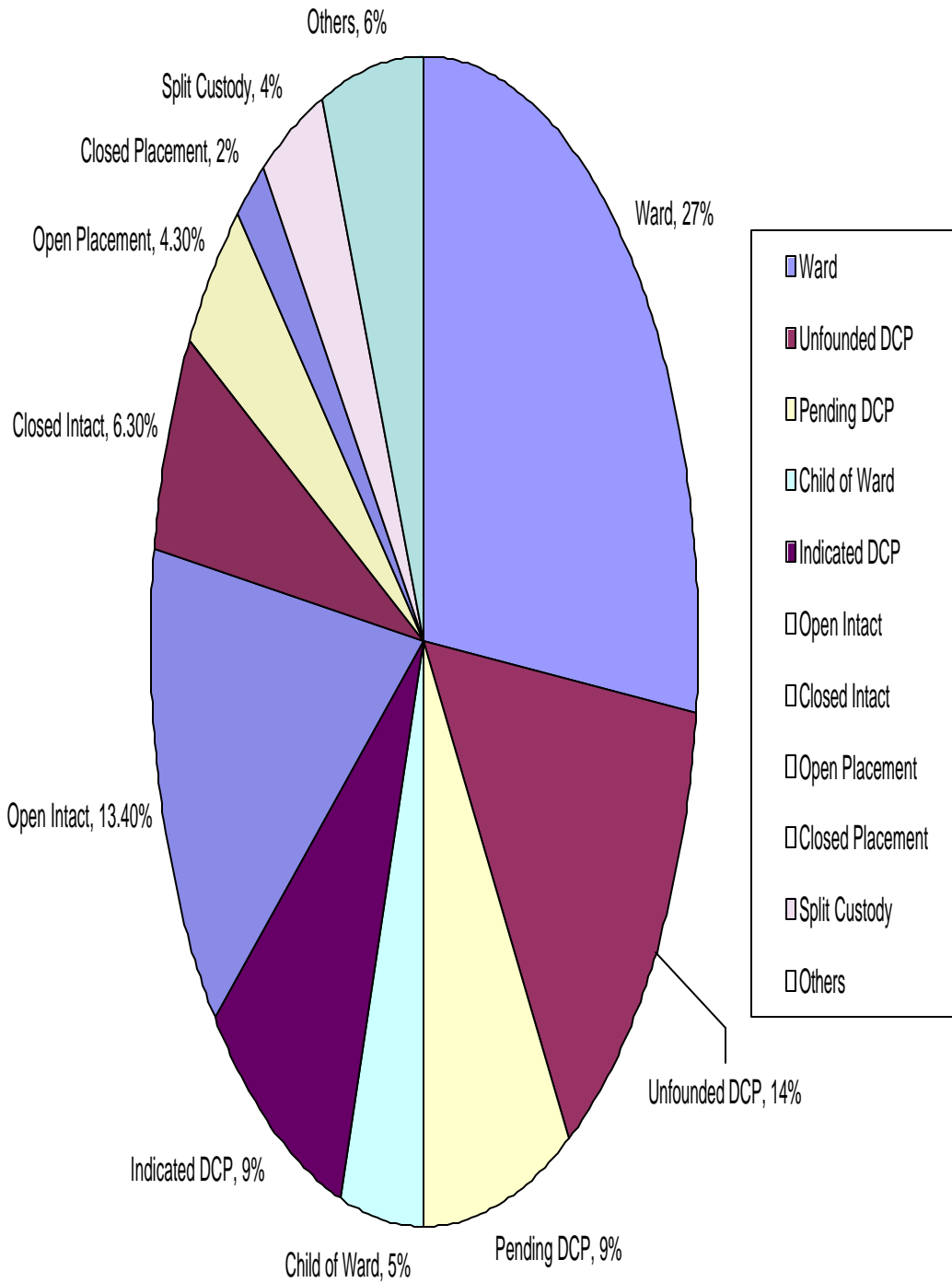


Table 10: Child deaths by DCFS case status at time of death and manner of death.

DCFS Case Status and Manner of Death	2000	2001	2002	2003	2004	TOTAL
Total Deaths	96	103	94	127	140	560
Ward	29	43	20	29	31	152
Natural	13	20	14	18	16	81
Accident	6	9	3	3	3	24
Homicide	7	10	3	7	8	35
Suicide	0	0	3	1	2	6
Undetermined	3	4	0	0	2	9
Unfounded DCP Investigation	7	14	7	20	29	77
Natural	0	5	2	9	16	32
Accident	2	6	0	6	8	22
Homicide	4	2	3	4	2	15
Suicide	0	0	1	0	0	1
Undetermined	1	1	1	1	3	7
Pending DCP Investigation	10	6	8	15	11	50
Natural	0	1	7	6	6	20
Accident	5	1	1	3	1	11
Homicide	3	3	0	5	2	13
Suicide	0	0	0	0	0	0
Undetermined	2	1	0	1	2	6
Child of Ward	5	4	6	12	2	29
Natural	1	1	1	6	1	10
Accident	1	1	2	3	1	8
Stillbirth	2	0	0	0	0	2
Homicide	0	0	2	2	0	4
Suicide	0	0	0	0	0	0
Undetermined	1	2	1	1	0	5
Indicated DCP Investigation	8	14	9	12	6	49
Natural	1	4	7	7	3	22
Accident	4	7	0	4	3	18
Homicide	1	1	1	0	0	3
Suicide	0	0	0	0	0	0
Undetermined	2	2	1	1	0	6
Open Intact	9	12	20	19	15	75
Natural	6	6	6	4	8	31
Accident	0	5	7	10	1	23
Homicide	1	1	5	1	1	9
Suicide	0	0	0	0	1	1
Undetermined	2	0	2	4	4	12
Closed Intact	5	2	8	7	13	35

DCFS Case Status and Manner of Death	2000	2001	2002	2003	2004	TOTAL
Natural	2	2	2	3	3	12
Accident	2	0	4	1	5	12
Homicide	1	0	0	3	4	8
Suicide	0	0	0	0	0	0
Undetermined	0	0	2	0	1	3
Open Placement	3	4	5	2	10	24
Natural	3	2	4	2	9	20
Accident	0	0	0	0	0	0
Homicide	0	0	0	0	1	1
Stillbirth	0	2	0	0	0	2
Undetermined	0		1	0	0	1
Closed Placement	3	1	4	2	2	12
Natural	3	0	3	1	1	8
Accident	0	1	0	0	0	1
Homicide	0	0	1	1	1	3
Suicide	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0
Split Custody	10	0	4	1	8	23
Natural	0	0	2	1	3	6
Accident	1	0	0	0	2	3
Homicide	1	0	1	0	2	4
Stillbirth	3	0	0	0	0	3
Undetermined	5	0	1	0	0	6
Adopted	0	2	2	1	1	6
Former Ward	5	0	0	1	1	7
Open Return Home	0	0	0	1	0	1
Closed Return Home	2	0	0	0	0	2
Homicide by a ward	0	0	0	2	0	2
Interstate compact	0	1	0	0	1	2
Open preventive service	0	0	1	1	3	5
Closed preventive service	0	0	0	2	1	3
Subsidized Guardianship	0	0	0	1	0	1
Child of former ward	0	0	0	0	3	3
Extended family support	0	0	0	0	2	2

GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

ALLEGATION

Police found a three year-old boy chained to his bed by the neck during a raid of his foster home. Following the discovery, the Department learned the home had exceeded its licensed capacity for foster children and that neither of the two private agencies that were supervising children in the home was aware of the other's involvement with the family.

INVESTIGATION

The three year-old boy was one of four siblings who had been removed from his mother's care as a result of ongoing medical neglect and risk of physical harm. The private agency responsible for handling the children's cases moved the boy and his seven year-old sister through a number of various homes before placing them with the couple who were licensed foster parents. At the time the siblings were placed, the foster parents already had four of their daughter's children living with them, the oldest three of whom had been adopted by the couple through the agency. The youngest, a three year-old girl, resided with them in a relative foster placement.

Four months after the two non-relative siblings were placed in the home, the private agency permanently closed, necessitating the immediate transfer of all cases. In such instances, the Department's case assignment unit distributes cases to other public and private organizations on a rotating basis, utilizing a computer program that weighs the factors of a child's case against organizational attributes and appropriateness to determine where cases should be directed. In this instance, however, the then-Director of the Department ordered all 59 of the agency's cases involving non-relative foster children to be transferred to a single private agency, although the Department had research demonstrating the strain a large influx of cases has on an agency's ability to provide effective services. Although the second private agency had recently requested expansion of its contract with the Department, by accepting the transfers, the second agency's total number of non-relative foster care cases grew from 31 to 85, increasing the agency's caseload by 174% in one day. Department contracts are awarded to private agencies based on a performance-based system that identifies achieving permanency for children as the ultimate goal. Because the second agency had successfully met its past permanency goals, the cases were transferred without an evaluation of other performance measures utilized by the Department.

Although the closing agency had placed three children in the foster parent's home, the two siblings were considered a non-relative placement while the three year-old granddaughter was identified as a relative placement. As a result, the siblings' case was included in the wholesale transfer of non-relative cases to the second agency while the three year-old girl's case went through the normal computer matching process and was assigned to a third private agency for services. After the closing agency's various cases were assigned, the physical case records had to be distributed to the receiving organizations. During this process, Department staff neglected to document where files were transported or the names of the individuals who accepted them. Responsibility for overseeing the couple's foster home license was delegated to the third private agency, however the licensing file, which contained vital information regarding the household, including the number of children present, was sent along with the siblings' case file to the second private agency. Although the second private agency's licensing worker later learned she had received the file in error, she did not inform her supervisors, staff from the third agency or the Department that she was in possession of the original licensing file.

The second agency's handling of the siblings' case was consistently poor, characterized by minimal effort and

an absence of documentation. Both children had been evaluated by the local school district and identified as requiring special services. The three year-old boy was found to be severely delayed in his physical, cognitive, social and communicative skills. The seven year-old girl had a diagnosed adjustment disorder and demonstrated aggressive behavior and developmental delays. The boy was eligible to participate in special education classes at the local school, however the foster parents never completed his enrollment. Despite her obligation to ensure the children's education, the assigned caseworker from the second agency never contacted the school or conducted required visits. As a result of the caseworker's inaction, the boy missed an entire year of school. In addition, although the second agency's educational liaison raised concerns regarding the foster parents' lack of commitment to the children's schooling and failure to become involved in the seven year-old's efforts to retain daily lessons, the caseworker relied entirely upon the foster parents' positive reports and recorded in her notes that both children enjoyed school. In an interview with the OIG, the caseworker stated that she trusted the foster mother. When asked if that trust was called into question after it was learned the foster mother had lied about enrolling the boy in school, the caseworker stated her belief in the foster mother remained unchanged.

Upon transfer of the three year-old girl's case, an intake worker from the third private agency conducted two home visits. In her case notes, the worker listed the two non-relative children as members of the household residing with the couple in a foster placement. The intake worker completed her involvement with the case after two months and it was transferred to a caseworker for services. At about this time, the third agency learned of its responsibility for the couple's foster care license. Without knowledge of the existing file, a licensing worker attempted to construct a new licensing file and requested the foster parents complete various forms which required the inclusion of the names of all household members. The foster parents did not list the two non-relative children or mention their presence to the licensing worker from the third agency. Neither the licensing worker nor her supervisor spoke with the girl's current caseworker or the intake worker who could have informed them of the presence of other foster children in the home. The licensing worker and her supervisor also took it upon themselves to reduce the capacity of the foster parents' license from four children to one. In an interview with the OIG, the licensing worker stated she and her supervisor concluded the limit had been set at four to include the three year-old girl and her three siblings who had already been adopted by the foster parents and assumed the other spaces were no longer necessary. The licensing worker did not ask the foster parents about the license or inform them after the capacity was reduced.

Police raided the foster parents' home in response to allegations of narcotics activity being conducted from the house by their adult son. Neither agency was aware of the son's presence in the home and had not been informed by the couple that he lived there. While searching the house, an officer located the three year-old boy secured to a bed by a thick chain that had been wrapped around his neck and padlocked. The foster mother told police she had become frustrated in her attempts to prevent the boy from leaving his bed during the night and had resorted to the chain to control his behavior. During their search of the house, officers discovered cocaine and marijuana as well as two handguns, one of which was found in the three year-old boy's room.

Following the raid, a child protection investigation was initiated and the foster parents and their adult daughter, who also lived in the home, were indicated for risk of physical injury by neglect to all of the children in the home. The foster parents were indicated for risk of physical injury by abuse and the foster mother was additionally indicated for tying/close confinement, inadequate food and cuts, welts and bruises against the three year-old boy. Concurrent to the child protection investigation, the Department's licensing division conducted a separate investigation of the foster home. Although it was determined the foster parents had violated numerous standards and the complaint against them was substantiated, the final licensing report did not include a specific recommendation for revocation of the foster home license.

The siblings were removed and placed with their four year-old brother in a relative foster home. The three

year-old boy and seven year-old girl underwent comprehensive medical, psychological and educational evaluations. The evaluations produced detailed recommendations for each child designed to improve their cognitive and physical skills and assist them in overcoming the trauma associated with their previous living environment. Although the clinical psychologist who conducted the evaluations stressed the need for implementation of the recommendations, staff from the second agency reported at a case staffing six months later that the siblings' new foster parent had not followed through with any of the recommended activities or treatments. Despite this lack of compliance and apparent disregard for intervention deemed vital by medical and child welfare professionals, staff from the second agency stated the new foster parent's adoption of the siblings would be completed within two months of the staffing.

The Department ended its foster care contract with the second agency and case management of the three year-old boy and his seven year-old sister were transferred to a fourth agency. The fourth agency followed up with all clinical and educational recommendations regarding the children. Unrelated problems with the new relative foster home necessitated moving the siblings to another non-relative foster home. Criminal charges of unlawful restraint against the foster parents who chained the three year-old boy to the bed are pending.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The family case should be transferred to a private agency experienced in working with children with developmental disabilities.

The Department no longer contracts with the private agency. This case was transferred to an agency with a specialized contract.

2. The siblings' level of care should be increased to specialized because of their disabilities, the trauma experienced in a state licensed foster home, and the lack of ameliorative and early intervention services provided during their tenure with the second private agency.

This case was transferred to an agency with a specialized contract.

3. The third private agency should interview the new relative foster parent and review the children's clinical records in order to develop individual treatment plans for the siblings prior to the transfer.

This case was transferred to an agency with a specialized contract. The children were placed with a relative and later removed due to continuing concerns regarding the relative's ability to care for the children.

4. The third private agency should convene a family meeting to determine if the siblings can be maintained in their current family placement with agency support and support from extended family; another family placement with cooperation, transition, and ongoing involvement from the grandmother; or in a non-relative specialized placement. The agency should document the family meeting decisions and follow-up activities that stem from it. Copies should be shared with the relatives and placed in the children's files.

This case was transferred to an agency with a specialized contract.

5. The Department should immediately determine how many children who may be in need of early intervention or special education services are in the care of the second private agency and determine whether the children's cases should be transferred from the agency.

The Department no longer contracts with the private agency.

6. When cases are transferred between agencies, the Purchase of Service (POS) Division should track child and foster home files by establishing records inventory and sign-over procedures.

Procedures will be established. Completion date: January 2005.

7. Determining foster home licensing responsibility in split cases is a clinical decision that should not be made by the Department's Central Office of Licensing. When transferring or assigning child cases, the Department needs to first identify all children in the foster home and assign children's cases and licensing responsibility to receiving agencies. If on rare occasions a split between agencies cannot be avoided, the Department's Case Assignment Unit, in conjunction with Purchase of Services Monitoring, should develop an individual agreement between the agencies on the role and monitoring duties of each agency with six-month clinical reviews.

Purchase of Service (POS) foster home licensing in a split case will be determined based on a clinical review process. POS will initiate discussions with the Clinical Division to insure the development of a uniform process for implementation. Meetings will be convened in late January 2005 to develop a process. Implementation date: March 2005.

8. Foster home licensing staff should convene meetings with all caseworkers with children currently placed in a foster home prior to the annual and monitoring home visits by the licensing worker. The purpose of the meeting should be to assist the licensing worker in becoming more familiar with the home by gathering information about the home, reviewing services provided the foster children in their care, and asking caseworkers to identify any concerns about the home.

Foster home licensing staff will convene meetings with caseworkers with children currently placed in a foster home prior to the annual and monitoring home visits. Implementation date: April 2005.

9. Department licensing enforcement procedures must provide for immediate licensing revocation proceedings with findings of egregious licensing violations.

Rule 383, Licensing Enforcement, is currently under review. The definition for egregious licensing violations will be included in the revisions.

10. The OIG previously recommended collaboration between the third private agency's casework and licensing staff (OIG Report 97-3956). Sharing information about families internally continues to be a problem. Administration of the third private agency must critically examine and remedy the lack of substantive interdepartmental case communications.

OIG Response: The OIG shared the report with the agency. The agency submitted a response to the recommendations made in the report. The Inspector General met with agency executive staff and a member of the Board of Directors to discuss the report.

The agency agreed with concerns raised in the OIG report, namely (1) case management and licensing efforts were incomplete in obtaining information; (2) there was a breakdown of communication about the household when the case was transferred between caseworkers; and (3) inadequate notification of two case management agencies supervising placements in the same home.

In response to (1) above, the agency now aggressively seeks information from DCFS on the prior licensing history of a home and is adapting its own computer profile database system to identify and note outside placements. In instances in which the agency has more than one caseworker in a foster home, information is

communicated by the resource staff to the requesting caseworker. Approval of the foster home as a resource for additional children is confirmed with the licensing worker and any other caseworker involved with the family. For on-going services in the home, the agency has adopted a procedure to assure communication between licensing and case management occurs. Prior to annual and monitoring licensing visits to a foster home, the licensing worker accesses the computer system to identify all caseworkers involved with the home and contacts the caseworkers about pertinent issues in the home.

In response to concern (2) above, the agency's internal transfer of cases now includes information on all children living in the home and any outside agencies involved with them. Additionally, case management supervisors now review their caseworkers' Home Visiting Sheets each month. These sheets will include information on other children seen in the home.

In response to concern (3) above, the agency is addressing the issue of a lack of interagency communication by having its licensing workers communicate with other agencies identified as being involved with the household. The agency does suggest that the Department develop more comprehensive measures to address this issue of multiple agencies involved in a household.

GENERAL INVESTIGATION 2

ALLEGATION

A child protection investigator engaged in a personal relationship with a registered sex offender and had investigated allegations of abuse against the individual shortly before the relationship began.

INVESTIGATION

The registered sex offender was initially convicted of child pornography and criminal sexual abuse for an incident that occurred 10 years earlier involving his 15 year-old son and the boy's 14 year-old girlfriend. The child protection investigator, who was a caseworker at the time, had provided intact services to the family three years later in response to child behavioral problems that arose in the home. The investigator worked on the case for one year. The case was closed for services five years later.

One year after the family case was closed, the hotline received a call reporting risk of harm to a 15 year-old boy. The reporter alleged the boy's mother had allowed the sex offender to move into her home and have unsupervised contact with her son despite being aware of his previous transgressions with minors. The child protection investigator was assigned to the case. An OIG review of the case notes found the investigator incorrectly reported the offender's criminal history to her supervisor and erroneously stated he had participated in treatment. Based on the boy's belief the offender posed no risk to him and the fact the offender's ex-wife, who made the report, had frequently made similar allegations, a decision was made to unfind the report.

Seven months later a similar call was made to the hotline reporting risk of harm to the investigator's nine year-old son. A child protection investigator from another Department field office (hereafter referred to as 'the worker') was assigned to conduct the investigation to avoid a conflict of interest. During her initial interview with the worker, the investigator acknowledged a personal relationship with the offender. The investigator stated she had never been involved with the offender in a professional capacity but acknowledged she had previously investigated an abuse report against his son. The investigator had not alerted her supervisor to her personal relationship with the offender when she was assigned the son's case. The investigator told the worker the offender had stayed overnight at her home once while her son was at his father's house. On another occasion, the investigator told the worker the offender was never required to participate in treatment by the Department and that the original incident that led to his conviction involved a girl who had claimed to be 18 years old.

The worker later interviewed the offender's ex-wife who informed him of the investigator's previous involvement with their family. The worker also spoke with the father of the investigator's son who stated the boy told him the offender spent the night in the investigator's home while the boy was there. The worker and his supervisor subsequently re-interviewed the investigator. During the interview, the investigator disclosed her previous involvement with the family as a child welfare professional and verified that the offender had slept over at her home while her son was present. She stated she was not concerned for her son's safety because the offender had never demonstrated a proclivity towards boys. When asked about the child pornography charge involving a boy and girl that led to the offender's conviction, the investigator stated she must have overlooked the facts in the case record. The worker determined there was sufficient proof to indicate the offender and the investigator for risk of harm. The investigator appealed the indicated finding. The appeal is currently pending. During the course of the OIG investigation, the investigator resigned and surrendered her child welfare license.

Following the investigation, the investigator transferred from the division of child protection to the State Central Register (SCR) which accepts abuse and neglect hotline reports. In accepting the transfer, a decision was made to waive the investigator's indicated finding for risk of harm. Currently, the Department has no standardized system or guidelines for reviewing, assessing, or documenting such waivers.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should ensure that the Department's Office of Employee Services is notified when the subject of a child protection investigation is a Department employee. In addition, if the subject holds a Child Welfare Employee License, the OIG Child Welfare Employee Licensing Division must be notified.

Child investigation reports involving DCFS employees are investigated in accordance with Procedures 300, Reports of Child Abuse and Neglect. The Office of Employee Services is notified once a report is indicated and if the employee is in a direct service position. The Department will notify the Office of Employee Services of pending abuse and neglect investigations involving employees. The Department will request that the OES not place this information into the employee's personnel file unless or until the investigation is indicated. The OIG is notified by the State Central Register of an investigation involving an employee. The OIG then tracks the case through SACWIS and pursues appropriate licensure action upon an indicated finding.

2. Assessment and waiver of indicated Child Abuse and Neglect Tracking System reports for Department employees must be documented, with a signed determination of decision, centrally filed for future reference and assessed in accordance with Rule 385, Background Checks.

The Department will review the current process and make any appropriate revisions.

GENERAL INVESTIGATION 3

ALLEGATION

The caseworker for a brother and sister, ages 16 and 14, failed to investigate their father's allegation that a convicted sex offender resided with them in their relative foster home.

INVESTIGATION

The two children were the oldest of five siblings who had been removed from their parents' custody five years earlier and received services through a private agency. During that time, the two eldest children lived in the home of their aunt in an unlicensed relative placement. The boy was removed from the home following a series of incidents involving poor behavior both at home and in school. The boy was placed in the home of another relative, but three months later, after a period of worsening behavior and repeated pleas by the boy to return to his previous placement, he was returned to the aunt's home. The girl remained in the home throughout this time.

Upon learning his son was going back to the aunt's home, the father told the children's caseworker the aunt's boyfriend had previously been convicted of raping a nine year-old girl. In an interview with the OIG, the caseworker stated she was unaware of the aunt's boyfriend prior to the father's allegation. The caseworker stated she did not perform a background check on the boyfriend because the father did not provide the man's name. The caseworker did not ask the father for the name or attempt to establish his identity by speaking with the aunt, the children or other collateral contacts. In addition, the caseworker neglected to notify her supervisor of the father's allegation. The caseworker's failure to adequately assess the information provided by the father or take action to determine its validity allowed the children to remain in a potentially dangerous living situation. Although both the caseworker and her supervisor stated during interviews with the OIG that the father was often belligerent and verbally abusive towards the caseworker and their contentions were supported by the case record, the gravity of the allegation should have superseded any reservations the caseworker had regarding the source.

Six weeks after his statement to the caseworker, the father reiterated his allegation against the boyfriend during a permanency court hearing. The father told the court the aunt had a registered sex offender living in her home. When questioned by the judge, the caseworker stated the agency had been unaware of the boyfriend. In her interview with the OIG, the caseworker said her statement to the court was intended to mean that the agency had been unaware of the boyfriend's name. The court ordered the agency to conduct an investigation as to whether the boyfriend was in fact living in the aunt's home. The aunt and both children acknowledged the boyfriend was sometimes present in the home but denied he lived there. The caseworker and her supervisor developed a safety plan which stipulated the boyfriend was prohibited from having any contact with the children.

One month after the court hearing, the father contacted the private agency to report the boyfriend had accompanied the boy to a subsequent court hearing. The private agency responded by informing the aunt that because she had violated the safety plan, the children would be removed from her care. The aunt appealed the decision to the Administrative Hearing Unit, however while the appeal was pending, the aunt requested the children be removed from her home. Two weeks after the aunt requested the children's removal, the Administrative Law Judge (ALJ) presiding over the appeal ruled in favor of the aunt. The ALJ based their determination on an unwillingness to disrupt a long-term placement and a belief that the children's age and size helped mitigate the potential risks of living with a convicted sex offender. The ALJ deemed the safety plan adequate but recommended additional monitoring of the home by the private agency. Despite the ALJ's ruling and the Department's approval of the decision, the private agency complied with the aunt's request and placed the children in the home of another relative.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The caseworker should be disciplined for failing to inform her supervisor of critical information in accordance with the agency's personnel policies.

The redacted OIG report was shared with the private agency. The case has been reassigned to a different worker.

2. The portions of this report relevant to the Administrative Law Judge decision should be shared with the Chief ALJ and Department staff responsible for reviewing ALJ recommendations.

The report has been shared with the Chief ALJ and appropriate Department staff.

GENERAL INVESTIGATION 4

ALLEGATION

Two brothers were placed in respite care with a Department employee who was the focus of a federal investigation for allegedly accessing web sites depicting child pornography.

INVESTIGATION

The OIG was contacted by the Department of Homeland Security regarding an investigation into the use of e-mail addresses and credit card numbers attributed to the Department employee to access child pornography on the internet. The employee, a child protection supervisor, had worked for the Department for seven years. In addition to his professional duties, the employee was licensed as a respite foster parent through a private agency.

The OIG sought the assistance of the Department's chief legal counsel to place a hold on the employee's foster home so that children would not be placed with him while the criminal investigation was pending. The chief legal counsel agreed to request that the Placement Clearance Desk place an informal hold on the home. However, when the chief legal counsel made this request of the Placement Clearance Desk, she was informed that the Desk could not put a hold on future placements without notifying the foster parent. Not wanting to alert the foster parent to the federal investigation, the Department's general counsel arranged instead to have the Placement Clearance Desk contact the chief legal counsel in the event children were placed in the home.

Two weeks after the request was made, the Placement Clearance Desk contacted the chief legal counsel to inform her that two brothers, ages 12 and 9, had been placed in the home for weekend respite care three days earlier. The chief legal counsel then informed the OIG of the situation. Following a consultation with ethics staff, the OIG determined the potential risk to the children outweighed any negative effects the employee's awareness of the investigation might have on pursuing a criminal case against him. The chief legal counsel concurred and contacted the Placement Clearance Desk to place an immediate hold on the home. The OIG contacted the executive director of the private agency that licensed the employee as a foster parent who agreed to remove the boys from the home and refrain from placing any other children with the employee.

While the OIG investigation was pending, the employee voluntarily relinquished his foster care license. In an interview with the OIG, the employee refused to answer questions about his alleged use of credit cards to access child pornography on the internet. Following the interview, the employee resigned his position with the Department and surrendered his child welfare employee license. Although there were concerns regarding the employee's behavior and continuing relationship with one of the boys, in interviews with the OIG both boys stated he had never abused them. The federal investigation against the employee was later closed due to insufficient evidence to pursue a criminal indictment.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The ethical balance of notifying someone of a criminal investigation or protecting children by placing a hold on a foster home should always favor the protection of children.

The Department agrees. No action was necessary.

2. Procedure 301, Appendix E, Placement Clearance Process, should be amended to create an emergency procedure permitting involuntary holds to be placed on a home without immediate notice to the foster parent under certain limited circumstances. The OIG suggests the following language for the procedure: When a foster parent is under investigation for an act which, if true, would jeopardize the health, safety or welfare of children to be placed in the home, and the Director determines 1) that providing notice to the license holder may jeopardize the investigation and 2) that there is a reasonable basis for the investigation, the Director may place an involuntary hold on the placement for up to 120

days without notice to the foster parent.

The Department agrees that the Director may place an involuntary hold on a foster home and notify the agency of the hold in confidence. Procedure 301, Placement and Visitation Services, is currently being revised and language authorizing the Director to place a hold without notification to the foster parent will be included.

GENERAL INVESTIGATION 5

ALLEGATION

Five children were allowed to remain in an unlicensed placement along with a relative with an extensive criminal history.

INVESTIGATION

The five children had been removed from their mother's custody as a result of parental neglect. The children were adopted by their maternal great-aunt and resided in the home she shared with her adult son. Following the great-aunt's death four years later, the adult son asked his aunt to move into the family home to help raise the children, who ranged in age from five to fifteen years old. In response to the death of the children's adoptive parent, Department post-adoption services workers conducted a home visit and evaluation. During their assessment of the home, post-adoption workers learned the adult son had an extensive criminal history that included a conviction for aggravated criminal sexual assault against two 14 year-old girls.

A child protection investigation was initiated following a call to the hotline to report the adult son had whipped one of the children with an extension cord. During the investigation, some of the children confirmed the adult son did reside with them in the home. The child protection investigator ultimately indicated the adult son for abuse and the aunt for abuse by neglect. A safety plan was established that prohibited the son from living in the home and the family was referred for intact family services (IFS). Post-adoption workers contacted the OIG for assistance in addressing the issue of the adult son's presence in the children's home. The OIG contacted intact family services to discuss the possibility of screening the children into court based on the indicated report and the adult son's criminal history. The OIG referred the case to the State's Attorney's Office which agreed to file a petition for dependency. The case was screened into court and the Department was granted temporary custody of the children.

After the siblings were removed from the home, the Department assigned the four younger children to a private agency for placement. The OIG was contacted by the children's Guardian ad Litem (GAL) who disagreed with the agency's decision to place the four children in three separate foster homes. The GAL also stated the second oldest child, who had special educational needs, had not been to school since the private agency assumed control of her case and had expressed her desire to resume attending classes at her high school. The private agency had been the subject of a previous OIG investigation which raised significant concerns regarding the agency's ability to provide effective services.

The Department had placed the oldest child, who was diagnosed as autistic and mentally retarded, in a shelter for developmentally disabled children. The Department's Placement Review Team (PRT) had reached a decision not to place the girl in specialized foster care based on the aggression and anger she demonstrated while in the shelter. However, the PRT had not reviewed the girl's school records or any other documentation to determine her strengths and functioning prior to entering the shelter.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should remove the children from the private agency and make a diligent effort to place the siblings together.

Due to the second child's connectedness in the home and community, she will not be placed with her siblings, but will continue weekly visitation with her siblings. The oldest child is placed in a specialized home in which she is attached and stable and continues regular visitation with her siblings.

2. The Department should make every effort to maintain the second oldest child at her high school.

The child continues to attend her high school and is doing well.

3. The Department should review the oldest child's school and health records before ruling out specialized foster care for her. Consideration should be given to placement with a provider that specializes in working with mentally retarded children.

The child is in a specialized foster home.

GENERAL INVESTIGATION 6

ALLEGATION

A child protection investigation of physical abuse by a woman against 13 year-old twin boys raised questions regarding the actual parentage of the boys and another 13 year-old girl in the family home.

INVESTIGATION

The OIG received a request for technical assistance from the child protection investigator assigned to the abuse report. The investigator had been unsuccessful in attempts to obtain basic information from the woman and her husband. The couple provided conflicting information to the investigator regarding their legal relationship to the children or where the children had been born and the woman produced two different birth certificates for the 13 year-old girl. The investigator requested the OIG to perform out-of-state criminal background checks on the couple.

The OIG reviewed birth certificates for the three children. All three children had been born in other states. The OIG contacted the Department of Health in the state of the girl's birth for clarification of the multiple birth certificates. A Department of Health employee stated that one document, which listed the woman as the girl's parent, was invalid. A second certificate listing the man and another woman was affirmed as an official document. The OIG learned from the Bureau of Vital Statistics in the state of the twins' birth that information provided corresponded to Bureau records, however the twins were identified as having different birth names than those known to the child protection investigator. The twins birth certificates also listed the name of the man and a different woman as the parents.

The OIG located the three biological mothers identified on the children's birth certificates, including the girl's two different certificates. In interviews with the OIG, two of the mothers related similar stories of being misled and coerced into listing the father as a biological parent on the children's birth certificates. The mothers stated they each met the couple while pregnant and considering adoption. The girl's mother stated that after she decided not to release her baby for adoption the woman remained in contact and was present at the hospital when the mother delivered. The mother stated the woman offered to complete hospital registration forms and included the couple's names as the biological parents. The twin's mother stated she lived with the couple prior to her delivery but changed her mind regarding adoption shortly after the boys were born. The twins' mother explained she had agreed to list the man as the father at the couple's suggestion in order to eliminate the need for adoption fees. She stated the couple became angry after she decided not to proceed with the adoption, assaulted her and alerted police the mother had an outstanding warrant. The mother was arrested and the couple left the state with the boys. After the mother was released from jail, she could not locate the couple or her twin sons. The third mother, a teenager at the time she gave birth, had been coerced by her grandmother into giving her child to the couple.

The OIG conducted criminal background checks on the couple. The man had previously been convicted of battery and resisting arrest and was the subject of a pending charges for aggravated battery of police and a fireman. The couple had three adult sons who were also living in the home. Criminal background checks conducted on the adult sons found all three had extensive histories of criminal convictions for offenses including domestic battery, aggravated battery, aggravated battery of a police officer, possession of controlled substances and arson. One son had an outstanding warrant which included an alert he was "armed and dangerous." As a result of the information obtained regarding the family's historical involvement with guns, drugs and violence, the OIG contacted local law enforcement and obtained a narrative of emergency response calls to the family home. The narrative showed that during the previous year, officers had responded to the home 49 times. Officers were summoned to respond to reports of narcotics trafficking, shots fired or an individual in possession of a firearm, assault, battery and violations of orders of protection. Some police responses involved attempts to serve arrest warrants.

The report against the couple was indicated and the Department took custody of the children. The findings of the OIG investigation were shared with juvenile court authorities. As a result of the OIG investigation and with the assistance of the Department's legal division and the juvenile court, the three children began visitation with their birth mothers.

GENERAL INVESTIGATION 7

ALLEGATION

The OIG was notified by the Department of a videotape showing very young children being surreptitiously transported between a daycare center and a day care home in an apparent attempt to avoid a licensing investigation for overcrowding.

