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

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

JANUARY 2006

Denise Kane, Ph.D.
Inspector General

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OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

January 1, 2006

To Governor Blagojevich and Members of the General Assembly:

A senior member of my staff recalled being taken aback when she first read a morning report on a child death. In the report, a Department staff member demonstrated her savvy by warning the administration about the potential media fallout that the child's death could create. The death was referred to as a "heater" case. The label "heater" implied that the child's death would have been deemed insignificant if it weren't for the possible negative press. The death of any child, especially through violence, negligence or accident is a tragedy that deserves due introspection and examination. In a recent commentary, Clarence Page recalled a great lesson he learned while he was in the Pentagon's Defense Information School. This lesson is that the best response to a lie is the truth, not the spin. Avoiding the temptation of spin also applies to investigations defined as "heater" or "high profile" cases, since the label raises the risk that a public relations spin will accompany the designation.

Both spin and these special designations give the impression that behaviors will be driven, not by public accountability, but by public perception. The power invested in public investigative bodies must always be curbed by an understanding that we are public servants. The public is not served by investigations that lose integrity when they become a means for public relations or damage control. Ultimately, as Clarence Page points out, rather than giving the public an arena for accountability, spin control damages credibility. "Truth inevitably comes out, in true democracies, and once you lose your credibility, it's hard to get it back".

The publishing of an annual report helps create a public arena of accountability for both DCFS and the Office of the Inspector General. This year's annual report includes a five-year review of cases with law enforcement involvement. Cases referred for criminal investigation and prosecution may take a number of years before final disposition. Therefore, if the facts in an individual case warrant consideration of discipline or discharge, this administrative remedy is recommended while the criminal case is pending.

I respectfully submit the DCFS Office of the Inspector General's 2006 annual report for your review.

With hope for our children's safety,

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 OIG created and maintains a database of child death statistics that compiles critical information related to child deaths in Illinois. The following chart summarizes the death cases reviewed in FY 05:

Table 1
Child Death Cases Reviewed in FY 05

Child Deaths in FY 05 Meeting the Criteria for Review	**139**
Preliminary Investigations Conducted	**21**
Case Records Reviewed	**106**
Full Investigative Reports Submitted to DCFS	**3**
Investigations Pending	**9**

Summaries of death investigations with a full investigative report submitted to the Director are included in the Investigations section of this Report. See page 65 of this Report for a summary of all child deaths reviewed by the OIG in FY 05.

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 are 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, through the 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.

A committee composed of representatives of the OIG, the Child Welfare Employee Licensure Board and the Department's Office of Employee Licensure screens referrals for CWEL Investigations. 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.

In FY 05, 19 cases were referred to the OIG for investigation. One temporary suspension of a Child Welfare Employee License was granted. In addition, the OIG provided technical assistance to the Office of Employee Licenses in 17 cases. The following chart reports disposition of the 19 cases investigated in FY 05:

Table 2
CWEL Investigation Dispositions in FY 05

Recommendation for No Licensure Action	**6**
Voluntary Relinquishment	**10**
Revocation	**1**
Charges Pending	**2**

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 05, the OIG performed 7,766 searches for criminal background information from the Law Enforcement Agencies Data 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 it may

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 notification by the State Central Register 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 05, the OIG received 2,305 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 a temporary hold be placed on an agency's intake of new cases or that an employee be placed on 'desk duty' pending the outcome of the investigation.

[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.

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." In order to conduct thorough investigations while at the same time ensuring the integrity of records, investigators may impound files. 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 and the Governor. 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.

Systemic reform recommendations are organized into a format that allows analysis of recommendations according to the function within the child welfare system that the recommendation is designed to strengthen.

See page 215 of this Report. 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 made or may work directly with the Department or private agency to implement recommendations that call for systemic reform. The OIG may also develop 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 OIG's response to calls received in FY 05:

Table 3
Calls to the OIG Hotline in FY 05

Information and Referral	**1278**
Referred to SCR Hotline	**241**
Referred for OIG Investigation	**180**
TOTAL Calls	**1699**

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 05, 436 Statements of Economic Interest were submitted to the Ethics Officer. Of the 436 submitted, 61 indicated potential conflicts of interest. The 61 were further reviewed and 15 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. One case was referred to the Executive Office of the Inspector General for possible referral to the Ethics Board for a violation of the Gift Ban Act.

Table 4
OIG Action on FY 05 Statements of Economic Interest

Economic Interest Statements Filed	**436**
Statements Indicating Possible Conflicts	**61**
Advisory Letters Sent to Employees	**15**

The OIG Ethics staff also coordinated DCFS compliance of the statewide ethics training mandated under the Illinois' State Officials and Employees Ethics Act of 2003. Approximately 3,500 employees were trained in FY 05.

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

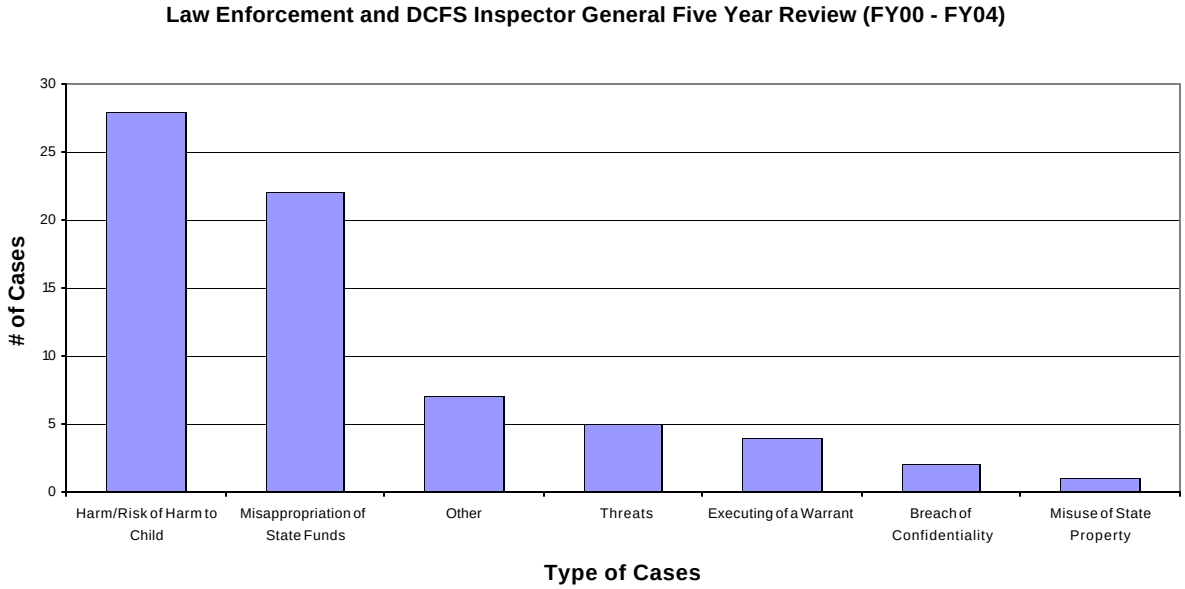
Informed by OIG investigations and practice research, the OIG's Project Initiatives assist the Department's Division on Training in the development of practice training models for caseworkers and supervisors. The model initiatives are interdisciplinary and involve field testing of strategies. The initiatives are evaluated to ensure the use of evidence-based practice and to determine the effectiveness of the model. See page 209 of this Report for a full discussion of the current initiatives.

LAW ENFORCEMENT AND DCFS INSPECTOR GENERAL FIVE-YEAR REVIEW (FY 2000 - 2004)

The DCFS Office of Inspector General was created following the homicide of a three-year-old child who was returned to the care of a violent mentally ill parent. The Illinois State Police, local law enforcement and the Inspector General's Office investigated the case.

In the course of an investigation, the OIG may discover facts suggesting criminal activity. The Inspector General refers these cases to law enforcement. In addition to referrals to law enforcement, the OIG also receives requests for assistance from law enforcement. Often, the investigative efforts between law enforcement and the Office of the Inspector General are collateral. Law enforcement investigations and prosecution may take a number of years before disposition. Administrative investigations usually conclude within a year of the alleged acts of wrongdoing. After law enforcement completes its investigation, the Inspector General reviews the findings to determine whether further administrative action by the Department is warranted. The monitoring unit of the Inspector General's Office follows the law enforcement referral and/or administrative action.

From FY 2000 through FY 2004, sixty-nine cases were referred to law enforcement or law enforcement sought assistance from the Inspector General's Office. During the five years, thirty persons have been successfully prosecuted; three cases are still pending prosecution after indictment. Twenty-two private or state employees have been terminated or have resigned. All terminations were upheld when administratively appealed. Possible harm or risk of harm to a child was involved in twenty-eight cases. Three were homicides. Eleven cases involved sexual exploitation of children. Misappropriation of state funds, theft or fraud was involved in twenty-two cases. Over $300,000 of state funds has been recovered through court order or settlement. Summaries of the 69 cases include the action taken by the OIG and the outcome of the case. The cases have been categorized as harm/risk of harm to a child; misappropriation of state funds; threats; breach of confidentiality; misuse of state property; execution of warrant and other.