INVESTIGATION

The Department's licensing division forwarded to the OIG information obtained during the course of a licensing investigation of the child care center. The licensing division had received a complaint that children were being transported from the center to private homes to alleviate overcrowding. The complaint also stated the children were being transported in a private vehicle without proper safety restraints. The OIG impounded the center's licensing file. A videotape included as part of the file showed children being loaded into a minivan without the use of car seats and being transported to the private residence on two occasions. The licensing investigation had substantiated obvious violations committed by the day care operation. Licensing investigators confirmed the day care home exceeded capacity after finding 12 children in the home, most of whom the day care provider could not identify by name. The OIG recommended to the Director's office that the center be closed immediately. The Director concurred and the center was closed. The day care center filed suit against the Department.

Licensing investigators learned that although the center was licensed for 96 children, application of the formula used to determine capacity found the available space was only adequate for 54. In an interview with the OIG, the licensing representative who had licensed the center for 96 children stated she initially used the formula to determine the center's capacity but failed to adjust the license to reflect renovations made inside the center that greatly reduced the space. The worker stated she might have thought the area appeared crowded during her visits but she did not count the children present or review attendance records. An OIG review of attendance records found there were more than 100 children enrolled at the center for whom the center received daily child care payments from the Department of Human Services.

The OIG learned the licensing representative owned a laundry facility. Four former employees of the daycare center provided evidence that the daycare center used the licensing representative's laundry facilities. The employees stated they had seen the worker pick-up and drop off laundry from the center on multiple occasions. The OIG subpoenaed all accounts payable and receivable from the laundry. The licensing representative repeatedly failed to provide the documents and obstructed the investigation. When questioned by OIG investigators about a \$4,000 loan to the laundry business from the owners of another child care center the worker monitored, the worker stated she had never accepted the loan. At a later date, the worker acknowledged accepting the loan and stated she had quickly repaid it, although she was unable to provide any documentation to substantiate her account.

The OIG reviewed records of a third child care facility the licensing representative was responsible for monitoring. Reports completed by an inspector of the county Department of Public Health following two visits to the facility listed numerous physical plant and food service violations. In an interview with the OIG, the licensing representative acknowledged receiving and reviewing both reports prior to approving the facility's license and that she had recorded the facility as being in compliance without following up on the violations. The worker characterized one violation, hot water from the faucets measured at over 150 degrees Fahrenheit, as an "environmental" issue and outside the scope of her duties. Department Rules require licensing workers to monitor hot water temperature. The worker's supervisor approved the worker's decision to license the facility.

During the course of the OIG investigation, a subpoena was issued requesting any and all permission slips from the first child care center to determine if parents had consented to their children being transported to the private residence. All of the slips provided by the center were for the same date which did not correspond to

the date of either trip shown on the videotape. The majority of the slips text allowed for the children to take a trip to two libraries. A single line between the text and signature line allowed for "other activities" to take place at the private residence. All of the slips were embossed with the seal of a notary public. In an interview with the OIG, the notary public stated she was the sister-in-law of the center's owner and had affixed her seal to the slips without observing the parent's signatures. An OIG review of the center's financial records found a check made out to the notary public for \$1,300 dated the day before the date on the slips.

The OIG met with the Director of the Department and recommended the Department issue and immediate Order of Closure because the behavior of staff at the day care center threatened the health, safety, morals or welfare of the children. The Director agreed with the recommendation. The day care center filed a motion for a temporary restraining order, which was denied. The Administrative Hearings Unit (AHU) upheld the closure order, however the center appealed the decision. In November, 2004, the Circuit Court ruled that the closure order was proper. The court ruled that, according to the Child Care Act, "[The Department] must immediately shut down a day care center without pre-deprivation if it deems that the health, safety, morals or welfare of the children are jeopardized".

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The licensing worker's employment should be terminated from the Department for failure to cooperate with an OIG investigation, for violation of conflict of interest rules and for substandard work performance.

The employee resigned from the Department with no reinstatement rights.

2. The licensing worker should be referred for revocation of her child welfare employee license.

The OIG learned that the licensing worker does not carry a child welfare employee license.

3. The Department should require Statements of Economic Interest from all licensing representatives, supervisors and administrators.

The OIG is conferring with the Office of the Executive Inspector General on this issue.

4. Refer the notary public to the appropriate Inspector General.

The OIG referred the notary public to the appropriate Inspector General.

5. Counsel and retrain the licensing worker's supervisor on the necessity of documenting poor licensing work and follow through with discipline when appropriate. Counsel the supervisor on reviewing records and recommendations more closely before signing off on them.

The Department agreed. The employee was counseled.

GENERAL INVESTIGATION 8

ALLEGATION

The OIG assisted in a federal criminal investigation in which a private agency caseworker allegedly sold children's names and social security numbers for purposes of tax fraud.

INVESTIGATION

The OIG was contacted by the U.S. Treasury Department and alerted to their investigation of the private agency caseworker. A concurrent investigation conducted by the OIG raised additional concerns regarding the caseworker's suitability to serve as a child welfare professional.

The OIG learned the caseworker had engaged in a sexual relationship with a client while previously employed at another private agency. The client was a relative foster parent for four wards. The caseworker began an intimate relationship with her soon after he was assigned the family case. The caseworker fathered the client's two children but was unwilling to be involved with them. The client had to petition the court to establish the caseworker's paternity and initiate child support payments. An OIG review of records from the Department of Public Aid found the caseworker owed more than \$22,000 in past due child support payments based on a court order issued two years earlier.

An OIG review of the caseworker's Child Welfare Employee License application found he had answered "no" to a question regarding previous convictions for any offenses other than traffic violations. A criminal background check on the caseworker found he had two prior convictions for theft and deceptive practices.

In an interview with the OIG, the caseworker stated it was his intention to voluntarily terminate his employment with the private agency and surrender his CWEL. The private agency later informed the OIG the caseworker had been terminated by the agency.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. If the caseworker does not surrender his Child Welfare Employee License, the Department should pursue license revocation.

The OIG will implement this recommendation.

OIG update: After learning the worker did not surrender his CWEL, the OIG filed a complaint with the Administrative Hearings Unit (AHU). After charges were filed, the worker relinquished his CWEL. Based on the worker's voluntary surrender of his license, the OIG withdrew, without prejudice, its complaint with the AHU.

GENERAL INVESTIGATION 9

ALLEGATION

A private agency was alleged to have committed fiscal mismanagement without action being taken by the Department.

INVESTIGATION

The Department initiated an audit of the private agency after receiving an anonymous letter alleging the agency's executive staff misused state funds for personal purposes. Department auditors determined there was no evidence to support the allegations, however, the auditors determined expenses attributed to the agency's chief executive officer (CEO) constituted fringe benefits. The auditors gave no indication whether the expenses were supported by documents justifying the expenses. Department auditors also found the salaries of agency administrators to be excessive. The OIG investigation compared the CEO's salary with the compensation paid to other private agency directors and found the CEO received \$50,000 more during the previous fiscal year than the mean salary of the directors of comparable agencies. The CEO's salary was also in excess of the Governor's salary (\$150,000). The Department audit did not indicate whether the private agency was in contract compliance or in violation of the Illinois Procurement ACT (30 ILCS 500/50-13) in relation to the CEO's salary. In addition, the agency's independent audit results indicate that the agency's deficit has grown from \$244,499 to \$478,279.

Department auditors reviewed financial records for FY 03 but did not note any change in operations that would suggest that the agency would not be operating at a deficit or that the agency was in a position to eliminate the deficit. Also, the agency's independent accounting firm prepared the interim financial statements. Information on the statements should have indicated a deficit eight months into the fiscal year. However, the OIG found the audit lacked analysis and discussion within the context of the agency's current deficit or a reduction in support and revenue from the previous year.

As pointed out in the final Department audit, the agency's accounting firm clearly presented conflict of interest issues. The accounting firm's FY 02 fees, reported at \$116,000, were not detailed. Based on the information provided by the accounting firm, the work done as a consultant to the agency and the services provided were claimed to be only \$5,000. Presumably, the balance is the audit fee of \$111,000. These expenses could clearly be substantially reduced through the use of another accounting firm. The OIG found that in accordance with generally accepted accounting practices, the accounting firm should have cited conditions that presented material weaknesses in internal controls, such as the use of a rubber stamp to endorse checks, the use of unnumbered checks, the lack of a viable cost allocation system, and the lack of board oversight.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department field auditors' site visit to the agency should occur soon after the close of the 2004 fiscal year to determine whether the agency remains financially insolvent.

If the agency's deficit remains the same or has increased, the Department should terminate its contracts with the agency.

Should the Department continue to contract with the agency, the agency must meet the following requirements:

- An acceptable cost allocation system is established and implemented**
- Establish and implement effective internal accounting controls**
- Achieve resolution of the apparent conflict of interest involving the accounting firm; the agency should hire a new auditor**

The Office of Field Audits should be advised to contact the Illinois CPA Society for a consultation on the appearance of conflict of interest involving the agency's current auditor.

The Contract Compliance unit went to the agency to obtain updated information. The Licensing Unit also met with the agency and presented them with a corrective action plan. The Agency Performance Team has submitted their report and are waiting for the overall report from the Contract Compliance Unit. At that point, the Department will proceed with follow-up action.

OIG Response: The Department has not shared the corrective action plan or agency performance team report with the OIG and therefore the OIG cannot assess whether the recommendation has been adequately implemented.

2. Rule 434, Audits, Reviews and Investigations or the Office of Field Audits procedures should be amended: To prohibit the practice of CPA firms from performing annual audits of agencies for which the CPA firm is providing accounting services; To require and enforce the requirement of agencies having a comprehensive cost allocation system; When an agency is almost exclusively funded by DCFS, the Department's auditors must presume that disallowed costs are not funded by outside revenue. DCFS auditors should be prohibited from accepting an agency's explanation for the manner in which the agency is reducing a deficit or paying back disallowed expenses. DCFS auditors must always obtain proof of the agency's assertions.

Refer all agencies that have employees with salaries exceeding the Governor's salary amount to the Director's Office for a waiver determination. No waiver should be given to a CEO's salary of more than the Governor's salary when the agency is operating in a deficit or when an analysis shows that the CEO's salary exceeds the mean salary of CEOs of private agencies with a similar budget size. Waivers should be documented and centrally maintained.

Refer child welfare agencies operating with deficits to the Agency and Institution Licensing (A&I Licensing) unit for investigation of licensing violations (Rule 401, Licensing Standards for Child Welfare Agencies, Subpart C: Administration and Financial Management, Section 401.200). The A&I Licensing unit should be expected to determine what other licensing violations exist as a result of the agency's failure to maintain a degree of financial solvency.

Rule 434, Audits, Reviews, and Investigations, has been revised and is in the review process.

3. The Department should review and revise field audit procedures to streamline the auditing procedures and increase capacity to perform more audits each year. Valuable staff time is spent reviewing documents in order to identify disallowed expenditures. The cost to discover and recover disallowable expenditures can often exceed the amounts recovered. Field auditors should have sufficient flexibility to direct their efforts to discover and take steps to require the agency to correct obvious deficiencies in areas, such as financial controls and Board oversight in relation to the agency's finances and service delivery.

Seven staff have been assigned to field audits.

OIG Response: The OIG supports the assignment of additional field audit staff, however the Department did not provide a response regarding the necessity for developing protocols for field audit staff to allow them to focus on the issues of critical importance in their reviews.

4. The Office of Field Audits should routinely request complete copies of AG990 (Federal forms 990 are

required with the AG 990) for all agencies whose revenue from government sources exceeds a certain level, i.e., 97%, for the following reasons:

- The document provides assurance that the agency is in compliance with Federal and State laws.**
- The forms are a valuable source of salary data.**
- The forms provide a list of Directors of the Board, and their compensation, if any.**

This recommendation is under review.

GENERAL INVESTIGATION 10

ALLEGATION

During the course of conducting child welfare employee license investigations, the OIG has found variances among the personnel policies of private agencies, particularly as they relate to information regarding the criminal histories of prospective employees.

INVESTIGATION

While it would seem obvious that all organizations involved in child welfare would be diligent in their efforts to vet prospective employees, the OIG has identified certain areas which can create confusion for employers or present unexpected complications following the hiring of an unsuitable employee.

Department rules allow for the hiring of an individual prior to their clearance of a criminal background check by the state police. If it is later determined the employee has a previous conviction that reduces their attractiveness as an employee or prohibits their involvement altogether, they can be dismissed. However, workers are only barred from receiving unemployment insurance if they are terminated for misconduct committed in relation to their current position. Private agencies that neglect to conduct thorough entrance interviews and ensure all potential issues are addressed completely risk paying unemployment benefits to former employees who would ostensibly have been terminated for due cause.

In instances where potential employees acknowledge a criminal history, underlying documents, such as arrest reports, should be obtained. The information provided should be examined and compared with the potential employee's account of events. Incidents should be thoroughly explored in order to develop a clear understanding of the pertinent facts and to identify any possible extenuating circumstances.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG should prepare an information transmittal to all private agencies consistent with this report.

The OIG will prepare the information transmittal.

2. The Department should send a policy transmittal to its Agency and Institution Licensing Division to ensure that in checking compliance with Licensing Standard 401.210, the licensing representative should document compliance with the procedures outlined in the information transmittal.

DCFS Legal is working with the Contract Office on this issue.

OIG Response: Whether the Department boilerplate language is amended to require these personnel policies, DCFS Agency and Institution Licensing should still be required to monitor adequate personnel policies in POS agencies.

3. All Department staff who review private agency criminal background check assessments should be notified that when a criminal background assessment suggests that the agency does not have personnel standards that ensure that, "all persons working directly with children are of reputable and responsible character," staff should refer all such agencies for a licensing investigation.

The Department will notify Purchase of Service staff who conduct background checks to notify Department Agency and Institution Licensing with any agency personnel concerns.

GENERAL INVESTIGATION 11

ALLEGATION

The parents of a 10 year-old boy with a rare genetic disease were the subjects of a hotline report of abuse and neglect that was originally unfounded but was later indicated following a request for review by the mandated reporter. The parents claimed the Department violated its own rule in the process of reversing the initial determination.

INVESTIGATION

The boy's medical condition causes neurological malfunction and is characterized by periodic crises which increase in frequency as children age, often requiring hospitalization. One such crisis resulted in the boy being admitted to a hospital where he remained for two months. At that time, the boy's physicians decided to release him to his parents for one week in order to determine whether his home might be a more conducive environment for treatment. After spending a week at home, the boy was readmitted to the hospital. Following his readmission, hospital staff placed a hotline call and stated that upon his return the boy was dehydrated, smelled of urine, exhibited dulled senses and had an unexplained needle mark in his arm. The hotline accepted the call against the parents for medical neglect and risk of harm. A child protection investigator was assigned to the case and ultimately determined the allegations to be baseless and unfounded the report.

In an interview with the OIG, the child protection investigator stated his rationale for arriving at his decision was that the boy was seen by three medical professionals in the days and hours prior to returning to the hospital, including one of the few physicians in the nation with experience in treating his disease. Another, the doctor who monitored his home care, told the parents to readmit the boy but did not express that it was urgent they do so. The investigator also stated that debate existed within the medical community on the subject of feeding patients during crisis episodes and the parents had been advised against it by a nationally recognized expert. This decision provided a reasonable explanation for the boy's dehydration. Although the hospital suggested the boy might have been over-medicated, hospital staff did not perform tests to confirm the possibility. Tests conducted for over-sedation were negative.

Following the conclusion of the investigation, the hospital was notified of the investigator's decision to unfound the report and requested an administrative review by the Department. Department rule allows for mandated reporters, such as medical personnel, to request a review of unfounded reports within 10 days of notification. Department rule and statute both require the appropriate regional Multidisciplinary Review Committee to examine the case and then offer recommendations to the child protection administrator concerning the adequacy and accuracy of the investigation. The child protection administrator then makes a final determination. The corresponding Department procedure allows for the child protection administrator to either resolve complaints or forward them to the Multidisciplinary Review Committee, however the language used is unclear regarding the extent of the administrator's authority. The OIG found that, despite Department rule and statute, only one of the Department's six geographic regions had ever established a Multidisciplinary Review Committee and it had been disbanded.

In the absence of a review committee, the child protection administrator conducted an independent examination of the case. After consulting with the investigator's supervisor, the Department nurse and the hospital that made the initial report, the child protection administrator reversed the unfounded determination. In an interview with the OIG, the administrator stated she believed the language in Department procedure regarding complaint resolution authorized her to overturn a final determination without benefit of analysis by a committee. In response to the decision to indicate the report against them, the parents requested an administrative review by the Department and argued in federal court that the Department's actions violated their constitutional right to due process. The presiding judge ordered the Department to comply with its own regulations.

During the child protection investigation, a doctor from the hospital repeated portions of a confidential conversation between the boy's mother and the hospital chaplain. The OIG questioned the chaplain's sharing of privileged information with the doctor and the doctor's further dissemination of private information.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department must initiate Multidisciplinary Review Committees in all regions.

The Department is in the process of identifying Downstate and Cook County members for Multidisciplinary Review Committees. Completion date: January 2005.

2. A Protocol must accompany the creation of such committees to include:

- A provision describing the appointment process for committee members, following the guidelines for qualifications of members set out in the statute
- A provision that the committees should be expanded on an ad hoc basis as necessary to address any complex circumstances in the investigation under review. For example, in this case, the question of appropriate treatment of a rare genetic disease would necessitate the committee's consultation with one or more experts in the field who have no personal stake in the case. Mental health, pediatric, ethics, forensic and other experts should also be consulted by the committee as necessary to fully understand the facts and context of the investigation under review.
- A provision that the Department should provide all the records in its possession concerning cases referred to the committee. Committee members should limit their review to the written record in the case, except for consultation provided by disinterested outside experts as appropriate. Evidence outside the written record should not otherwise be considered. Any *ex parte* communication with a committee member should be documented and reported to the child Protection Manager and made a part of the record on review. An *ex parte* communication is any written or oral communication to a committee member either 1) by or on behalf of the mandated reporter or the subject or 2) by any person that requests or contains information or argument regarding the review of an investigation.
- A provision that any member of a committee who has been involved in the case under review, or who has a financial or personal relationship with any of the parties whose behavior or credibility is an issue in the case, should recuse him or herself from participation in the committee's review of the investigation in question.
- A confidentiality provision that requires that meetings be closed to the public, members sign confidentiality agreements, all records of investigations be kept confidential and returned to the Department, and deliberations and recommendation reports of the committee be kept confidential from the general public. Exception: Department is required by statute to prepare an annual report to the General Assembly on the number of investigations reviewed during the previous fiscal year, the number of investigations a committee found to be inadequate, and a summary of the committees' comments and of corrective action taken by the Department in response.
- The committee should produce a written finding, with identified bases of the finding, which is shared with the child protection manager and becomes part of the record.
- Child protection managers should regularly review Multidisciplinary Reports to inform practice and training.

- Procedures for forwarding committee recommendations to the appropriate Department administrators, for those administrators to record their responses to committee recommendations, and for Department reporting in summary form to the General Assembly.

The protocol for the Multidisciplinary Review Committee is complete.

OIG Response: The OIG reviewed the Multidisciplinary Review Committee Protocol. The protocol does not include any of the provisions recommended above.

3. The determination by the child protection administrator should be voided. The Department should immediately convene a Multidisciplinary Review Committee, as suggested by the Department's Legal Division, to review the hospital's request for review, according to guidelines developed by the Department. The Multidisciplinary Review Committee should include a national expert in the boy's rare disease.

A review of the determination in the investigation has been completed using the Multidisciplinary Review Committee approach. A letter will be completed by December 2004.

OIG Response: According to the Administrative Hearing's Unit, the appeal of the previous finding of medical neglect had been held in abeyance pending the outcome of the Multidisciplinary Review Committee. It is still in abeyance.

4. The OIG should refer the disclosure of the mother's private discussions by the hospital chaplain and the doctor to the hospital's ethics panel for review.

The OIG referred the matter to the hospital's Director of Pastoral Care.

GENERAL INVESTIGATION 12

ALLEGATION

The foster mother for nine year-old twin boys with Type 1 juvenile diabetes failed to adequately meet their medical needs.

INVESTIGATION

Type 1 Diabetes is characterized by an inability to produce sufficient levels of insulin in the body. As a result, individuals with Type 1 diabetes are dependent upon daily insulin injections and require vigilant monitoring of their blood sugar levels. A temporary imbalance in insulin levels can cause serious illness or death while sustained neglect of the condition can lead to long-term health problems such as blindness, kidney failure and heart disease.

Throughout the nearly five years the boys were placed in her home, the foster mother failed to effectively manage the boys' disease. Soon after the boys began classes at their new school, the district nurse arranged for them to attend treatment at a pediatric endocrine clinic to receive specialized treatment. An OIG review of the boys' medical records found the twins' attendance at appointments was sporadic, including one five-month period when they were not seen at the clinic. Involved medical personnel noted both boys had little to no understanding of how to identify their own symptoms of increased or decreased insulin levels. Medical staff also reported the foster mother did not assume responsibility for instituting an insulin schedule or managing the boys' dietary requirements. Although the foster mother was provided with two glucometers to measure the boys' blood sugar levels and was repeatedly instructed to use them exclusively with each child, she persisted in using one unit to test both boys, rendering the information obtained useless. Medical personnel documented missing, incomplete or unverified information provided during visits that prevented physicians from accurately assessing the boys' conditions. While the boys' natural mother participated in diabetes education sessions offered by the clinic, the foster mother repeatedly failed to attend.

On one occasion, the foster mother was not present at a clinic visit despite the fact the boys had been picked up and transported from her home. During the visit it was determined the boys required hospitalization because of excessively high blood sugar levels. The foster mother did not visit the boys during the eight days they remained in the hospital. The boys frequently required transportation to medical appointments because the foster mother stated she was unable to drive. An OIG review of the foster mother's licensing file found she had twice attested to the fact she would be able to provide necessary transportation for wards. An OIG review of the foster mother's driving record found her license had been suspended six years earlier. In an interview with the OIG, the family's private agency caseworker stated she was aware the foster mother's license was suspended. An OIG review of the case file found reference to the foster mother's "male companion" to assist with transportation needs. There is no formal recognition in either the case file or the licensing file as to the identity or role of the foster mother's boyfriend in the home. Although the foster mother had reported various health problems to medical personnel, including her own poorly managed diabetes, which she hoped involvement with the boys would encourage her to address, her licensing application listed no significant health concerns. During the course of the OIG investigation, the foster mother stated she was being asked to move from her home by the landlord because of noise complaints related to the twins and their three other siblings she cared for. The caseworker told the OIG the foster mother had informed her she was moving because the landlord had sold the building. The OIG contacted the landlord who stated the foster mother was being evicted for failure to pay four months rent.

The OIG found numerous deficiencies with the case management provided by the private agency caseworker. Her reliance on the foster mother's self-reports and failure to confirm basic facts compromised the boys' medical treatment. In addition, the OIG identified several occasions when the caseworker virtually ignored allegations of corporal punishment made by the boys against the foster mother. The caseworker either neglected to relate the reports or minimized them to the hotline so as to undermine their importance. An OIG

review of the caseworker's criminal history found she had multiple convictions for forgery and deceptive practices as well as an outstanding warrant. In addition, two of the caseworker's children had been found to be neglected and dependent seven years earlier while she was their caretaker. After conducting a review of the caseworker's history and job activity, the private agency terminated her employment for poor performance.

The ongoing OIG investigation combined with a proposed permanency plan to grant the foster mother subsidized guardianship of the twins and one of their siblings prompted a referral for an Agency Performance Team (APT) review. APT reviews are utilized by the Department to facilitate resolution of issues that prevent cases from progressing to closure. The APT liaison assigned to the case reviewed the case record but not the foster home license file. In an interview with the OIG, the APT liaison stated she did not possess the authority to review foster home licensing files. The OIG confirmed with the Department's associate deputy director that APT liaisons are prohibited from reviewing licensing files but can request staff from another unit in the division (agency & institution licensing) to review a foster home license file for compliance.

Prior to the completion of the OIG investigation, the twins were removed and placed in specialized foster care while their siblings were placed together in a traditional foster home.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The foster mother's home should be referred for a licensing investigation to address: use of corporal punishment, falsification of form regarding transportation, verification of attendance at required training, providing false information concerning whether her boyfriend lived in the home, providing false information regarding her reason for changing residences, whether she provided false information concerning her reason for not visiting the twins during their hospitalization, and whether her health problems affect her ability to provide foster care. Depending on the outcome of the investigation, the private agency should determine whether to recommend revocation or transfer of her foster home license. The Department should not approve transfer of her license to another agency until all outstanding licensing issues are resolved.

The foster mother is no longer licensed to provide foster care.

2. The private agency should review all children's case records and foster home license records that were under the caseworker's management. Such review should look for accuracy of information and include documented activities such as required trainings attended by foster parents.

The Private Agency, on its own initiative, reviewed all case and licensing records under the caseworker's management.

3. Wards diagnosed with juvenile diabetes should receive medical treatment through pediatric endocrine clinics to benefit from specialized medical care, i.e., pediatric endocrinologist, developmental ophthalmology specialist, retinal specialist, and development and implementation of individualized Diabetic Care Plans.

Wards with Juvenile Diabetes can receive their routine medical treatment through their primary care physician. Their specialty care should be overseen by a pediatric endocrinologist, who would make the necessary subspecialty referrals. Regional nurses can assist caseworkers with locating pediatric endocrinologists. Reference to this will be included in the draft nurse referral policy guide which will be finalized for submission to the Office of Child and Family Policy by January 2005.

OIG Response: The OIG agrees, but believes that the requirement of a pediatric endocrinologist in such

cases should be formalized.

4. Wards diagnosed with juvenile diabetes should have individualized Diabetic Care Plans as outlined by the American Diabetes Association. Diabetic Care Plans should be incorporated into the child's Individualized Education Program.

The pediatric endocrinologist would develop the Individualized Diabetic Care Plan.

5. The Department should require all licensed foster parents caring for medically complex children to attend medical trainings relevant to the needs of the children in their care.

Training for foster parents to care for a medically complex child is arranged by the child's healthcare provider. Department Rule 402.12(a) states "Each foster parent shall be willing and able to assume appropriate responsibilities for the child or children received for care." In addition, the Department has a specialized foster care review committee which may assist in referral of children to specialized foster care programs able to meet their particular needs.

6. The Department must immediately rescind any policy prohibiting Agency Performance Teams (APT) access to agency records and inform all private agencies that APT Liaisons should have full access to all relevant records.

The Department has no written policy prohibiting APT access to any purchase of service records. APT staff are not qualified or trained in Rule 402 to make recommendations in licensing requirements. They are also not trained or certified accountants to review and validate financial and accounting matters. If allegations of improper and illegal practices related to licensing and financial matters are brought to the attention of APT or if they come across such issues when reviewing case files, they are required to report it to their supervisor for appropriate notification to audits and Agency and Institution Licensing.

GENERAL INVESTIGATION 13

ALLEGATION

A 14 year-old male Department ward was injured during a fight with another boy at a residential facility. The 14 year-old accused facility staff members of either failing to intervene in the fight or physically assaulting him themselves.

INVESTIGATION

The fight between the two residents occurred after the 14 year-old had his privileges revoked because facility staff believed he had stolen personal property during a group outing. The 14 year-old believed another resident had turned him in to staff. The 14 year-old made threats against the other boy on the way back to the campus and, after arriving at the facility, threw a full can of soda at the boy in the presence of staff while riding in an elevator. The second ward had multiple physical disabilities and was described by staff as being very popular among the other residents. After throwing the can, the 14 year-old was taken back to his unit by staff while other residents went to dinner.

The 14 year-old's aggressive behavior continued to escalate as he knocked pictures off the walls, slammed doors and continued to make threats against the other boy. When the other residents returned from dinner, the 14 year-old's behavior worsened. Staff ordered all residents into their rooms immediately. A 16 year-old resident challenged the 14 year-old to throw something at him as he had done with the other boy. The boys began fighting and were separated by staff. The fight lasted one to two minutes, but during the fight the 14 year-old lunged at the other boy and fell on his face, landing at the 16 year-old's feet. The 16 year-old kicked the 14 year-old and stomped on his face, head and neck before staff were able to regain physical control of the boys. Staff asked the boys if they required medical attention and, after both declined, ordered each of them into their rooms.

Within one to two hours the 14 year-old asked to see the facility nurse who determined he needed medical attention. The boy was transported to a hospital and was found to have blunt trauma to the face and midsection as well as numerous soft tissue injuries to his neck, shoulders and back. A treaded shoe print was visible on the boy's neck. At the hospital, the boy told a nurse that a staff member had actually engaged in beating him along with the 16 year-old. However, when speaking to a doctor, the boy implicated two staff members but not the 16 year-old. The 14 year-old also stated that a third staff member observed the beating and laughed. The social worker contacted the State Central Register to report the incident.

The following day the boy was interviewed by investigators from the Office of the Guardian ad Litem (GAL) and implicated the first staff member he had identified to the nurse. The 14 year-old's account of events varied significantly among the three reports he made. The child protection investigator assigned to the case failed to thoroughly examine the facts. The investigator neglected to retrieve a written statement taken from the 14 year-old boy at the hospital following the fight and an Unusual Incident Report (UIR) written by one of the involved staff members. In addition, the investigator failed to identify the sources of statements recorded in her case notes. In an interview with the OIG, the investigator was unable to clarify the ambiguous information presented in her notes. Although the investigator's work on the case appeared to be superficial and despite her failure to follow direct instructions to obtain critical documents, the investigator's supervisor approved the decision to unfound the report and signed off on the investigation.

A criminal background check of one of the two staff members accused of beating the 14 year-old boy found two convictions for domestic violence incidents. At the time he was hired by the residential facility, the staff member denied having any criminal history. When facility management became aware of the employee's criminal history, they failed to review underlying documents pertaining to the incidents. Facility management instead based their decision to retain the employee on his self-report of the domestic violence conviction.

Neither the OIG or law enforcement found evidence to support the 14 year-old's account of events. The

boy's statements were inconsistent and were contradicted in significant aspects by witnesses. Medical personnel found the boy's primary injuries to be consistent with a fall and that the injuries related to being kicked and stomped could have been inflicted in a matter of seconds. Medical personnel concurred, however, that kicking and stomping a person on the ground can easily result in severe injuries or death. The 16 year-old has a history of positive academic achievement contrasted with significant disciplinary problems. His inability to control his behavior in this situation could have resulted in serious injury and legal charges against him. The 16 year-old's father has been identified as an invested parent and his viability as a potential caretaker should be further explored.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The residential facility should take appropriate supervisory or disciplinary action toward the staff member with the criminal background to address the falsification of his application, an assessment of prior criminal history based on a review of underlying documents, minimizations of his domestic violence history and his failure to seek timely Intensive Therapeutic Services (ITS) intervention and a nurse's consultation on the 14 year-old boy's injuries.

The agency terminated the staff member's employment.

2. The residential facility needs to develop policy requiring Intensive Therapeutic Services consultation when aggressive behaviors escalate or continue over time and facility management needs to strongly encourage nursing consultation in questionable situations, even if the youth declines treatment.

The OIG shared the report with the agency. The Inspector General met with agency executive staff and a member of the Board of Directors to discuss the report. The agency has instituted a new policy detailing guidelines for mandatory Intensive Therapeutic Services (ITS) consultation.

3. The 16 year-old boy should meet with the Medical Examiner to ensure his awareness and acceptance of responsibility for the 14 year-old boy's injuries.

The Department agrees. An update will be provided by February 2005.

4. The child protection investigator should be disciplined for substandard documentation and failure to secure critical documents.

The employee was disciplined. The employee's grievance of the discipline is pending.

5. The child protection investigator's supervisor's manager should review this report and the DCP investigation approved by the supervisor and determine whether the supervisor should be disciplined.

The report was reviewed by the appropriate manager. The manager determined that discipline was not warranted.

6. The Department must work aggressively with the 16 year-old boy's father as a potential for return home.

The Department agrees. An update will be provided in February 2005.

GENERAL INVESTIGATION 14

ALLEGATION

Child protection investigators indicated an abuse report against the stepfather of a 16 year-old boy without conducting necessary interviews or a scene investigation.

INVESTIGATION

The father of the 16 year-old boy contacted the State Central Register (SCR) to relay his son's report that the boy's stepfather had thrown him through a door.

The next day, the assigned child protection investigator interviewed the boy at his school as well as the school guidance counselor who provided the investigator with the places of employment and work phone numbers of the boy's mother and stepfather. The investigator also attempted to meet with the boy's 14 year-old sister, however the girl was absent from school that day. Following these initial efforts, the investigator did no other work on the case for a ten-week period before attempting to visit the children's mother and stepfather at their home. Although the investigator was aware both parents were employed and had their work phone numbers, he attempted a home visit during the middle of the day. The investigator then returned to his field office and wrote a letter to the parents advising them to call him at work. At the end of the day, the investigator went on medical leave. In an interview with the OIG, the investigator attributed the extended period of inactivity on the case to an increased caseload related to a staffing shortage at the field office. The investigator stated consideration of privacy rights prevented him from attempting to visit the mother or stepfather at their places of employment and he did not call them at work because the boy had suffered only very minor injuries and the investigator was not concerned for his safety.

After the investigator went on medical leave, the child protection investigation remained dormant for three months until his supervisor assumed responsibility for the case. The supervisor interviewed the boy once again before meeting with a Department administrator. The result of the meeting was a decision to indicate the report against the stepfather for risk of harm. Following the meeting, the supervisor attempted to visit the family home but was unable to locate the residence. The next day the supervisor interviewed the boy's 14 year-old sister who substantiated her brother's account and stated the altercation was an isolated incident and she felt safe in the home. One month later, the indicated report against the stepfather was approved by the Department administrator. The supervisor based her decision to indicate the report solely on her conversations with the two children. In an interview with the OIG, the supervisor stated the investigator's attempted home visit and letter combined with her fruitless effort to find the family's house constituted sufficient "good faith" efforts to contact the parents. In child protection investigations, Department procedure specifically requires in-person communication with the alleged perpetrator, the children's caretakers and the alleged victim within seven days after a report is taken unless good faith attempts fail to locate the individuals.

The stepfather appealed the indicated report of risk of harm against him. An Administrative Law Judge (ALJ) determined the Department had failed to provide a preponderance of evidence to support the indicated finding and recommended the report be expunged. The Department accepted the recommendation and reversed the indicated finding against the stepfather.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The child protection supervisor, who assumed direct investigative responsibilities for this investigation while the investigator was on medical leave, should be counseled because she did not model effective investigative procedures.**

The Department agrees. The supervisor will be counseled.

- 2. The Department should inform field managers that contacting a family at work is not a violation of privacy during an investigation.**

The appropriate Department Administrator will be attending regional management meetings to discuss this issue.

GENERAL INVESTIGATION 15

ALLEGATION

A mother complained that a Department caseworker had intervened in private custody proceedings between herself and her children's paternal grandmother and had provided false information to the court.

INVESTIGATION

A paternal grandmother entered a Department field office seeking information regarding obtaining guardianship of her two grandchildren who resided with their mother. The caseworker accompanied the grandmother to a court proceeding where she was awarded guardianship of the children. The court order noted the children had been placed with the grandmother. The Department had no open case or legal relationship with the children involved.

One year later, the grandmother contacted the caseworker on behalf of the children's father who sought to terminate child support payments to the mother. An OIG review of the case file maintained by the State's Attorney found a letter written on Department letterhead and signed by the caseworker. The letter erroneously stated that the mother had previously been indicated for inadequate supervision of her children and that they had been taken into custody by the Department. In addition, the court order issued as a result of the hearing noted the caseworker's report that the children had been removed from the mother two years earlier by the Department and placed with the grandmother. The court order also references the caseworker's agreement to deliver copies of the placement papers to the State's Attorney. The Department had never removed the children and the mother had not been indicated for neglect of her children.

In an interview with the OIG, the caseworker reiterated her belief the mother had been indicated for inadequate supervision of her children and additionally stated issues of physical abuse and neglect had resulted in one child suffering hearing loss. There was no information contained in the case record to support the caseworker's contention. Although the caseworker insisted her continued involvement in the case occurred under supervisory direction, her supervisor stated to the OIG he never reviewed or approved her participation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be disciplined for providing misinformation to the court, failing to check the veracity of information before providing it to the court and for overstepping boundaries in "supporting" the grandmother in her efforts to gain guardianship of her grandchildren.

Discipline was imposed. The employee filed a grievance, which is pending.

GENERAL INVESTIGATION 16

ALLEGATION

A Department employee misused her position by writing correspondence, on Department letterhead, to her husband's employer. The letters instructed the employer to discontinue garnishing the husband's wages for child support payments to his previous wife. The wage deductions were the result of a court order related to outstanding child support obligations in another state.

INVESTIGATION

An attorney from the other state's child support division contacted the employer and inquired why the company had not complied with the judicial order to garnish the husband's wages. In its defense, the company submitted two notices printed on Department letterhead and a third on plain paper instructing them not to deduct any wages from the husband's paycheck. The attorney forwarded the letters as well as the pertinent legal documents and other communications to the Department which, in turn, requested the OIG investigate the matter.

The OIG learned the Department employee had contacted the State's Attorney's Office to arrange a paternity test for her husband. The OIG interviewed the employee who acknowledged writing one letter, not on Department letterhead, which was signed by her husband. The employee refused to answer any further questions, claiming her privilege against self-incrimination. The OIG observed that both the letter the employee acknowledged writing and one of the supposed letters from the Department contained the same misspelling of a common word. In addition, the Department employee's former supervisor confirmed that the phone number provided in another document was the same as the Department employee's work number. The government attorney who initiated the investigation informed the OIG that paternity of the children had been established in 1994 and that the order against the husband had never been vacated or amended and had not expired, contrary to information provided in the letters.

The Department employee was interviewed by the OIG a second time pursuant to an agreement that any information disclosed would not be provided to authorities for use in a criminal investigation. The employee stated she "might" have written the letters to the company on Department stationery. The employee acknowledged the phone number that appeared on one document was hers.

During the course of the investigation, the OIG also learned the employee had submitted reimbursement requests to the Department for services provided by her husband and her sister for a program overseen by the employee. An OIG review of records found neither payment had ever been approved by the Department. The OIG referred this issue to the Executive Inspector General for investigation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The employee should be discharged for misconduct and using her state position for financial gain.**

The employee resigned from state employment effective as part of a settlement agreement with the Department. She agreed that she would not seek employment from the Department in the future.

GENERAL INVESTIGATION 17

ALLEGATION

A Department administrator personally interviewed a five year-old girl regarding possible sexual abuse rather than contacting the division of child protection in accordance with Department procedure.

INVESTIGATION

The Department administrator had been employed in his position for one month when he received a call from the five year-old's mother alleging sexual abuse against the girl perpetrated by the girl's father. The mother stated the father had previously been indicated for sexual abuse against the girl and expressed her concern over ongoing, court-ordered visitation with him. The administrator related the mother's concerns to her caseworker who informed him the mother had recently made similar reports which were unfounded. The parents were involved in a protracted custody battle and the father was appealing the earlier indicated report against him. Two weeks later, the mother called the administrator again and made specific allegations of abuse related to a recent home visit between the father and the girl. The mother asked the administrator if she could bring her daughter to his office in order to describe the situation directly to him. The administrator agreed and the mother and daughter arrived at his office later that day.

The administrator had been hired to serve as a community liaison and was neither expected nor qualified to conduct interviews with possible victims of sexual abuse. In an interview with the OIG, the administrator stated that after the mother reiterated the allegations, the administrator asked the girl to provide her account to him. After the girl verified her mother's statements, in the mother's presence, the administrator advised the mother to contact the hotline. The administrator stated he did not confer with his supervisor prior to speaking with the girl. In her interview with the OIG, the administrator's supervisor stated that after learning of the interview from the administrator she admonished him for inappropriate behavior. The administrator received a verbal reprimand and was instructed to speak with a Department deputy director for education regarding child protection investigations but was not formally disciplined.

Department procedure requires child protection investigators to schedule Victim Sensitive Interviews (VSI) in cases where sexual abuse is alleged. The purpose is to maximize the information gathered by allowing a specialist to interview the possible victim while minimizing potential trauma to the child by only requiring them to relate their story once. Victims are never to be interviewed in the presence of parents or other involved adults to help ensure children feel comfortable to relate their story without being pressured or coached. By conducting his own interview with the girl, the administrator risked undermining the integrity of the subsequent child protection investigation into the mother's allegations and subjected the girl to undue stress. In addition, the administrator's actions were beyond the scope of his responsibilities and in clear violation of Department procedure.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The verbal reprimand of the Department administrator should be documented in his next performance evaluation or his personnel file.

The reprimand will be documented in the next performance evaluation.

2. The Department administrator should receive ethics training on the issues of abuse of authority and the appropriate role of his position.

The administrator received clarification of his role and job duties.

GENERAL INVESTIGATION 18

ALLEGATION

The adoptive parents of an eight year-old boy with diagnosed learning disabilities were denied approval for post-adoptive services.

INVESTIGATION

The adoptive parents contacted the Department's post-adoption subsidy unit to request monetary support for tutoring, day care and respite services. The parents were informed that day care assistance could only be accessed if the provider offered necessary therapeutic intervention. The adoptive parents submitted a request for approval of a provider they had identified, however the request was denied, even though the boy qualified for day care subsidies, because the provider did not meet the Department definition of therapeutic day care. The parents were not informed of the criteria for compliance with Department guidelines or the names of previously approved appropriate day care providers. In an interview with the OIG, the supervisor of the Department's post-adoption unit stated it was standard practice for workers to contact the Department's division of contracts administration in response to inquiries from adoptive parents regarding available, qualified day care services. Maintaining a current database of approved providers in the post-adoption unit would streamline communication and allow for accurate information to be provided to adoptive parents in a more expedient manner.

The family was also referred for education assistance through an educational advisor. The educational advisor conducted a review of the boy's school records, discussed his history with his teacher, observed him in the classroom and worked with him on an assignment. The advisor then submitted a written summary of her assessment and a list of approved supplemental educational service providers to the adoptive parents, the post-adoption unit and the OIG. In an interview with the OIG, the director of the Department's educational access project stated educational advisors are initially encouraged to address issues through phone calls to a child's school but are required to make in-person visits if necessary. The review of a child's school records is not a routine aspect of the educational advisor's responsibilities.

A significant increase in the number of adoptions facilitated by the Department in recent years has created a strain on available staff and resources. A disproportionate number of requests for post-adoption assistance originate in concentrated areas within the state. Department staff and resources must be increased and allocated in relation to the number of incoming requests for post-adoption assistance.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The supervisor of the Department's Post-Adoption Unit should develop a training plan for all staff in the Cook County Post-Adoption Subsidy Unit. The training plan should include training on: Eileen Gambrill's *Guidelines for Giving Information*; the Educational Access Project; how to develop resources and maintain an updated informational database of community resources and service contractors; knowledge about Cook County community areas to develop a geographically-based response system; and rules, policy and procedures that affect adoptive and guardianship families. An analysis of incoming calls should assist staff in prioritizing allocation of staff time to the development of the most sought after resources. The supervisor should meet with the Advocacy Office for Children and Families for the purpose of developing effective linkage and communication between the two offices and to share resource databases.

A training plan for the Cook County Post-Adoption Subsidy Unit was developed and is on-going. In addition, a broader database of resources is being developed. The Eileen Gambrill Guidelines for Giving Information is being utilized in the development and use of this database.

2. A responsibility of the Department's Educational Access Project is to identify problematic trends for

systems intervention. Project staff should examine the number, pattern and nature of education-related calls to the DCFS-Cook County Post-Adoption unit and the response of education advisors, to determine whether requests for educational assistance can be more effectively handled, i.e., allocation of time of education advisors and educational liaisons to Post-Adoption Services. The Department should ensure that educational advisors are available to review adopted and guardianship children's records when necessary to best advocate for educational services. The Educational Access Project staff should train post adoption staff on available educational services and resources targeting those communities with the highest adoption rates.

There has been ongoing training for staff by the educational advisors.

GENERAL INVESTIGATION 19

ALLEGATION

A 20 year-old male ward was placed at a mental health facility after a court determined he was unfit to stand trial for two counts of battery. The Department had previously designated the ward as being a “sexually aggressive” youth. The Department of Mental Health requested that the OIG assess the appropriateness of the designation in order to determine placement options for the ward.

INVESTIGATION

The ward first became involved with the Department when he was seven years old after staff at his school contacted the hotline to report he was being physically abused. The subsequent child protection investigation resulted in indicated reports against the ward’s father for excessive corporal punishment and against his uncle for sexual abuse of the ward’s sister. The child protection investigation report noted the ward likely witnessed the sexual abuse of his sister and may have been a victim of sexual abuse himself. Following the investigation, the ward was removed from his father’s custody and spent portions of the next 13 years between 8 group-home placements, 7 psychiatric hospitalizations and 3 juvenile detention placements. The case record showed the ward, who was identified as being mildly mentally retarded, was molested by peers and at one point was raped by two older boys who forced him to engage in anal sex.

The ward’s first reported incident of inappropriate sexual behavior occurred when he attempted to grope a housekeeper at his group home. The incident occurred just five months after the ward had been raped by the older boys. As a result of this single event, the ward was assigned to the Sexually Aggressive Children and Youth (SACY) program. The SACY program has since been discontinued by the Department after OIG reports documented a pattern of arbitrary decision-making and widespread inconsistencies in the application of policies that contributed to the long-term stigmatization of children who may or may not have been correctly identified for inclusion in the program. The Department created the Sexual Abuse Program (SAP) to replace SACY, however, the cases of many wards were directly transferred without reconsideration of their inclusion in the database.

The ward’s case history included a number of elements previously identified by the OIG as flaws inherent in the old SACY program. The ward was involved in only four incidents that could be judged as sexually problematic, however, his SACY designation prompted various child welfare and mental health professionals to view all of his behavior in a sexual light. Evaluations and assessments repeatedly focused on his sexualized behavior at the expense of a more comprehensive perspective. Non-aggressive incidents, such as the ward being found masturbating alone in his room or the discovery of pornography in his possession, were used to bolster the poorly substantiated contention he was a sexual predator. The ward’s early exposure to sexualized behavior and the cumulative effects of known and unknown sexual abuse against him were not considered in determining a course of treatment for him. A number of the alleged instances of sexually aggressive behavior involving the ward were recorded as fact despite being based on vague reports and minimal or non-existent investigation. Treatment plans failed to recognize how the ward’s diagnosed mental health issues influenced his behavior. A psychiatric evaluation that identified his developmental delays as a more pressing concern than the sexual behavior he exhibited was ignored in favor of conclusions that bolstered the notion of the ward as a sexual predator. A review of Unusual Incident Reports (UIR) involving the ward shows a sharp spike in reports coincided with his transfer to a new group-home placement and his increased refusal to comply with his medication schedule.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The ward should be placed in a treatment facility for individuals with developmental disabilities that can adequately address his aggression and property destruction. The ward’s name should be removed from the SAP database.**

The ward was placed in an appropriate group home. The ward was removed from the SAP database. His case has been closed.

GENERAL INVESTIGATION 20

ALLEGATION

A Department task force concluded child protection and follow-up workers could contact relevant collateral sources to monitor families. Although the findings of the task force were approved by the Department they were never implemented into policy.

INVESTIGATION

In 2001, the Department convened a task force to address issues of confidentiality regarding child protection investigations. At issue was the ability of investigators and follow-up workers to utilize relatives, friends, neighbors or other collateral contacts to monitor families. Department policy at the time required that in instances where an indicated finding led to an open case but the family refused services, or monitoring of a family was to continue following the closing of an investigation, collateral contacts could not be used. Although the basis of this policy was to preserve the involved family's right to confidentiality, the task force identified the inherent shortcomings of such practice. The task force cited a case in which a family was referred to Intact Family Services (IFS) after the father was indicated for abusing his baby. A requirement of the service plan was the father's agreement to move out of the family home. The intact worker did not communicate with any collateral contacts to ensure the father left the home and relied on the family's report. The father, in fact, remained in the home and subsequently committed a fatally abusive act against the baby.

The task force concluded that, in the interest of balancing a family's right to confidentiality with children's right to safety, the Department should allow workers to enter into agreements with families informing them of the potential that collateral contacts will be utilized for purposes of monitoring. These agreements would notify families of the possibility of worker communication with collateral contacts without specifying which, if any, individuals might be questioned. Supervisory approval would be required to prevent the utilization of collateral contacts from becoming an intrusion on a family's right to privacy.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. Department Procedure Sections 300.60 and 300.90 should be amended to ensure that follow-up workers can contact collateral sources in an open case when necessary for monitoring.**

The procedures were amended accordingly.

GENERAL INVESTIGATION 21

ALLEGATION

The Guardian ad Litem (GAL) for a 17 year-old female ward alleged staff at the residential facility where she lived had failed to properly secure confidential records. The girl complained to the GAL after a fellow resident revealed specific information about the girl's history of sexual abuse to other residents at the facility.

INVESTIGATION

The 17 year-old girl complained after another girl told other residents the 17 year-old had previously been sexually abused by her uncle and had perpetrated sexual abuse against her younger siblings. Residential facility staff informed the OIG of the results of an internal investigation of the incident that determined the girl who shared the information had obtained it from a third resident who had a previous relationship with the 17 year-old and was privy to her history with the Department. Facility staff stated that documents containing such information were inaccessible to residents and informed the OIG of procedures for ensuring the protection of confidential information. In an interview with the OIG, the girl who shared the 17 year-old's history stated she had learned the information from another resident. The OIG determined the facility had not breached the 17 year-old's right to confidentiality.

Following the initial investigation, the OIG reviewed the information at issue contained in the 17 year-old's case file. The girl had been designated for inclusion in the Department's database of Sexually Aggressive Children and Youth (SACY) when she was 11 years-old. [The Department has since renamed the project the Sexual Abuse Program (SAP).] The girl was designated following a report from her foster mother at the time that she had engaged in public masturbation. This report also referenced unattributed allegations the girl had forced her younger siblings to engage in sexual activity with her and each other. An OIG review of the girl's SACY screening form found no evidence any substantive investigation occurred into the origin of the reports of inappropriate sexual activity between the siblings. The girl's case file showed she had been seriously and chronically sexually abused by her uncle when she was five years-old and had also been sexually abused by an older male cousin. In addition, the girl had reported she and her siblings had been severely physically abused by their mother. Despite the absence of any examination into serious allegations against the girl, she was given a SACY designation and identified as a threat for predatory sexual behavior.

A previous review of the SACY program conducted by the OIG four years earlier found numerous systemic problems that compromised the Department's ability to provide effective services and stigmatized wards. In the girl's case, her initial identification at age 11 as a sexually aggressive youth, based on unverified accounts from unknown sources, created significant obstacles for her throughout her involvement with the Department. As a SACY ward, the girl's living conditions within her various placements were greatly restricted as were her contacts with peers and her own siblings. SACY plans required her to be monitored while sleeping, using the bathroom or spending time with other children.

During the six years following her SACY designation, the allegation the girl had abused her siblings was repeatedly invoked as justification for moving her in and out of placements and used as a basis for interpreting her behavior. The unverified information was accepted as fact by subsequent professionals involved in her case. Evaluators continually attempted to focus on presumed issues of sexual aggression at the expense of addressing her diagnosed mental health problems, substance abuse issues and demonstrated physical aggression. Efforts at treatment focused on the girl's possible role as a perpetrator rather than her verified status as a victim of sexual abuse. In addition, the inability or unwillingness of a succession of involved child welfare professionals to conduct a comprehensive review of the girl's case file resulted in her undergoing nine SACY evaluations during a six-year span. Furthermore, the girl's denial of sexual abuse against her siblings or reluctance to engage in discussions on the topic was often viewed as evidence of her culpability and interpreted as an obstacle to be overcome in treatment.

After the girl gave birth to her own child at age 16, she moved into a residential facility for wards with children. During a permanency hearing regarding the girl's status, the hearing officer was incorrectly informed the girl had not completed a required SACY assessment. In an interview with the OIG, the regional SACY coordinator stated SACY evaluators differ in their tendencies to submit findings in a timely manner. Such delays cannot be accepted by the Department when the results are instrumental in determining the services to be provided to Department wards. During the same permanency hearing, the hearing officer was informed the girl was living in the residential facility with other wards and their young children. In response, the hearing officer expressed her reservations about such a placement for a SACY ward and referred to the mother, who was not present, as a "pedophile," "pedophiliac" and "child molester."

In response to the OIG's initial review of the SACY program in fiscal year 2000, the Department accepted recommendations intended to ensure that accusations of improper sexual conduct by wards were immediately and thoroughly investigated and that children who had in fact committed misconduct were provided with appropriate services and care. Although the Department committed to an overhaul of the system and renamed SACY the Sexual Abuse Program (SAP), the recommendations themselves have not yet been implemented.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should ensure that the regional SAP administrator immediately removes the girl's name from the sexual abuse database.

The girl's name was removed from the database in May 2004.

2. The Department's clinical division should ensure that providers of sexual abuse evaluations submit their final reports and recommendations to the regional coordinators within two weeks of completion. This requirement should be reflected in all program plans.

Revised Sexual Abuse Program (SAP) standards have been drafted. The standards require providers of sexual abuse evaluations to submit final reports and recommendations to regional coordinators within two weeks of completion.

3. The Department should create a system for tracking when sexual abuse assessments are requested and when they are returned to the regional coordinators. In order to prevent repeated assessments of the same sexual abuse allegations, the regional coordinators should gather together all previous and relevant psychological assessments for the service providers. Service providers should receive all prior assessments and requests for assessments.

A tracking system has been created and will be in place by January 2005.

4. A redacted copy of this investigation should be shared with the Chief Hearing Officer to review the hearing officer's handling of this case.

The OIG shared the report.

5. The Department must immediately implement the OIG's previous recommendations for the SACY program made in FY 2000 and accepted by the Department.

The revisions to the Sexual Abuse Program guidelines (Procedure 302, Sub-Part B) will be finalized by January 2005.

GENERAL INVESTIGATION 22

ALLEGATION

A private agency providing management of a family's case placed a nine month-old girl in the foster home of an agency program director.

INVESTIGATION

The private agency assumed responsibility for the family case after the baby was taken into custody by the Department following repeated domestic disturbances between her parents. The baby, who had pulmonary hypertension and used a ventilator to assist her breathing, was placed in a specialized foster home through the agency. A court hearing resulted in the baby being made a ward of the court and established a goal of returning her to her parent's home within one year. The parents retained their right for supervised visitation.

Three months after the baby was taken into custody, her foster parent requested her removal citing her own health problems. An OIG review of the case file found no evidence agency staff asked the parents to identify any relatives who might provide placement options. Although the baby's maternal grandmother and paternal great-grandmother, who each lived out-of-state, contacted the agency regarding the possibility of having the baby placed with them, agency staff believed the court would not approve an out-of-state placement. The assigned private agency caseworker identified a second non-relative foster placement with a woman and her young son. Because the second foster parent was employed full time, the agency arranged day care services for the baby.

In an interview with the OIG, the baby's second foster parent stated that two months after the baby was placed in her home, the private agency's program director inquired if she would consider adoption. Upon being informed by the second foster parent she would be unable to adopt the baby, the program director expressed her desire to adopt the baby. Although the baby's goal remained return home, the parents' compliance with services had been sporadic and their volatile behavior persisted after their daughter was removed. The program director was aware of the parent's lack of progress and the diminishing likelihood the baby would be returned to their care. Three months after the program director spoke to the second foster parent regarding possible adoption, the baby was removed and placed in the program director's home.

During her involvement with the case, the program director misrepresented facts, manipulated information and utilized her position of authority within the agency in order to secure the placement of the baby in her home. In order to complete the placement, the program director requested the transfer of the family case to another private agency. In order to expedite the baby's placement in her home, the program director incorrectly told the caseworker from the receiving agency the baby's placement with the second foster parent was being disrupted. In response to questions raised during a case transfer staffing as to why an out-of-state placement with the baby's maternal grandparents had not been pursued, the program director erroneously stated the grandfather was a former drug dealer. In an interview with the OIG, the program director stated she had concerns regarding the second foster parent's care of the baby and felt the relationship between the two lacked a strong bond. The private agency caseworker assigned to the case told the OIG the second foster parent was an excellent caregiver and that the baby "loved" her. In her interview with the OIG, the second foster parent stated she was never made aware of any concerns regarding her care for the baby and only became aware of the baby's impending removal through conversations with the program director.

The transfer of the case to the receiving agency required Agency Performance Team (APT) approval, however APT staff did not critically assess the transfer request. The APT worker did not confirm inaccurate information provided to her that the second foster parent had requested the baby's removal. In an interview with the OIG, the involved APT worker said she was aware of the reason behind the case transfer but stated she was not her duty to identify conflicts of interest. The APT worker stated transfers between agencies are,

“pretty much a done deal once APT gets involved.” In his interview with the OIG, the APT worker’s supervisor stated the receiving agency would have been responsible for determining whether the program director’s home was a suitable placement.

In her role of leadership within the private agency satellite office, the program director made a decision within her official capacity as a child welfare professional to have a client placed in her home in foster care. Although some private agency staff had reservations regarding the program director’s efforts to facilitate the baby’s placement in her home, the program director’s supervisory role discouraged them from widely voicing their objections. Administrators from the private agency’s central office became aware of the intended placement, however they relied upon unverified information provided by the program director and failed to recognize or adequately address the scope of the conflict of interest involving their workers.

The baby’s maternal grandparents ultimately requested assistance from the Department’s help unit. During a family meeting, the help unit worker determined the baby had been removed from the second foster parent’s home unnecessarily and that the maternal grandparents had been unreasonably excluded from placement consideration. In addition, it was learned the program director had not received required supervisory approval for the baby’s placement in her home. A decision to place the baby with the maternal grandparents out-of-state was upheld by the court.

During the course of this investigation, the OIG became aware of a second case involving the placement of a client in the foster home of an agency employee. Although the circumstances of the case did not approach the issues raised in this instance, it demonstrated the need for improved awareness of conflict of interest considerations among child welfare professionals.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should issue a policy directive to private agencies to ensure that prior to a child specific placement for an employee, the agency should conduct a review to

ensure a child’s case will be transferred to an objective decision-maker who: (a) is fully informed as to the reasons for the transfer; (b) will verify of all critical facts underlying decision-making; (c) will conduct a thorough search for alternative placements; (d) will consult at least three other agencies regarding foster and adoptive resources; and (e) will make a placement decision.

Agency Performance Teams will continue to conduct case transfer staffings for all case transfers within the agency and between agencies.

OIG Response: The OIG believes that standards or guidelines for evaluating employee conflict of interest must be formalized.

2. The Department should require APT staff to ensure that prior to approving a case transfer between private agencies because of conflicts of interest for the purpose of foster or adoptive placement, APT should ensure that the agency conducted the review required in recommendation one.

The case transfer approval form will be revised to indicate that there is no real or apparent conflict of interest. Completion date: January 2005

3. If the private agency program director returns to child welfare employment in Illinois, she should receive ethics counseling around conflicts of interest.

The Department agrees. The OIG Ethics staff will conduct the ethics training if the program director returns to child welfare employment. The Department also requested that the OIG pursue revocation of the director’s

child welfare employee license. The OIG was unable to refer this employee for child welfare employee licensure action because of the 30 day time limit for bringing charges as provided in Rule 412, Licensure of Child Welfare Employees.

4. The Child Welfare Advisory Committee (CWAC) should include organizational and clinical ethical issues rising from the field on their annual agenda. This case, with the facts altered, should be included on the agenda for CWAC's May 2004 meeting.

OIG Ethics staff presented this issue for discussion at the May 2004 meeting.

5. The private agency did not update the Department regarding current case manager assignments. Agency Performance staff should monitor the private agency's case manager assignments to ensure compliance with accurate reporting to the Department regarding changes or corrections of case manager assignments.

APT Liaisons monitor agency compliance on a monthly basis and written feedbacks are given to agencies for immediate action.

6. This report should be shared with the APT worker and her supervisor for review and discussion of APT's role in following up on future conflict situations. The APT worker and her supervisor should also review and discuss the conflicts of interest section (Chapter 5) of the Companion Handbook for the Code of Ethics for Child Welfare Professionals.

The report was shared with the APT worker and her supervisor.

7. Private agency administrators and staff involved with this case should review and discuss this report.

The OIG shared the report with the private agency. Agency administrators and staff reviewed and discussed the report.

8. Involved private agency staff should also complete and discuss the conflicts of interest section (Chapter 5) of the Companion Handbook for the Code of Ethics for Child Welfare Professionals.

The OIG shared the report with the private agency. The involved agency staff completed and discussed the above mentioned conflicts of interest section of the handbook.

GENERAL INVESTIGATION 23

ALLEGATION

At the request of the Department, the OIG assisted in locating wards missing from private agency placements. The OIG also assessed the current status of services to wards who run away from private agency placements and return to their mentally ill biological parents.

INVESTIGATION

The effort to locate the missing wards concentrated on those under the age of 18 as well as wards over 18 who were pregnant, parenting or had been diagnosed with a mental illness. The OIG identified 190 wards missing from private agencies who met the criteria for age or vulnerability. The Department and the OIG located 123 (65%) of these wards by filing missing person reports, meeting with current and former caseworkers, researching various databases and talking to family members and friends. Caseworkers provided valuable information concerning wards' previous patterns of running, as well as contact information for their family and friends.

Of the 123 wards located, 51 (42%) repeatedly ran away from placements to the homes of parents and relatives. In many cases the children had been removed from these homes after the Department found the adults were unsuitable caregivers. Some wards reported they returned to these homes because of bonds with parents and relatives while others sought a less restrictive environment than they experienced in their placements. During the course of the project, the OIG became aware of a representative case involving two brothers, ages 16 and 14, who had been taken into Department custody but habitually ran from placements and returned to the home of their mentally ill mother.

At the time of the OIG's involvement, the 16 year-old had been absent from his placement for 15 months while the 14 year-old had been away from his foster home for six months. Both boys had resided with their mother since running away from their placements and staff from the private agency responsible for case management were aware of their presence in the home. The boy's 18 year-old sister, who was also a ward and the mother of a 19 month-old girl, had run away from her placement in an independent living facility and was believed to be living with her boyfriend at an unknown location.

Both boys stopped attending school or participating in services after running away. In addition, both had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and post-traumatic stress disorder and were believed to have stopped taking their medicine after leaving their placements. The mother had been diagnosed with bi-polar schizoaffective disorder and an OIG review of records from the Department of Human Services found she had not filled prescriptions for her psychotropic medications or participated in mental health services during the previous year. The family's prior involvement with the Department resulted in a Parenting Assessment Team (PAT) determination that the mother's mental illness was the primary cause of her inability to provide adequate care and prohibited her from developing necessary parenting skills.

Although private agency staff attempted to meet with the boys they were denied access to the house and reported the boys would flee if they observed workers in the vicinity of the home. Agency staff expressed frustration with Department regulations halting payments to agencies for a ward after the child has been on run status for a 14-day period while requiring the agency to continue to attempt to provide services. Such a policy can diminish the effort invested in locating runaway wards and fails to address the need for effective methods of reengaging them with services.

After examining the facts of the case the OIG contacted the hotline and consulted with local police. Police went to the family home and transported the 16 year-old to the Emergency Reception Center (ERC.) The 14 year-old fled the home upon the officers' arrival. The OIG facilitated meetings between the private agency, the children's Guardian ad Litem (GAL), the State's Attorney's Office and the Department in order to

develop a strategy for providing services to the children in the future. The brother's caseworker eventually spoke with both boys in the mother's home. The two boys expressed a desire to remain in her home and to enroll in a local high school.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should ensure the two brothers are immediately enrolled in an alternative school program that can provide the assistance of an education case manager and transportation stipend. The older ward should receive assistance in obtaining summer employment in addition to summer school services. While the younger ward obtains his eighth grade diploma, assistance should be provided for development of an Individual Education Plan (IEP) and transitional services for his fall high school enrollment. It should be explicit that both youth can continue their education at their enrolled schools throughout the next school year.

The GAL and Department staff from the divisions of legal, clinical, and operations have worked jointly to assist this family with resources and support services.

2. The Department should request an expedited PAT consultation and review for exploration of services that can mediate risks for the two brothers, their sister and her child.

The referral was made.

OIG Update: The referral for an evaluation was made by the Parenting Assessment Team Coordinator to one of the teams. The case was then re-referred to the team that had conducted a previous evaluation on the family. That team attempted to begin the assessment process, but the mother and the two brothers refused to participate. The mother has been on the run for the last six months. The brothers have been placed in a group home.

3. The assistance of the Help Unit should be obtained for the collaborative meetings between the Department's legal division and the officers of the court to develop a plan agreed to by all parties and provide a Report of the Guardian to the court.

The Department agrees. HELP Unit staffings were held and a mutually agreed to plan was developed.

OIG Response: The Department did not provide a response with regards to providing a Report of the Guardian to the court.

4. Independent living program's contract for pregnant and parenting teens should be amended to require a) proactive efforts in engaging the mother and child's support system and b) an adapted NAMI psycho-educational and peer support program for teen wards within its programs with mentally ill parents.

The Independent Living and Transitional Living Program specialty contracts, that include pregnant and parenting teens and the mentally ill, are being amended for FY 2006. Completion date: July 2005.

5. The Department should consider developing and piloting specialized contracts for community-based integrated child welfare/mental health treatment services for older adolescents with mentally ill parents transitioning to independent living or when there exists consideration for reunifications services. Such programming should include psycho-educational and peer support components for wards who have parents whose mental illness includes major disorders such as major depression, bi-polar, and psychotic disorders with or without substance abuse disorders.

The Mental Health/Behavior Development system is currently in development under the Program Improvement Plan. This is expected to be completed in FY 2005-2006.

6. The Department needs to develop realistic funding mechanisms for services to wards with chronic runaway behavior.

Intensive stabilization Services are being developed to address this issue.

7. The Administrative Case Review (ACR) administrator should sample ACR reviews of missing and runaway wards to ascertain the relevancy and sufficiency of the assigned tasks.

This sample review will be completed by June 2005.

GENERAL INVESTIGATION 24

ALLEGATION

Previous OIG investigations have identified excessive hot water temperature as a potential danger to wards, particularly the very young or disabled. The OIG reviewed the establishment of hot water temperature standards by the Department and compliance with those regulations by licensed facilities.

INVESTIGATION

Burn injuries can be devastating to families. Burns have long been recognized as among the most painful injuries a person can suffer and survive, often requiring long periods of rehabilitation, multiple skin grafts, and painful physical therapy. Burn injuries may also leave victims with lifelong physical and psychological trauma. The peak age for accidental scald burns is between the ages of one and two when children begin to develop mobility but have yet to acquire means to identify danger or protect themselves from harm. Almost 25% of all scald burns among children are from hot tap water and tend to be more severe and cover a larger portion of the body. Scald burns from hot tap water are associated with more deaths and hospitalizations than other hot liquid burns.

Existing data regarding cutaneous (skin) burns is based on evidence from the study of adults, whose skin is thicker than children's. Children burn more quickly and at lower temperatures. Current research shows that contact with water at a temperature of 130 degrees Fahrenheit will a full-thickness burn to adult skin after only 30 seconds. It is hypothesized that water 130 degrees or higher will produce partial and full-thickness burns to infants and young children in one-half to one-fourth the time of adults.

The OIG review found that current Department rules regarding maximum water temperatures are not applied uniformly across all licensed facilities. Day care centers and foster family homes that accept children under the age of 10 or who are developmentally disabled are required to maintain a hot water temperature at or below 115 degrees Fahrenheit. Homes providing individual or group day care and group homes are not subject to licensing standards regarding maximum hot water temperature. While licensing workers are responsible for monitoring compliance with standards, these efforts are limited mostly to a review of documents and do not include direct verification.

When investigating an allegation of burns or scald injuries, checking hot water temperature can be critical to determining whether a burn was the result of an accident or abuse and neglect. Despite changes in Department Procedure requiring licensing workers and child protection investigators to measure hot water temperatures, the OIG found the necessary checks were not being conducted. Licensing workers and child protection investigators made the OIG aware of impediments to accurate and effective water temperature measurements. Knowledge of measurement techniques varied widely and the unavailability of thermometers was frequently cited as the reason water temperatures were either not obtained or inaccurately recorded. Furthermore, Department procedures for measuring water temperature were not in accordance with available literature on tap water scalds. According to the National Institute of Occupational Safety and Health, water temperature should be measured by holding an approved thermometer under a stream of running water until the temperature ceases to rise.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The index of water temperatures and corresponding exposure times at which scalding will occur currently identified in rules and procedures for foster homes and child protection investigations should be corrected to accurately illustrate the time and hot water temperature at which infants and young children will suffer partial and full-thickness scald burns and the time and temperature at which older children will suffer the same.

The Office of Child and Family Policy (OCFP) has updated Department procedures as to burn indexes.

2. Rules and Procedures for all Department licensed facilities should be amended to include a maximum water temperature standard (either 115° or 120° Fahrenheit), and standards for testing and correcting, as previously outlined for foster homes in Policy Guide 99.12, Hot Water Temperature in Foster Family Homes.

A draft policy guide has been developed providing instruction to private and DCFS staff with regards to the maximum hot water temperature in licensed facilities. Completion date: February 2005.