Case 1	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to local law enforcement
ISSUE	Homicide
ACTION TAKEN	During an Intact Family Recovery staffing, the OIG learned that a mother new to the program previously had a child who died. The OIG began an investigation into the circumstances of the child's death to ensure that there was no risk to the infant and other children currently in the mother's care. The OIG obtained information from the County Medical Examiner's Office that the nine-month-old infant died eleven years earlier from a subdural hematoma due to blunt trauma. His death was classified as a homicide. The infant had been hospitalized for three months with the injuries that eventually caused his death. The OIG contacted the local police department and learned that a full investigation of the infant's death was never conducted. The local police expressed interest in investigating the case and OIG staff met with investigators from the "cold case" division. The OIG shared information it obtained and provided assistance in locating witnesses from DCFS who had been involved in investigating the alleged perpetrator of the infant's death.
OUTCOME	The mother's boyfriend at the time of the infant's injuries confessed to killing the infant. He was charged with first-degree murder, pled guilty, and was sentenced to 22 years in the Illinois Department of Corrections.

Case 2	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to local law enforcement and State's Attorney
ISSUE	Alleged sexual abuse of a minor
ACTION TAKEN	The OIG learned that an older caregiver was having problems keeping a 71 year-old minister away from her 14 year-old granddaughter, whom she adopted. The granddaughter had been pregnant and the minister arranged an abortion. The OIG was able to identify the minister who was exploiting the girl. A hotline report was made and indicated for sexual abuse. The OIG solicited the assistance of the Child Advocacy Center and the local police department to bring charges against the minister. The minister was initially charged with contributing to the delinquency of a minor, but the case was dismissed because the girl did not appear. The minister was later arrested and charged with kidnapping, aggravated criminal sexual assault, aggravated criminal sexual abuse and unlawful restraint and released on bail. The OIG also informed law enforcement that the minister carried a police badge and regularly impersonated a police officer. On a court date regarding the above charges, law enforcement set up surveillance at the criminal courts building and watched as the minister arrived for his court appearance, produced his badge, and told the sheriff's deputies that he was an active police officer on duty. During the course of the sexual assault case against the minister, the OIG became aware he was seeing the girl in direct violation of a Judge's order. The Chicago Police and the States Attorney's Office were notified, and the Judge revoked bond and the minister was jailed.

OUTCOME	The indicated DCP finding was appealed and the Department held the appeal in abeyance pending the outcome of the criminal charges. The criminal charges were dismissed three years later and the child protection appeal was then reinstated, but the finding was overturned on appeal because the child, who was by then 18 years old, refused to testify. The grandmother, who made the initial complaint, stated that she was tired after the criminal case dragged on for years, and would leave the minister's fate, "in the hands of the Lord." The minister was convicted on the charge of impersonating a police officer and placed on one-year conditional discharge.

Case 3	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the U.S. Customs Service
ISSUE	Exploitation of a child in drug trafficking
ACTION TAKEN	The U.S. Customs Service suspected that a 20 year-old Department ward in an independent living program was "renting" her child as cover for drug runners traveling between the U.S. and Central America. The Customs Service suspected the couriers were smuggling cocaine inside baby formula containers. The Customs Service required the OIG's assistance to locate the mother. The OIG verified the mother's address and put the Customs Service in touch with the ward's caseworker.
OUTCOME	The mother pled guilty in Federal Court. She was sentenced to 10 months in Federal prison and four years of supervised release.

Case 4	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to the State's Attorney's Office
ISSUE	Homicide
ACTION TAKEN	A 17 year-old ward, who had been incarcerated for about 30 days on a domestic battery charge, was released when the battery charge was dropped when the victim failed to appear in court. The 17 year-old was in an independent living program. She had a long history of psychiatric hospitalizations, numerous placements and violent behavior. The day she was released from jail, she attacked a 21 year-old former ward that she knew from a prior group home placement, stabbing him several times. (Twenty-four stitches were required to close his neck wounds.) The 17 year-old was arrested shortly after the incident, but charged with a simple battery and released on a personal recognizance bond. Later that night or early the next morning the 17 year-old allegedly murdered a 20 year-old female Department ward in her apartment. The police asked the 21 year-old to assist them in apprehending the 17 year-old on the murder. The OIG contacted the State's Attorney's Office to inform them of the attack the evening before the murder of the 21 year-old and the fact that the 17 year-old had been charged with a simple battery.

OUTCOME	The 17 year-old was subsequently indicted on charges of first degree murder of the 20 year-old and attempted first degree murder and aggravated battery of the 21 year-old. The 17 year-old has been incarcerated awaiting trial since March 2, 2002. She was found unfit to stand trial when she refused to take medication. After a period of psychiatric hospitalization and forced medication, she was found fit, but subsequently again found unfit. In January 2005, the 17 year-old was returned to the jail. In. June 2005, the 17 year-old (now 21 year-old) was indicted on new charges of aggravated battery on a peace officer.

Case 5	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the Division of Child Protection Referral to law enforcement
ISSUE	Children without legal relationship to their caretakers
ACTION TAKEN	A child protection investigator requested the assistance of the OIG when she was unable to verify basic biographical information about three thirteen year-old subjects of the child protection investigation, such as their place of birth, birth dates, biological siblings and parentage. The OIG investigated an allegation that the children had no legal relationship with their caretakers.
OUTCOME	The OIG located the biological mother of two of the children; she was living in Michigan and had been searching for her children for thirteen years. The information was shared with child protection and juvenile court. The juvenile court ordered visits between the biological mother and the children. The OIG located the mother of the third child in Iowa. The OIG referred the results of the investigation to the appropriate state, local and federal law enforcement authorities. Law enforcement declined to investigate.

Case 6	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the State of Indiana authorities
ISSUE	Death investigation
ACTION TAKEN	The OIG assisted in the police investigation into the death of a 12 year-old ward placed with his maternal grandmother in Indiana.
OUTCOME	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 7	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the Department of Homeland Security
ISSUE	Child pornography
ACTION TAKEN	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, used his credit card to purchase child pornography. The OIG conducted a full investigation.
OUTCOME	The employee resigned and relinquished his child welfare and foster care licenses. No criminal charges were filed.

Case 8	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the Guardian *ad litem*
ISSUE	Protection for a federal informant
ACTION TAKEN	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.
OUTCOME	The OIG provided intervention to assure that the ward was discharged from the hospital into a safe environment, where she has remained.

Case 9	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to local police department
ISSUE	Sexual molestation
ACTION TAKEN	A teacher was indicated for sexual molestation of his ten year-old daughter. The child protection worker never inquired as to the father's employment and, as a result, the school was never notified of the indicated finding. The father informed the school that the report against him had been unfounded and he continued his employment as a teacher. The local police department had not taken any action against the father. OIG investigators met with the Deputy Chief of Detectives of the local police department.
OUTCOME	Based on the information supplied by the OIG, the police revisited the case and arrested the father. He pled guilty to one count of Aggravated Criminal Sexual Abuse and was given 30 months of probation. The local school board terminated him as a teacher and the State Board of Education withdrew his teaching certificate. He is listed as a sexual predator on the Illinois sex offender website maintained by the Illinois State Police.

Case 10	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from a local police department
ISSUE	A caseworker took a five year-old boy, who was in placement in a traditional foster home, to visit his relatives out of state. The worker noticed that the boy had difficulty manipulating his fingers and had marks on his wrists. The worker took the boy for a medical exam when they arrived in the visiting state. The boy explained that he had been tied up by his foster father and hung on a door by his t-shirt; an explanation the doctor determined was consistent with his injuries. The worker called the abuse and neglect hotline and notified the local police in the city where the foster father lived. The boy remained with the relatives out of state and was recently adopted by that family.
ACTION TAKEN	The local police department requested assistance from the OIG in securing the boy's medical records and preparing a case against the foster father.
OUTCOME	The local police did not seek prosecution of the foster father.

Case 11	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to Parole Department
ISSUE	Convicted sexual offender
ACTION TAKEN	During a child protection investigation, the OIG was contacted for technical assistance with an out of state criminal history on a registered sex offender who was living in a home with three young girls. A criminal history evaluation conducted by the OIG revealed that the man had a substantial criminal history in Illinois and Tennessee, including a conviction for sexual battery against a 15 year-old girl. There were also outstanding warrants in the state of Tennessee. The OIG notified Tennessee authorities of the man's whereabouts but they declined to extradite. Because he was on parole in Illinois, the OIG notified the parole supervisor that he was living in a home and acting as caretaker to three young girls, one of whom was the age of his victim in Tennessee.
OUTCOME	The parole supervisor dispatched an officer to the home and notified the parolee that he must cease all contact with the girls and that future contact would be considered a parole violation. The man was placed on electronic monitoring. Also, the OIG noted that the law enforcement database only listed the man as a sexual offender, not a *child* sex offender. After notification by the OIG, the man is now listed as a child sex offender.