3. A system should be established for ensuring the uniform availability of operable thermometers to all child protection investigators and licensing workers.

Tracking of functional thermometers is done on an ongoing basis so dysfunctional units can be quickly replaced.

4. Child protection investigators and licensing workers should be trained on how to properly measure hot water temperature, as well as the temperature and corresponding exposure times at which scalding will occur in infants and children.

A workgroup to revise the child protection training curriculum has been convened and will incorporate recommendations into the appropriate training modules.

A workgroup revising Procedure 300, Child Abuse and Neglect Reports has been convened. This recommendation regarding the allegation of burns will be incorporated into the revision. Completion date: May 2005

GENERAL INVESTIGATION 25

ALLEGATION

A Department attorney was alleged to consume alcohol during work hours, submit false travel vouchers, neglect to follow supervisory directives and fail to attend scheduled court hearings. The attorney had also recently been arrested for driving under the influence of alcohol.

INVESTIGATION

Child welfare professionals who had been involved with the attorney on court cases stated that although he was a knowledgeable and able lawyer, he did not follow through on work required to complete cases and was unreliable. The child welfare professionals stated it was necessary to contact the attorney's assistant in order to obtain follow-up documents. In addition, the workers said the attorney's repeated failure to appear at court hearings angered judges and resulted in frequent rescheduling which delayed the resolution of cases. A review of court dockets found several instances when the attorney was not present for scheduled court hearings.

An OIG comparison of the attorney's schedule and his travel reimbursement requests found numerous discrepancies. Some instances recorded the attorney as being in two places at once while others claimed he made trips to hearings when court dockets showed he had not appeared. In his interview with the OIG, the attorney denied missing court hearings or falsifying travel vouchers. The attorney acknowledged being an alcoholic and that he had resumed drinking one year earlier after a period of twenty-one years of sobriety. An OIG review of the arrest report found the attorney was combative and belligerent towards law enforcement officers and hospital staff at the time of the incident and additional state troopers were summoned to bring him under physical control. The attorney is currently on medical leave from the Department.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discipline the attorney up to and including discharge.

The Department attorney resigned.

2. A copy of this report should be shared with the Attorney Registration and Disciplinary Commission.

The OIG shared the report with the ARDC.

3. The OIG has previously recommended that the Department develop a policy regarding substance abuse in the workplace. That recommendation is repeated again.

A Substance Abuse Policy Committee has formed to develop a policy for the Department.

OIG Response: This recommendation has been made continually since 1998, and although it is a low frequency event the OIG believes it is critical to implement this recommendation.

GENERAL INVESTIGATION 26

ALLEGATION

A pharmacist used prescription records to contact a Department licensing worker regarding an investigation of a day care center.

INVESTIGATION

During an unannounced visit to an in-home day care center, the licensing worker and a colleague found 22 children present in the facility, which was only licensed to accept 12. The workers advised the operator she was in violation of the license and accepted an agreement the situation would be rectified by the following day. The next day, the workers conducted a follow-up visit. Although they initially found the center to be in compliance with their license, as the workers were leaving they observed three additional children being dropped off at the home. The workers returned to the center and waited until three children were picked up from the home.

That evening a woman arrived at the licensing worker's home. The woman identified herself as the grandmother of a boy who attended the facility and advocated on behalf of the day care operator. The licensing worker advised the woman she could not discuss the case with her, citing confidentiality issues. In an interview with the OIG, the licensing worker stated she recognized the woman as the proprietor of a local pharmacy where she filled her family's prescriptions. The licensing worker stated the woman informed her she had utilized old prescription records to locate the worker's home. Although the licensing worker stated she did not feel threatened during the encounter, she expressed concern the woman might use information regarding the her family's medical records for personal reasons.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The pharmacist's use of the licensing worker's confidential medical records was unethical. The pharmacist's name and a copy of this investigation should be submitted to the**

Illinois Department of Professional Regulation.

The Department agrees. The OIG referred the pharmacist to the Illinois Department of Professional Regulation.

GENERAL INVESTIGATION 27

ALLEGATION

A Department employee was prevented from registering for computer courses offered by the Department.

INVESTIGATION

The employee complained to the OIG he had been the victim of discrimination. The employee had sent an e-mail to the instructor who oversaw the Department's computer education program requesting enrollment in a course involving a particular software program. The instructor responded by e-mail that in order to register for the class the employee would have to fax an enrollment form to the Department's Registration Unit. The instructor also informed the employee that he could not take the course unless the software program was present on his work computer. The following day, the employee wrote to the instructor again seeking confirmation of his enrollment. The instructor reiterated his previous statements regarding the employee's eligibility to take the course. The employee responded by suggesting he would take legal action against the instructor if he was not admitted to the course.

The employee then sent another e-mail to the instructor and stated the software program was on his home computer and he wished to take the class for his own benefit. The transmission was hostile and threatening in nature and failed to recognize the central elements of the instructor's initial response. The employee had also sent a copy of the e-mail to his own supervisor. The supervisor told the employee that since the software program was not present on his work computer and did not relate to his professional duties, he could not take the course. The supervisor also noted the unprofessional tone of the message and directed the employee not to engage in further contact with the instructor without receiving prior approval from the supervisor.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The supervisor had already counseled the employee about his interactions with the computer instructor. The supervisor should advise the employee that there is a procedure to follow when requesting training.**

The Associate Deputy Director met with the employee and his supervisor.

DEPARTMENT FOLLOW-UP ON FY 03 RECOMMENDATIONS

The following OIG recommendations were made in the previous Fiscal Year but were not fully implemented before the Annual Report was issued. Their current implementation status is detailed below.

- **Procedure 300, requiring investigators to seek court orders when the child can not be located, should be redrafted to coincide with the States Attorney's criteria for case screening: (a) when the investigator has exhausted all diligent efforts to establish contact and (b) when there is an identifiable risk of serious harm to the child (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 1).**

FY 03 Department response: The Department agrees and Rule and Procedures will be revised by March 1, 2004.

FY 04 Department follow-up: DCFS Procedure 300 is under revision and its expected completion date is March 2005.

- **The Department should meet with the Chicago Police Department to identify and specify circumstances in which the police can offer assistance when families cannot be found or are uncooperative (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 1).**

FY 03 Department response: The Department and the OIG previously were working with the Chicago Police Department in an effort to further communication. These efforts will resume in January 2004.

FY 04 Department follow-up: DCFS will revive the link of Chicago Police Stations and Child Protection Managers. The DCFS liaison will facilitate communication and cooperation. Due to changes in Cook DCP Managers since this was first initiated, there is a need to make sure there is a DCP representative for each station. This will be completed by March 2005.

- **The Department should require training of all child protection investigators on the handling of criminal cases when a child has been a victim of violence. Investigators should be taught how to arrange for services for the victim with the State's Attorney's Victim Witness Unit and the Attorney General's Crime Victims Compensation Program. The Victim Witness Unit would provide support for victims in court, including transportation, and serve as an advocate for the victim. The child protection investigator should accompany the child victim and non-offending parent/caretaker to his/her first appointment with the State's Attorney's Witness Victim Unit to ensure that both jurisdictions (criminal and child protection) safeguard the best interest of the child. Where a conflict may exist between the parent's desire to remain in a domestic violence situation and the child's need for protection, the investigator should contact the Department's Legal Division who can request that a Guardian *ad litem* be appointed for the child in domestic relations court. The Crime Victim Compensation Program would provide the victim with medical and hospital expenses, counseling by psychiatrists, clinical psychologists or certified social workers and compensation for loss of earnings or support and other losses or expenses not covered by**

insurance. However, the Attorney General's Compensation Program prohibits use of the funds if the adult victim continues to reside with the abuser (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 1).

FY 03 Department response: The Department's Division of Legal Services will work with the OIG to develop training.

FY 04 Department follow-up: The Department's Division of Legal Services informed the OIG that it cannot implement this recommendation. The OIG will refer the recommendation to the Task Force formulating training for child protection investigators and , at the suggestion of the Division of Legal Services, will work with the Deputy Director of Training to provide an internet link for caseworkers to Attorney General's office website.

- **Procedures 300, section 300.50(J) should be amended to correctly reflect the index of water temperatures and corresponding exposure times at which a scald will occur for infants and children compared to adults. Investigators should be required to hold the approved thermometer in the stream of hot water until the temperature stops rising and record the amount of time that elapsed from turning on the water until the temperature stopped rising. If the family refuses to allow the investigator test the water, the investigator should solicit the help of law enforcement (when they are also investigating the incident), or building management or the local building department for access to the hot water heater. These procedures should be cross-referenced with procedures 300, Appendix B, Burns (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 2).**

FY 03 Department response: The Division of Clinical Services and Professional Development will amend policy to incorporate this recommendation.

FY 04 Department follow-up: DCFS Procedure 300 is under revision and is expected to be completed by March 2005. OCFP completed amendments to 300.50 (j).

- **The Department should conduct a record review to insure that intact family case managers are complying with the current expectation that families are visited on a weekly basis (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 3).**

FY 03 Department response: The Deputy Director for the Division of Child Protection will provide the results of the record review by February 1, 2004.

FY 04 Department follow-up: The Department's Division of Quality Assurance conducted a review of intact cases in Cook County in May 2003. The results of that review were shared with the OIG.

- **The Department should establish a unit equipped to assist non-custodial fathers in obtaining legal custody and/or guardianship of their children in appropriate cases. (See OIG #971,918) (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 4).**

FY 03 Department response: Following the Department's federal reviews, DCFS will be obligated federally to satisfy issues related to non-custodial parents. The Department will provide a Program Implementation Plan by March 31, 2004.

FY 04 Department follow-up: As part of the Program Improvement Plan the Department is improving use of the Diligent Search Service Center which will assist in locating fathers, locating

paternal relatives as placement resources, and reduce delays at juvenile court caused by parent-locator issues. In addition, Integrated Assessment will do a better job of assessing and engaging fathers at the onset of case intervention. Other measures of the plan include working with existing parent advocacy groups, training on parent-child visitation practice and increasing the use of Child and Family Team meetings. In March 2005, the Department will begin measuring progress in implementing these and other tasks as part of our reporting process to the federal government.

- **The contract for the umbrella program contract designed to oversee pregnant and parenting wards should be revised to require the first private agency and their subcontracted agencies to: A) read the entire case record as the initial step in the comprehensive assessment process; B) compile a viable list of the teen parent and infant/child's extended support system; C) invite and involve the support system in a care and support plan for the young family, and in cases that may require private guardianship, arrange a mediated family conference and follow up services; D) obtain necessary consents from the teen parent on her/himself and on her/his non-ward child so that well baby and doctor/medical/rehabilitation records for ongoing care of the infant/child, and documentation of the parent's medical care can be secured (See OIG report #020288 et. al., March 1, 2002) (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 5).**

FY 03 Department response: The Department is currently in the process of revising contracts with the private agency's umbrella program designed to oversee pregnant and parenting wards. These recommendations will be included in those revisions.

FY 04 Department follow-up: These recommendations were incorporated into the FY 05 Program Plan.

- **The Department should provide foster parents with special service fees to cover the expense of an additional phone line for home monitoring of wards on probation (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 6).**

FY 03 Department response: The Department agrees with the need to provide foster parents with the financial assistance to obtain the necessary tools to do home monitoring of wards on probation. A comprehensive process will be developed to provide for exceptions to payment for foster parents in these situations. This process will be finalized by April 1, 2004.

FY 04 Department follow-up: The Department has contacted the phone service company and learned that a second phone line is unnecessary. The phone company has offered another way to add in the second line with an existing line. The Department will, when appropriate, provide this second line to assist foster parents with home monitoring of youth on probation. A process is currently being established that will provide guidance on identifying when this would be appropriate and how to proceed.

- **When a ward in Independent Living enrolls in college or embarks on initial employment opportunities, as part of the ward's subsidy agreement the ward should sign a consent, which will allow caseworkers to contact their school or employment counselors (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 7).**

FY 03 Department response: The Division of Education and Transition Services will develop an agreement with wards who are in Independent Living Programs that they must meet their

obligation to stay in school and/or have employment in order to continue to receive their ILO payment. This agreement will be implemented by March 1, 2004.

FY 04 Department follow-up: The Department has restructured the ILO/TLP programs. As part of this restructure, there will be four different levels with requirements of the youth to participate at each level. The youth will be required to meet defined benchmarks prior to being allowed to move to less restrictive living settings.

The Department has not shared the ILO/TPO Program structure and the OIG cannot determine whether the restructuring addresses the recommendation.

- **The Department should identify teenage wards that are high-risk for continuing violence and assess the population for size, placement, and case status. This group will likely include the wards identified as receiving multiple psychiatric hospitalizations in a single year and wards that are involved in both delinquency and adult courts (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 8).**

FY 03 Department response: The Deputy Director for the Division of Clinical Services and Professional Development will provide data to the Director on the number of wards who are hospitalized and have violent tendencies by March 1, 2004. Integrated Assessment will target this population.

FY 04 Department follow-up: The Director receives information on the number of wards who are psychiatrically hospitalized through weekly reports from the Psych Hospitalization Unit.

The following seven recommendations received a combined response:

- **The Department should immediately cease placing youths under 18 years of age in unsupervised apartments. For wards 18 + years in the high-risk category (identified above), the Department should require progressive step-down placements prior to independent living. The Department should not place high-risk youth in an ILO placement unless they have demonstrated progress in a transitional (supervised) living arrangement. This would exclude placing a ward from a psychiatric hospitalization directly into an unsupervised living arrangement (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 8).**
- **The Department should develop a placement model similar to halfway houses for high-risk wards (17 years and older) who have been released from the Juvenile Division of the Department of Corrections or are violating probation orders. The ward should be held strictly accountable for school, work, curfew, etc. The Department should consult with programs such as Safer Foundation or Isaac Ray regarding the development of secure halfway houses (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 8).**
- **In cases where the older youth desire to return to a parent who has had a history of substance abuse, the Department should adapt and pilot the specialized substance abuse services of the Intact Family Recovery project for Family Reunification Services. The use of extended visits can allow opportunities for applied problem-solving with the support of the IFR teams. In cases where the involved youth is a parent, the IFR team can assist in early childhood services and well-baby checks (from OIG FY 03 Annual Report, General Investigation 30).**

- **In cases that involve a parent with prior mental health history, a Parenting Assessment Team evaluation focusing on return of the older youth can provide a guided plan for services and extended visits that lowers risk while reunification occurs (from OIG FY 03 Annual Report, General Investigation 30).**
- **In cases where older pregnant or parenting youth are found living with boyfriends or the father of their child or with the child's paternal family the Department must make an effort to involve the boyfriends, the fathers and the extended paternal family in a family conference for the future safety of the young family (from OIG FY 03 Annual Report, General Investigation 30).**
- **Some children on the lists of missing children are in reality living back with their parents. These children, who are listed as missing, are in an unauthorized placement with self, in an unauthorized placement with the parent, or living with the parent. All such children should be shown with a living arrangement as HMP (home of parent). The unapproved nature of the placement can then be explored with family conferencing (from OIG FY 03 Annual Report, General Investigation 30).**
- **Children with Child Protection Warrants with whom the Department has no legal relationship should be entered into the CYCIS database with a living arrangement category that reflects the reality of their situation. If a list of such children could be generated from CYCIS, the Department could then be looking for those children as well as those with whom it has a legal relationship. The child in this category is not technically a missing child nor an abducted child, but is a child that the Department and the Court believed was at risk. A Child Protection Warrant would not have been issued unless the Court found probable cause (from OIG FY 03 Annual Report, General Investigation 30).**

FY 03 Department response: The Department is currently in the process of changing policies as they relate to the 5,200 kids over 18 years with whom the Department has a relationship by June 1, 2004. This recommendation will be part of those changes.

FY 04 Department follow-up: The Department is implementing several new programs and strategies aimed at addressing the needs of the older population of DCFS wards. This approach coined, "Lifetime", has several major reforms. Integrated Assessment will provide for a more clinical and comprehensive assessment of the child and family functioning and provide a solid groundwork for service delivery. Trauma treatment is a comprehensive effort to identify appropriate treatment protocols, programs and opportunities for youth. The Transitional Living and Independent Living programs have been redesigned resulting in the development of a seamless continuum of services transitioning youth to adulthood. The Foster Care Caseload Re-Design, implemented in FY 2005 contracts, reduces the private agency foster care caseloads from 18-1 to 15-1 to assist in improving the quality of the casework. The new contracts remove prescriptive staffing rules thereby providing more flexibility to target staff as necessary to reach new well-being performance outcomes.

Other reforms include Intensive Stabilization Services which are innovative, informed approaches to engaging the youth and stabilizing his/her life and relationships before emerging from the system into adulthood. Family Supported Adolescent Care will identify and engage a new cadre of foster parents singularly committed to serving older adolescents during their transition to adulthood. And last, the Residential Performance Unit will be responsible for tracking the progress of youth during stays in residential facilities to ensure progress and timely discharge

back to community based living. This unit will also monitor the ability of providers to successfully serve the youth in their care.

- **The Department should amend section 6.5a of the LEADS protocol to eliminate allegation #11's restrictions to age and disability (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 9).**

FY 03 Department response: The Department agrees to amend the LEADS protocol.

FY 04 Department follow-up: The protocol will be amended by February 2005.

- **OIG investigation #971365 completed on December 31, 1998, recommended that drug screens should include the use of breathalyzers to test for alcohol. The OIG reaffirms this recommendation made four years ago. Each child protection office should have a breathalyzer available and an intact family worker trained to administer it. Breathalyzers can be purchased for approximately \$350.00. (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 9).**

FY 03 Department response: The Department has concerns associated with equipment and training necessary for implementing this recommendation. However, the Department agrees that in cases involving severe alcoholism, the Department needs to have appropriate equipment and expertise to enable it to service and monitor such cases. The Department will explore alternative protocols to facilitate access to breathalyzers.

FY 04 Department follow-up: The Department is convening a group of child welfare and substance abuse providers in December to discuss alcohol and drug testing procedures for DCFS involved families. Recommendations made by the providers will be incorporated into Department procedures. Completion date is March 2005.

Although the workgroup is currently addressing substance abuse issues only with regard to employees, the OIG is hopeful that the workgroup can next address substance abuse issues relating to families.

- **If urine drops are used in conjunction with breathalyzers there should never be more than 12 hours notice before a drug drop is submitted. In addition, the days and times of alcohol tests must vary to avoid testing patterns (from OIG FY 03 Annual Report, Death and Serious Injury Investigation 9).**

FY 03 Department response: The Department agrees to amend policy according to what the appropriate professionals recommend.

FY 04 Department follow-up: The Department is convening a group of child welfare and substance abuse providers in December to discuss alcohol and drug testing procedures for DCFS involved families. Recommendations made by the providers will be incorporated into Department procedures. Completion date is March 2005.

- **The Department should draft a Conflict of Interest Rule similar to Rule 437 that applies to private agencies. The rule should prohibit multiple relationships and other relevant conflicts of interest within private agencies. The rule should be accompanied by training for private agency staff on conflicts of interest issues and forums for discussing applied**

ethics issues. The OIG Ethics Office can provide assistance with these efforts (from OIG FY 03 Annual Report, General Investigation 12).

FY 03 Department response: The Department agrees that there needs to be a provision in provider contracts that is consistent with Rule 437. The Deputy Director for Monitoring and Quality Assurance, in cooperation with the Deputy Director for Budget and Finance, will work to incorporate this into all fiscal year 2005 private agency contracts.

FY 04 Department follow-up: FY 05 contracts are still being put in the system, this provision will be part of an amendment to those contracts and will be completed by the end of the third quarter.

- **The Department should issue immediate memorandum to all child welfare administrators to stop assigning investigations to reporters who observe abuse or neglect outside their professional duties (from OIG FY 03 Annual Report, General Investigation 16).**

FY 03 Department response: DCFS agrees. The Deputy Director of Child Protection will issue this memorandum by February 1, 2004.

FY 04 Department follow-up: A memo to child protection staff was issued in October 2004.

- **The Department should develop a uniform method of dealing with the Juvenile Court in the various counties so that workers are not allowed to request temporary custody and guardianship orders when the intention is to leave the children in their biological home. The Department's Legal Division should ask courts to issue orders of protection in such cases rather than temporary custody orders and guardianship orders (from OIG FY 03 Annual Report, General Investigation 17).**

FY 03 Department response: The Department agrees to identify counties where these issues exist and determine what would work best in that particular region.

FY 04 Department follow-up: When a problem is identified in a certain county, senior staff will meet and resolve issues. This is an ongoing process.

- **The Department should examine the average time spent in the field by workers on the supervisor's team and compare that time to other teams. The Department should assess whether the average time workers spend in the field meets the public's expectations of how much direct contact workers have with their clients and collaterals (from OIG FY 03 Annual Report, General Investigation 22).**

FY 03 Department response: The Department and the AFSCME union have agreed to design a statewide time study by March 1, 2004. The design will also be shared with the OIG.

FY 04 Department follow-up: Because of the length of AFSCME negotiations, their time study was not initiated in 2004. The Department will attempt to reengage AFSCME in 2005.

- **To reduce fraud within the Norman Fund program, private agency requests for Norman Funds should come from an authorized designee in the business or administrative office of the agency. The authorized designee would be responsible for an internal control system of requests including:**

- **Work directly with the Norman Fund coordinator in obtaining Norman Funds requests by reviewing documents such as:**
 - **A copy of rental agreement**
 - **A copy of the invoices for clothes/furniture**
 - **Maintaining original receipts upon completion of purchases**
- **Periodically test the reliability of the client information being provided by the caseworker and assure that the payee is a legitimate provider, by:**
 - **Contacting landlords to verify available rentals**
 - **Ensuring that vouchers for clothing and furniture are being used only for the client.**
- **The authorized designee must give final approval before forwarding the necessary documents, with the name of the caseworker authorized to pick up the check with their phone number. The caseworker who subsequently picks up the check must show a driver's license, sign a receipt and provide a phone number. If the agency is not large enough to have a business office, the authorized designee should be an administrator of the agency. A file should be maintained on all clients receiving Norman Funds for a period of not less than 2 years (from OIG FY 03 Annual Report, General Investigation 24).**

FY 03 Department response: The Department is preparing to make a number of changes regarding Norman Cash Assistance. Per this recommendation, some of the following changes will be included in the next draft of the Norman manual:

- The Department has implemented a process by which private agency requests are made to special Purchase Of Service (POS) Norman liaisons who work for the Department. These POS Norman liaisons will be trained on how to identify possible fraudulent requests. When appropriate, the person approving the Norman Cash Assistance request will ask for invoices or other documents supporting the request.
- The Department will audit a portion of the requests approved to ensure that the client received the assistance requested.
- The person approving the request will make sure that the worker's name and phone number appear on Form 370-5.
- When the cash assistance check is not mailed to the provider, the cash assistance provider will make sure that the person picking up the check will show proper identification and sign for the check.
- The POS Norman liaison will keep a copy of the request and the supporting materials for at least two years. The worker will also keep a copy of the request and the supporting materials in the case file.

FY 04 Department follow-up: Most of the suggested changes to the Norman Cash Assistance process have been implemented and are currently being done. Following the finalization of the Norman Manual, the remaining changes will be complete.

- **A large number of missing pregnant or parenting youths had been placed in Chicago by a private agency based outside of the city. In order to develop a better working relationship with the Chicago Police Department and other agencies needed to assist these youths, the private agency should open a satellite run unit in Chicago (from OIG FY 03 Annual Report, General Investigation 30).**

FY 03 Department response: The Department agrees that there is a need for a better working relationship with the Chicago Police Department and other agencies in the area. Because of the

many changes in the programs for older youth, a comprehensive solution to this issue will be developed by March 1, 2004

FY 04 Department follow-up: One of the major reforms of the Department includes Intensive Stabilization Program. This program is designed to address issues of youth that are on run or have frequent placement moves.

- **The Department should initiate a safety campaign to address home safety, including sleep safety. This report, Dr. Kalelkar's videotape, "The Hazards and Risk Factors of Co-Sleeping and Bed Sharing," public service safety videos, and other free printed materials should be made available to workers to help them understand the importance of reducing environmental risks (from OIG FY 03 Annual Report, General Investigation 32).**

FY 03 Department response: The Department will make up 0 -1 Packet bags that include important information on safe sleeping for all families with which the Department has involvement. In addition, the Department will arrange for a visit from a public health nurse for all families with a child 0 - 1.

FY 04 Department follow-up: In June 2004 the Home Safety Checklist was operationalized for use by Investigative and Permanency Workers. There is a section labeled "Sleeping" that addresses issues raised in this report. The Division of Child Protection, External Affairs and Communication are working collaboratively to develop this.

- **Department's Procedure 314 Educational Services should make clear that for children placed in group homes or residential facilities the DCFS caseworker shall (a) communicate at least quarterly with the child's school, including at least one in-person visit annually; (b) read the child's Individualized Education Program (IEP) plan to identify the child's learning issues; (c) seek meeting dates of MDC/IEP conferences and attend the MDC/IEP conferences; and (d) notify the state board of education of educational surrogate parents that are unavailable or uncooperative and/or request that a new surrogate parent be appointed (from OIG FY 03 Annual Report, General Investigation 33).**

FY 03 Department response: Rule 314 has been under revision and is due to be completed by February 1, 2004.

FY 04 Department follow-up: Procedures 314 has undergone significant changes and is in final draft. The new procedure is due to be released by February 2005.

- **The Department Division of Health Policy, in conjunction with HealthWorks of Illinois should develop and distribute a directory of pediatric palliative and hospice services. The directory along with the American Academy of Pediatrics policy statement on palliative care for children should be disseminated to HealthWorks physicians, the South Side Health Consortium and HealthWorks lead agents throughout the state (from OIG FY 03 Annual Report, General Investigation 34).**

FY 03 Department response: The Division of Health Policy will disseminate this information by February 1, 2004.

FY 04 Department follow-up: On March 15, 2004, DCFS sent out a memo to all Primary Care Providers of children for whom the Department is legally responsible with a copy of the

American Academy of Pediatrics' Policy Statement regarding Palliative Care for Children. Also enclosed was a list of Illinois pediatric Hospice Providers

- **Department Child Welfare Nurse Specialists should be assigned to the Division of Child Protection. Nurses then could utilize their medical background, and obtain necessary supervision by the child protection team. Also, Department Nurses should work with the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC), in order to conduct scene investigations, collect medical records, and conduct collateral interviews in cases involving children with head injuries. Finally, the Chief of Nursing Services should be transferred to and placed under the supervision of the Department's Guardian's Office to assist in medically complex cases (from OIG FY 03 Annual Report, General Investigation 36).**

FY 03 Department response: There will be a review and redesign of the reporting and structure of the nurses by March 1, 2004.

FY 04 Department follow-up: The Department will clarify nurse roles and responsibilities including the reporting structure by June 2005.

COOPERATION WITH LAW ENFORCEMENT AGENCIES

In furtherance of our statute, the OIG frequently works closely with law enforcement entities. The following cases are illustrative of that cooperation.

Case # 1

The Chicago Police Department requested assistance in their investigation regarding the kidnapping of a 3-year-old child by a ward of the Department. The 3-year-old was found the next day. She was in the company of the 14-year-old female DCFS ward and an adult male. The child was not harmed. The 14-year-old was developmentally delayed and had been in a state facility in Central Illinois for several years. DCFS moved the ward into a foster home in Chicago, from which she ran away within a week. She was missing for several months when she took the 3-year-old from her mother. The 14-year-old was charged in a delinquency petition. She was returned to the state facility. Several months later, the State moved to dismiss the delinquency petition. The adult was charged with a misdemeanor, pled guilty and was placed on probation for a year.

Case # 2

A child protection investigator requested assistance from the OIG when she was unable to verify basic biographical information about three thirteen year-old subjects of the investigation, such as their place of birth, birth dates, biological siblings and parentage. The OIG investigated an allegation that the children had been kidnapped. The OIG located the biological mother of two of the children who was living in Michigan and had been searching for her children for thirteen years. The biological mother of the third thirteen year-old was found in Iowa. The information was shared with child protection and juvenile court. The OIG referred the results of the investigation to appropriate state, local and federal law enforcement authorities.

Case # 3

The OIG received information from the DCFS Advocacy Office about a woman who reported that she had outstanding child abduction charges against her and an outstanding fugitive warrant from another state. After verifying the outstanding warrant, the OIG furnished current information on the woman, including her address, to the appropriate local law enforcement.

Case # 4

The OIG cooperated with Indiana authorities in their investigation into the death of a 12 year-old ward placed with his maternal grandmother in Indiana. The grandmother and her adult son were charged with criminal neglect of the boy based on alleged excessive corporal punishment. The grandmother was found guilty on the criminal charges of neglect and sentenced to seven years imprisonment. The charges against the uncle are still pending.

Case # 5

A DCFS employee was alleged to have released confidential address information to a federal parolee who had previously threatened the family involved. After a preliminary investigation, the OIG referred the matter to the Illinois State Police for investigation of official misconduct. The employee chose to resign and relinquish her child welfare license.

Case # 6

An Assistant State's Attorney at Juvenile Court requested assistance from the OIG to locate a 12 year-old chronic runaway. The OIG obtained addresses of key locations where the child had ties assisting the State's Attorney's Office in locating the girl.

Case # 7

The Department of Homeland Security contacted the OIG requesting assistance in an investigation they were conducting into the trafficking of child pornography. There were indications that a DCFS employee, who was also a foster parent, was involved. The OIG conducted a full investigation and submitted a report to the Director. Following the OIG investigation, the employee resigned and relinquished his child welfare and foster care licenses.

Case # 8

A local police department requested the assistance of the OIG in assessing the risk involved for children who had fled from a foster home. The OIG provided information to the police department to assist in determining if an Amber Alert for the children should be issued.

Case # 9

A child protection investigator requested a criminal background check on an individual who was wanted by law enforcement. The LEADS information indicated the person was wanted for a sexual assault and was armed and dangerous. There was also an outstanding warrant on drug charges. The OIG provided location information to the Sheriff's police. The individual pled guilty on the drug charge and was sentenced to 18 months probation.

Case # 10

The Illinois State Police requested assistance on a referral from the U.S. Postal Service. A mail carrier had noted that there were an unusual number of envelopes containing checks directed to one address. The Postal Service believed the checks were issued by DCFS. The OIG investigation found that the checks were not from DCFS, but rather from the state child support disbursement office. The woman had moved and not furnished a new address to the disbursement office, which had been accumulating the checks. When they had a new address for the recipient, the disbursement office sent all the checks at once.

Case # 11

The U.S. Treasury Department requested assistance from the OIG in their investigation involving a private agency worker who was suspected of selling children's Social Security numbers for people to use in filing tax returns. The OIG learned that the worker was in arrears in child support payments and that the child support payments were to support two children he fathered by a DCFS client on his caseload. The OIG conducted a full investigation and submitted a report to the Director. Following the OIG investigation, the worker resigned and relinquished his child welfare license.

Case # 12

The Illinois State Police sought the assistance of the OIG in locating a worker who subcontracts with a DCFS contractor suspected of telephone harassment.

Case # 13

A 15-year-old ward was in need of protection as she was a federal informant. The child was in a psychiatric hospital and needed to be discharged to a safe environment. The OIG provided intervention to assure that ward was discharged from the hospital into a safe environment.

Case # 14

The Illinois State Police requested assistance from the OIG in their investigation of improper conduct by a DCFS employee. The State Police investigation found no improper conduct by the DCFS employee.

Case # 15

The OIG was alerted to a website which purported to be from DCFS, but was not. The OIG referred the matter to the Attorney General's Office.

Case # 16

The OIG assisted local law enforcement in locating a man who was the subject of a child protection investigation and had outstanding warrants for assault, escape from jail, and resisting arrest. Based on the information provided by the OIG, the man was arrested.

Case # 17

A man who was seeking custody of his brother was misidentified as a sex offender on the State Police Sex Offender database. After verifying that the information was incorrect, the OIG assisted the man in getting his name removed from the database.

OIG INITIATIVES

ETHICS

Child Welfare Ethics Advisory Board

The Child Welfare Ethics Advisory Board was formed in March 1996. Its members are an interdisciplinary group appointed by the DCFS Inspector General and act as an advisory body to her on child welfare ethics issues. The Board considers inquiries submitted by child welfare practitioners and ethics issues arising in OIG investigations. The Board met five times during FY 2004 and welcomed two new members, Dr. Armand Gonzalzes, a pediatrician, and Dr. Teresa Jacobsen, a professor of psychology with clinical experience assessing teen parents.¹

The Board considered ethical issues arising in cases the OIG was investigating and in response to questions submitted by practitioners in the field. Dr. Kane asked the Board's advice about the ethical implications surrounding decisions to place DCFS wards in secure facilities. Although a statute and DCFS licensing rules exist that permit such locked facilities, none are currently in existence in Illinois. Dr. Kane had previously recommended to the Director that placement in secure facilities was sometimes necessary for severely troubled wards, and that DCFS had a fiduciary duty to these children. The Board discussed how the children that need secure placements can fairly be identified; those with severe behavior problems are easier to assess than those whose psychiatric diagnoses may merely be predictive of future problems. The Board suggested that an advocate for the child be built into the process and that the time periods for review of placements in secure settings should be shortened.

The Board continued its discussion from the previous year about the Department's ethical responsibilities to teen wards who are parents, and to their babies. The Board noted the difficulty of evaluating when it is appropriate to respect teens' self-determined choices about raising a child. One member pointed out that workers seem to have a bias toward protecting the autonomy of the teen, and that that bias could lead them to assume decision-making capacity. Board members reiterated their overriding concern that the interests of the babies of these teens, who are not themselves wards, are not being adequately protected. The Board agreed on the ethical necessity for some kind of mechanism to advocate for the interests of the babies of wards and that better evaluations of wards' parenting ability should be performed and relied upon by workers. Because of the Board's interest in teen parenting issues, OIG staff began a review of the case files of wards who lost custody of their babies as a result of abuse or neglect. These case files will be compared with a randomly selected group of files of teen parents who retained custody.

¹ During this fiscal year, 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
Armand Gonzalzes, M.D., pediatrician
Teresa Jacobsen, Ph.D., Associate Professor of Psychology, University of Illinois at Champaign-Urbana
Jimmy Lago, MSW, MBA, Chancellor, Archdiocese of Chicago
David Ozar, Ph.D., Director, Center for Ethics and Social Justice, Loyola University Chicago
Ada Skyles, Ph.D., J.D., Fellow, Chapin Hall Center for Children, University of Chicago (Chair)
Eugene Svebakken, MSW, Executive Director and CEO, Lutheran Child & Family Services

A private child welfare agency administrator submitted an inquiry to the Board about licensing close relatives of its employees as foster parents. The agency has a policy prohibiting its licensing its own employees. Employees who want to be foster parents must be licensed and monitored by another agency. The administrator asked the Board whether licensing mothers, sisters, or cousins of employees, for example, would be ethically problematic. This agency operates in small town settings where it can be difficult to find alternatives for licensing prospective foster parents. The Board discussed suggesting third party oversight of the licensing process in such cases, but concluded that ongoing supervision of the foster parent by the agency also creates a conflict of interest. Since DCFS has offices in all areas of the state, the Board advised the administrator to refer close relatives to the nearest DCFS office for licensure.

The OIG became aware of a federal investigation of a DCFS employee who was also a foster parent for allegedly accessing child pornography sites on the Internet. No charges had yet been brought against the man, whose foster parent license was valid. Dr. Kane asked the Board whether it would be ethical for the private agency issuing the foster parent license to put a hold on placing any children in the man's home without notifying him, for fear of compromising the federal investigation. The Board concluded that safety of foster children is paramount, so temporary holds such as this may be justified. They recommended that a policy should be developed to apply during criminal investigations or investigations of other kinds of improper behavior (to be specified in the policy). A hold on placements could be justified while such investigations were pending, but with an effort to be as above board as possible with the suspected party.

The Board also discussed issues raised in an OIG investigation of a private child welfare agency supervisor who decided she wanted to become the foster parent of a child on her agency's caseload and used her position to achieve that result. Although the supervisor did take some steps to avoid a conflict of interest, such as transferring case management responsibility for the child to someone else in her agency and by going to another agency to obtain a foster parent license, the Board concluded that she did not go far enough. Responsibility for case management should have been given to someone outside the supervisor's chain of authority. The agency that licensed her merely acceded to the supervisor's request that this little girl be placed with her rather than conducting an independent search for the placement that would best serve the best interests of the child. The public could not be confident that this decision was made objectively.

OIG Ethics Staff Initiatives

In conjunction with the DCFS Communications Office, the ethics staff created an ethics button on the DCFS Intranet. Hypothetical scenarios presenting ethical dilemmas and their solutions are posted on this site as well as links to the Code of Ethics and information about the Child Welfare Ethics Advisory Board. An example of an ethical dilemma posted in the D-Net is the following: "Tom is a DCP investigator. He has just been assigned a hotline call against his son's soccer coach. What should Tom do?" The suggested solution is that Tom should ask his supervisor to assign the investigation to someone else because Tom's preexisting relationship could interfere, or appear to others to interfere, with his objectivity. The solution also includes a brief discussion of the reasons why conflicts of interest can undermine public confidence in the Department.

In November 2003 a breakfast was held at the University of Chicago's School of Social Service Administration to introduce a handbook produced by the ethics staff entitled "Pastoral Care and Child Welfare: A Handbook for Hospital Chaplains and Child Welfare Professionals." The handbook describes the professional and ethical responsibilities of chaplains and child welfare workers in detail so that each may have a better understanding of the other's role and work together to make sure that the spiritual needs of ill and hospitalized wards are addressed. Practical information about the operation of the child welfare

system and contact numbers for DCFS and hospital chaplains in Cook County is also included in the book.

The second volume of a two volume set of handbooks entitled “Ethical Child Welfare Practice” was completed by the ethics staff, with contributions from Martha Holstein, Ph.D. and Eileen Gambrell, Ph.D. Volume II covers ethical issues in child welfare supervision and administration and is written in the format of a story about a fictional child welfare agency and the ethical dilemmas its staff encounters. The book will be distributed to supervisors and administrators within DCFS and at private child welfare agencies throughout Illinois.

The OIG Ethics Coordinator made two joint presentations with a representative from the American Bar Association Center for Children and the Law, one at the New York State Law Guardians Conference in Syracuse, NY and the other to a meeting of child welfare professionals in Baltimore County, MD. Both presentations described the differences and similarities between legal ethics and child welfare ethics and analyzed the ways in which these two sets of responsibilities intersect and sometimes conflict in child welfare cases.

The OIG Ethics Coordinator conducted trainings for new DCFS Licensing staff in Springfield and for staff of a private agency that had particular ethical issues it wanted addressed. The Ethics Coordinator also presented an overview of the OIG Ethics Program and other state ethics requirements to the senior administrators of DCFS in April.

Three private child welfare agencies that had begun a training consortium asked for an ethics component for their program. The ethics staff conducted two discussion groups with representatives from the three agencies. On the theory that ethics trainings and discussions are more likely to thrive if the burden of organizing them falls on many shoulders, the ethics staff decided to expand the group and invitations were extended to all agencies in the Chicagoland area. Representatives from about twenty agencies participated in one or more of the three multi-agency ethics discussions that were held in FY 2004. The discussions are planned to continue on a bi-monthly schedule into the next fiscal year. The discussions covered ethical issues that the agencies may have in common such as client decision-making capacity, confidentiality, and professional boundaries. The Ethics Coordinator made a presentation to the Child Welfare Advisory Council (“CWAC”) at its May meeting to inform them about the multi-agency discussion groups; ethical issues of common concern that arise in the discussion groups will be forwarded to CWAC for its consideration.

DCFS Ethics Officer

As Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General reviews the Statement of Economic Interest forms that senior DCFS employees are required to file by May 1 of each year 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 and cautionary letters were sent to filers about ways to avoid conflicts of interest.

Ethics Training

As required by the State Officials and Employees Ethics Act of 2003, state officials and DCFS initiated ethics training for all new, contractual, seasonal, and temporary employees. The online ethics training consisted of four lessons on various topics ranging from bribes to conflict of interests to professional boundaries. Upon completion of the lessons, all employees were asked to complete a ten-question quiz testing them upon the material presented. There were four one-month training periods for which the OIG

Ethics staff was asked to notify those employees registered for the particular period and keep track of their completion status. Upon conclusion of each period, the OIG submitted a report to the Executive Office of the Inspector General. Over 3,250 employees completed the online ethics training in FY 04. In addition to all DCFS employees, all Boards and Commissions associated with DCFS were asked to complete a similar ethics training. In FY 05, the Inspector General will attend board and commission meetings to answer questions arising from the ethics training.

HOME AND FIRE SAFETY TRAINING

A home and fire safety training program was developed and implemented by the OIG Project Initiatives staff in response to a number of child deaths and serious injury from fire and other environmental hazards. In FY 02, the OIG reviewed 10 child deaths from residential fires, seven more than the previous year. Five of those children were in families that had intact family cases open at the time of the fire. The findings from these investigations prompted the OIG Project Initiatives staff to establish relationships with the Chicago Fire Department, the Lombard Fire Department Public Education Coordinator/President of the Illinois Youthful Firesetters Intervention Association, and Cook County Medical Examiner's staff to train workers on fire and home safety. The training curricula, initially designed for case managers, supervisors and licensing staff, provides practical home and fire safety information and strategies to help parents, caseworkers and licensing staff ensure the health and safety of intact families, wards and their child/ren. The curriculum also includes a manual entitled *A Helpful Guide for Parents and their Caregivers*. The manual and associated checklists are designed to be interactive tools used by workers during home visits with young parents and caregivers.

In FY 2004, the training curriculum was revised to also meet the needs of child protection investigators. The training curriculum focuses on child, home, fire and water safety; co-sleeping and entrapment; SIDS; abusive head trauma/shaken baby syndrome; firearms safety; violence prevention; and the key childhood developmental stages that can trigger dangerous or even deadly child abuse. Training on the curriculum continued in FY 04. Over 400 DCFS and private agency staff participated in the home and fire safety training in the Cook, Central, and Southern Regions.

In June 2004, the Department issued the official Home Safety Checklists to be used by permanency workers and child protection investigators to assist in identifying household safety concerns and reducing the risk of serious accident and injury to children. In FY 05, these checklists are being revised in response to feedback from workers who have been using the checklists with the families they serve.

TEEN PARENTS

In 2003, the Office of the Inspector General conducted a review of cases selected by the Teen Parent Services Network for the Hill Class attorney and monitor as a representative sample of the network services to DCFS pregnant and parenting teen wards. The report identified a number of concerns including high rates of domestic and community violence, lack of knowledge of home safety and child hazards, and caseworkers lack of familiarity with family support and community resources. In response, the OIG developed a number of trainings to strengthen workers abilities to address these concerns.

Domestic and Community Violence Training

Domestic and community violence continue to be significant factors in investigations involving teen wards conducted by the OIG. Pregnant and parenting teen wards and their children are particularly vulnerable to the multiple negative effects of violence. In FY 2004 the OIG convened a series of meetings with the Office of Violence Prevention in the Chicago Department of Public Health, TPSN, Aunt Martha's and DCFS to address violence among parenting teen wards and their families. Ann Parry from the Office of Violence Prevention designed and delivered a series of four trainings entitled "Choosing non-violence." These trainings were held in the spring of 2004 to interested TPSN workers and supervisors from Aunt Martha's and Pathways.

In FY 2005, the OIG in conjunction with the city of Chicago, Attorney General's Office and local universities will schedule additional non-violence trainings for Pregnant and Parenting Teen Wards in Cook County. These trainings will address children's exposure to violence, teen dating violence, critical thinking and consequences, crying baby and shaken baby syndrome and healthy expressions of strong emotions.

Home Safety Training

A Home Safety Training Workshop specifically tailored for pregnant and parenting teens was developed and implemented in FY04. This training describes the most common household dangers and outlines simple steps that, when taken, reduce the risk of unintentional injury and death. The goals of this interactive three-hour workshop are to lower infant and child mortality, and provide an effective home safety assessment and educational tool that can assist young parents in promoting the safety and well-being of their children. Two Home Safety Training Workshops were held; the first for participants at Maryville Parenting Teen Center, and a second workshop at a community church-St. Paul and the Redeemer Church-for the Pathways Teen Independent Living Center. A total of forty-five parenting teen wards and twenty case managers participated in the workshops. In FY05 Project Initiatives will continue to offer this workshop to pregnant and parenting teen service providers.

Eco-map Training

The Office of the Inspector General, in conjunction with the Teen Parent Service Network (TPSN) developed three trainings designed to help workers utilize a community approach by familiarizing them with the value of family support and community resources through the use of Hartman and Laird's "Eco-Map."² An Eco-Map is a hands-on, educational tool that workers develop in conjunction with the teen ward to provide knowledge and help access a network of resources located within a mile of the ward's home. Also, this task-centered community approach involves family members and other relevant individuals in developing solutions to problems.

The three Eco-Map trainings took place at two model early intervention programs during the months of September, October and November 2003 and 113 case managers attended these trainings. The first training took place at the Carol Robinson Center located in the Lawndale community. The second training took place at El Valor located in the South Chicago neighborhood and the last training took place once again at the Carol Robinson Center. These sites were chosen to provide caseworkers with an opportunity to view a quality child focused resource that their clients could utilize. The training used a task-centered approach to help caseworkers identify, explore and connect with resources in their client's community. As part of the day long training, participants ventured out into the community to identify resources and

² Hartman, Ann and Joan Laird. "The Family in Space: Ecological Assessment." Family-Centered Social Work Practice. New York: The Free Press, 1983.

then returned to share their knowledge with the group. At the end of the day, the caseworkers, which had either personally visited or received information on approximately twelve community resources, developed an Eco-Map with the resources they had identified. During FY05 the Teen Parent Services Network will assume responsibility for conducting these trainings for their case managers.

OLDER CAREGIVER PROGRAM

The Older Caregiver Project was initiated as a pilot program in 2001 to remedy identified risks following a series of Inspector General investigations involving vulnerable or dependent caregivers and a Department review of foster homes caring for five or more children. By July 2004 an estimated 5,000 caregivers over the age of 60 were providing care for 10,480 Illinois children through DCFS foster care, relative placements, adoption or subsidized guardianship. The Department initially funded Metropolitan Family Services to serve DCFS older caregivers in Chicago and suburban south side communities, home to the majority of the older caregivers families. In 2003 the project was expanded to serve DCFS older caregivers living in Chicago's west side communities.

In FY 2004 a workgroup under the direction of OIG Project Initiative staff drafted an older caregiver training manual for state and private agency child welfare workers. The manual based on a lifespan, safety and permanency approach includes: geriatric and child assessments; identification of specialized elder support services; specific strategies to address common challenges in cross-generational families and the use of family conference mediation. Where available the family conference mediation process identifies extended family and indigenous supports to develop reliable and safe back-up care plans for children and if necessary establish alternative caregiving arrangements for children and/or the older caregiver.

The workgroup is comprised of staff from Department of Children and Family Service, Illinois Department of Aging, the Chicago Department of Aging, Area Agencies on Aging, the Illinois and Chicago Taskforce on Grandparents Raising Grandchildren and Metropolitan Family Services. The workgroup provided expert advise on the training curriculum and committed to a system of communication and service reciprocity among child welfare and aging professionals to better serve our older caregiver population and their children. The practice wisdom and integrated knowledge gained from families served continue to inform the training initiative.

A statewide blueprint for FY 2005 training includes training of clinical services professionals, licensing and adoption supervisors and workers, post adoption workers, agency performance monitors and administrative case reviewers.

SPECIAL NEEDS RESOURCE

Several FY 03 and FY 04 investigations determined that child welfare investigators and workers were not knowledgeable about chronic medical problems or conditions such as sickle cell anemia, diabetes and cerebral palsy that present investigative or service challenges. To help remedy this deficit, the Inspector General's Office with the University of Illinois Department of Public Health, Mental Health and Administrative Nursing and the College of Nursing produced a user-friendly reference workbook on the most common features of specific medical conditions and their relevant caretaker issues. The reference information is designed to provide practical guidance to investigators, workers and caregivers and can be website available. The Department is reviewing the final draft of the workbook.

APPENDICES

Appendix A: Elise Meredith Death Report (fictional name)

Appendix B: Caimile Akerman Report (fictional name)

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Office of the Inspector General

REDACTED REPORT

The Office of the Inspector General released this report for teaching and 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: 04-1212
Minor: Elise Meredith (DOB 4/03, DOD 1/04)
Subject: Child Death

SUMMARY OF COMPLAINT

Eight-month-old Elise Meredith died in January 2004 from neurogenic shock due to a closed head injury.¹ The mother's boyfriend, 21-year-old Joel Combs, confessed to shaking Elise because she was crying and he was stressed out trying to feed Elise and her 19-month-old sister while cleaning the house. He was arrested and charged in her death. The Office of the Inspector General investigated this child's death because there was a pending child protection investigation of burns, cuts, welts, and bruises to Elise by the boyfriend at the time of her death.

INVESTIGATION

On Saturday afternoon, December 6, 2003, a nurse from Memorial Hospital, called SCR reporting an abuse allegation on seven-month-old Elise Meredith. According to the CANTS initial report:

A mother had brought her 7-month-old child to the hospital with a 2nd degree burn to her left cheek. The mother disclosed that she only noticed the burn this morning. Last night when she came back from work the girls were already sleeping and the babysitter didn't tell her anything about the incident. The babysitter told the mother he was going to fry something, he was with the baby in his arms, the baby bent forward and fell into the hot pan. Reporter states Elise had bruises on both sides of her forehead and under her eye, those bruises look very suspicious.

SCR contacted weekend on-call worker, Barb Valent, to initiate the investigation. Ms. Valent notified the DCP Assistant Regional Administrator of the call. Ms. Valent is employed as a child welfare specialist and has been cross-trained as a child protection investigator. The DCFS Office had been without a supervisor for a year and the Assistant Regional Administrator covered the supervision of the on-call workers. He instructed Ms. Valent to do a risk management plan with the mother not to have Joel watch

the children. If the mother maintained that he would remain as the babysitter a safety plan would have to be initiated.² Ms. Valent explained to the OIG investigator that a risk management plan is one step below a safety plan.

At 9:10 Sunday morning, December 7, Ms. Valent met the mandate to see the child victim who lived about 14 miles from the Office. In addition to seeing the young victim, Ms. Valent conducted a two-hour investigative home visit. Cece Yaeger, the 21-year-old mother, reported to Ms. Valent that Joel had been watching the children at the time of the injuries. She never had concerns about him. He had been watching the children “for a long time,” since September 28 with no problems. When the mother was asked Joel’s last name, the mother told the investigator she only knew him by his nickname. Ms. Yaeger asked Joel for his last name. The investigator failed to ask Joel for any identification and accepted that his last name was Cobbs.³

Ms. Yaeger said the children were sleeping when she came home from work the night before (Friday, December 5). She worked 2-9 p.m. on Saturday and Sundays and 4-9 p.m. Monday, Tuesday, Thursday and Friday. Saturday morning she asked Joel to explain what happened. Joel told her he was making hot dogs holding Elise. Elise wiggled out of his hands into the pan. Joel told her the bruising came from 18-month-old Faith hitting her sister with a toy. The children were in the bedroom playing for about an hour. The bedroom door was open and he was trying to clean the living room. Ms. Yaeger gave the investigator her pediatrician’s name. She professed her love for her children and her anger at Joel. She didn’t want anyone to hurt the children. The mother agreed to ask a friend to watch the children.

Ms. Valent noted Elise had two ½ inch bruises to her left cheek and a red mark with blisters. She observed the mother feeding her breakfast. Besides a runny nose, the child appeared to the investigator to be alert and active, cooing and babbling to her mother. Her sister, Faith, played peek-a-boo with the investigator and appeared age appropriate in her speech and play. Faith seemed comfortable with the mother and Joel. The investigator took two Polaroid pictures of Elise and two of her sister. Elise’s pictures showed her reaching out while being held. They did not show the bruises. The burn, although poorly focused, appeared red and U-shaped.

Ms. Valent documented that 21-year-old Mr. Cobbs stated he was cooking hot dogs with Elise in his arms. She fell forward and hit the pan. He quickly got her up and wiped her face with a baby wipe. Afterwards he noticed a red mark around a blister. He said he tried looking for an antibiotic but was unable to find any. She was crying and he held her to make her comfortable. After she was done crying he put her in the children’s bedroom to play. She was playing with a toy. Her sister, Faith, was throwing toys around while he was picking up. He kept taking the toys and putting them up but not high enough. Faith hit Elise with a toy. When their mother came home they were all asleep. He agreed to leave the home and stay with friends. He stated he understood he should not watch the kids until the report was resolved. Ms. Valent noted for the record a description of the kitchen. She also noted the home was cluttered with toys.

Ms. Valent, Child Welfare Specialist, called the DCP Assistant Regional Administrator and advised him of her initial findings. He instructed her to have someone else watch the children because Joel did not tell the mother about the injuries right away and did not seek immediate medical attention for the child.

In an interview with the OIG investigator, Ms. Valent explained she asked the mother about arranging for another babysitter. The mother stated she had a friend, Julie, who was going to move in. Ms. Valent insisted that she had to contact the friend immediately. Ms. Valent gave the mother her cell phone to contact the potential babysitter. After the phone call, the friend came over to be interviewed by Ms. Valent. Julie, 18-years-old, agreed to stay with the children. She confirmed for the investigator that she

would start caring for the children that day while the mother worked. Julie stated that she had planned to move into the home with her son. She and her son were going to stay in an upstairs bedroom.

Ms. Valent also clarified that, although undocumented in her notes, she asked Mr. Cobbs to show her how he was holding the baby when the burn occurred. She described him holding the baby on his hip with his left arm, cooking with his right hand. Ms. Valent also clarified that although it was not noted in the record, Mr. Cobbs told her Faith had hit her sister two times with a toy. Ms. Valent did not inquire which toy Faith used to hit her sister.

Ms. Valent completed a safety assessment, rating factor #14 (paramour is the alleged or indicated perpetrator of child maltreatment or poses a significant risk to children in the home) as the only factor positive for clear evidence or cause for concern. She made no entry for the paramour safety factor in the family strength mitigating circumstances section of the CERAP. The CERAP instructions note that the family strength and mitigating circumstances section is not to be completed if all the children are safe. Ms. Valent noted the safety decision as safe with a narrative, "Joel will no longer be watching the children until advised by the Department he can: Cece has gotten a girlfriend to now watch the children while she is at work." Since the safety decision was checked safe, no safety plan was required.⁴

Late that night at 11:35 p.m., after Ms. Valent's visit on December 7, a second reporter, Officer Jones of the local police department, called SCR to report:

The biological father of Elise and sibling came to his office on December 7, 2003, and stated Joel (unknown), Cece's boyfriend, used drugs while taking care of the children while Cece was working. The reporter stated the father said Joel was not able to supervise the children when he was under the influence of drugs. The reporter would like CPI to call him.

Hand-Off to Primary Investigator

Ms. Valent, Child Welfare Specialist, reported to the OIG investigator that she finished writing her investigative notes sometime before 9:30 a.m. on Monday, December 8. She gave Jake Polski, the assigned investigator, an oral report and left to perform her regular duties. Later that afternoon at 3:25 p.m., Memorial Hospital faxed a copy of the emergency room records to the DCFS office per the consent Ms. Valent had obtained from the mother.

At 9:05 a.m., Kiah Doling, newly appointed supervisor of the investigations team, itemized a plan of 16 things for the assigned investigator, Mr. Polski, to do. The first few tasks revolved around contacting and interviewing the reporter and sources. Subsequent tasks included interviewing the physician who treated the injury and requesting medical records. The fourteenth task required "if necessary an appropriate safety plan or risk management plan had to be developed after seeing the children (and consulting with the supervisor)." Ms. Doling also checked that the case involved a paramour. Mr. Polski reported to the OIG investigator that he left the office as soon as he received Ms. Valent's oral report. He did not read or print out the CANTS report. Thus, he was unaware of the call from Officer Jones. When he arrived at the home, Mr. Cobbs was standing on the front stoop of the house. Mr. Polski said that he and Mr. Cobbs entered the house together. Mr. Polski's investigative notes began with his interview of the mother. The mother reported that her friend was going to watch her children full time while she worked and would be moving in. She was due to arrive that afternoon at 1 p.m. The mother agreed not to have her boyfriend live with her or watch her children unless told otherwise by DCFS. She signed a release of information form for her child's doctor. Mr. Polski screened the mother for drugs and domestic violence. Mr. Polski then noted his observations of the sister, Faith Meredith. He reported the child was crawling and walking

around the room interacting well with the mother and Joel. He noted the child had no bruises or marks, was happy and clean and appeared to have a good bond with her mother.

Mr. Polski's interview notes of Joel documented that Joel informed Mr. Polski that he was not going to watch the children, and he felt bad about what had happened to Elise. Mr. Polski did not note in his interviews whether the couple was interviewed separately. His interview note documented: "Joel is no longer living in the home as he has agreed to until this investigation is completed. Joel had just come over a few minutes ago to get some more of his belongings." Mr. Polski did not explore with the couple how they met, or the central role Mr. Cobbs had in the children's lives. Mr. Polski completed a substance abuse screen on Mr. Cobbs. The screen noted no problems. Joel left the home just before Mr. Polski left. The children's father, who went to the police station the night after the burn incident to report Mr. Cobbs' alleged substance abuse, was never contacted during the initial investigation.

Mr. Polski reported to the OIG investigator that he was quite firm in informing Joel that he could not stay in the home. While there were no notes documenting that Mr. Polski saw Elise, Mr. Polski stated that he observed Elise that day and he would provide the OIG investigator with his notes on this observation.

Although the day before the mother's friend, Julie, had agreed to move into the home and be the children's caretaker, she was not at the home when Mr. Polski arrived. The mother told Mr. Polski that the babysitter was expected to be there at 1 p.m. Mr. Polski made no further inquiry as to the plans for Julie moving into the home.⁵

Following the home visit, Mr. Polski stopped by the Police Department for a report of the burn call. At the time of the incident, the Police Department had one full-time and about half a dozen part-time law enforcement officers. Around noon on December 8, Mr. Polski spoke with Officer Agnew.⁶ According to Mr. Polski's investigative note, Officer Agnew said there was no report on the burn call since the officer did not believe there was a problem in the home; the burn was an accident caused when the child's head touched the rim of the pan.

Between December 8 and December 18, Mr. Polski never reviewed the full CANTS report. Since Mr. Polski was unaware of Officer Jones' call to SCR reporting Mr. Combs' alleged substance abuse problem, he did not ask Officer Agnew about Officer Jones' call. Investigator Polski completed one more contact on the case before the death of Elise. Although this contact is dated December 8, in an interview with the OIG investigator Mr. Polski stated that date was a typographical error. Mr. Polski made an in-person visit to the office of Elise's pediatrician on December 18 and requested the doctor's records. The doctor was not in the office. His nurse pulled Elise's medical record.

Mr. Polski obtained a copy of the pediatrician's medical notes of December. The notes documented a general eight-month health check of Elise and follow-up of her emergency room visit that noted multiple ecchymosis and a second-degree burn on her left cheek that was healing. The doctor noted the child was deficient in her immunizations. He also noted the mother was working with DCFS because Elise had been seen the week before about some concerns of bruises and a burn. Those bruises and burn appeared to be healing. Several yellow/green ecchymosis on the forehead were resolving and one small one on the chest⁷ "all of which were noted previously."

During his investigation, Mr. Polski never interviewed the reporting nurse at Memorial Hospital. Mr. Polski clarified for the OIG investigator that he never saw the emergency room records of December 6, but obtained the one page medical report from the Clinic of the follow-up visit on December 15. When shown the December 8 records from Memorial Hospital that were in the investigative hard file bearing the fax notation, Mr. Polski reiterated that he had never seen the records. Mr. Polski separated out Elise's doctor's single page report of December 15 stating this was the only medical record he reviewed.

Memorial Hospital Medical Records' staff informed the OIG investigator that a release of records consent form witnessed by Ms. Valent, Child Welfare Specialist, was received on December 8. At 3 p.m. on December 8, Medical Records faxed the emergency room records to the DCFS office. In a phone interview with the OIG investigator, the nurse from the pediatrician's office stated that the emergency room records were faxed to the Clinic (pediatrician's office) on December 9.

Mr. Polski noted in his contact note that while in the doctor's office he reviewed "medical records" documenting that in addition to the burn there were small round marks on the child's head. Mr. Polski wrote that Ms. Yaeger had stated that the marks were caused when the child's sister hit her with a toy. He also summarized the doctor's review of the bone survey X-Rays done at Memorial Hospital.

On the day Elise died Mr. Polski completed a LEADS check on Joel *Cobbs* and Cece Yaeger. Since he never inquired about Mr. Combs' history, he was unaware that Mr. Combs had moved to Illinois only a few months prior, necessitating a national LEADS.⁸ Mr. Polski's LEADS check had an incorrect spelling of Mr. Combs' name. Because of these errors the LEADS result was a false negative.

On the day of Elise's death, Supervisor Doling reassigned the case to Investigator Wakely to complete the "A" investigation. Mr. Wakely documented two attempts to reach the reporter of the "A" investigation, a nurse from Memorial Hospital. He left a message for her that the case was being indicated. He closed the case without interviewing her, concluding in his notes that his office had the information from the medical records and that her only involvement was as the ER nurse who was calling SCR at the doctor's request. The nurse had a more integral function in the reported allegations. The ER records (contained in the DCP records) included the triage and discharge notes written by this nurse with her description of the injuries and the mother's account of the events.

On January 27, Mr. Wakely spoke (phone contact) with Elise's doctor who stated he saw Elise for a follow up about the burn after her visit to the ER. The mother told him about the fall into the pan but he had concerns that the story was a little improbable. Since the mother told him DCFS was called and involved, he didn't call the hotline.

The following day Mr. Wakely spoke with the DCFS nurse. Mr. Wakely noted in the record that he asked her about seven-month-old Elise's physical development, explained the burn scenario and showed the DCFS nurse the photographs of Elise. Mr. Wakely documented that the DCFS nurse opined that the child's "injuries" were consistent with the event, a child her age wiggling and squirming, could be a contributing factor. "She doesn't believe the mark was from a deliberate act."

The DCFS nurse reported to the OIG investigator that Mr. Wakely, DCFS investigator, stopped her in the hall, asked her to wait a minute and showed her the photos of Elise. The nurse stated she did not take notes of the conversation because it was done in passing. She did not know about the bruises nor did she review the ER reports. She stated she assumed Mr. Wakely was only asking about the development of a seven-month-old and the possibility of an accident with a seven-month-old child. She told Mr. Wakely that because children that age squirm and wiggle it was possible for a child to get burned in the manner explained to her. She stated she was not told that the child had bruises and did not see any in the pictures but did not remember studying the pictures for bruising. If she had been told about the bruises she would have been more probing asking who, what, where, when and how questions. If the bruises were on different planes she would have had concerns. She did not consider her conversation with Mr. Wakely a consultation. She described herself as usually being a stickler for details as she had formerly been an investigator with the Sheriff's office. She did not recall saying that she did not believe it was a deliberate act. The DCFS nurse stated that in the future she was not going to make any more assumptions. If any

investigator asks her a question about an injury, she will look at the record, call the doctor and write up her notes.

The field office headcount includes a supervisor and a four-member child protection unit covering three counties. Three of the four investigators were over the BH compliance level.

Elise's death occurred in January and her case was reassigned to Mr. Wakely. Ms. Doling stated to the OIG investigator that she believed Mr. Polski told her just before she left on vacation that he was going to unfound the Yaeger case. When she wrote the Morning Report, she contemporaneously accepted the oral accounts of Mr. Polski. The January 2004 morning report detailed that Mr. Polski saw Elise:

CPSA Polski was assigned this report on 12-8-03 & proceeded to re-interview all subjects at the residence. Polski reiterated the agreement not to have Joel in the home or watch the children with the mother & observed Elise to be happy clean and crawling around. Polski noted child interacted well with her mother & seemed to be well bonded.

Ms. Doling told the OIG investigator that Mr. Polski reported to her while she was writing the morning report that he had seen the child victim crawling on the floor. The Morning Report also reiterated that the Police Department's Officer Agnew advised they had responded to the burn and determined the burn was an accident and there were no problems in the home. No police report was generated.

On January 28 Ms. Doling wrote a supervision contact note noting a statement by Mr. Wakely that the bruises on Elise were not the same age as the burn and "mom presents the sibling in the home caused them & we have no evidence to prove otherwise." The sequence "A" allegations were concluded with burns by neglect indicated with the evidence and rationale:

The child had an elliptical⁹ burn on her cheek. Joel admits he was holding the baby while cooking and she fell on the edge of the pan.

Any normal person would know it was dangerous to hold an active 8 month old over a hot surface while holding it with one hand. His engaging in this behavior showed reckless disregard for the baby's safety.

The allegation of cuts, welts and bruises was unfounded with the evidence and rationale:

Baby Elise did have some small, light bruising on her facial area.

Moms (sic) explanation that her older sister had hit he (sic) with a toy could be consistent with the observed injuries.

There is no evidence to refute Moms (sic) explanation and it is consistent with the injuries.

The PSA, Ms. Doling, conducted a final supervision with the CPI regarding the case and agreed with the CPI's finding.¹⁰ Management appeared to ignore the internal inconsistencies between the hospital medical records which noted two bruises on the cheeks (also noted by Ms. Valent) and two bruises on the forehead; the mother's statements that the bruises and burn were observed by her on the same day after the babysitter reported the child had been hit by her sister and accidentally burned when she fell into a pan; the follow-up doctor's report of multiple healing ecchymosis and a burn, and Mr. Wakely's recorded evidence and conclusions of the "A" investigation.

The PSA for the office stated to the OIG that the use of risk management plans was an incorrect regional policy and has been discontinued. In addition, he reported that his region area initiated weekly

management telephone conferences that include all injury investigations of children under age ten, paramour cases and unsafe CERAPs. A review (see below) of this regional investigative practices for cuts, welts and bruises found that administrative review of these allegations was already in existence at the time of Elise's fatality.

Emergency Room Records

Memorial Hospital's Emergency Department records document that Elise arrived at the hospital shortly after noon on Saturday, December 6, 2003. She had bruising to her left cheek, right and left forehead and a 2nd degree burn the size of a half-dollar, to her left cheek. Abuse was suspected and DCFS was called. According to triage notes:

Mother said child was with babysitter yesterday. Mother came home and child was in bed. Mother called the babysitter. The babysitter told her she was holding the baby and cooking and the baby slipped out of arms and sustained burn to the left cheek. Also she reported to the mother that sibling was hitting child in head with a toy. And now there are bruises all over head.

The child was sent for a limited bone survey. Results showed no evidence of old or new fractures. The mother was given medication for Elise and instructed to see her physician in the morning if the child developed a fever. The grandfather was listed as the emergency contact.¹¹ A business card for a parent educator of an early childhood initiative was copied to the record with a notation that she was a friend of the family. After Elise's death, Ms. Yaeger told the police that it was the early childhood initiative's worker who advised her that Elise needed to be seen by a doctor.

Ms. Yaeger returned to the emergency room the following evening, December 7, and was seen in the triage department again by the same nurse as before. Elise had watery eyes, green sputum and had been vomiting, preceded by coughing. She had a 100.4 fever. She was described as awake and playful with the face burn reddened around perimeters. She was prescribed antibiotics.

Review of Investigation Practices for Allegations of Cuts Welts and Bruises

The investigative errors that permeated the Yaeger case prompted the OIG investigator to explore whether these errors were case specific or systemic to that region. The OIG investigator reviewed a random sample of 20 of the 97 investigations for allegations of cuts, welts and bruises (#11/#61) in that region opened during the three-month period, September-November 2003. During this time period two teams were over BH assignment compliance levels.

Of the twenty cases in the sample, two were excluded since they involved allegations against facilities. Seventeen families were represented in the sample with 17 children because one alleged victim had two allegations called in: the first allegation was for cuts, welts and bruises by neglect, and the second was called in fourteen days later alleging cuts, welts and bruises by abuse. The alleged victims ranged in age from 10 months to 16 years old. Six of the alleged victims were age six years or younger.

In one case, domestic violence was reported, but the police department was not contacted. Only two LEADS checks were run by the DCP investigators. SCR did not run any because of insufficient information at the time of the hotline report. In the two cases where LEADS were run, one involved a 13-year-old girl who alleged her father had hit her while she was visiting him and the second involved a 14-year-old boy placed with his aunt. He and the aunt got into a fight in front of neighbors. In one of the two LEADS that were completed the LEADS was run over three months after the case came in, on the day the case was to be closed. Although Administrative Procedure # 6 requires LEADS checks for

allegations 11 and 61 when the child is under age six, none were completed for the six children in the sample who were under the age of six. In addition, the paramour policy requires LEADS when the paramour is the alleged perpetrator in any investigation of allegations 11 and 61. Again, in the two cases in the sample where the paramour was the alleged perpetrator and the children were over the age of six, LEADS were not completed. The written investigative plan/supervisory consult in the majority of cases did specify a LEADS check be completed. However, even if one excluded the supervisory request for LEADS, in 59% of the investigations the investigative plan/supervisory consult was not fully followed.