Case 12	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from a local police department
ISSUE	Kidnapping
ACTION TAKEN	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.
OUTCOME	The adult was charged with a misdemeanor, pled guilty and was placed on probation for a year. 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.

Case 13	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to local police department
ISSUE	A group home employee allegedly impregnated a 15 year-old Department ward
ACTION TAKEN	By the time the OIG was notified, the employee had resigned from the group home and obtained employment with the city of Chicago. The OIG contacted law enforcement and the former employee was arrested and charged with criminal sexual assault.
OUTCOME	The employee was convicted on the charge of Criminal Sexual Assault of a victim between the ages of 13 and 16. He was sentenced to 4 years in the Illinois Department of Corrections and must register as a sex offender.

Case 14	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to local police department
ISSUE	Sexual assault
ACTION TAKEN	In the process of investigating a case in which foster parents were alleged to have sexually and physically abused their foster and adoptive children, the OIG noted that the brother of one of the foster parents was a registered sexual offender and that he was living in the foster home at the time that the sexual abuse by the foster father was disclosed. The OIG conducted a criminal background check of the maternal uncle and learned that he previously was convicted of felony burglary, was charged with 1st degree sexual assault of a child, which was pled down to 4th degree sexual assault, was convicted of possession of a firearm by a felon, and was arrested for domestic abuse, disorderly conduct and 3rd degree sexual assault. The OIG contacted local law enforcement to alert them to the presence of another possible perpetrator at the home.
OUTCOME	The foster father was convicted on three counts of Predatory Criminal Sexual Assault to a Child and sentenced to serve three consecutive 20-year sentences.

Case 15	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to the Illinois State Police
ISSUE	Solicitation of minors over the internet
ACTION TAKEN	A preliminary investigation by the OIG revealed a file on a Department computer technician's work computer that contained sexually explicit internet chat room conversations with females identifying themselves as under age 18. The OIG referred the employee to the Illinois State Police (ISP) for investigation of solicitation of minors over the internet. The state police investigation confirmed that at least one of the participants in the chat room was a female under the age of 18 and the Department employee had identified himself to her as also being under 18. The state police referred the investigation to the State's Attorney's Office which declined prosecution because the employee did not arrange to meet with any of the minors.
OUTCOME	After the ISP completed their investigation and the State's Attorney declined to prosecute, the OIG conducted a full administrative investigation. The employee was terminated from Department employment.

Case 16	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to the State's Attorney's Office
ISSUE	A 5 month-old child was seriously injured in her home. The case was investigated by the Division of Child Protection (DCP) and indicated to an unknown perpetrator because of the number of people in the home at the time of the abuse. Protective custody of the child and another sibling was taken and a Petition for Adjudication of Wardship was filed in Juvenile Court. The State's Attorney of the county requested that the petition be dismissed without adjudication because he did not believe he could prove allegations against the parents.
ACTION TAKEN	The OIG advocated with the State's Attorney to determine alternate theories that would ensure the child's safety.

OUTCOME	The State's Attorney filed a petition for temporary custody. DCFS was granted guardianship of the child and placed her in a specialized foster home. The permanency goal is adoption by the foster parents.

Case 17	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to Immigration and Naturalization Services
ISSUE	Convicted felon wanted for deportation
ACTION TAKEN	During the course of an investigation involving a private agency where the Executive Director of that agency was also a foster parent of two wards, the OIG learned that the Executive Director's live-in boyfriend was a known drug dealer and a convicted felon wanted by the Immigration and Naturalization Service (INS) for deportation. The OIG obtained all the information and documentation regarding the convicted felon and referred the matter to INS.

Case 18	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the State's Attorney's Office
ISSUE	Employee charged with DUI
ACTION TAKEN	A Department caseworker was arrested and charged with Driving Under the Influence when the worker became involved in an accident while transporting a minor child for whom the Department was responsible. The Office of the State's Attorney was unable to locate the minor child, a primary witness for the trial. The OIG located the child and made her available to the State's Attorney for the trial.
OUTCOME	The worker was acquitted on the criminal charge. She resigned from the Department and surrendered her child welfare employee license.

Case 19	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Joint investigation with the Illinois State Police
ISSUE	False information presented to court
ACTION TAKEN	The OIG conducted a joint investigation with the Illinois State Police (ISP) of a worker who claimed to have obtained criminal background information on a potential foster parent through a State Trooper. The worker falsely informed the court that the potential placement parent was cleared by a Law Enforcement Agencies Data System (LEADS) check, when in reality he was a convicted child sex offender and the child placed with him was consequently placed at risk.
OUTCOME	The child was removed from the placement. The worker resigned and surrendered her child welfare license.

Case 20	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to the Illinois State Police
ISSUE	Sexual abuse in a group home

ACTION TAKEN	The OIG investigated a group home for allegations of female staff members engaging in sexual relations with the young men in the program. The OIG referred the results of the investigation to the Illinois State Police.
OUTCOME	The group home was closed. Two staff members were charged criminally and found guilty of Criminal Sexual Assault. They were sentenced to time served and must register as sex offenders.

Case 21	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from a local police department
ISSUE	Sexual molestation
ACTION TAKEN	The OIG received a request for assistance from police investigating an allegation that a Department child welfare specialist had molested his daughter's friends while they were in his home.
OUTCOME	The State's Attorney's Office declined prosecution. The child welfare specialist's employment with the Department was terminated.

Case 22	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the State Central Register
ISSUE	Inappropriate conduct by employee
ACTION TAKEN	A DCFS Licensing worker was arrested and charged with contributing to the delinquency of a minor and harboring a runaway, after it was discovered that a 16 year-old girl had been living in her home. The girl was involved in sexual relations and drug use with the investigator's 34 year-old brother, who also lived in the home. The licensing worker told the police she was aware of the behavior, but that it was confined to her brother's room. The OIG obtained all police information related to the investigation.
OUTCOME	The criminal charge was dismissed. The licensing investigator was discharged. She grieved her termination.

Case 23	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from local police commander
ISSUE	Sexual molestation
ACTION TAKEN	A teenage girl accused her stepfather of molesting her. The stepfather had previously been convicted of molesting her in 1995. The stepfather was living with the daughter and her mother, who had stated to police that she did not believe the charges. The commander was concerned about the mother's willingness to protect her daughter in this environment. The OIG forwarded the information regarding the stepfather's previous conviction to the Division of Child Protection (DCP) investigator assigned to the case.
OUTCOME	The girl was subsequently removed from the home and remained in placement for two years before returning to her mother. The step-father was found guilty of Criminal Sexual Assault on a family member and sentenced to 15 years in the Illinois Department of Corrections and received a concurrent 15 years for violation of probation from the earlier sexual assault.

Case 24	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Referral to Wisconsin authorities and Chicago Police Department Extradition Unit
ISSUE	Convicted sexual offender
ACTION TAKEN	During the course of a pending investigation, the OIG learned of an individual who was receiving state payments for babysitting a five year-old girl. This individual had an extensive criminal past including a conviction and subsequent imprisonment for raping a five year-old girl. He was currently wanted for a parole violation in Wisconsin. The OIG notified the Wisconsin authorities and the Chicago Police Department Extradition Unit.
OUTCOME	The individual was apprehended.

Case 25	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Joint investigation with the local police department
ISSUE	Allegations of sexual abuse of minors
ACTION TAKEN	The OIG assisted the Chicago Police in a sexual abuse investigation of a foster parent, licensed by a private agency who was alleged to have sexually abused several department wards who were placed with him. The States Attorney declined to prosecute. Two years later, federal prosecutors contacted the OIG because of information they learned while investigating the foster parent for threatening behavior on an airplane. The federal prosecutors sought the OIG's assistance to locate prior children who had been placed with him.

Case 26	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Joint investigation
ISSUE	Missing Department wards
ACTION TAKEN	The Department requested the OIG's assistance in coordinating the Missing Children's Project. The OIG investigated and interfaced with local law enforcement statewide and federal agencies to help the Department identify and locate over a hundred missing wards.

Case 27	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from a local police department
ISSUE	Runaway
ACTION TAKEN	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 28	
CATEGORY	Harm/risk of harm to a child
NATURE OF INVOLVEMENT	Request for assistance from the State's Attorney's Office
ISSUE	Runaway
ACTION TAKEN	An Assistant State's Attorney at Juvenile Court requested assistance in locating a 12 year-old chronic runaway. The OIG obtained addresses of key locations where the child had ties.
OUTCOME	The girl was located.