Of the 18 cases in the sample, only one case included a detailed scene investigation and probing investigative questioning. Almost a quarter (24%) of the investigations had internal factual inconsistencies that were not questioned by administrators. For example, a child reported his mother's boyfriend had thrown him into his room while the parents were arguing. The child came to school with injuries on the sides of both temples. The parent told the investigator the injuries happened on the family's trampoline. The worker closed the case saying the child hurt himself hitting an iron bar on the trampoline. No scene investigation was noted and the family was not instructed to put protective coverings over the bar. The investigator's written conclusion listed as evidence that the siblings stated that their brother got the bruising from jumping on the trampoline, however, the investigator's contact notes did not support this statement.

In a report involving an 11-year-old child, the child told his teacher that his mother hit him with a belt. The teacher, who made the call, stated that the child had bruises on both legs. The reporter stated that she had previously called in on the family. In the course of the investigation, the investigator recorded contradictory information. After meeting with the alleged victim, the investigator documented that there were *no marks or bruises* on the child. However, two months later in supervision, the investigator stated that he had seen *faint marks* made from a belt on the child's legs (emphasis added).

In 72% (13) of the investigations, the DCP investigator saw the child within 24 hours. In 22% (4) of the investigations, the alleged victim was not seen for a month or more. In one case, the investigator made an attempt at 5 p.m. to see the children in one of their divorced parent's home (the divorced parents had joint custody). The family was not at home. The worker noted a good faith attempt. There was no further activity for two months. No attempt was made to see the children at school.¹² The two reporters were never contacted. In a society where it is common to have working parents, it is not efficient (although presently it is accepted practice) to describe a 5 p.m. visit as a good faith attempt to see the family.

DCP protocol dictates that the child protection investigator meet with a supervisor to develop an investigatory plan. Two of the teams were without supervisors for this period; the PSA would have to cover supervision in the absence of a supervisor. In the 18 investigations reviewed, 56% (11) of the supervisory consultations included in the tasks the language *safety or risk management plans if necessary*. Only one investigation had a safety plan.

Of the 18 CERAPs, one was ruled unsafe and 17 were ruled safe. Nine investigations involved paramours. The paramour policy requiring weekly visits was followed in one case. The sample's solitary safety plan involved an 11-month-old baby who was a subject of two consecutive investigations. The first, for facial bruising, had no safety plan. The second investigation was for an allegation of a broken arm. The safety plan was initiated the day after the second report.

ANALYSIS

In the January 2004 Inspector General's Report to the Governor and the General Assembly, the Inspector General recommended systemic changes in child protection investigatory procedures. One recommendation (page 7 of the report) foreshadows the problems noted in this investigation:

Child protection trainings must emphasize investigative practices including, but not limited to: (a) basics of fact-finding interviews, including who, what, where, when, why, and how of the incident; construction of a 24 to 72 hour time line of events leading up to the incident; and verification of information provided; (b) basics of a thorough scene investigation, including documentation of observations and measurements and mock demonstration (reenactment) by caregiver(s) of the incident using appropriate props (such as a lifelike doll) in the environment where the incident occurred; and (c) collaborative logical analysis of information (scene investigation, interviews, and physical examination of the child) with medical personnel and law enforcement involved in the investigation.

In this case, these basic investigative tasks were not completed. When Ms. Valent, the mandate worker, interviewed the boyfriend about Elise's injuries she did ask him to recount the incident and she did complete a cursory scene investigation, but the questioning was not sufficiently probative. Her interview and scene investigation should have included careful documentation of the boyfriend's explanations for the injuries, the mechanism of each injury (seeing the pan Elise allegedly fell into and identifying the specific toy(s) that allegedly caused the bruises to Elise's face), and a full re-enactment by the boyfriend of the events that led to Elise's injuries. Injuries inconsistent with the history provided by the caregiver is one of the most telling factors for inflicted injuries (Jewett & Ellerstein, 1981; Renz & Sherman, 1992; see Nellie Paulsen Death Report, Office of Inspector General Report to the Governor and General Assembly, January 2004). Had Ms. Valent asked to see the pan that Elise allegedly fell into, she could have established whether or not it matched the burn mark on Elise's face and could have ruled it in or out as the mechanism of injury.

Mr. Polski did not complete any of these critical investigative activities. When he assumed responsibility for the investigation, he talked with Ms. Valent, but did nothing further. He did not print out and read the CANTS report so he had no knowledge that Officer Jones from the Police Department had made a second call to SCR based on the complaint of the biological father that Mr. Combs was using drugs while caring for the children. Because he was unfamiliar with the narratives of each of the CANTS reports, Mr. Polski left himself unprepared for investigative interviews with the mother and Mr. Combs. Neither Mr. Polski nor Ms. Valent asked Mr. Combs for identification to ensure the correct spelling of his name for LEADS and CANTS checks. The failure of investigators to request adequate identification for valid LEADS and CANTS checks has been noted in past OIG investigations. While the Department agreed with a 2002 OIG recommendation that proper identification (valid driver's license or state ID) be obtained in the course of investigating caretakers, the requirement has not been effectively instituted in practice (see Death and Serious Injury Investigation 11, in the January 2003 Inspector General's Report to the Governor and the General Assembly). The LEADS Protocol (Administrative Procedure # 6) was not revised, so it still does not require the caretaker informant to provide identification for a valid LEADS and CANTS inquiry.

In his interviews with Ms. Yaeger and Mr. Combs, Mr. Polski could have worked with the mother and her paramour to construct a 24 to 48 hour time-line of events leading up to the injuries. Questions should have been asked about seven-month-old Elise's normal routine, what her and the caretaker's moods were on the day of and preceding days, whether the child was fussy or crying, sleeping normally or not, and other baseline information that helps an investigator learn what stressors or risk factors may have been present prior to the injuries. The regular pattern of the couple's day and childcare activities was not obtained. It was only after the death of the child, when asked, that the mother stated the boyfriend going to bed early on the day of the injuries was unusual. Unknown to the investigators, the mother had separated from the baby's father only weeks before the new boyfriend moved in with her.

Although second-degree burns normally heal within two weeks without scarring, they are extremely painful (Reece, 2001). The boyfriend's description of wiping the injured child's burn wound with a baby wipe would only exacerbate the child's pain. Whether the child appeared inconsolable to him or why he never called the mother for advice was never explored. The boyfriend reported that after the child was calmed, he placed her in a bedroom with her 18-month-old sister to play. It was then that the subsequent alleged bruising occurred. No details of the mechanisms of any of the injuries were obtained.

A risk management plan was made without any real consideration of whether the mother would comply with it. The relationship between the mother and her boyfriend should have raised a safety concern. The mother and paramour had a relatively new relationship untested by time. The mother had met the paramour at the end of September. Shortly afterwards, he moved into the household and the mother left him in charge of watching two children under the age of two and maintaining the house while she worked. Ms. Yaeger's questionable judgment in having Mr. Combs move in shortly after meeting him and allowing him to watch her children, while not even knowing his last name, should have alerted the investigators of the possibility that she could not be relied on to enforce a risk or safety plan.

There was no further questioning of the plan for the mother's friend, Julie, to move into the home. The verbal promise by an 18-year-old alternative caregiver was accepted without realistic monitoring. Although the mother named (available in the ER records) both a professional support person from an early intervention program and a family support person, the child's grandfather, neither was contacted to offer support and assist in risk reduction efforts.¹³ The children were determined to be safe with a myopic risk management plan. There was no verification, through unannounced visits, of whether the promised alternative caregiver had actually moved in and the boyfriend had moved out.

After Elise died, the "A" sequence investigation was turned over to Mr. Wakely to complete. Mr. Wakely did not talk with the nurse reporter of Elise's injuries or any of the emergency room treating physicians before he made his recommendation to indicate the case for a burn by neglect and unfounded the allegation of cuts, welts and bruises. Mr. Wakely did speak with the DCFS nurse, but only informed her about Elise's burn, not the bruises. Based on the information given to her, the nurse opined that Elise's burn could have occurred in the manner described. She told the OIG investigator that she would have had concerns if she had been told about the bruises. It was inappropriate for Mr. Wakely to request an opinion about whether abuse occurred from the DCFS nurse without giving her full facts and prior to interviewing the mandated reporter or treating physicians at the hospital. The DCFS nurse should have been wary of the request for quick opinions. A previous OIG investigation documented its common practice.¹⁴ This type of practice permits the unscrupulous to abdicate investigative responsibilities.

Mr. Wakely's rationale for indicating the burn for neglect was that "any normal person would know it was dangerous to hold an active eight-month-old over a hot surface while holding it with one hand. His engaging in this behavior showed reckless disregard for the baby's safety." His rationale for unfounding the cuts, welts and bruises allegation was that "baby Elise did have some small, light bruising on her facial area; mom's explanation that her older sister had hit he (sic) with a toy could be consistent with the observed injuries; and there is no evidence to refute Moms (sic) explanation and it is consistent with the injuries." These rationales demonstrate that Mr. Wakely accepted the mother's and the boyfriend's self-report about how the injuries occurred without input from the medical professionals who treated Elise and without thoroughly reviewing the documents associated with the investigation. Ms. Doling signed off on the investigation not noticing the inconsistencies and minimizations with Mr. Wakely's written conclusion that no evidence refuted the mother's explanation that the small "light" bruising were the result of the victim's sister hitting her.

Risk Management Plans

The Region's systemic use of risk management plans in lieu of safety plans was troubling. DCFS's paramour policy in effect at the time of this case,¹⁵ details that an appropriate safety plan may require that the paramour leave the custodial parent's residence during the investigation. The policy also requires weekly monitoring of all children during the course of the pending investigation when the child victim is under the age of ten. In this case, neither of the children was monitored nor was either of the couple contacted over the next month.

Mr. Polski believed he was required only to have 30-day contacts with the family since there was no safety plan, only a risk management plan. And once the risk management plan was developed and approved by the field manager, it was not questioned by Mr. Polski's supervisor who shortly afterwards went on vacation. Ms. Valent, the mandate worker, stated that a risk management plan sufficed since the family agreed to manage the problem by securing another babysitter and having the paramour move out of the home, and safety plans are not to be used when the case is assessed to be safe.

The case was assessed as safe because of the couple's agreement to follow the risk management plan. However, the argument of there being no safety risk because a risk management plan was initiated is a circular argument since without the risk management plan the children would have been assessed as unsafe triggering a safety plan. According to Procedure 300 (Appendix-G, p.13), a safety plan is to be used to control or immediately resolve or reduce the potential of imminent risk of moderate harm until a more stable change can take place. The practical difference is that safety plans require weekly monitoring components. Moreover, the use of the risk management plan depended on the mother's judgment, of which there was ample cause to be skeptical.

The Center for Child Welfare Policy, North American Resource Center for Child Welfare has recently reviewed present practices and issues in the national risk assessment initiative (The APSAC Advisor, Winter, 2004). Though they report that the "objectives of safety assessment are fairly clear, considerable confusion remains about the relationship among safety assessment, risk assessment, investigation, and the substantiation of maltreatment." Among the problems are the rhetorical, confusing, discontinuous and contradictory messages that safety assessments are qualitatively different from risk assessments: "Safety assessment, stripped of ideology and rhetoric, essentially combines substantiation of maltreatment and emergency case planning."

The use of risk management plans in lieu of safety plans appeared to be accepted practice within the region. A review of a random sample of 18 Region investigations into cuts, welts and bruises during the months of October, November and December 2003 showed that more than half of the supervisors' tasks detailed the undifferentiated language "safety or risk management plans" without specification on the differences between the terms. The DCP Assistant Regional Administrator stated to the OIG that the practice has been discontinued. Even if one accepted that the risks were managed by a promise that the paramour was moving out and securing an alternative babysitter, one would still have to test the waters to see if the plan held true over the course of the investigation. The presence of a paramour may increase risk of abuse or neglect. And as emphasized in the paramour policy, children under the age of six are at the greatest risk of abuse. Yet, the paramour and LEADS policies were systemically ignored in the majority of the sampled Region investigations.

Items on safety assessments require probing for information. Here, despite the fact the burn allegation was ultimately indicated following the death of the child, there was no probing for information. Nor in the end was there indication of the allegation of cuts welts and bruises. The presence of bruises is associated with a child's age and developmental stage (See OIG January 2002 Report to the Governor and the General Assembly, Redacted Report Carolina Yardley). It is rare for infants younger than six months

to have bruises. Several studies have been conducted to determine normal baseline data on bruises for children. Sugar and his colleagues found that bruises are very uncommon for pre-ambulatory infants who are younger than nine months. The presence of bruises was associated with the child's age and developmental stage. Of the 5.6% of the group (ages six through eight months) with bruises, only 2.2% of those children not yet walking (pre-cruisers) had bruises. The percentage of children with bruises increased with the child's mobility development (infants walking over those who were crawling) and age, 51.9% of the children walking at these ages had bruises. In another study of 511 pre-cruisers, 6% had bruises on their forehead (Sugar, Taylor, Feldman, Puget Sound Pediatric Research Network, 1999). The authors of these studies concluded prudent physicians should seriously consider the possibility of inflicted injury or medical illness when (1) evaluating a young infant who has any bruises and (2) when bruises in infants or toddlers are on atypical sites. Bruises located in non-bony areas such as buttocks, *cheeks* (emphasis added) or genitalia, or on relative protected area like ear lobes, neck, or upper lip are highly suspicious (Richardson, 1994). In this case, the boyfriend's explanation that seven-month-old Elise suffered four bruises, two on the cheek and two on her forehead from her sister hitting her with a toy was improbable.

Contrary to Mr. Wakely's written rationale in the unfounding of the allegation of cuts, welts and bruises, the emergency room records, the treating physician's notes and the mother's hearsay statements about what her boyfriend had reported to her, would lead one to conclude that the events leading to the bruising and the burn occurred in the hours that the paramour was watching the child on Friday, December 5. The burn was indicated for neglect, not abuse, with the rationale that a reasonable person would know that one does not care for a seven-month-old child by holding the child while cooking. The likelihood of an accidental burn and accidental multiple bruises (4) on different areas of a pre-cruiser's face all sustained on the same day is low.

Inefficient Investigative Methods

In this case and in one of the sample cases there were examples of investigators using common but inefficient methods to contact key informants and victims. For example, rather than arranging with the office manager a time for an interview between the doctor's scheduled appointments, the investigator showed up at the physician's office when the physician was not there. Rather than leaving numerous messages during normal weekday hours for weekend emergency room reporters to call the investigator, investigators should request the assistance of hospital staff in contacting reporters. In today's economy and the reality of dual-employed parents, conducting initial home contacts during 9 to 5 work hours is more likely than not to be a futile attempt. Management should assist investigators to develop efficient and effective strategies to overcome common investigative obstacles. Likewise, management should routinely provide investigators with current evidence based literature on common problems encountered in the field. It is disconcerting that the pertinent findings from OIG death investigations do not reach the front line professionals. DCFS administrators did not effectively share the 2001 OIG redacted death investigation of an infant with prior bruising with the field, leaving investigators, nurses and their supervisors ignorant on the pediatric literature on bruising. (OIG Report #010128, Carolina Yardley [redacted name]) Critical OIG reports are redacted for teaching purposes so that errors are not repeated.

Shaken Baby Research

Encouragingly, included in the hard file of Elise's death investigation were website print outs of shaken baby research. Research reports the average age of victims is six to eight months with the typical shakers being boyfriends or fathers in their early twenties. Frustrations with crying or toileting are listed as common precursors. Prevention strategies include education and guidance on handling incessant crying and stressful situations (American Academy of Pediatrics, 1993; Philips, 1996; Rameriz, 1996; Showers, 1997). Prior to the shaken baby allegation there were no prevention risk management strategies or

services sought other than the alternative babysitter and the temporary moving out of the paramour. There were no unannounced visits to insure that the plan for an alternative caretaker was implemented. Mr. Polski demonstrated a lackadaisical investigative approach, despite having a manageable number of investigations. Mr. Wakely followed suit. The management of the field office, perhaps because of worker shortages or rhetorical understandings of safety and risk management that permeated the particular region, minimized the careful investigative probing needed for investigations. OIG recommendations for the education of investigators on bruising, burns, and other injuries to children and careful scene investigations have not been instituted in practice or trainings. The infrequency of violence towards children may reinforce superficial investigations; in the vast majority of cases investigated by DCP, there won't be a subsequent lethal outcome. However, investigators cannot afford such gambles and neither can the child victims.

RECOMMENDATIONS

1. *This recommendation addresses personnel issues.*
2. *This recommendation addresses personnel issues.*
3. To address deficiencies noted in this report, the Department should institute investigative training targeted specifically to the regional area. The training should be two tiered.

Management and supervisor investigative training should address:

- The need for individualized supervisory directives and assurances that the directives have been followed or amended prior to case closing; and
- The use of this investigation and its conclusions with previous OIG investigations on children's bruising and injuries as teaching tools to develop a system for the reviewing of evidentiary logic in future child injury cases.

Supervisor and investigator training should address:

- Comprehensive scene investigations
 - Preparing historical timelines
 - Ascertaining and verifying mechanics of injuries
 - Critical analysis of operating assumptions and bias in safety decisions
4. The Department should ensure that the practice of using risk management plans in lieu of safety plans is discontinued.
 5. In child abuse and neglect investigations where DCFS nurses are consulted, both the nurse and the investigator must document the questions asked, the information provided, the records reviewed and the answers given.
 6. DCFS Administrators should develop and train nurses in standards for providing information to DCP investigators (See recommendations in OIG Report, File # 972415). Previous OIG death and serious injuries investigations should be included in the training. Supplemental training will be necessary on bruising and other forensic issues relevant to abuse or neglect.¹⁶
 7. SCR should request a home phone number of medical, emergency room or law enforcement reporters who work weekend or night shifts.

8. The Administrators should develop an effective communication system with local hospitals to assist investigators with contacting key medical informants in abuse and neglect investigations. In hospitals with child protection teams, the chair of the team can assist in developing a timely response. In hospitals without a child protection team, DCFS management should reach out to hospital administrators to have a designated contact to assist the investigator in contacting a mandated reporter and other key hospital informants. If requested by the hospital, DCFS should assist in the formation of ad hoc child protection team that can be convened on an as needed basis.
9. The Department should (1) conduct a cost benefit analysis for on-call workers to assist investigators in completing key tasks when a unit is consistently above the BH compliance level and (2) explore piloting a four day flextime work week for DCP investigators to conduct evening home visits.

¹ Because the exact mechanism of injury cannot always be determined (e.g., shaking versus impact injury or both), medical professionals use different terms, such as closed head injury, to describe the symptoms presented from inflicted cranial injury. The term “abusive head trauma,” used by Carole Jenny, M.D., in 1999 (Journal of the American Medical Association) is increasingly being used to refer to inflicted head trauma.

² The CPI’s investigation note read “...do a risk management plan with mom to not have this guy watch the kids. If mom says this guy is he (sic) babysitter and that’s it, do a safety plan...”

³ Throughout the first investigation Joel is referred to as Joel *Cobbs* and Joel *Combs*, but primarily Cobbs. His legal name is Joel Combs. He was a Wisconsin resident prior to September 2003 and had a Wisconsin driver’s license. A LEADS check was not completed until after the death of Elise. The investigators requested only an Illinois LEADS. SCR completes Illinois LEADS. Out of state LEADS require the assistance of the OIG. Routinely, OIG investigators complete out of state LEADS at the request of DCP investigators.

⁴ The instructions for family strengths or mitigating circumstances read: For each safety factor that has been checked yes, describe any family strength or mitigating circumstances. *The section is not to be completed if all the children are safe* (italics added). The directions for the safety decision state: Identify your safety decision by checking the appropriate box below (check one box only) this decision should be based on the assessment of all safety factors and any other information known about this case.

⁵ During the death investigation, Julie told the police that she still lived at home with her father. She never moved into the Yaeger home. Mr. Combs was living in the home at the time of Elise’s death.

⁶ Officer Agnew was a sergeant with the Police Department. SCR did not request a collateral police investigation. It is unclear whether Officer Agnew referenced Officer Jones’ response to the father’s complaint the day after the burn. Following the death of the child, Officer Jones stated to Investigator Wakely that he did not believe the father. Officer Jones stated he visited the home and saw no drug paraphernalia.

⁷ The chest bruise was not noted in the December 6 ER records and no follow-up questions regarding this bruise were noted.

⁸ During the investigation of Elise’s death, Joel told the police that he met Ms. Yaeger in Wisconsin while he was helping a friend move. Ms. Yaeger informed the police that Joel moved into her home “just after Christmas.”

⁹ The Polaroid picture showed a U shaped mark. The hospital records describe the injury as half-dollar in size.

¹⁰ Similar to investigative problems noted in another Region. (See OIG report # 010128). Ms. Doling reported that Mr. Polski like some of the other male investigators were uncomfortable with cases that involve babies.

¹¹ Following the death of Elise, Mr. Wakely interviewed Mr. Meredith, who stated that Cece and the children lived with him in September 2003. Shortly after Elise’s death, Faith was placed in his care.

¹² The report was made on October 3. The children attended school and were available for interviews at the school.

¹³ The child had a relationship with the paternal grandfather as he reported that the mother and the children lived with him for a while in September.

¹⁴ See OIG Report # 972415.

¹⁵ The policy in effect at the time of this case was Appendix H - Paramour Involved Families, August 15, 2000 - PT 2000.18. This policy was revised effective March 12, 2004. The revisions to the policy include a Paramour Assessment Checklist.

¹⁶ In response to recommendations in previous OIG investigations (Pediatric Palliative/ Hospice Care, File #020987, February 21, 2003; and Memorandum on the Role of DCFS Nurses, January 30, 2003), the Department agreed to review and redesign the reporting structure of the DCFS nurses by March 1, 2004. (See Report to the Governor and General Assembly, January 2004, pp. 144 and 147.) The review and redesign has not been completed.

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Office of the Inspector General

REDACTED REPORT

The Office of the Inspector General released this report for teaching and 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: 03-1231

Minors: Caimile Akerman (a.k.a. Caimile Palmer), DOB 9/00
LaKeshia Akerman, DOB 11/01

Subject: Serious injury to a child monitored by the Department

SUMMARY OF COMPLAINT

The Office of the Inspector General (OIG) opened an investigation of the Akerman family case because two-year-old Caimile Akerman received a life threatening injury while her family had an intact family case open with the Department. Caimile was diagnosed with second-degree burns and bruises. She had splash burns on the tops of her feet, up her legs and under her calf. She had bruises on her chest, buttock, and legs. The police arrested the mother and her paramour. The paramour admitted beating Caimile with a belt and bathing her four days earlier. The mother claimed she and her boyfriend did not immediately seek medical attention for the two-year-old because she feared Caimile would be removed from her care. Nine months earlier, a four-month-old daughter had been removed from the mother's care and placed elsewhere after another paramour shook the infant to the point of brain damage and blindness.

INVESTIGATION

Vanessa Akerman's history with DCFS

DCFS received guardianship of Vanessa Akerman and her three younger siblings (ages 15, 10, 9, and 6) in August 1995. Initially the three younger siblings had been placed with their father, but he relinquished custody to the Department, stating he could not take care of them. A year and a half later, Vanessa's younger siblings were returned to the care of their mother and DCFS closed their case in July 1997, while Vanessa remained a ward of the state. Vanessa was pregnant at the time the Department prepared to return her siblings to their mother. In October 1996, the 16-year-old ward gave birth to Javonte Styler.

Vanessa's caseworker called the hotline shortly after the birth of her son, Javonnte, because Vanessa had threatened to harm the child during labor and attempted to leave the hospital while in labor. She had been diagnosed bi-polar with a major depressive disorder. The teenager was subsequently psychiatrically hospitalized and her son was placed in the temporary custody of his father, Peter Styler, (who lived with his own mother). DCP unfounded the allegation of risk of harm against the teenage mother, determining it was a dependency case. A year later, in August 1997, Peter Styler's aunt called the hotline to inform DCFS that Peter Styler and Vanessa Akerman were in jail.¹ The court granted guardianship of Javonnte to DCFS. In October 1997, a few days prior to her 18th birthday, the court granted Vanessa Akerman's request for emancipation from DCFS wardship; at the time she was incarcerated pending trial on felony forgery charges.

Parental rights of Vanessa Akerman and Peter Styler were terminated in December 1998. Javonnte was placed in the home of another paternal aunt who offered to adopt him. However, the case could not pass adoption screening because the aunt's husband had an extensive criminal history.² Javonnte remained in the home and a private guardianship arrangement with the aunt was completed in December 2001.

First child abuse investigation ("A" sequence)

Five months after five-year-old Javonnte's guardianship case was closed, Vanessa Akerman's four-month-old daughter, LaKeshia, was admitted to the hospital with bilateral retinal hemorrhaging and suffering from Shaken Baby Syndrome;³ as a result of the head trauma, LaKeshia is severely mentally retarded and blind in her left eye. The hospital social worker that called the hotline noted that the mother's paramour admitted injuring LaKeshia.

Vanessa (age 22) explained to the treating physician that she left four-month-old LaKeshia and 18-month-old Caimile in the care of her former boyfriend, Carl Palmer (age 23), while she went to a drugstore midday on March 20, 2002. Ms. Akerman said Mr. Palmer was the father of 18-month-old Caimile,⁴ and Ms. Akerman was staying with him because she was homeless. Vanessa reported Mr. Palmer left shortly after she returned home. When LaKeshia woke up she cried and would not take her bottle. When Vanessa's boyfriend got home she asked him about the baby and he said they should call 911. LaKeshia was taken to the hospital and then transferred to a Children's Hospital.

DCFS Child Protection Investigator (CPI) Warren Karger was assigned the investigation. Mr. Karger interviewed Mr. Palmer at the police station. Mr. Palmer explained that he was babysitting the children while Ms. Akerman went to the drugstore to get ointment for Caimile. He said he had LaKeshia in his arms and his daughter Caimile began playing with a wall socket. When he went to get Caimile he dropped the baby on her head. He checked the baby to see if she was okay. She was crying so he shook her for two to three minutes. A detective from the Police Department verified Ms. Akerman's story that she was not at home when the incident occurred. Mr. Palmer was arrested.

Vanessa Akerman notified LaKeshia's father, Jacob Seaberg, that the infant was in intensive care.⁵ When Mr. Seaberg arrived he told the hospital social worker that Vanessa had not allowed him to see his daughter since she was a month old. The hospital staff recorded the following information from Ms. Akerman and Mr. Seaberg:

Mother and father [of LaKeshia] stated Carl Palmer has a very bad temper[,] has a history of domestic violence towards mother[, and] is currently on parole for same. Parents also stated Mr. Palmer has threatened to kill [LaKeshia] in the past – stating he is not happy that he is not the biological father of [LaKeshia]. Mother stated she stays with him because she has nowhere else to live – has lived in a shelter on and off.

The following month, Vanessa Akerman moved into a community-based transitional living shelter at Alpha House.⁶ On April 17, the hospital social worker asked CPI Warren Karger to conduct a visit to Alpha House to assess its appropriateness for the mother and child. CPI Karger phoned the program director who told him her program was a “center for individuals with developmental disabilities.”⁷ Mr. Karger then called the hospital back to authorize LaKeshia’s discharge to her mother at Alpha House, stating he would open an intact family case.

Prior to LaKeshia’s discharge, the hospital social worker made arrangements for Ms. Akerman to “room-in” with LaKeshia to learn techniques for feeding and administering medication. The hospital also taught paternal grandmother Betty Myer the skills needed to care for LaKeshia. The hospital social worker had to meet with Ms. Akerman following complaints from the nursing staffing that “mother spends most of her time in bed and does not appear interested in learning [patient] care.” Ms. Akerman required cueing to feed or change the baby and did not always respond to cueing. When Ms. Akerman did not get medication for LaKeshia, the hospital made arrangements for Ms. Myer to pick it up from the pharmacy.

Mr. Karger, CPI, allowed protective custody of LaKeshia to lapse.⁸ The hospital made arrangements for LaKeshia to be discharged to her father, Jacob Seaberg, and grandmother, Ms. Myer, with DCFS consent. The hospital also made arrangements for continuing therapy (occupational, physical, and speech). Although there was no evidence in the investigative records that CPI Karger went to the Myer/Seaberg home to assess it for appropriateness prior to LaKeshia’s discharge, CPI Karger told OIG investigators that he did assess the home. He could provide no explanation for why his assessment was not documented. Mr. Karger documented that he telephoned the father on April 22, 2002, who acknowledged paternity of LaKeshia and said he could care for his daughter. He reported he was employed and had medical insurance. The CPI informed the father that his daughter would be released to him. There was no evidence that Mr. Karger interviewed Ms. Akerman, requested Department records for review, or interviewed any collateral sources.

Safety Evaluation

In Mr. Karger’s initial Child Endangerment Risk Assessment Protocol (CERAP) on LaKeshia (March 22, 2002), the only safety factor noted for concern was that a paramour was the alleged perpetrator of physical abuse. In the safety plan, Mr. Karger noted Ms. Akerman would not allow Mr. Palmer to have any contact with her daughters, and she would visit LaKeshia and cooperate with all requests by medical personnel. The sole signature on the safety plan was Mr. Karger’s.

Mr. Karger requested a neighboring DCP office complete a parallel contact to visit Caimile and complete a safety plan. When contacted by that office’s CPI, Troy Redding, the paternal aunt said she was a family friend and Ms. Akerman had asked her to watch Caimile but did not specify for how long.⁹ The paternal aunt stated she would be willing to sign a safety plan if Ms. Akerman contacted her and arranged a specific length of time for care-taking and provided her with paperwork to get medical attention, if needed. CPI Redding completed a CERAP and Caimile remained with the aunt under a safety plan. He also instructed the caretaker not to allow the mother to take Caimile unless approved by DCFS staff. Mr. Redding rated Caimile as safe. Ms. Akerman had agreed to participate in DCFS services and the paramour was in jail. According to CPI Redding’s notes, his interview was limited to assessing Caimile’s safety; he did not seek information regarding Ms. Akerman.

On April 22, two new safety plans were prepared and signed by CPI Karger. Vanessa Akerman signed a plan specifying:

- The minor [presumably Caimile] will remain in care of the natural mother,
- Mother will follow up with all medical appointments,

- Mother will be responsible for all necessary items for the minor,
- Mother will follow rules of Alpha House, and
- The intact family worker would monitor the plan.

The second plan contained the signatures of Ms. Akerman, Mr. Seaberg, and Ms. Myer:

- Child [presumably LaKeshia] will be released to natural father,
- Paternal grandmother will support the natural father in care of the minor,
- Father will follow up with all medical appointments along with therapies,
- Mother will play active role in minor's care,
- Father will be responsible for all necessary items for the minor (clothing, food, etc.), and
- Mother has agreed to allow the child to be released to natural father.

Domestic violence was never addressed in the DCP investigation. Mr. Karger told OIG investigators that Ms. Akerman told him Mr. Palmer, her boyfriend, had threatened to harm her before but had never harmed LaKeshia. Mr. Karger also said that a police detective told him the police had been out to the home previously and that there were domestic problems. Mr. Karger cited Ms. Akerman's cooperation and her freedom from Mr. Palmer because he was in jail as mitigating factors in the case.

A criminal background check of Carl Palmer in the DCP investigation revealed an order of protection and one arrest for Domestic Battery. Ms. Akerman had requested the order of protection for herself, Caimile, and LaKeshia. The order was issued February 1, 2002, and expired February 22, 2002. There was no documentation in the DCP investigation to indicate whether Mr. Karger spoke with Ms. Akerman about the protective order. In the OIG interview, Mr. Karger did not recall if he spoke with Ms. Akerman about the protective order.¹⁰ During the OIG investigation Mr. Karger resigned.

Three days before Mr. Palmer injured LaKeshia, he was arrested for Domestic Battery. A police report was not in the DCP investigation. According to the police report, which OIG staff procured, Ms. Akerman was the victim and the arrest occurred at the same residence as LaKeshia's injury. Ms. Akerman explained to police that she and Mr. Palmer had been arguing all day and he "got mad and hit her, and pushed her in the face with his hand." Ms. Akerman refused medical attention but was tendered a domestic violence packet.

On May 16, 2002, Mr. Karger and a supervisor¹¹ indicated Carl Palmer for Head Injuries (allegation #2) to LaKeshia and Substantial Risk of Physical Harm (#10) to Caimile. Vanessa Akerman was indicated for Substantial Risk of Physical Harm (#10) to LaKeshia because she "failed to follow through with aftercare plan of involved minor after minor was being discharged from the hospital." A family case was opened for intact family services.

DCFS Intact Family Services

When the Akerman family case was handed off from CPI Karger to intact family worker Sue Braham and her supervisor Kathy Perez on April 24, 2002, Vanessa Akerman had moved to Alpha House, which offers a community living arrangement for persons who are homeless or on the verge of being homeless. Caimile was expected to join her mother there.¹² The intact record indicated that DCFS staff expected the housing program to assist Ms. Akerman with obtaining permanent housing, employment, and domestic violence counseling. The intact supervisor noted the history of domestic violence. Ms. Braham was to follow up on the status of LaKeshia's therapies, begin assessment of the family's needs, check on the status of a mental health assessment of the mother, and ensure that Mr. Palmer had no contact with LaKeshia if he was released from jail. Ms. Braham also received a schedule from her supervisor, Ms. Perez, for paperwork completion (CERAP, social history, service plan, etc.).

On May 1, Ms. Perez and CPI Karger made a transitional visit with Ms. Akerman and Caimile at Alpha House, where Ms. Perez explained the intact family program. The director of Alpha House described their services, which included a room, food, transportation to appointments, and some clothing. The director stated that she had made an unsuccessful attempt to arrange counseling but would try another agency where Ms. Akerman was to begin parenting classes. Caimile was sitting on her mother's lap drinking juice and Ms. Perez noted she appeared happy and bonded to her mother.

On the same day, Ms. Perez and CPI Karger visited LaKeshia at the father's address. Mr. Seaberg reported that LaKeshia required fluid to be drained from her head, which was bandaged, but she had not had any seizures since she was hospitalized. He reported she received daily physical therapy, occupational therapy twice a week, and speech therapy once a week. Mr. Seaberg said he wanted LaKeshia to remain with him permanently. He shared care of LaKeshia with his mother. Mr. Seaberg worked nights at a fast food restaurant and reported that he expected to become an assistant manager.

May 2002

During the first 30 days of intact family services, Ms. Braham, intact family worker, visited both children weekly. Mr. Seaberg reported he had quit his job to spend more time helping his mother take care of LaKeshia. He provided updates on LaKeshia's therapies and medical appointments, again reiterating his desire to keep his daughter. LaKeshia's mother visited LaKeshia for the first time in a month on Memorial Day (May 27) at Mr. Seaberg's residence.

Ms. Braham spoke with the Alpha House director during each visit about Ms. Akerman's progress. The Alpha House director reported the mother was attending parenting classes and counseling sessions. The director also told Ms. Braham that she suspected Ms. Akerman was a "habitual liar." On May 21, the director reported that Ms. Akerman had left her daughter with her roommate several times in the past week, adding that the roommate did not like Caimile. There is no evidence in the case file that Ms. Braham conducted a CANTS or LEADS check on the roommate who babysat Caimile. Ms. Braham followed up on the director's concern that Caimile had an extensive diaper rash, but Ms. Braham did not see anything when she checked the child.

On May 17, Ms. Braham spoke with a former employee from another shelter. He stated he knew Ms. Akerman "very well" and described her as a "prolific liar" and someone who would benefit from a psychiatric evaluation. He noted that she had often left Caimile at the shelter and stayed away overnight. He said that Caimile "was often chafed, suffering from diaper rash, and that it was pretty bad."

Ms. Braham confronted Ms. Akerman regarding her explanation as to why she had not visited LaKeshia: Ms. Myer, grandmother, would not allow a weekend overnight visit and LaKeshia had asthma and could not be out in rainy weather. When the worker questioned the father he denied Ms. Akerman's claims. During one visit Ms. Akerman told the worker she was upset because she had not agreed to LaKeshia's discharge from the hospital to her father. Ms. Braham followed up with the hospital social worker who stated that Ms. Akerman's claim was not true. The social worker reported the hospital staff's concerns about Ms. Akerman's ability to care for LaKeshia, the mother's expectation that nursing staff would meet all of the infant's needs, and that Ms. Akerman was confronted on more than one occasion about her apathy towards properly caring for LaKeshia.

All parties signed a new safety plan on May 30, stating that LaKeshia would continue to live with her father for the next three months, after which another evaluation would determine if the plan would be extended.

June 2002

A 30-day family conference to discuss the Client Service Plan took place on June 12. The meeting was attended by Vanessa and Caimile Akerman, Jacob Seaberg, and Betty Myer as well as Ms. Braham and Ms. Perez from DCFS and the director from Alpha House. The Client Service Plan listed Mr. Seaberg's tasks as:

- Provide a safe, stable, and nurturing environment for LaKeshia,
- Ensure all medical and in-home appointments for LaKeshia are kept,
- Ensure that LaKeshia receives her prescribed medications (Dilantin and Phenobarbitol),
- Provide the worker with copies of LaKeshia's immunization records,
- Ensure visitation is allowed between LaKeshia and her mother,
- Maintain all WIC appointments,
- Notify DCFS of any unusual incidents or changes in residence.

While not a part of the Client Service Plan, Ms. Perez noted that Mr. Seaberg was also expected to:

- Establish paternity by DNA testing (since he was not on LaKeshia's birth certificate),¹³
- Provide paternity documentation to SSI (Supplemental Security Income) in order to receive benefits for LaKeshia, and
- Compile a list of LaKeshia's therapists and contact information for the worker.

The June Client Service Plan required Ms. Akerman to:

- Continue regular visits with LaKeshia and participate in learning her proper medical care,
- Complete parenting and counseling classes,
- Complete psychological evaluation and follow all recommendations,
- Provide a safe, stable, and nurturing environment for Caimile,
- Locate suitable housing for herself and her children,
- Provide the worker with copies of both children's immunization records,
- Transfer WIC coupons for LaKeshia to Mr. Seaberg,
- Keep all medications, etc. out of reach of children, and
- Notify DCFS of any unusual incidents or changes in residence.

After the meeting Ms. Braham accompanied the parents to a nearby WIC office to transfer WIC coupons to Mr. Seaberg.

Although Ms. Braham knew Ms. Akerman had been a ward and her oldest child, Javonte, was not in her custody, Ms. Braham did not contact Ms. Akerman's previous service providers or request Department records on Ms. Akerman for review. Ms. Braham had undocumented contacts with Javonte's guardians about Ms. Akerman. Ms. Braham reported to Ms. Perez, in a June 26 supervision meeting, that Javonte had been "adopted" by a non-relative family and that family confirmed that Ms. Akerman had another girl who died of crib death.

From June to August, Ms. Braham saw Caimile four times (see Table 1). Ms. Braham saw Caimile once in June at the 30-day family conference. Although she made two attempts, Ms. Braham did not see Caimile again until a month later on July 18. She saw Caimile again the following week but then did not see her for another month, until August 29. Ms. Braham usually noted that Caimile was well dressed and showed no signs of abuse or neglect.

Table 1: Summary of Ms. Braham’s observations of Caimile and LaKeshia.

2002	Caimile		LaKeshia	
	Visits	Attempted*	Visits	Attempted*
May	5	1	5	0
June	1 (in office)	2	2	0
July	2	1	2	0
August	1	2	3	0
September	1	1	1	0
October	4 (1 in office)	0	4	0
November	1	1	2	1
December (before 12/20)	1	1	1	0
Total (in 8 ½ mo)	16	9	20	1

* No worker visits are recorded as unannounced; Ms. Braham told OIG staff that she made both announced and unannounced visits.

Family Social History

A June 7, 2002 Social History completed on the Akerman family indicated that Vanessa Akerman was 22 years old, and dropped out of school after ninth grade. Her mother was addicted to heroin and crack cocaine. Vanessa Akerman did not know anything about her natural father but maintained a relationship with her stepfather. Collateral contacts indicated that Ms. Akerman had experienced sexual and physical abuse, neglect, and abandonment.

Vanessa Akerman had four children. She was 16 years old when her oldest, Javonte, was born. His guardians reported that Ms. Akerman had another daughter who died of crib death. Name, date of birth, and date of death of this child were not recorded in the case file and there was no record of anyone questioning Ms. Akerman about her second child. Ms. Braham told OIG investigators that Ms. Akerman said the baby died of SIDS but wouldn’t provide any other information.

According to Ms. Akerman, she met the fathers of Caimile and LaKeshia (her two youngest daughters) while living in a transitional housing program. She has since lived in homeless shelters with her daughters in three different towns. Ms. Akerman reported that Carl Palmer hated LaKeshia’s father, Jacob Seaberg, and Mr. Palmer threatened to kill or harm LaKeshia even during pregnancy. The social history noted, “on more than one occasion, [Ms. Akerman] was involved in domestic abuse incidents with Mr. Palmer and the police were called to their residence.”¹⁴ Ms. Akerman told the worker she was on two years’ probation following an arrest for theft.¹⁵

Ms. Akerman acknowledged that she needed parenting training for LaKeshia’s special needs and was willing to do whatever was necessary to have LaKeshia returned to her. She stated that she loved her daughter and wanted to provide a home for her as soon as she was financially able. During the open intact case, the worker did not observe Ms. Akerman with LaKeshia. Ms. Braham documented her observation that 21-month-old Caimile and her mother appeared to have a loving bond. Ms. Braham identified Ms. Akerman’s strengths as her good judgment in allowing LaKeshia to live with her father, where she could receive consistent care. Ms. Akerman’s weakness was identified as staying with an abusive paramour who had previously threatened to harm her child.

Ms. Akerman attended parenting and counseling classes. A June 30, 2002 letter from the agency confirmed that Ms. Akerman completed all ten sessions of Family Reunification Group. The group facilitators reported that Ms. Akerman completed all assignments, attended group and counseling sessions, and had shown signs of enhanced parenting skills. Their recommendations were for Ms.

Akerman to procure housing, childcare, employment, and continue individual counseling as a form of support. In a June 27, 2002 letter, her therapist wrote that after 12 sessions he concluded that Ms. Akerman was “capable of parenting her daughter without any reservation.” In an interview with OIG staff, her therapist reported that he only observed Ms. Akerman with Caimile but was aware of LaKeshia’s injuries and her special care needs.

According to the Social History, 22-year-old Mr. Seaberg graduated from high school in 1997 and attended one year of college. He met Ms. Akerman during a brief stay at a shelter where he lived at age 19, during a period when he did not get along with his mother. Mr. Seaberg hoped to have his daughter live with him permanently. He quit his job as a manager at a fast food establishment in order to stay home with his daughter. Mr. Seaberg relied on his mother and stepfather for support and LaKeshia’s care.

July – August 2002

LaKeshia was scheduled for eye surgery on July 2, 2002. Hospital staff contacted Ms. Braham that day to verify whether Mr. Seaberg was eligible to sign consent papers regarding the surgery. Ms. Braham faxed a copy of the safety plan to the hospital and LaKeshia had the surgery.

In a psychological evaluation referral, Ms. Braham wrote Vanessa Akerman “doesn’t seem to know how to set boundaries, or when to use good judgment, to ensure that her children are free from risk of harm or safety issues.” Ms. Braham requested the evaluation “as part of an ongoing assessment which will determine [NM’s] ability to care for a special needs child.” She noted Ms. Akerman had lived only in shelters in the past seven years and that collateral contacts referred to Ms. Akerman as a “prolific liar.” The psychological evaluation¹⁶ diagnosed Ms. Akerman as having Major Depressive Disorder (Recurrent) and Borderline Personality Disorder (Provisional) and recommended:

- Visitation arrangements continue because “this client does not possess the skills and emotional flexibility to provide competent care for this special needs child at present;”
- Individual psychotherapy is “essential to resolve early developmental trauma and rather long standing depressive disorder” by a “nurturant” [*sic*] psychotherapist “with expertise in working with the characterologically [*sic*] disorder and highly resistant young adult;”
- Maintaining contact with minor child and taking classes regarding the long-term impact of her injuries and the realistic expectations needed by the caretaker; and
- Domestic violence counseling.

In August 2002, there were various reports of problems regarding Ms. Akerman’s level of cooperation. She did not show up for an appointment with Mr. Seaberg to transfer WIC coupons, her whereabouts were unknown from at least August 16 through 21, and she was asked to vacate Alpha House because she had been inconsistent paying her rent and was suspected of stealing from her roommate.¹⁷ Ms. Myer also reported difficulty getting LaKeshia’s anti-seizure medication prescriptions filled because Ms. Akerman had not changed LaKeshia’s medical card from HMO to Medicaid. When the worker said she would check into the problem, Ms. Akerman claimed she had applied for the change in medical coverage. Ms. Myer stated that she felt Ms. Akerman was “really not interested in taking care of her child.”¹⁸ Ms. Myer compiled a list of Ms. Akerman’s visits (see Table 2) and noted that Ms. Akerman had only visited with LaKeshia once during therapy. Ms. Myer wrote that Ms. Akerman, “has never given [LaKeshia] a bath, fed her, or changed a diaper in all of her visits. She never asks if she needs anything.”

Table 2: Ms. Myer’s recollections of Ms. Akerman’s visits to see LaKeshia as of August 26, 2002.

Month	No. of visits	Comments
May	2	One 15-minute visit and one five-hour visit.
June	2	Did not visit when LaKeshia had surgery on June 5. Called on June 16 to see how the surgery went.
July	None noted	
August	3	As of August 26.

On August 27, Ms. Perez and DCFS Field Service Manager Tina Gable staffed the Akerman case. The safety plan was scheduled to expire on August 30. Ms. Gable did not believe LaKeshia should be returned to her natural mother at that time. While Caimile remained with Ms. Akerman, she was to be included in the safety plan. Ms. Gable suggested completing a CERAP and extending the safety plan. The following tasks were to be incorporated into the safety plan and Client Service Plan:

- (1) Regarding LaKeshia, Ms. Akerman was to:
 - Assist and participate with the specialists,
 - Attend medical appointments,
 - Gain an understanding of her medication,
 - Visit consistently, and
 - Participate in domestic violence counseling.
- (2) Caimile was not to be supervised by anyone who displayed violent behavior as identified by the mother's admission as well as CANTS/LEADS checks.
- (3) The worker was instructed to make case referrals to Clinical Division and Nursing.
- (4) The worker should monitor the children at home weekly (see Table 1 for actual visits).

Ms. Gable stated that if Ms. Akerman was resistant, the case was to be screened with the Assistant State's Attorney. Ms. Braham was to assess Caimile's safety every five working days. The updated Client Service Plan also incorporated recommendations that Ms. Akerman participate in intensive therapy and complete parenting classes for a special needs child.

Ms. Braham visited both families separately on August 29, and reviewed the new safety plan. Mr. Seaberg and Ms. Myer, grandmother, signed the plan that day and Ms. Akerman signed the plan on September 12. Both girls appeared well cared for. Ms. Akerman stated she was not in agreement with the Safety Plan, did not require domestic violence counseling or therapeutic counseling but agreed to cooperate. When Ms. Myer told Ms. Braham she was seeking legal counseling for custody of her granddaughter, Ms. Braham advised her to delay Probate Court proceedings until DCFS no longer had an open case.

Ms. Braham did not attempt to screen the case when Ms. Akerman refused to cooperate, by not attending therapeutic counseling or informing the caseworker of Caimile's whereabouts, as instructed by the Field Service Manager. Ms. Braham told OIG investigators that Ms. Akerman cooperated with Alpha House implemented services, but the services were "light weight" and the "mother put on a good act." Ms. Braham did not agree with the June counseling assessment, concluding that Ms. Akerman "was capable of parenting her daughter without any reservation."

September – November 2002

In a supervision meeting with Ms. Perez on September 11, Ms. Braham reported that Vanessa Akerman expected to move to a shelter in another town. Ms. Perez assigned Ms. Braham the following tasks:

- Contact therapists regarding status and progress,

- Follow-up on LaKeshia's immunization updates and request updated immunization record,
- Continue to work with mother around housing,
- Make all necessary referrals for services once mother is more stable,
- Complete nursing and clinical referrals,
- Refer mother for individual therapy, and
- Continue monitoring family to ensure safety, health, and well being of the children.

During a September 12 visit, Ms. Akerman told Ms. Braham that she would not complete paperwork voluntarily stating Mr. Seaberg was LaKeshia's father. Ms. Braham stated her attorney advised her that Mr. Seaberg would be called into court regarding child support and she should not complete paperwork regarding his paternity. Ms. Akerman stated that she had applied for Section 8 housing in January 2001 but was told the wait was from two to five years. Ms. Braham explained to OIG staff that Ms. Akerman was not eligible for a Norman Funds Grant because she had no means of further supporting housing costs. Ms. Akerman stated that she was scheduled to move to the other shelter, with transportation from Alpha House, on September 17. Ms. Braham called the shelter the following day and discovered that Ms. Akerman was not on its waiting list. Ms. Braham reported Ms. Akerman's lack of housing to the owner of Alpha House and a relative of Alpha House's Director. Ms. Braham and the owner also spoke about Ms. Akerman's visit to a Legal Aid Clinic. The owner said Ms. Akerman wanted overnight visits with LaKeshia and child support from Mr. Seaberg.

During a visit to see LaKeshia, Ms. Braham learned that the father and grandmother continued to experience difficulties getting the needed range of medical care for LaKeshia because of Ms. Akerman's HMO insurance coverage. Four months had passed since the family asked Ms. Akerman to change her coverage to Medicaid. At that time, Ms. Akerman reported it would take up to 72 days for Medicaid to start. Mr. Seaberg was scheduled to take LaKeshia to the WIC office to update her immunizations.

Ms. Braham visited Alpha House on September 17, the day Ms. Akerman was scheduled to move, however no one had seen Ms. Akerman since the previous evening. Ms. Akerman's roommate claimed that Ms. Akerman stole her TANF grant money (Temporary Assistance for Needy Families) and her food stamps. She filed a police report; however, the police did not think anything could be done since she had given Ms. Akerman the code for her LINK card. The roommate also reported to Alpha House's Director and Ms. Braham that Ms. Akerman had been having an affair with one of the male employees of Alpha House. While Ms. Braham was at the shelter, Mr. Seaberg contacted the shelter for an address because he wanted to send a court summons to Ms. Akerman regarding paternity of LaKeshia.

On September 20, Ms. Akerman and Caimile moved to a homeless shelter. Shelter staff contacted Ms. Braham on September 23. Ms. Akerman gave shelter staff a copy of the old safety plan and gave permission for Ms. Braham to provide them copies of the new safety plan, service plan, and social history. Shelter staff provided Ms. Akerman with carfare to visit LaKeshia every day during the first week; however, Ms. Myer reported that Ms. Akerman never visited LaKeshia in September.

On October 1, Ms. Braham met with Ms. Akerman, her shelter case manager and Program Director. Ms. Braham raised questions about Ms. Akerman's alleged visits to the Myer home, the accusations of theft at her former shelter, and her visit to Legal Aid. Ms. Akerman initially insisted she visited with LaKeshia. She also stated that she had not done anything wrong and wanted LaKeshia returned to her care. Ms. Akerman eventually admitted that she had agreed to allow LaKeshia to live with the paternal grandmother until she "got herself together." Ms. Akerman told shelter staff that Ms. Braham had not provided any services. Ms. Braham explained that she held off making a therapy referral until Ms. Akerman found stable housing. Since she was now at a shelter, Ms. Braham planned to refer Ms. Akerman for an intake

appointment. According to Ms. Braham, Ms. Akerman was agitated because she was being asked to complete tasks stating, “I didn’t do anything.”

In early October, Ms. Myer received the first Supplemental Security Income (SSI) check payable to her. LaKeshia was to receive a medical card through SSI and the Department of Human Services (DHS) was to adjust Ms. Akerman’s grant beneficiaries. Ms. Akerman reported her TANF funds had been sanctioned because she missed a nutrition class.

During an October 10 home visit by Ms. Braham, Ms. Myer reported that 10-month-old LaKeshia had a new occupational therapist through early intervention services. The occupational therapist was scheduled to provide in-home services for at least six months.¹⁹ LaKeshia’s progress included sitting upright in a high chair.

After approximately three weeks at the new shelter, Ms. Akerman moved to another shelter because of crowding. Ms. Braham visited her there on the morning of Thursday, October 17. Ms. Braham described Caimile as “adjusting to her new environment; she was dressed in night clothing, and clung to her mother, obviously still sleepy.” Ms. Akerman stated she had plans to see LaKeshia that week. In the afternoon, Ms. Braham visited LaKeshia. Ms. Myer reported that LaKeshia now had developmental, occupational, physical, and speech therapy sessions and the schedule was almost daily. Ms. Myer reported that although Ms. Akerman told her she would be out to see LaKeshia on Wednesday, October 16, she neither came nor called. Ms. Myer also reported having to pay for LaKeshia’s medication because the medical card had not yet been transferred to Ms. Myer. Requests of Ms. Akerman to call DHS had not elicited any change. A DHS representative phoned the pharmacy authorizing reimbursement to Ms. Myer.

Between late September and early November 2002, Ms. Braham conducted three reviews of Client Service Plan goals. LaKeshia’s father, Jacob Seaberg, achieved satisfactory ratings on all assigned tasks. Ms. Braham rated Ms. Akerman’s progress as unsatisfactory regarding the following tasks concerning LaKeshia: learning proper medical care, administering medication, and attending medical appointments. Regarding Caimile, Ms. Akerman failed to locate housing, provide a stable environment, or produce immunization records. Ms. Akerman also did not attend therapy, domestic violence classes, or parenting classes for a special needs child.

Ms. Braham rated Ms. Akerman’s progress as satisfactory regarding transferring LaKeshia’s WIC coupons, notifying DCFS of unusual incidents or changes in address, and keeping dangerous items out of the reach of children. Ms. Akerman also successfully completing parenting classes, counseling classes, and a psychological evaluation.

Ms. Braham rated Ms. Akerman’s performance as “Unsatisfactory” on tasks for which Ms. Braham never made a referral (domestic violence classes and parenting classes for a special needs child). On the same service plan Ms. Braham rated herself as having done a “Satisfactory” job providing the parents with referrals for services. In an interview with OIG staff, Ms. Braham stated that because it was difficult to get Ms. Akerman to follow through on tasks, Ms. Braham focused on obtaining a psychological evaluation and pursuing one of three recommended services (obtaining individual therapy and not domestic violence classes or specialized parenting classes).

There was a clinical staffing on the family on October 23, 2002. In attendance were Ms. Akerman, Caimile, Ms. Myer, IFS worker Sue Braham, IFS supervisor Kathy Perez, and an employee from DCFS Clinical Services. Ms. Akerman was asked to prioritize time with her daughter. The issues identified at the staffing included tasks for Ms. Akerman:

- Make at least once weekly visits to see LaKeshia (the DCFS Clinical Services employee offered to check on availability of another shelter to make visits easier);
- Participate in LaKeshia's therapy sessions, which occur almost daily (Ms. Myer wrote down therapy schedule);
- Call the toll free number to get another medical card sent to Ms. Myer (who was currently receiving SSI benefits for LaKeshia); and
- Participate in therapy (Ms. Akerman claimed she couldn't find the building for therapy).²⁰

Furthermore, as part of concurrent planning, DCFS Clinical suggested that Ms. Myer get her foster parent license. After the staffing ended, Ms. Akerman accompanied Ms. Myer for her first visit with LaKeshia in nearly two months. A status clinical staffing was scheduled for December 4. Ms. Perez explained to OIG staff that the outcome of the clinical staffing was to give Ms. Akerman another chance. However, Ms. Akerman was informed her case would be screened into court if she did not comply with the assigned tasks.

Ms. Myer provided Ms. Akerman with a schedule of LaKeshia's therapies and brought her home to visit LaKeshia after the clinical staffing. According to Ms. Myer, Ms. Akerman observed a speech therapy session with LaKeshia but had little direct interaction with her daughter. The following day Ms. Myer told Ms. Braham that "Caimile...was wearing a soiled diaper with a strong, foul order" and Ms. Akerman had to be reminded to change the diaper before leaving the home.

Ms. Braham worked on the medical card issue and Ms. Myer received a medical card from the Department of Public Aid on November 1. However, Ms. Myer reported problems regarding consent for treatment at a doctor's appointment for LaKeshia on November 2 because Mr. Seaberg still had not established paternity. Ms. Braham had referred Ms. Myer for licensure, but she was turned down because the child's father still lived in the home. An updated Client Service Plan, dated November 1, noted that Mr. Seaberg assisted his mother with LaKeshia but did not reside with her. Ms. Myer was no longer working because of the amount of home therapy LaKeshia required. Ms. Akerman had not complied with the terms of the safety plan and was rated as making unsatisfactory progress since implementation of the plan in August.

In a supervision meeting on November 6 with Ms. Perez, Ms. Braham reported that Alpha House staff informed her that Ms. Akerman was "expected to marry a male who is a former employee at Alpha House." Also that "the adult male, name unknown at this time has been observed as being abusive to minor Caimile." Ms. Braham was instructed to follow-up with Ms. Akerman on: (1) An assessment to receive intensive therapy, (2) Caimile's immunization record, (3) involvement and cooperation in services. Ms. Braham was instructed to continue to ensure the safety of the children and assess the needs of the family. There is no evidence from the record regarding any follow-up about the potentially abusive adult male involved with the family or if the Child Abuse Hotline was called.

Ms. Braham saw both children the following day, November 7, 2002. Ms. Myer reported that the new medical card would expire the following week and she had not heard from Ms. Akerman. Ms. Akerman visited LaKeshia for her birthday on November 16. Also in November, Ms. Akerman moved twice to new shelters (her fourth and fifth since April) and was reported to be uncooperative with service providers. On November 20, Ms. Akerman told Ms. Braham she left Caimile with a sitter while working at a telemarketing firm for the previous two weeks; however, she gave Ms. Braham an inaccurate phone number for the sitter. On November 22, Ms. Akerman's case manager at the Shelter told Ms. Braham that she had only seen Ms. Akerman once in the two weeks since her check-in date and that meeting took place because Ms. Akerman received a notice of discipline. The shelter case manager reported that Ms. Akerman gave improbable information regarding employment and reported that Caimile was in a day care

center during her working hours. The shelter case manager would not provide any additional information without consent for release of information from Ms. Akerman. No further information was provided regarding Caimile's whereabouts during Ms. Akerman's absence from the shelter. There is no evidence Ms. Braham obtained a consent for release of information from Ms. Akerman.

Ms. Braham was required to complete a past due six month CERAP, current service plan, and social assessment for submission to her supervisor by December 6.

December 2002

Ms. Braham visited the Shelter on December 3, 2002. Vanessa Akerman was not there but Ms. Braham met with the shelter case manager. Although their conversation was restricted since Ms. Akerman had not signed the shelter's consent for release of information, the shelter case manager reported that Ms. Akerman was under suspicion for having stold money from a staff member's office and required prompting to change her daughter's diaper when her pants were soaked. Also, Ms. Akerman had requested carfare to see her "mentally ill" daughter. The case manager agreed to remind Ms. Akerman about the clinical staffing scheduled for the following day.

The second clinical staffing was held on December 4 with Ms. Myer, Ms. Braham, Ms. Perez, and two DCFS clinical staff. Ms. Akerman called to say she did not have carfare and was therefore not in attendance. The purpose of the staffing was to determine if Ms. Akerman had followed through with any service plan tasks pertaining mainly to LaKeshia. Clinical's summary noted Vanessa Akerman had not:

- participated weekly in LaKeshia's therapies as agreed (she had only seen LaKeshia once since the last clinical staffing),
- facilitated the medical card change over to Ms. Myer as agreed, and
- followed through with referral for individual counseling (individual psychotherapy and domestic violence counseling that were recommended after a psychological evaluation diagnosed her with Major Depressive Disorder and Borderline Personality).

Furthermore, Ms. Akerman:

- claimed to be leaving her two-year-old daughter with a sitter but would not give information to caseworker,
- was without stable housing and was moving between shelters,
- had a history of making poor decisions regarding individuals caring for her children (her youngest daughter was severely abused by one of these caretakers), and
- her present paramour reportedly does not like two-year-old Caimile (according to Ms. Braham).

Ms. Akerman was reported to have visited LaKeshia only once in seven weeks, had not participated in any of LaKeshia's therapy appointment, and refused to sign paternity papers. Ms. Braham described Ms. Akerman as having made no progress since the first clinical staffing, i.e., she had not achieved a stable housing situation and she had yet to follow up with referrals. DCFS clinical and management decided that the case would be screened into Juvenile Court with a possible screening date of December 6. Efforts were noted to be underway to find a relative placement for Caimile.

Mr. Seaberg had not taken a paternity test, was unemployed and received unemployment. His mother noted that he was immature but ready to assume full responsibility for his daughter. Ms. Myer also expressed interest in adopting LaKeshia.

Ms. Braham, intact family worker, completed a CERAP dated December 11 in which the worker determined the children were unsafe, noting:

To date, Ms. Akerman has not attended a [counseling] session and has not complied with the terms of the safety plan, due to expire 12/31/02. Worker will follow the recommendation of DCFS Clinical, and present this case to the State's Attorney, no later than 12/18/02.

Ms. Braham saw Ms. Akerman on December 10, gave her a bus pass voucher and told her about her intent to screen the children's cases into Juvenile Court. Ms. Akerman told Ms. Braham that she was scheduled for job training on December 16 through DHS and would take Caimile to day care. Ms. Braham did not record any further information about the day care name or location or the job training location. The shelter case manager told Ms. Braham that she was surprised to see Caimile so clean and well dressed and that it must be because DCFS was visiting. The shelter case manager also stated she would try and get Ms. Akerman to sign a consent because she would really like to speak with Ms. Braham.

Ms. Akerman was not at the shelter from December 16 through the 19 (Monday to Thursday). It does not appear that Ms. Braham was aware of Ms. Akerman's absence and on December 20 she screened the case with an Assistant State's Attorney (ASA). The ASA and his supervisor agreed that Caimile's case warranted screening but requested a meeting with DCP worker Mr. Karger in order to gather more evidence.²¹

Ms. Braham screened the case more than two weeks after being instructed to do so. Her supervisor, Ms. Perez, told OIG investigators she did not follow-up with Ms. Braham on her efforts to screen the Akerman case. Ms. Braham told OIG investigators there were a number of factors in moving the case to screening: there was a lot going on with her other cases, she hadn't screened a case in a "long time," she had to ask DCP staff about the procedure, and there was "lots of paperwork involved [in screening]."

Sue Braham told OIG investigators she believed Ms. Akerman's situation was never stable. Ms. Braham described her attempts to get Ms. Akerman to comply with services as a "cat and mouse game," stating that she did not pursue domestic violence counseling because she was trying to get Ms. Akerman to participate in a psychological evaluation and that Ms. Akerman would choose to make herself unavailable for services.

Second child abuse investigation ("B" sequence)

On December 20, the hotline was called by a hospital to report that Caimile Akerman had burns and bruises. The Emergency Room physician explained Caimile's injuries to the Child Protection Investigator (CPI) as:

- Abrasion to the right chest that looked about a week old;
- Rash in the perineal area that appeared to come from a consistent diaper rash;
- Second degree burns on the tops of her feet, up her legs, and under her calf - burns appeared to be hot liquid or splash burns;
- Linear bruise on buttock;
- Looked like she was hit with a straight hanger; and
- Bruising on her thighs that appeared to come from blunt trauma.

A pediatrician at a children's hospital informed the CPI she was a child abuse specialist. She reported that Caimile had burns and sores on the perineum²² and the burns looked like splash marks. The burns on the

top of her feet appeared to be 24 hours old. There were no burns on the bottom of her feet. She had burns and open lesions on her buttock that appeared to come from being whipped with a switch. She also had burns on her thighs and legs. All of the burns appeared to be second degree. She had a bruise on her chest and an abrasion on her shoulder.²³

According to the CPI's notes, Vanessa Akerman's version of what occurred was as follows: She took Caimile to day care on Monday.²⁴ The day care provider told Ms. Akerman she could not bring Caimile back until she finished her application and provided her school schedule (the day care provider told the CPI that Caimile had no marks on Monday – the provider thought she would have noticed if there had been marks because Caimile's clothes smelled and the provider removed and washed them. She was certain Caimile was well). Ms. Akerman stated she asked her boyfriend Ronald Lucas²⁵ to watch Caimile while she went to school on Tuesday. At the time, Mr. Lucas was separated from his wife and three children and living with his aunt. Ms. Akerman called Mr. Lucas at 1:00 p.m. to check on Caimile. She stated he told her Caimile had diarrhea and "shit all over everything" and "you might be mad at me because I whooped her with a belt for shitting everywhere and playing in it." He said she only had a little mark on her thigh from the belt. She called him again at 3:30 p.m. and he told her that Caimile was in the bath. When Ms. Akerman returned to the home, she saw that Caimile had a large scar on her thigh and "some big bubble things on her ankles and feet." She stated that she wanted to take Caimile to the hospital but Mr. Lucas told her she would get into trouble. She stayed with Mr. Lucas Tuesday and Wednesday night and he returned her to the shelter on Thursday evening.

According to the shelter case manager, Ms. Akerman left the shelter on Monday and brought Caimile back on Thursday evening around 8:20 p.m. She told night shelter staff that Caimile had an allergic reaction to some medication for a rash. The shelter case manager believed the night staff did not see Caimile's injury. On Friday morning (December 20), Caimile was fully dressed in snowsuit and shoes when the case manager noticed women in a circle in the hallway. She went to investigate and found that Ms. Akerman had taken off Caimile's shoes and socks and the case manager saw the burns. Ms. Akerman showed her some cream and stated that Caimile had an allergic reaction to the cream she received from a doctor for a rash. The case manager did not see the name of the cream but thought it was an over the counter product.

Ms. Braham explained the case status to the CPI, stating that she had been at court that morning attempting to screen the case but the ASA required a meeting with 'A' sequence investigator Warren Karger. Ms. Braham also told the worker that although LaKeshia was supposed to be living with her father, she lived with her paternal grandmother and Mr. Seaberg lived with his aunt. Mr. Seaberg went over to his mother's house frequently to help with LaKeshia's care. On December 23, 2002, a second CPI assessed Ms. Myer's home regarding LaKeshia's care and documented the home was appropriate and Ms. Myer appeared to be a good caretaker for LaKeshia.

The CPI called Mr. Lucas' aunt and spoke with Mr. Lucas' cousin. The cousin stated that she lived in the home, Ronald is her cousin, and that he just started living there "not too long ago." In a later interview she stated that Ms. Akerman and her daughter stayed in the house but Ms. Akerman "used to just lie around and she wouldn't even feed or see to the little girl." The cousin said that "the girl's mama is real trifling; she use to let the little girl doo doo all over herself and she won't even clean her up." The cousin knew Mr. Lucas had watched the girl while Ms. Akerman went to school one day but she was not at home and didn't know what happened.

The CPI took Protective Custody of Caimile and LaKeshia on December 27, 2002. DCFS was awarded temporary custody of the children on December 30, 2002. The judge ordered paternity tests for Caimile and LaKeshia at a January 6, 2003, court hearing.²⁶

The police arrested Vanessa Akerman on December 20 and Ronald Lucas on December 23. The Police Detective told the CPI “Ronald Lucas was charged with Domestic Battery after he confessed to whipping Caimile with a belt and giving her a bath after she defecated on herself.” The Detective reported Mr. Lucas stated he did not try to burn Caimile.

Mr. Lucas and Ms. Akerman’s cases were tried in Domestic Violence court. Ms. Akerman plead guilty to Contributing to Neglect of a Child and was sentenced to two years of conditional discharge on May 15, 2003. The court also sent her to a parenting program and issued an order of protection prohibiting Ms. Akerman from abusing Caimile. Mr. Lucas was found guilty on one count of Domestic Battery and sentenced to 90 days imprisonment and two years conditional discharge in September 2003. The court issued an order of protection prohibiting Mr. Lucas from abusing Caimile or being in the same household with her.

DCFS indicated Ms. Akerman for Burns (Second Degree); Cuts, Bruises, Welts, Abrasions and Oral Injuries; Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare; and Medical Neglect. Ronald Lucas was indicated for Burns (Second Degree); and Cuts, Bruises, Welts, Abrasions and Oral Injuries.²⁷ DCFS opened placement cases on Caimile and LaKeshia.

Field Service Manager Tina Gable

Early in the intact case, the child protection supervisor had emailed Ms. Gable explaining the family would require “long-term intact services.” OIG staff interviewed Field Service Manager Tina Gable about the appropriateness of the Akerman case for intact family services. Ms. Gable said that Ms. Akerman’s statement of paternity and Mr. Seaberg’s agreement was sufficient to place LaKeshia with her father. Split cases were common and intact family could service a case even if the child was not with a parent but with a relative. The goal was to reunite the mother and child. Ms. Gable said intact family could service high-risk cases because the court expects reasonable efforts to work with a family to prevent placement. Ms. Gable agreed that the worker should get the history of a parent when he or she is a former ward, noting that Ms. Braham did get Ms. Akerman’s history through collaterals although not through DCFS. Ms. Gable suggested a referral for a clinical staffing to the intact family supervisor, however Ms. Gable told OIG staff that Department clinical staff do not provide caseworkers with recommendations.