Case 29	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the Illinois State Police and the State's Attorney's Office
ISSUE	Fraudulent Vouchers
ACTION TAKEN	The OIG investigated use of purchase vouchers to fraudulently obtain goods from branches of a discount department store chain in the Chicago area. The OIG was able to identify several people who were repeated users of the vouchers and to establish interrelationships between the parties. One person identified in the OIG investigation was a Department employee. The OIG referred the results of the investigation to the Illinois State Police and to the Cook County Office of the State's Attorney.
OUTCOME	Six individuals were indicted. Five pled guilty and received terms of probation from 18 months to 3 years with restitution in amounts from $800 to $3000. The sixth defendant was found guilty at a bench trial, sentenced to 30 months probation and $300 restitution. She appealed and the Appellate Court affirmed her conviction.

Case 30	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the Illinois State Police Task Force on Financial Crimes
ISSUE	Financial mismanagement by a private agency
ACTION TAKEN	The OIG received several complaints alleging mismanagement and misappropriation of funds by a private agency, which had only recently begun operation. The OIG compiled relevant information regarding misappropriation of funds and forwarded it to the Illinois State Police Task Force on Financial Crimes for investigation.
OUTCOME	The State's Attorney's Office declined to prosecute. The agency is paying restitution in the amount of $226,000.

Case 31	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Request for assistance from the State's Attorney's Financial Crimes Unit
ISSUE	Felony theft
ACTION TAKEN	The OIG was notified that a Child Welfare Employee Licensed caseworker had been criminally charged with felony theft of $330,000 of state funds. The OIG initiated a Child Welfare Licensing investigation, which focused on significant misrepresentations the employee had made to secure child welfare positions. Throughout the investigation, the OIG assisted and coordinated with the State's Attorney's Financial Crimes Unit and U.S. Postal Inspection Service.

OUTCOME	The worker's Child Welfare Employee License was revoked. The criminal case is pending.

Case 32	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the Illinois State Police Task Force on Financial Crimes
ISSUE	Financial improprieties by a private agency director
ACTION TAKEN	The OIG received a complaint alleging that a private agency was operating outside the parameters established for not-for-profit organizations or childcare institutions. The OIG found that the agency, which was in serious organizational distress, was not adhering to acceptable standards of financial practice. The agency's Executive Director owned two buildings that he rented to the agency for use as residential group homes at prices that an independent assessor determined to be substantially above fair market value. The OIG forwarded the information to the Illinois State Police Task Force on Financial Crimes for investigation.
OUTCOME	A warrant was issued for the agency director, but he died before the warrant could be executed.

Case 33	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the Illinois State Police Task Force on Financial Crimes
ISSUE	Daycare payments
ACTION TAKEN	A review of the day care payments processed by a temporary employee who had been working in the Office of Child Development for six years found that an unusual number of duplicate payments, totaling $26,649, had been made to a single licensed daycare provider. The OIG compiled the information and forwarded it to the Illinois State Police Task Force on Financial Crimes for investigation.
OUTCOME	The Department fired the temporary employee and informed the staffing agency she worked for of the reason for the termination. The employee was not prosecuted.

Case 34	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to law enforcement
ISSUE	Theft of wards' funds
ACTION TAKEN	The OIG investigated allegations and cooperated with an ongoing criminal investigation in which a private agency caseworker had taken funds from three DCFS wards who had developmental delays.
OUTCOME	The caseworker was convicted of Financial Exploitation of the Disabled.

Case 35	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the State's Attorney's Office
ISSUE	Possible fraud by an adoptive parent
ACTION TAKEN	An infant was removed from her mother immediately after birth and placed in the home of a relative by the Department. The relative already had private guardianship of two older siblings through Probate Court. One of the siblings was severely handicapped and

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

Case 36	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to State's Attorney's Office and the Illinois State Police
ISSUE	Daycare payments
ACTION TAKEN	The OIG investigated an allegation against an individual who accepted daycare payments using a false identity.
OUTCOME	The State's Attorney's Office declined to prosecute.

Case 37	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to Illinois State Police, Internal Investigations Division and Department of Public Aid
ISSUE	Allegation of theft of a ward's money
ACTION TAKEN	The OIG investigated the theft from a ward who had received a settlement for an automobile accident in which he had been involved about 9 years earlier. The check for the settlement was made out to the ward, who had just turned 18. As he had no bank account, the private agency worker offered to see that the check was deposited for him. The worker solicited the aid of a friend, who worked at the Department of Public Aid (DPA). The DPA worker deposited the check in her personal account and withdrew all of the money in increments, without giving any to the ward. Once the evidence and documentation was obtained, the OIG referred the case to the Illinois State Police, Internal Investigations Division and notified DPA, as it involved one of their employees.
OUTCOME	The Illinois State Police investigation revealed that the ward had received the money and used it to purchase drugs.

Case 38	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to State's Attorney's Office and the Illinois Attorney General
ISSUE	Foster care payments

ACTION TAKEN	The Department paid grandparent foster parents for the care of their two grandchildren who were living with them out of state. The Department learned that the parents had moved back to Michigan, and that the children were actually living with their parents, and not with the grandparents. The grandparents claimed that they had turned the money they received for foster care over to the parents. The Department does not pay for children to live with their natural parents. The case was referred to the Office of the State's Attorney and to the Illinois Attorney General. The Attorney General's Office took jurisdiction and attempted to secure repayment of the money for foster care. The OIG provided assistance by obtaining all documentation and copies of vouchers paid.
OUTCOME	The parents are paying restitution in the amount of $3,500.

Case 39	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Request for assistance
ISSUE	Theft of foster care payments
ACTION TAKEN	A complaint came to the attention of the OIG when foster care payment checks made out to a foster parent were forged and deposited in various checking accounts. The State Treasurer was attempting to have the banks pay back the money, as the checks were forged. One bank refused to repay the money unless the Department corrected the situation, at which time the matter was brought to the attention of the OIG.
OUTCOME	The US Postal Service investigated the case. The forger was prosecuted in Federal Court for mail fraud and assumption of a fictitious name and address. The forger was sentenced to 21 months imprisonment and restitution of $22,582.

Case 40	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to State's Attorney's Office and the Illinois Department of Public Aid
ISSUE	Billing irregularities
ACTION TAKEN	The OIG learned that a home health care service was double billing for in-home nursing services. After completing the investigation and obtaining the documentation, the OIG referred the matter to the Department of Public Aid and to the Office of the State's Attorney for investigation.
OUTCOME	The State's Attorney declined to prosecute.

Case 41	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to State's Attorney and the Illinois Attorney General
ISSUE	Financial Irregularities
ACTION TAKEN	During an investigation of a private agency, the OIG uncovered serious financial irregularities with the agency, including a tax liability debt of over $6 million. The irregularities appeared to be criminal in nature. The case was referred to the Office of the State's Attorney and subsequently to the Attorney General's Office.
OUTCOME	The agency was closed. The State's Attorney's Office declined to prosecute.

Case 42	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the Illinois State Police and the State's Attorney's Office
ISSUE	Embezzlement
ACTION TAKEN	A private agency caseworker was suspected of embezzling Department funds allocated to assist clients in securing housing, food, and essential medical care. A preliminary investigation by the OIG revealed that 12 of the 19 checks issued, as a result of requests submitted by the caseworker, were drafted to the caseworker's husband and other acquaintances. The 12 clients listed, as the beneficiaries of the fund assistance, had not requested the funds and had no knowledge that their names had been used to obtain money from the Department. The OIG referred the case to the Illinois State Police and to the Office of the State's Attorney.
OUTCOME	The worker was found guilty of state benefits fraud and sentenced to two years probation and $10,000 restitution.

Case 43	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Request for Assistance from out-of-state State's Attorney's Office
ISSUE	Allegation of fraud
ACTION TAKEN	This out-of-state State's Attorney's Office requested OIG assistance to investigate a case of alleged fraud with a possible connection to children in placement in Illinois.
OUTCOME	The OIG investigation failed to reveal any association with current or past wards in Illinois.

Case 44	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the Illinois State Police and the State's Attorney's Office
ISSUE	Fraudulent use of Norman funds
ACTION TAKEN	An employee of a private agency that administers the distribution of Norman funds for Department clients devised a scheme for having checks made out to family members and friends. After investigating the fraud and compiling evidence, the matter was referred to the Illinois State Police and State's Attorney's Office.
OUTCOME	As a result of the subsequent investigation, indictments were obtained on four persons. All pled guilty and received probation terms from four years to one year and restitution from $300 to $7,000.

Case 45	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the State's Attorney's Office
ISSUE	Identity Theft
ACTION TAKEN	The OIG investigated a complaint of the unauthorized use of a foster parent's social security number by a private child welfare agency receptionist. The OIG completed a criminal background check on the receptionist and found that she had already been convicted of identity theft. The OIG assisted the executive director of the agency in referring the matter to the State's Attorney to investigate if there were more victims of identity theft.

OUTCOME	The receptionist was found guilty on eight indictments for ID theft after pleading guilty on the eight cases. She was placed on eight concurrent probations for 30 months, with the first year in intensive probation and 6 months in the Cook County Department of Corrections. There are petitions pending on the eight cases for violation of probation, and eight warrants are outstanding for the receptionist.