Child Protection Investigator Warren Karger

Warren Karger has worked at DCFS for over 7 years.²⁸ He became a Child Protection Investigator/Specialist in August 2000. Mr. Karger has worked on four different DCP teams and has had at least that many supervisors. His annual reviews since moving to DCP have been below average.

Conflict of Interest

Mr. Karger knew Jacob Seaberg and Vanessa Akerman prior to his assignment to investigate LaKeshia Akerman’s injuries. Mr. Karger told OIG investigators he met them when he was involved with a homeless shelter for young adults. Mr. Karger would not explain to OIG investigators specifics of his involvement with the program, saying only that he worked and volunteered for the program, his family made donations to the program, and that his relationship with that program was “external from DCFS.” Mr. Karger also stated that he hired Mr. Seaberg to complete odd jobs around his house (e.g. cutting grass, cleaning out the garage). Mr. Karger said that both Mr. Seaberg and Ms. Akerman, while residents of the shelter, had been to his house, although neither of them had been invited inside.

Mr. Karger told OIG investigators that he recognized the names of the parents on the CANTS 1 form and that he told his supervisor that he knew the parents. However, there is no notation in the DCP

investigation that Mr. Karger knew the parents prior to the investigation or that he informed his supervisor. His supervisor at the time informed the OIG investigators that Mr. Karger did not tell her about his previous relationship with the parents. The supervisor stated that if she had known about their prior relationship, she would have removed Mr. Karger from the case and assigned another CPI to investigate LaKeshia's injury. The supervisor also explained that avoidance of conflicts of interest extends to her as supervisor; in cases where *she* had previous contact with parties under investigation, the case would be moved to a DCP team she does not supervise.

Mr. Karger also identified, to OIG investigators, some repercussions of the conflict of interest, stating that Ms. Akerman knew where he lived and that was dangerous since he was indicating her case. Although Mr. Karger stated that, at the time, he did not think about the implications of Ms. Akerman knowing where he lived. Mr. Karger said, "I stayed neutral and [did] my job professionally and I assessed the situation based on information that I gathered at the time of doing my investigation."

Warren Karger's Performance Appraisals

Mr. Karger's supervisor at that time was temporarily supervising the team when Mr. Karger joined; she was his supervisor for a total of five months and she supervised him during the Akerman investigation. In Mr. Karger's October 2002 annual review, the supervisor described him as eager to complete work, dedicated to the clients, and working before and after his normal work schedule. When OIG staff asked her about the quality of Mr. Karger's investigative work, she explained that while he worked hard on his cases and worked well with clients, he did not always follow through on tasks and she had to work with him one on one. Reviews in his personnel file indicate Mr. Karger has difficulties with documentation. His October 2001 reviewer wrote that "It is this writer[']s opinion that the work place and timeframes for investigations is too fast for Mr. Karger." The following year, October 2002, his supervisor wrote:

This supervisor continued to work with Mr. Karger on ensuring case completeness. Mr. Karger required on-going supervision in completing assignments accurately, ensuring that all clients were seen, all reports and collaterals were contacted, and all allegations were addressed.

* * *

After working with Mr. Karger for a few months, it was becoming more apparent that there was seemingly a deficiency in comprehension and application skills, which affected Mr. Karger's ability to follow directions on task completion.

While she was a temporary supervisor of Mr. Karger's team, she was supervising a total of three investigative teams.

2003 Annual Review

Mr. Karger had not yet signed his October 2003 annual review at the time of the OIG investigation. His supervisor at that time provided the OIG staff with her portion of the review. She supervised Mr. Karger for five months, from May to October 2003.

In an interview with OIG staff, she said that Mr. Karger had problems with time management. She provided Mr. Karger with two "Directive" memorandums in August 2003.²⁹ One directive dealt with inadequate documentation of five cases including:

No documented contacts with child victims, no documented dailey [*sic*] attempts, and no document[ed] diligent efforts to locate the child victims at the onset of the investigation.

The second directive regarded non-acknowledgement of assigned cases in spite of verbal instructions and email notification to do so.

In October 2003, Mr. Karger's supervisor had a counseling session with him for "failure to cooperate with a directive to update the notes in the file" of one of his cases. "Failure to update the notes in the file has been a problem that has been addressed on numerous occasions."³⁰ According to his most recent supervisor, Mr. Karger transferred from DCFS to the Department of Corrections in June 2004, while OIG had two pending investigations on cases where Mr. Karger had been the child protection investigator.³¹

Akerman Children's Current Status

The Department closed LaKeshia's case in April 2003 and she remained with her father. Caimile has been in the same traditional foster home for a year and a half. Ms. Akerman had another child, LaAndrea Akerman, on November 19, 2003. LaAndrea was taken into protective custody on November 25 because of risk of harm ('C' sequence investigation). Ms. Akerman's history of allowing paramours to abuse her children and non-compliance with services to have her other children returned to her care supported an indicated finding of Risk of Harm. The Juvenile Court awarded temporary custody of LaAndrea to DCFS on December 1, 2003. LaAndrea and Caimile are in separate pre-adoptive traditional foster homes because Caimile's foster parent could not take another pre-adoptive placement.

Caimile's father was identified in May 2004 and the foster home agency plans to coordinate his visits with his daughter. LaAndrea's named father has not been located through diligent search. According to the caseworker, the next court date is for status on July 9; the case is at the dispositional stage. The goal for both girls is currently return home.

According to a CPI, Ms. Akerman "completed parenting classes and vocational training through the Department of Human Services." A caseworker documented that Ms. Akerman started therapy in June 2003 but "missed several appointments because of a complicated pregnancy." The caseworker also noted "Ms. Akerman resides with a friend whose children were recently returned to her from the Department and a paramour." Vanessa Akerman has continued to exhibit unstable housing and employment. She lived with her boyfriend's sister until a January 2004 altercation with her boyfriend where the police were called. Since January, she lived again with her boyfriend's sister but also lived in three different shelters. Since December 2002, Ms. Akerman has worked at two food service jobs for a total of three months. She is currently involved in parenting classes and weekly counseling. She was scheduled to start domestic violence classes in June. According to the caseworker, Ms. Akerman was referred to the Parenting Assessment Team.

ANALYSIS

LaKeshia's Father

Ms. Akerman never disputed that Mr. Seaberg was the father of LaKeshia. Even while she was pregnant with LaKeshia, Ms. Akerman's abusive paramour threatened to harm the child. Ms. Akerman described her paramour, who she believed was the father of LaKeshia's 18-month-old sister, as having a bad temper, a history of domestic violence and on "parole" for domestic violence. The police had been out to the home several times and despite a protective order Ms. Akerman reunited with her paramour, stating she stayed with him because she was homeless. She denied Mr. Seaberg contact with his daughter opting to stay with the abusive paramour.

Despite extraordinary efforts by the hospital to train Ms. Akerman, hospital staff recommended the child be released to the care of her father and paternal grandmother. Ms. Akerman had used a specially

arranged rooming-in learning opportunity to lie in bed while hospital staff cared for her injured daughter. She failed to make arrangements to get LaKeshia's discharge medication. It was hospital staffs' professional opinion that the mother did not appear interested in learning how to care for her daughter. In contrast, the hospital noted that the paternal family took every opportunity to learn how to care for the child.

Once the child was discharged, Ms. Akerman's lack of cooperation and self-centered behaviors continued to present obstacles to LaKeshia's on-going care. Although her daughter LaKeshia was placed with the child's father and paternal grandmother in April, Ms. Akerman continued to receive LaKeshia's TANF benefits. Mr. Seaberg and Ms. Myer could not fill LaKeshia's anti-seizure medication prescription or receive LaKeshia's WIC coupons. The mother's chronic disregard of LaKeshia's needs continued. Yet, the father and his mother persevered assuring that the child's special medical, occupational, physical, and speech therapy needs were met.

Two months after the child's discharge she needed eye surgery. Because the father did not have legal custody, the hospital questioned whether he could give medical consent for treatment. The next month, a psychological evaluation determined the mother did not possess the skills and emotional flexibility to provide competent care for LaKeshia. Again, the paternal family noted it was difficult to obtain the child's medication because the mother was still the legal recipient of the child's medical card. Despite the mother's patterned disregard of LaKeshia's interests, the DCFS intact worker discouraged the grandmother from attempting to secure private guardianship through probate court and discouraged the mother from completing the child support paperwork for paternity.

Both the DCFS field service manager and DCFS clinical viewed the family goal as return home to mother. Consideration of establishing and supporting the father as the primary custodian was not considered the family goal. No help was given for the father to establish paternity, gain legal custody,³² or to become the payee of the child's SSI benefits. He was treated as an outsider. Rather than working with the father, who had never harmed his child and who demonstrated the capacity and concern to meet his daughter's special physical and mental health needs, the Department worked under the premise that return to the mother was the only acceptable goal. Thus, a mother whose desires to be with an abusive man contributed to a child sustaining life threatening and permanently disabling injuries and who, after the abuse, consistently demonstrated little concern or ability to care for her medically comprised child was given preferential treatment to have the child returned to her.

Clinical staff reviewed the case twice. The father was not present at the reviews. The issue of the father's rights was never discussed. Rather than suggesting the father obtain legal custody through a protective order, clinical staff suggested the paternal grandmother get a foster parent license. The following month the grandmother attempted to become licensed but was informed by a private agency that she could not be licensed because the child's father resided with her. Subsequently, the father, who had never harmed his child and who, with his mother, took excellent care of the child, moved out of the home to reside with an aunt. It was only after Ms. Akerman's older daughter was beaten and scalded by another paramour that a child protection juvenile court protective order was obtained giving custody of LaKeshia to her father. He and his daughter live with the paternal grandmother.

The January 2004 U.S. Department of Health and Human Services Final Report, Illinois Child and Family Review, found that available fathers were not involved in case planning. In this case, although the child resided with the father, the father was not given substantive consideration or adequate services. Maintaining a one-dimensional focus of reuniting with a mother her child while ignoring the rights of a care taking father is discriminatory practice.

Minimizing Risk to a Sibling

Vanessa Akerman was not a stranger to the Department. As a former parenting state ward, her case history, including the circumstances involved when at 17 years old she lost guardianship of her first born son, was available. At the time, her mental health diagnosis of bipolar with a major depressive disorder and her criminal history lead the court to give guardianship of her son to the Department.

After LaKeshia's injury, intact family services initially focused on the DCP investigator's reductionist version of the case: *LaKeshia can return home when Ms. Akerman learns to care for her special needs*. The CPI indicated Ms. Akerman for substantial risk of physical injury only because she was unprepared to take LaKeshia home from the hospital. Therefore, the referral for intact services ignored the severe injury from abuse and the mother's role in relation to injury. The oversimplification of the presenting problems ensured the case was deflected to intact services. More importantly, the CPI's safety plan, which ignored more complicated problems of domestic violence, homelessness, and the mother's apathy towards her injured daughter, provided the initial direction for intact family services. A CPI's determination of a child (Caimile) as safe, without the need for protective measures, leads intact family staff to expect that additional evidence of risk is necessary in order to find the child unsafe. A previous OIG investigation found that when DCP declined to screen a case,

...a message was and is conveyed to intact family teams as well as to others that DCP has determined that the child(ren) are safe, making screening the case at a later date more difficult. At the very least, DCP should have made a notation stating that if the mother did not rapidly comply with necessary services, the case should be screened.³³

Intact family services did not consider screening Vanessa Akerman's case into court until three months after case opening (raised by the field service manager in August) and again two months later (raised at the clinical staffing in mid-October). From the initial case opening, however, it was apparent that Ms. Akerman had serious parenting deficits. In addition, there were incidents involving Caimile that warranted hotline calls and intervention, including screening, but intact family staff failed to respond.

Intact family staff also failed to adhere to the practice of obtaining CANTS checks on all adults assuming care taking responsibility for children of families involved in domestic violence. Information suggesting that the mother was leaving Caimile in the care of adults who expressed dislike for the child (e.g. roommate, paramour) should have elevated intact family intervention and monitoring of Caimile's safety.

Ms. Akerman had a history of a transient lifestyle moving in and out of shelters. Part of her safety plan for the care of her daughter Caimile required the mother to follow the rules of the transitional housing program. Ms. Akerman did not cooperate with the program. She failed to turn over her TANF cash grant for rent and within four months was asked to leave the program.

A psychological evaluation completed during the same period of time noted the mother had recurrent major depressive disorder, borderline personality disorder and needed domestic violence counseling and individual psychotherapy. The psychologist addressed his concerns over the mother's lack of skills and emotional flexibility to care for her special needs child but made no note of risk to the child left in her care. The nexus between her lack of stability and risk to her 18-month-old child (when she moved out of the housing program, began her nomadic lifestyle of drifting in and out of shelters, and had inconsistent contact with her intact family worker) was ignored to "give the mother a second chance."

An October clinical staffing addressed issues surrounding LaKeshia's care but was silent as to the protection of Caimile. By November, the intact family worker heard that the mother was involved with a man who was abusive towards Caimile. Protective daycare was not arranged. By the second clinical

staffing on December 2, 2002, the clinical coordinator noted the risks to Caimile and recommended the case be screened with a possible screen date in two days (December 4, 2002) and no later than December 18. Clinical staff did not note any obstacles to screening and did not provide technical assistance on the screening process.

Even after receiving direction to screen the case (on December 4), the worker waited over two weeks to seek protective custody. The supervisor failed to follow up with the worker to ensure the case was screened in and to assist the worker with any problems. Ms. Braham stated she needed to seek help from DCP investigators to compile the screening packet but she did not inform or work with her supervisor around these difficulties.³⁴ Ms. Braham's reported lack of confidence in taking a case to screening was clearly a barrier, as was Ms. Perez's lack of supervisory follow-up and direction. Ms. Perez should have known or found out that Ms. Braham was not comfortable taking a case to screening. In an OIG interview, Ms. Perez stated that she and Ms. Braham did not have a good working relationship and Ms. Braham subsequently elected to transfer to another team. The lack of communication between the worker and supervisor suggests their poor relationship compromised the performance of both employees.

Orders of Protection

Orders of Protection are not widely used in the Cook County juvenile system, however if the worker had been able to procure an order requiring the mother to keep the caseworker apprised of the whereabouts of Caimile (including day care or babysitting arrangements) in order to check on Caimile's safety, non-compliance with the order would have supported the worker's attempt to re-screen the case into court.

The Intact Family Recovery (IFR) project, a child welfare program focusing on clients with substance abuse problems, utilized Orders of Protection to encourage parents to comply with substance abuse treatment.³⁵ Program staff explained to participating parents that any safety risk to their child could result in a hotline call or court involvement. If parental non-compliance placed their child at risk, then workers could request Orders of Protection rather than seek temporary custody. If the parent complied with the Order of Protection, the court would vacate the order within six to twelve months. If the parent failed to comply with the order, the worker could petition the court for temporary custody.³⁶

While IFR staff encountered initial resistance from court participants and administrators,³⁷ a pilot project by the State's Attorney's Office resulted in procurement of 28 Orders of Protection in the first 24 months of the program (17% of the total number of family cases, N=167). Of the families receiving Orders of Protection, 89% entered recommended treatment (n=25), 64% completed recommended treatment (n=18), and 54% of the families remained intact (46% of involved families had temporary custody taken of their children). The Inspector General also noted anecdotal information from supervisors who stated that the protective order was the "single most effective tool for treatment compliance."³⁸

Coordinated Service Planning

Intact family staff was necessarily reliant, in part, on shelter staff to monitor Caimile's safety. Yet Ms. Braham repeatedly failed to obtain consents for release of information from Ms. Akerman in order to adequately monitor the mother and child through three different shelters. Intact family services require specific consents, so Ms. Braham could not have used a blanket consent to discuss Ms. Akerman's case with housing personnel.

While Ms. Braham involved staff from Alpha House in the initial case staffings, it was at a time when all professionals knew little about the family. When Ms. Akerman began moving between shelters, there is no evidence that Ms. Braham explained to shelter staff the reasons for DCFS involvement and the importance of the role of shelter staff. Ms. Braham needed assistance in monitoring Caimile's

whereabouts. Since Ms. Akerman was transient and had no family support, it was important for Ms. Braham to create alliances with other service providers involved with the family. Ms. Braham should have invited the service provider to the follow-up clinical staffing, ensuring transportation for Ms. Akerman and encouraging coordination with the shelter over Ms. Akerman's progress and Caimile's safety.

The intact family record documented that Ms. Akerman was receiving public aid. DCFS Policy Guide 99.01,³⁹ effective January 15, 1999, states:

Families which have an open intact case with the Department of Children and Family Services often experience problems in multiple life domains and require services from several state or community social service agencies, including TANF services from IDHS. Coordination of services between DCFS and IDHS is especially critical for our mutual clients because a family faces serious consequences for failing to comply with the service plan requirements of either agency. Such consequences may include TANF sanctions, substitute care of children, or possible loss of parental rights.

DCFS requires joint agency case staffings prior to developing the initial DCFS client service plan and on-going collaboration to facilitate the client's progress towards DCFS and IDHS goals. Although Ms. Braham documented that she attempted to contact the mother's IDHS caseworker, there is no evidence of collaboration between the workers. The Akerman family issues of homelessness and domestic violence and a father's right to legal custody of his child should have driven the initial client service planning which would have been more relevant had DCFS coordinated with IDHS. Coordinated services between DCFS and IDHS would have facilitated the following:

- Enable the father to care for LaKeshia by establishing a medical card in his name;
- When the father quit work to care for his daughter, he was eligible for food stamps and a TANF grant;
- The father could also have received employment assistance;
- Home health services might have been recognized as a paternal family need;
- Ensure the mother made monthly rent payments with her TANF grant to maintain housing and a safe place for Caimile to live;
- Require the mother to participate in domestic violence services as a condition of the TANF grant.
- Provide protective day care (by DCFS) for Caimile while the mother learned to care for LaKeshia and participate in services; and
- Provide day care (by IDHS) while the mother attended job training.

Warren Karger

Child welfare professionals should accurately and truthfully document their professional work according to agency policy and/or legal requirements in order to assure accountability and continuity in the provision of services to clients. *Code of Ethics for Child Welfare Professionals*, 1.09 (hereinafter *Code of Ethics*).

There is no record in the DCP file of the following investigative activities:

- in-person interview with the mother,⁴⁰
- police report of March 30 incident or record of request for a police report,⁴¹
- assessment of the father's home,
- assessment of Alpha House program and services, and

- collateral contact with mother's DHS worker.

There is also no DCP record of the hand-off meeting with Intact Family Services, although there is evidence it occurred since intact family services documented the meeting. In an interview with OIG staff, Mr. Karger claimed he conducted all of the above contacts and assessments. He exhibited some knowledge that indicated he spoke with the mother early in the investigation – he twice got addresses for an investigator in the neighboring county to check on Caimile's status. In an interview with OIG staff, Mr. Karger explained that when he completed the case, the file was given to a Department clerk to enter into the new computerized investigative system (SACWIS), insinuating that the clerk was the party responsible for the incomplete file. However, Mr. Karger admitted that he compiled the "contact list" which lists all contacts made during the course of the investigation. The contact list did not include any of the undocumented contacts that Mr. Karger claimed to have made. Mr. Karger's effort to redeem an inadequate investigation was unsupportable.

Following verification that Caimile was safe with a family friend, Mr. Karger did not interview the collateral source to learn more about Ms. Akerman's history or ability to protect her children or explore the viability of having a backup caregiver.⁴² Consequently, the CPI could not introduce the family friend as a possible backup caregiver for Caimile.

Mr. Karger also did not document his prior relationship with the parents. While he claims he informed his supervisor, the conversation was not documented in the file and his supervisor claims she was not informed. The Code of Ethics addresses a professional's responsibility when addressing potential conflicts of interests: "[c]hild welfare professionals should discuss past, existing, and potential multiple relationships with their appropriate superiors and resolve them in a manner which avoids harming and/or exploiting affected persons." During the OIG interview, Mr. Karger identified some of the potential problems stemming from this familiarity with the parents, such as danger to his family. Mr. Karger did not acknowledge the importance of avoiding such conflicts because if their potential to compromise objectivity.

It is possible that Mr. Karger's familiarity with LaKeshia's parents affected his objectivity so that any safety concerns were minimized. In fact, Mr. Karger was ready to immediately return a severely medically compromised infant to a young, homeless mother until hospital personnel intervened. His familiarity with Vanessa Akerman may also be the reason he did not interview collaterals or seek out her case record. Also, according to the investigation report, Mr. Karger did not assess the Seaberg home and family prior to placing LaKeshia with her father.

A mitigating factor in Mr. Karger's poor work quality is the inconsistent supervision of DCP teams. At the time of the Akerman investigation, his supervisor supervised three DCP teams including Mr. Karger's temporarily. Even though his supervisor supervised him for only five months, she was the most qualified administrator to complete his annual performance review the following fall. Although she supervised the Akerman investigation, two other DCP administrators signed approvals for the completion of the investigation in spite of the lack of documentation and follow-up.

Mr. Karger's supervisors were overextended, in part, because of his professional deficiencies – some of which were identified in another OIG report.⁴³ He has had three subsequent supervisors since the Akerman investigation. Each supervisor has had to independently evaluate his work and develop supervision plans to monitor his progress and address his deficiencies. Continued poor reviews brought into question Mr. Karger's appropriateness for child welfare positions.

Mr. Karger transferred his employment to the Illinois Department of Corrections in June 2004. Although he continues to hold a child welfare license, he is not a good candidate for rehire.

RECOMMENDATIONS⁴⁴

1. A redacted copy of this report should be shared with the DCFS Deputy Director of Purchase of Service Monitoring Division. He is currently chairing a committee to examine the involvement of fathers in child welfare services.
2. The Department and the State's Attorney's office should convene a work group to address how Orders of Protection can be used in intact family cases where there is concern about the safety of children but the case does not meet the urgent and immediate necessity hurdle to pursue custody. The Department should evaluate what specific and realistic goals for parents can be included on an Order of Protection that would help assure a child's safety or would provide support for pursuing custody later if the parent remains non-compliant.
3. When a parent's lack of compliance with the Department's client service plan and/or safety plan jeopardizes the health, safety, and welfare of the child(ren) but does not rise to the level of a hotline call, workers should seek a protective order. A child's welfare includes education and early intervention programs used as a safety net to monitor the child's well being. The Department should include guidelines in Procedures 302 – Appendix O (Intact Family Service) to determine when a caretaker's lack of cooperation places children at risk and warrants either a hotline call or seeking court involvement (such as an Order of Protection, requiring a parent to comply with the client service plan and/or the safety plan).
4. The OIG previously recommended that the Department include guidelines for workers on preparing and presenting cases for court involvement in Procedures 302 – Appendix O for Intact Family Services. This recommendation is reiterated.
5. The Department should place a “do not rehire” notification in Warren Karger's personnel file.
6. The Department needs to address the ongoing problem of adequate supervision of child protection teams. Reduced supervisor staffing levels in Child Protection directly affects the quality of investigative work. The Department needs to examine supervision staffing levels and give priority to filling open positions with full-time staff.
7. The Department should revise Department Procedures Part 302 – Services Delivered by DCFS to include Procedures for Assisting Fathers to File for Custody When the Parents Are Not Legally Married (located in Appendix B of this report).

ENDNOTES

¹ Peter Styler was charged with attempted armed robbery and Vanessa Akerman was charged with felony check forgery and theft.

² Case records indicate the paternal aunt married her husband after Javonte was placed in her home.

³ Shaken Baby Syndrome is more commonly referred to as abusive head trauma by medical examiner and coroner offices.

⁴ Paternity tests conducted a year later revealed Mr. Palmer was not Caimile's father.

⁵ Mr. Seaberg's date of birth is December 1979.

⁶ The DCP report did not indicate Ms. Akerman's residence prior to moving to shelter.

⁷ Preference was given to clients with social security disability income. Alpha House did not have any internal programs beyond providing housing and referred clients to other programs for services.

⁸ Mr. Karger took protective custody of LaKeshia on April 19 when the hospital reported that Ms. Akerman had not demonstrated an ability to provide for LaKeshia's needs.

⁹ The paternal aunt was Javonnte's guardian. There is no evidence that CPIs Karger or Redding were aware of the family relationship.

¹⁰ Caimile's injury occurred eight months after Mr. Karger referred the Akerman family for intact family services. OIG interviewed Mr. Karger ten months after Caimile's injury.

¹¹ The supervisor was the second supervisor on this case and approved the DCP findings on May 16, 2002. The supervisor's approval of the case was not entered into SACWIS and the Field Service Manager also signed off on the investigative findings August 2, 2002.

¹² According to case records, Alpha House is a three-story building that contains two apartments. When Ms. Akerman and her daughter Caimile moved in they shared the second floor apartment with another resident.

¹³ Establishing paternity was added to the service plan five months later on November 1, 2002.

¹⁴ Police Department records confirm that Mr. Palmer was arrested on March 17, 2002, for domestic violence against Ms. Akerman. The arrest occurred three days prior to the Battery of LaKeshia.

¹⁵ Ms. Akerman was arrested for retail theft and had to report monthly for probation. A background check on Ms. Akerman indicated she was arrested, convicted of theft and sentenced to time served and two years of probation on February 8, 1999.

¹⁶ Evaluation performed August 6, 2002.

¹⁷ Illinois Department of Human Services records indicate, in May, Ms. Akerman received a grant of \$377.00 a month from Temporary Assistance for Needy Families (TANF) and \$336.00 a month in food stamps. In September, Ms. Akerman's TANF grant was sanctioned for not cooperating with DHS and she received a reduced grant of \$198.00 a month and \$338.00 a month in food stamps.

¹⁸ From Sue Braham's case note of August 22, 2002.

¹⁹ LaKeshia had not yet been assigned physical and speech therapists.

²⁰ On October 22, Ms. Akerman told Ms. Braham she could not find the floor for the intake appointment. When confronted with the information that there was a receptionist in the lobby, Ms. Akerman then said she could not find the building. Ms. Braham gave her directions to the building and stated that she would request a bus pass for Ms. Akerman to attend counseling. Ms. Braham told OIG investigators that she did not transport Ms. Akerman to her first therapy appointment because the Department did not provide car insurance for such activities. Her supervisor, Ms. Perez, told OIG investigators that no staff are provided extra insurance but are all required to transport clients when necessary.

²¹ Ms. Braham did not get the name of the ASA but indicated that a DCP Investigator was a witness to their meeting. OIG investigators spoke with an ASA who worked on the case and stated that he did not understand why the case was not presented for screening after LaKeshia's injury.

²² The perineum is the area between the anus and the genital organs.

²³ Reports to the State Central Register indicated that Caimile's injuries were more extensive. The CPI received clarification from both doctors about what portions of the original reports were incorrect. Both doctors stated that the following reported injuries had not occurred: third degree burns, stabbed, vaginal trauma, or razor cuts. The CPI also noted Caimile had "green looking bruises on her cheek and fore head [*sic*]" although this was not confirmed by either physician statement.

²⁴ The CPI spoke with the day care provider and confirmed that Ms. Akerman had brought Caimile to day care on Monday.

²⁵ According to Mr. Lucas' wife and a criminal background check, Ronald (DOB 1/72) sometimes spelled his name Roland. His wife said they had been married 4 years but separated 3 months ago and he went to live with his aunt. Mr. Lucas' wife told the CPI that Mr. Lucas was good with kids and has never hurt a child to her knowledge. She stated that Mr. Lucas "has never whooped my kids with a belt." The CPI spoke to their children and found no signs of abuse or neglect.

²⁶ According to the Assistant State's Attorney, paternity results confirmed that Mr. Seaberg was LaKeshia's father but Carl Palmer was found not to be the father of Caimile.

²⁷ The indicated findings by allegation number are: No. 5 – Burns (Second Degree); No. 11 – Cuts, Bruises, Welts, Abrasions and Oral Injuries; No. 60 – Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare; and No. 79 – Medical Neglect.

²⁸ Mr. Karger was hired as a Child Welfare Specialist I in June of 1994 and promoted to a Child Welfare Specialist II in May 1995. He left the Department in October 1997, after a six-month leave of absence (active employment of 1

year and 11 months). He was rehired at the same grade in October 1997 and has been with the Department since (6 years and 6 months).

²⁹ Interoffice Memorandums from the supervisor to Warren Karger dated 8/19/2003 and 8/28/2003.

³⁰ Interoffice Memorandums from the supervisor to Warren Karger dated 10/10/2003.

³¹ The other OIG investigation was OIG report no. 04-1445.

³² See Appendix B for procedures for assisting fathers to file for custody when the parents are not legally married.

³³ See OIG report no. 02-0884.

³⁴ Creation of Intact Family Services Procedures 300, Appendix O has not been finalized by the Department. DCFS intact family workers have operated without guidelines since the program's inception.

³⁵ From Intact Family Recovery Project, DCFS Inspector General's Annual Report to the Governor and the General Assembly, January 2001, Appendix D.

³⁶ *Id.*

³⁷ According to the IFR report the major argument against Orders of Protection advanced by court personnel was that "if a family was in crisis enough to warrant court involvement, the result should be temporary custody." Intact Family Recovery Project, DCFS Inspector General's Annual Report to the Governor and the General Assembly, January 2001, Appendix D, page 15.

³⁸ *Supra* note 40, page 15.

³⁹ Intact Family Services – Procedures 302, Appendix O is currently in draft form and also requires workers to coordinate service planning with the Illinois Department of Human Services.

⁴⁰ In-person contact with the parent or caretaker of the alleged child victim (or good faith attempt) was required within 7 calendar days of receiving the abuse or neglect report. Procedures 300.50(c)(6) and 300.60(c)(1). The investigator is required to document all contacts and attempted contacts with the parents (and adult members of the household). Procedures 300.50(i)(1) and 300.60(d)(1). Such contacts should include "a summary of the facts gathered during the interviews, a description of the environment and the investigator's assessment of the credibility of the interviewee." Procedures 300.60(d)(1). The above-cited Procedures were in effect from October 1, 2001 through May 19, 2002.

⁴¹ A police investigative final finding or documentation of a request for a police report was required under DCFS *Procedures 300, Appendix B, Head Injuries and Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare* (Procedures were in effect from October 1, 2001 through May 19, 2002).

⁴² "If the family or subjects interview two or more possible collateral contacts, at least two must be interviewed by phone or in person." *Procedures 300, Appendix B, Head Injuries and Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare* (Procedures were in effect from October 1, 2001 through May 19, 2002).

⁴³ See OIG report 97-2684 on the Jensen family.

⁴⁴ Recommendations 2 and 3 were also made in OIG report no. 03-1483.

CAIMILE AKERMAN REPORT - APPENDIX B

Procedures for Assisting Fathers to File for Custody When the Parents Are Not Legally Married

In Cook County

1. Parent should go the Cook County Court Clerk's Office¹ to request assistance in filing a Petition to Establish the Parent/Child Relationship. In Cook County, such a petition is filed in the Domestic Relations Division of the Circuit Court of Cook County. If the father is in Chicago, it is the Clerk's Office at 28 North Clark Street, 2nd Floor. If the father is in a suburb, it is the Clerk's Office in the Municipal District where the suburb is located.² There is an Appearance and Filing Fee required. In Cook County the fee is \$271.00. However, a court can consider a motion to waive the filing fee in cases of poverty, but the father needs to request assistance from the Court Clerk with such a motion.
2. The Court Clerk's Office will assign a Judge and Court Room for the hearing on the Petition. In Chicago ask where the Courtroom is to which you are assigned. There are various locations one can go for the Hearing. The Downtown one is at 32 West Randolph. Make sure you note the Court date, the Courtroom number and the location of the Courthouse. In Municipal Districts 2 through 6, the Domestic Relations Division is in the same courthouse as all other divisions.
3. When at the Court Clerk's Office, the father should request a Summons and copy of the Petition to be served on the mother by the Sheriff's Office, so that legal service to the mother can be tracked and she can be defaulted, if properly served and she fails to appear in Court.
4. The Summons and copy of the petition (in duplicate) should be taken to the Sheriff's Office and legal service requested on the mother. Ask the Court Clerk where the Sheriff's Office is located. (In Chicago, the Sheriff's Office is in the Daley Center. Be sure to ask for directions the location of the Sheriff's Office to arrange legal service on the mother in a Civil matter.) Be sure that you have the mother's exact address and apartment number, if necessary, when requesting legal service.
5. If you do not know the mother's location, the Court will have to order publication, if it deems it necessary. Such an order would be issued at the first Court Hearing. Be sure to ask the Clerk in the Courtroom where to go to order the publication. You need to have a copy of the petition when you order publication. Be prepared to give the last known address you have for the mother when ordering the publication. The Court will have given you a continuation date for completion of publication, usually at least 30 days or more.
6. If you have ever established paternity in a Court of Law before the time you are requesting that the Petition to Establish the Parent/Child Relationship be filed, be sure that you obtain a certified copy of the order acknowledging that paternity from the Court that established it. (There is a nominal fee for a certified copy of a Court Order.) Such an order is obtained from the Clerk of the Court where paternity was established. For example, the Clerk's Office at Cook County Juvenile Court, if that is where the paternity was acknowledged.
7. Be sure to attend any scheduled court hearings on your petition. Be prepared to answer any questions of the Judge or State's Attorney at the Court Hearing. Be sure that you ask the Judge for a copy of any orders he renders. When you are granted custody of your child be sure to ask the Clerk in the courtroom for a certified copy or what you need to do to obtain a certified of the custody order.

In all Illinois counties besides Cook

Outside of Cook County the father should go to the County Courthouse and request assistance from the Clerk of the Court for a civil matter. The petition the father needs to file is the same, a Petition to

Establish the Parent/Child Relationship. Every county has an Appearance and Filing Fee for a petition. In each county the fee will be different. The fee can be over \$200.00. However, each county should have a means for the filing fee being waived because of poverty. Summons has to be served on the mother through the County Sheriff's office. Otherwise, the father needs the same information as required in Cook County and should attend all court hearings on the petition, request a copy of all orders and request a certified copy of the order of custody when granted.

¹ The Cook County Circuit Court is divided into 6 Municipal Districts. The location of the Court Clerk's Office in each of the 6 Municipalities is:

- 1) (City of Chicago) 28 North Clark St., Chicago, 2nd Floor, 312-345,4147
- 2) (Northeast Suburbs) 5600 Old Orchard Road, Skokie, 847,470-7250
- 3) (Northwest Suburbs) 2121 Euclid Avenue, Rolling Meadows, 847-818-2376
- 4) (Western Suburbs) 1500 Maybrook Drive, Maywood, 708-865-6040
- 5) (Southwest Suburbs) 10220 South 76th Avenue, Bridgeview, 708-974-6449
- 6) (South Suburbs) 16501 South Kedzie Parkway, Maywood, 708-210-4551

² If you are not certain of the Municipal District, call the one of the General Information numbers listed above to determine the correct Municipal District.