Case 46	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to local law enforcement
ISSUE	Forgery of foster care payment checks
ACTION TAKEN	The OIG learned that a woman was forging foster care checks. She cashed the checks over a period of time for an accumulated sum over $22,000. The OIG referred the investigation to law enforcement for criminal investigation.
OUTCOME	The woman was criminally prosecuted and pled guilty. She was sentenced to 21 months imprisonment and ordered to pay $22,000 in restitution to the State of Illinois.

Case 47	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Referral to the Illinois Attorney General's Office
ISSUE	Theft of state benefit time
ACTION TAKEN	An OIG investigation revealed that a Department administrator misused 16 days of sick benefit time to provide paid consulting services. The OIG referred the employee to the Illinois Attorney General for official misconduct.
OUTCOME	The employee was terminated from the Department. The administrator settled the case for payment of restitution for the 16 sick days.

Case 48	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Request for assistance from the Illinois State Police, Division of Internal Investigations
ISSUE	Child welfare services
ACTION TAKEN	The OIG assisted the Illinois State Police (ISP) Division of Internal Investigations in their investigation of a Department administrator for using her position to fraudulently obtain extensive services for her own children.
OUTCOME	The ISP was unable to verify the complaints regarding the fraud.

Case 49	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Request for assistance from the Illinois State Police
ISSUE	Suspicious child support payments
ACTION TAKEN	The Illinois State Police requested assistance on a referral from the US 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 determined that the accumulated checks were from the state child support disbursement office and directed to a legitimate recipient who had recently moved and had not yet furnished a new address to the disbursement office.

OUTCOME	The child support checks were delivered to the recipient at her new address.

Case 50	
CATEGORY	Misappropriation of state funds
NATURE OF INVOLVEMENT	Request for assistance from the US Treasury Department
ISSUE	Suspected sale of social security numbers
ACTION TAKEN	The US Treasury Department requested assistance from the OIG in investigating a private agency worker who was suspected of selling children's Social Security numbers for people to use in filing tax returns. The OIG assisted in the criminal investigation. The OIG also 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 into the matter.
OUTCOME	Following the OIG investigation, the worker resigned and relinquished his child welfare license. The Federal case is pending.

Case 51	
CATEGORY	Threat
NATURE OF INVOLVEMENT	Referral to the Illinois State Police
ISSUE	Threatening phone call
ACTION TAKEN	The OIG was informed that an Administrative Law Judge had received a voice-mail message from an unknown caller who threatened to kill her. The OIG compiled and transmitted the relevant information to the Illinois State Police for investigation.
OUTCOME	The caller could not be identified. No criminal charges were brought.

Case 52	
CATEGORY	Threat
NATURE OF INVOLVEMENT	Referral to Illinois State Police
ISSUE	Threat against Department employee
ACTION TAKEN	A former private agency employee threatened a Regional Counsel for the Department. The OIG compiled and transmitted the information to the Illinois State Police for investigation.
OUTCOME	The Illinois State Police declined to refer the case for prosecution.

Case 53	
CATEGORY	Threat
NATURE OF INVOLVEMENT	Referral to the Illinois State Police
ISSUE	Workplace threat
ACTION TAKEN	A DCFS worker, who had a history of threatening fellow workers and had been reinstated in her job after termination for prior incidents, again threatened a fellow worker, who was frightened by the threat. The worker was administratively charged. The OIG investigators sought the assistance of the Illinois State Police to have the worker removed from the premises. The worker was placed on administrative leave.
OUTCOME	The criminal charge was struck with leave to reinstate. The worker was terminated and the termination was upheld throughout the grievance process.

Case 54	
CATEGORY	Threat
NATURE OF INVOLVEMENT	Referral
ISSUE	Threat against a Department office
ACTION TAKEN	The OIG learned that a disgruntled former foster parent and subject of a prior OIG investigation called the Governor's office and threatened to "blow up" a Department office. Central Management Services police investigated the threat, but did not refer the matter to the Illinois State Police or otherwise alert Department personnel. Central Management Police reasoned that the threat was not direct because the foster mother had not stated that she would blow up the building, only that "someone" might.
OUTCOME	The OIG notified State Police and ensured that all offices that might have been possible targets for retaliation stemming from the case were notified to take necessary precautions.

Case 55	
CATEGORY	Threat
NATURE OF INVOLVEMENT	Request for assistance from Illinois State Police
ISSUE	Telephone Harassment
ACTION TAKEN	The Illinois State Police sought the assistance of the OIG in locating a DCFS subcontractor suspected of telephone harassment.
OUTCOME	The individual was not prosecuted.

Case 56	
CATEGORY	Breach of Confidentiality
NATURE OF INVOLVEMENT	Referral to Illinois State Police
ISSUE	Release of confidential address information
ACTION TAKEN	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.
OUTCOME	There was no criminal prosecution. The employee chose to resign and relinquish her child welfare license.

Case 57	
CATEGORY	Breach of Confidentiality
NATURE OF INVOLVEMENT	Request for assistance from local law enforcement
ISSUE	Case records
ACTION TAKEN	Police contacted the OIG when original client service records were found in an abandoned storage locker. The locker belonged to a former worker who had been disciplined previously for falsification of records.
OUTCOME	The OIG ensured that the records were returned and verified that the former worker was no longer employed in child welfare.

Case 58	
CATEGORY	Misuse of state property
NATURE OF INVOLVEMENT	Referral to the Illinois State Police
ISSUE	Misuse of state property
ACTION TAKEN	A child protection investigator on call for weekend duty took a state car and picked up his girlfriend. It was alleged that the couple was drinking and doing drugs while the employee was on call. While in the car, the couple became involved in a physical altercation that left blood stains inside the vehicle. The OIG referred the matter to the Illinois State Police for investigation.
OUTCOME	The State Police conducted an investigation, but the State's Attorney declined to prosecute. The employee resigned with no reinstatement rights.

Case 59	
CATEGORY	Executing a warrant
NATURE OF INVOLVEMENT	Request for assistance from local law enforcement
ISSUE	Outstanding warrant
ACTION TAKEN	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.
OUTCOME	Based on the information provided by the OIG, the man was arrested on the outstanding warrants.

Case 60	
CATEGORY	Executing a warrant
NATURE OF INVOLVEMENT	Referral to Local law enforcement
ISSUE	Outstanding warrant
ACTION TAKEN	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 61	
CATEGORY	Executing a warrant
NATURE OF INVOLVEMENT	Referral to local law enforcement
ISSUE	Outstanding warrant
ACTION TAKEN	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.
OUTCOME	The individual was located. He pled guilty on the drug charge and was sentenced to 18 months probation.

Case 62	
CATEGORY	Executing a warrant
NATURE OF INVOLVEMENT	Request for assistance from local law enforcement
ISSUE	Outstanding warrant
ACTION TAKEN	During an OIG investigation of a private agency worker, the OIG learned the individual was wanted on an outstanding warrant. The OIG coordinated with the local department and provided the information about her current residence and place of employment. However, the individual fled when the police and OIG investigators arrived at her place of employment.

Case 63	
CATEGORY	Other
NATURE OF INVOLVEMENT	Referral to the US Attorney's Office and the Illinois Attorney General
ISSUE	Possible Civil Rights Violation; Perjury
ACTION TAKEN	The OIG investigated a complaint that a child protection investigator exhibited bias against the parents' religious beliefs. During a shelter care hearing, the child protection investigator stated to the judge that because of the parents' religious affiliation it was likely they would attempt to hide the children from the Department. The OIG referred the case to the United States Attorney's Office for review of possible violation of the Civil Rights of the family. The OIG also referred the case to the Illinois Attorney General's Office for suspected perjury.
OUTCOME	The State's Attorney's Office declined to prosecute.

Case 64	
CATEGORY	Other
NATURE OF INVOLVEMENT	Request for assistance from the Illinois State Police
ISSUE	Violation of a court order
ACTION TAKEN	The Illinois State Police sought OIG assistance in an investigation of a DCFS worker based on failure to follow a court order.
OUTCOME	The Illinois State Police investigation found no basis for the allegations.

Case 65	
CATEGORY	Other
NATURE OF INVOLVEMENT	Request for assistance from the Illinois State Police (ISP), Internal Investigations Division.
ISSUE	Suspected misuse of criminal history information
ACTION TAKEN	The OIG investigated a DCFS worker for allegedly improperly accessing criminal history information regarding a household member of a co-worker and passing the information on to other co-workers. The same complaint was made to the Illinois State Police (ISP), Internal Investigations Division. The OIG conducted its investigation in conjunction with the ISP.
OUTCOME	The allegations were not substantiated and the case was closed.

Case 66	
CATEGORY	Other
NATURE OF INVOLVEMENT	Referral to the Illinois State Police
ISSUE	Misidentification as a sex offender
ACTION TAKEN	A man who was seeking custody of his brother alleged that he was misidentified as a sex offender on the State Police Sex Offender database. The OIG investigation verified that the information on the database was incorrect and the man had been misidentified.
OUTCOME	The man's name was removed from the database.

Case 67	
CATEGORY	Other
NATURE OF INVOLVEMENT	Request for assistance from the State's Attorney's Office
ISSUE	Services and treatment for a delinquent minor
ACTION TAKEN	The OIG received a request for assistance from the State's Attorney's Office regarding an 11 year-old boy with a pending delinquency petition who was charged with Criminal Sexual Assault. The State's Attorney's Office asked the OIG to help determine what could be done in the boy's best interest with regard to living arrangements, service and treatment. The OIG obtained copies of the boy's records and prepared them for review.
OUTCOME	The minor was found delinquent and successfully completed one-year probation.

Case 68	
CATEGORY	Other
NATURE OF INVOLVEMENT	Request for assistance from the Illinois State Police
ISSUE	Unspecified misconduct
ACTION TAKEN	The Illinois State Police requested assistance from the OIG in their investigation of improper conduct by a DCFS employee.
OUTCOME	The State Police investigation found no improper conduct by the DCFS employee.

Case 69	
CATEGORY	Other
NATURE OF INVOLVEMENT	Referral to the Illinois Attorney General's Office
ISSUE	Commercial exploitation
ACTION TAKEN	The OIG was alerted to a website that purported to be from DCFS, but was not. The OIG referred the matter to the Attorney General's Office.
OUTCOME	After authorities attempted to access the website, it was shut down. The investigation was closed.

LAW ENFORCEMENT AND DCFS INSPECTOR GENERAL CASE REVIEW (FY 05)

In FY 05, the Inspector General referred fourteen cases to law enforcement agencies and received two requests for assistance from law enforcement agencies. Four of the cases involved harm/risk of harm to children; nine involved theft or fraud; two involved execution of warrants and one falsification of records. The summaries of the cases are detailed below.

CASE 1
Federal Postal Inspectors requested the OIG's assistance in their undercover investigation of former foster parents for public aid fraud. The former foster parents had applied to become foster parents under assumed names and later adopted four DCFS wards, also under the assumed names and were continuing to accept DCFS post-adoption subsidy payments under assumed names. The OIG assisted the federal investigators and referred to the Illinois Attorney General's Office the question of whether the adoptions could be invalidated on the basis of fraud.

CASE 2
The OIG investigated a DCFS employee and private agency workers involved in the theft of LAN funds. The OIG referred the findings of the investigation to the State's Attorney's Office, which is conducting a criminal investigation.

CASE 3
The Illinois State Police and the OIG conducted a joint investigation that resulted in the indictment of a former Department employee. The individual was charged with criminal sexual abuse/force and aggravated sexual abuse.

CASE 4
A financial officer of a private agency transferred DCFS funds from the agency to her personal account. The OIG referred the findings of its investigation to the State's Attorney's Office for consideration of prosecution. The State's Attorney's Office is investigating the matter.

CASE 5
An adoptive mother placed her adopted child with a woman, but continued to accept the adoption subsidy for several years and never provided any financial support for the child. The child was located in another state, still living with the same woman. After verifying that the child was in a good home, the OIG referred the adoptive mother to the County State's Attorney's Office. In February 2005, the adoptive mother was indicted by the Grand Jury on a misdemeanor theft charge and two felony counts. In July 2005, she pled guilty to the misdemeanor count and was placed on a year's probation, with full restitution of $18,375, which she paid in full.

CASE 6
In August 2002, the OIG referred the case of a private agency worker involved with theft of Norman funds to the Illinois State Police. In August 2004, a Grand Jury indicted the worker on several counts of felony theft and forgery and state benefits fraud. In February 2005, the worker pled guilty to the charge of State Benefits Fraud and was sentenced to 4 years probation and restitution in the amount of $7,000.

CASE 7
The OIG began investigating the diversion of Department funds to an entity with financial ties to a Department Administrator. When the OIG became aware that the funds were deposited into a bank account over which the Administrator had sole control, the OIG referred the case to federal authorities for misuse of federal funds. The federal investigation is pending.

CASE 8
An OIG investigation of the physical abuse of children in a foster home found that the abuse by the foster parents was extensive, ongoing, and involved several children. The OIG referred the case to the local police department for consideration of criminal prosecution.

CASE 9
While assisting a DCFS worker in a determination of whether a home was suitable for placement by researching the disposition of a murder charge, the OIG investigator learned that there was an outstanding warrant on the same party for Home Invasion. After confirming that the warrant was still good with the issuing agency, the OIG obtained current information as to the location of the wanted person. The OIG furnished the information to the local police departments involved.

CASE 10
During an investigation involving the death of a child, the OIG investigators learned that a private agency homemaker falsified documents regarding her contacts with the family. The OIG referred the worker to the State's Attorney's Office for their review and consideration of criminal charges against the worker.

CASE 11
The Federal Bureau of Investigation and the United States Secret Service requested OIG assistance in the investigation of a Department employee who was allegedly accessing child pornography from international sources. This same individual later made a threat against the President of the United States who was about to visit his hometown.

CASE 12
The OIG received information from the Children's Account Unit regarding the theft of a child's computer by a foster parent. The DCFS ward was issued money for the purchase of a computer to assist him in doing his schoolwork. He was a special needs student. The ward was placed into another foster home. The former foster mother refused to turn over the child's computer claming she was keeping the computer as compensation for damage that had been done to her home by other foster children. When the foster mother failed to produce the computer, the OIG asked the local police department to investigate the theft of the computer by the foster mother.

CASE 13
The OIG investigated an allegation that a computer used by an Administrator at a private child welfare agency contained pornographic images. The OIG impounded the computer and coordinated with the Attorney General's High Tech Crimes Unit. The analysis by High Tech Crimes failed to reveal any evidence of pornography. A subsequent allegation was made about a second computer at the same facility. This computer was the property of the Chicago Board of Education. The OIG notified the Inspector General's Office of the Board of Education and they took possession of the second computer.

CASE 14
DCFS issued a $552 check to a ward after she graduated from the Illinois School for the Deaf for personal items in anticipation of her attending college. A cousin of the ward intercepted and cashed the check. The ward was issued a second check. OIG investigators met with the cousin, who admitted taking the check and agreed to pay back the money to DCFS. When the cousin failed to repay the money, the OIG

referred the matter to the State's Attorney's Office. The State's Attorney's Office was unable to locate the cousin and closed the case.

CASE 15

A local police department requested assistance in tracking down the owner of a vehicle who had driven off without paying for gasoline. The Secretary of State's office listed the lessor of the vehicle as DCFS. The OIG determined that 'DCFS' referred to a car rental facility and has no connection with the Department.

INVESTIGATIONS

This annual report covers the period of time from July 1, 2004 to June 30, 2005. The Investigations section has three 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 the OIG conducted a formal investigation. Part II contains summary information about all child deaths in Illinois (reported to the State Central Register) in FY 2005 and individual summaries for each child case. Part III 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 newborn baby died after being delivered into a toilet by her mentally ill mother. At the time of the baby's death, the Department had been offering reunification services to the mother for five years and her oldest child had been in Department custody for the same amount of time.

INVESTIGATION

The family's involvement with the Department began after the hotline received a call alleging the mother, who was six months pregnant at the time, was physically abusive to her three year-old son and gave him cold medicine unnecessarily in order to put him to sleep when she did not want to care for him. The mother's mental illness and developmental delays severely limited her ability to care for her son independently. At one point during the child protection investigation of the report, the mother became physically threatening towards the investigator before pulling out her own hair, jumping up and down and banging her head against a television set. The investigator contacted local police who responded to the scene and stopped the mother from leaving the home with the boy. The boy was taken into protective custody and placed in a traditional foster home. The mother was indicated for Cuts, Welts and Bruises as well as Substance Misuse and a family reunification case was opened through the Department.

The case remained open for reunification services for the next five years. During that time the mother consistently displayed intellectual limitations, emotional instability and an unwillingness to comply with the provisions of her service plan. Nine months after the case was opened, and three months after the birth of her second child, the mother participated in a psychological assessment. The mother acknowledged her inability to perform many basic tasks related to child care and reported a recent suicide attempt. The doctor determined the mother, "[did] not have minimal skills necessary to provide adequate parenting," and should be monitored in the presence of her children. Despite the doctor's conclusion and the fact the mother's oldest son was in foster care, her younger son was allowed to remain in her custody. While the case was open, the mother had two psychiatric hospitalizations during which she told staff she heard the voices of deceased relatives. She was prescribed psychotropic medications but used them sporadically. Her housing situation remained tenuous as she moved through a series of homes and apartments belonging to friends, relatives and

boyfriends although she received $700 per month in housing assistance. The mother frequently resided in the home of her children's maternal grandmother who had a history of mental illness and had been investigated for neglect when the mother was a child. The mother had two sisters who also demonstrated cognitive limitations and whose children had been removed from their care. The grandmother's boyfriend was alleged to have sexually abused one of the sisters who in turn had been indicated for sexually abusing her niece. The mother engaged in numerous romantic relationships with men who friends alleged took advantage of her, however few of these individuals were identified by the involved workers.

Throughout the Department's handling of this case, the caseworker assigned to provide reunification services and her supervisor failed to provide effective case management or adequately assess risks posed to the younger son who remained in the mother's care. Upon the younger son's birth, three months after the case was opened, hospital staff refused to immediately release him to the mother since they were aware her older son was in Department custody. At that time, the caseworker and her supervisor were aware of the circumstances that had resulted in the older boy's removal, however the caseworker told hospital staff that if they did not have concerns, the Department had no legal responsibility to the child.

The educational and developmental needs of both boys went unaddressed. When the older boy was taken into Department custody he presented speech and language impairments and was found to be eligible for special education services. Although a doctor recommended the creation of a behavior management plan, an OIG review of the case file found no evidence one was designed. The younger boy was never referred to an early intervention program to ensure his cognitive, physical and psychosocial development. Department Procedure requires that wards exhibiting conditions recognized as or contributing to developmental delays be referred for early intervention services. However, since the younger boy remained in his mother's custody, no such referral was made.

The workers also failed to work towards achieving permanency for the older boy as he remained in his foster home for five years with a goal of return home. His elderly foster mother served well as a caretaker and developed a relationship with the mother as an additional source of support, however she had excluded herself as a potential adoptive parent, citing her advanced age. The caseworker and her supervisor continued to focus on the mother as the boy's eventual caretaker despite her inability to demonstrate any progress toward that goal over several years.

For the first four years the case was open, the mother received homemaker services through a private agency. Throughout that time, the homemaker reported the mother was "upgrading her parenting skills" although no improvement was noted. The homemaker's notes were often vague accounts of what services were provided and repeated common phrases without insight or critical assessment. The homemaker also neglected to note significant developments that occurred in the home, such as the mother's hospitalization for burns to her face and scalp. In addition, The OIG identified multiple instances where the homemaker had documented providing services in the mother's home when the mother was known not to be present, including during one of her psychiatric hospitalizations. The notes also showed the homemaker continued to provide her services uninterrupted after the mother was evicted from her residence.

After five years of involvement with reunification services through the Department, with one child in foster care and the other in her custody, the mother gave birth to a baby girl while at home. The mother delivered the infant into a toilet where she drowned. The mother reported to police she had seen the baby moving following its birth but left her in the bowl. Police officers reported the grandmother's home, where the mother lived with her then five year-old son, was in a state of extreme disarray and smelled of feces, urine and bleach. The grandmother told police there were no lights in the home because the landlord had warned existing electrical problems could result in a fire if any were turned on. The mother's boyfriend, who also lived in the home, told police they obtained water from neighbors and used kerosene heaters for warmth. The

mother was hospitalized after becoming belligerent with medical personnel treating her and was subsequently indicated for Environmental Neglect, Inadequate Shelter and Death By Neglect. She was also criminally charged with first-degree murder. The five year-old boy was found to be non-verbal and lacking in many basic skills, such as potty training. The boy was taken into custody by the Department.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be disciplined for failing to assess the case, failing to provide appropriate services, failing to communicate with the mother's mental health providers, child welfare professionals servicing her sister's and the county's special education district, poor documentation and failing to move the older boy towards permanency.

The worker was disciplined. The report was reviewed with the supervisor.

2. The caseworker's supervisor should be disciplined for her failure to ensure the caseworker was appropriately assessing and servicing the case and moving the case towards permanency.

The supervisor was disciplined.

3. The site administrator should be disciplined for lack of diligence in rectifying problems repeatedly identified in numerous chronic and one critical ACR feedbacks.

The site administrator was disciplined.

4. The assistant administrator for the region should pull a sample of the caseworker's cases to determine if the extent of her problematic casework demonstrated in this case is reflected in other cases.

The caseload was reviewed. The review identified missing case entries and ACRs. A corrective plan was implemented to correct these issues.

5. Any open cases in the region with goals of return home for more than three years should be reviewed by the regional administrator or his designee, including reading of the record, to determine if management intervention is needed.

This was implemented and this child's was the only case with these dynamics. A corrective action plan has been implemented requiring review of all cases of children with goals of return home over than two years.

6. The OIG will refer the falsification of homemaker records to the county's State's Attorney for possible prosecution.

The Department agrees. The case was referred by the OIG.

7. The homemaker should be disciplined by the private agency in accordance with their personnel policy.

OIG Response: The OIG shared the report with the private agency and the President of the Board of Directors of the agency. The Inspector General met with the Chief Executive Officer and a member of the Board of Directors to discuss the report. The homemaker is no longer employed by the agency.

8. The Department should extend the expectation that wards are immediately referred for pre-school

education, including early intervention services, as identified in Procedures 314.70, to children at home with their parents.

The Department's Internal Awareness campaign includes two brochures: 1) targeted at workers (including intact workers) and foster parents laying out the importance of pre-school interventions; this is currently being distributed 2) targeted at workers (including intact workers) is being developed explaining the advantages of working with pre-school staff. An Information Transmittal is being drafted.

The Guide for workers (including intact workers) is being developed in cooperation with Head Start collaboration office at DHS.

The Department agrees to develop training to ensure caseworkers attempt to address the need for early intervention services for children in intact families.

9. The regional administrator should convene a workgroup of supervisors, managers, mental health professionals and State's Attorneys in the region to develop a collaborative approach to cases involving dependency and risk of harm.

This recommendation was implemented with a series of meetings with State's Attorneys, Judges, managers, and psychologists from the region. The plan is to have direct training with staff and supervisors to address risk relative to intact families once the statewide reorganization is complete. Targeted completion date is Spring 2006.

10. A clinical review of the older boy should be conducted to determine if his foster mother's foster care payment is commensurate with the care he receives.

A clinical staffing was convened at the local field office. It was determined that the foster parent should be receiving the specialized foster care rate for the child. The rate has been changed.

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

A four month-old boy died from a blunt force trauma injury to the head inflicted by an unknown perpetrator. At the time of the boy's death his family was involved with intact family services.

INVESTIGATION

The family came to the Department's attention upon the boy's birth when he tested positive for cocaine, marijuana and opiates. The hotline received a call from a reporter who stated the mother may take the baby and leave the facility against medical advice. The report was accepted and the assigned child protection investigator met the mother at the hospital the same day. The mother denied using drugs other than marijuana during her pregnancy but agreed to a substance abuse assessment, stating she would do whatever was necessary to retain custody of her son. The mother stipulated, however, she would only participate in an outpatient program because she did not want to be separated from the baby.

The following day, the investigator met with the mother again and completed a Child Endangerment Risk Assessment Protocol (CERAP). Although the mother admitted to smoking a quarter ounce of cocaine weekly prior to her pregnancy and a history of heroin addiction, which she claimed to have overcome while jailed on drug charges, a question addressing whether substance abuse might affect her ability as a caretaker was marked "no" by the investigator. Since the investigator did not note the presence of any safety factors the development of a safety plan was not required. The mother accepted placement in an outpatient drug treatment program and agreed to move in with her brother and his wife. The case was referred for intact family services through the Department.

The baby's father was incarcerated at the time of the initial investigation for violating his parole following his earlier imprisonment for auto theft. The child protection investigator did not conduct a criminal background check on the father. In an interview with the OIG, the investigator stated she did not conduct the check because the father was not in the home at the time and the mother expressed ambivalence about resuming their relationship following his release. The investigator did not contact the father's parole officer to learn the circumstances of his violation or his release date. Four days after the CERAP was conducted, during a meeting to open the intact family services case, the investigator learned from the mother that the father's parole violation was related to an act of domestic violence against her while both were experiencing narcotic withdrawal. An OIG review of police records found the father had been arrested for kicking the mother when she was five months pregnant with their son. Despite the revelation of domestic violence issues in addition to further evidence of serious substance abuse, the investigator did not revise the CERAP or implement a safety plan.

An intact caseworker was assigned to provide services to the family, however responsibility for direct involvement with the family was assumed by a student intern assisting in the office at the time. The intern met with the mother and the child protection investigator in the home of the brother and sister-in-law. The intact caseworker had no previous experience supervising an intern and received no instruction on Department policy or procedure regarding such arrangements. The caseworker was knowledgeable about the case and spoke to the intern frequently during unscheduled informal conversations but had little direct involvement. In an interview with the OIG, the intact supervisor stated she regarded the intern, who had worked for three years in a domestic violence shelter, as a domestic violence "expert" and said she deferred to her judgment, rhetorically asking OIG investigators, "What do I know about domestic violence?" The intact supervisor further stated she would have been unable to provide much assistance to the intern, as her duties did not include direct service work.

Two weeks after the mother began outpatient treatment she was expelled from the program following

sporadic attendance and two failed drug tests. The mother's non-compliance with services prompted the intern to call the hotline and report the mother's continuing drug use. The report was accepted and the same child protection investigator was assigned to the second case. The investigator spoke to the mother who admitted using cocaine four days earlier but stated she had taken her son to a neighbor's apartment before getting high and picked him up after she had come down about 20 minutes later. The investigator did not ask for the neighbor's name or make any attempt to verify the mother's story. The mother informed the investigator the baby's father had been released from jail the day before and was present in the home, sitting in a bedroom with the infant. The investigator did not speak with the father and his presence in the home did not compel her to obtain his criminal history. The investigator learned from the intern she had not attempted to locate the mother at her home prior to calling the hotline. Based on this fact and the mother's unconfirmed account of leaving the baby with a neighbor while she used drugs, which the investigator characterized as a "care plan," the investigator unfounded the report.

Shortly before the report was unfounded the mother informed the intern the father had moved in with her. The intern continued her involvement with the intact family case, helping the mother enroll in an inpatient drug treatment program. During her time in treatment the father missed required scheduled drug tests and was turned away while attempting to visit the mother at the inpatient facility after staff determined he was under the influence of narcotics. The mother told the intern she was worried the baby's maternal grandmother would cease making payments on the mother's home since the father was living there and using drugs. On two occasions, ten days before and one week after the mother was in the inpatient treatment program, she was admitted to hospitals for medical treatment. The mother told the intern that both times she was given morphine before she was able to relate her opiate-related substance abuse problems to staff, although she was conscious and conversant both times. The day after the second hospital visit, the four month-old baby died from a close head injury due to blunt force trauma. The county coroner ruled the death a homicide, however law enforcement officials were unable to establish whether either or both parents were responsible for the baby's injury. The Department indicated a report for Death by Neglect against an unknown perpetrator.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for failing to identify substance abuse as an issue possibly compromising a mother's ability to care for her child despite the mother's admission that she smoked cocaine weekly prior to her pregnancy and had a history of heroin addiction. The investigator failed to revise the Child Endangerment Risk Assessment Protocol or implement a safety plan in response to revelations of domestic violence issues and further evidence of serious substance abuse. The investigator also failed to conduct a LEADS check or interview the father, who was living in the home, and failed to verify the mother's assertion that a neighbor provided childcare while the mother used cocaine.

The child protection investigator was disciplined.

2. The intact family caseworker and intact family supervisor should be counseled for inadequately assessing risks and for not providing the intern with adequate case oversight, counseling or the supervision necessary to competently manage a complex substance affected family case.

The caseworker and supervisor were counseled.

3. The Department's Clinical Division should develop a protocol on the utilization, monitoring and supervision of student interns.

An internship program manual and accompanying Policy Transmittal are being developed and have been returned to the Office of Training for specific revisions requested by the Deputy Director. A work plan is

being developed and revisions expected to be completed by the middle of January 2006. Implementation will begin as soon as approvals are finalized.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

A three month-old baby died of complications of his premature birth. Both the infant and his mother tested positive for cocaine upon his delivery. The baby was the mother's third child born positive for the presence of cocaine. At the time of the baby's death the family had an open case for intact services.

INVESTIGATION

By the time the mother gave birth to her fourth child, the third born exposed to cocaine, she had an eleven-year history of intermittent involvement with the Department. During that time the family had been the focus of two separate intact service cases that documented the mother's chronic cocaine use and participation in the drug trade among her friends and extended family. The youngest of the mother's three daughters suffered from congenital heart disease that required consistent medical attention and all three girls spent a substantial amount of time in the care of relatives. After hospital staff received test results confirming the presence of cocaine in the fourth child's system following his birth, they contacted the hotline and a child protection investigator was assigned to the case.

Prior to meeting with the mother the investigator learned that two days before the birth, the mother had been admitted to the same hospital for treatment of injuries and that when she arrived to deliver the baby she had cuts and bruises on her face. The mother told the investigator the injuries had been inflicted by the infant's father. The investigator did not ask the mother the whereabouts of her three other children or make an attempt to visit them to assess potential risks to their well-being. The following day the investigator spoke to the baby's father who acknowledged previous physical altercations with the mother. Although the mother had stated she filed a police report against the father regarding her most recent injuries, the investigator did not attempt to obtain a copy of the report or make an effort to determine if other calls had been made to law enforcement from the home. The investigator also neglected to perform a Domestic Violence Mini Screen despite both the mother's and father's admissions of domestic violence in their relationship.

The investigator referred the mother to an inpatient drug treatment facility, however her entry into the program was delayed for one month until space became available. Although the investigator noted the presence of domestic violence issues and identified both children as being placed at high risk, she believed the mother's inpatient status mitigated the threat posed by domestic violence. The investigator did not gather information about the father or conduct a Law Enforcement Agencies Database System (LEADS) check on him. The child protection report was indicated against the mother for Substance Misuse and the family was referred for "short term" intact services through the Department.

The caseworker assigned to provide services to the family was initially unable to meet with the mother because the investigator failed to attend a scheduled meeting at the substance abuse treatment facility. As a result, the caseworker was denied access by staff as an unapproved visitor. After the caseworker's status was established he completed a Child Endangerment Risk Assessment Protocol (CERAP) that concluded the two youngest children would be safe as long as they resided at the inpatient treatment center. The CERAP also determined the mother's other two children to be safe in the care of their maternal aunt although the caseworker had never visited the home or observed the children. On the day the CERAP was conducted, the infant boy was again released from the hospital and transported to the treatment center where he was placed in his mother's custody. Prior to the baby's release, the mother had admitted to staff at the treatment facility that she used cocaine while on leave to visit the infant in the hospital. Both the caseworker and his supervisor were aware of the mother's drug use while away from the program at the time the CERAP was approved.

One week after the CERAP was completed the mother was discharged from the substance abuse center for belligerent behavior and non-compliance with rules. The caseworker picked up the mother and her two

children and transported them to a shelter. The caseworker waited at the shelter until staff took the family's names and instructed the mother to call him daily until he identified another treatment program for her. The caseworker then completed another CERAP which concluded the two youngest children were unsafe based on the mother's admitted drug use and her expulsion from substance abuse treatment. In an interview with the OIG, the caseworker related his understanding that the shelter was intended to provide families with housing for extended periods, if necessary. The caseworker stated he did not provide staff at the shelter with any of his contact information nor did he inform them of the mother's history of drug use or the medical conditions present in her two young children. The caseworker said he did not explore placing the family in the home of relatives because the mother dismissed her living with relatives as an option. In a separate interview, the caseworker's supervisor stated he was aware the shelter was intended to serve as a temporary "holding station" while families transitioned to other accommodations. The supervisor told the OIG he believed the caseworker was unfamiliar with the nature of the shelter.

Staff at the shelter transported the family to another, more appropriate location, however the mother left the facility with her children and did not contact the caseworker. Three days later the baby boy was brought to a hospital emergency room where he was pronounced dead of bronco-pulmonary dysplasia related to his premature birth. The caseworker did not learn of the baby's death until three days later when he was contacted by the mother. The caseworker continued his involvement with the family as the intact service case remained open, however an OIG review of the case record found a paucity of meaningful actions taken to provide stability for the family or ensure the surviving children's safety. The mother continued to be non-compliant with services and openly acknowledged her ongoing drug use. Neither the caseworker nor his supervisor initiated any contact with any of the children's medical providers or school personnel. After the mother again agreed to enter inpatient treatment it was determined the two youngest daughters should reside in a separate placement. The caseworker and his supervisor recommended the mother's 19 year-old niece, who was caring for her own three month-old son, be granted guardianship of the girls. The niece was not approved for guardianship by the Department's Legal Division and the case remained in flux. The involvement of a new intact family supervisor who assumed responsibility for overseeing the case led to significant improvements in service and resulted in the Department being granted guardianship of the youngest daughter. However, the mother discontinued her participation in substance abuse treatment prior to completion taking the youngest girl with her. Soon afterwards, the next oldest daughter ran away after being approached at school by a Department worker. At the time of this report, the whereabouts of both children are unknown.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discipline the intact family services supervisor for neglecting to ensure that children were safe and properly monitored through intact family services; failing to take protective custody of a medically fragile infant whose mother was non-compliant with drug treatment, who was involved in a domestic violence relationship, and who demonstrated impulsive and verbally aggressive behavior; failing to explore placement options for the infant before placing him in a shelter; and demonstrating poor judgment when he proposed an inexperienced 19 year-old to become the children's guardian without full information and assessment of the young adult.

The supervisor was disciplined.

2. The Department should counsel the intact family services caseworker for failing to take protective custody of a medically fragile infant whose mother was non-compliant with drug treatment, who was involved in a domestic violence relationship, and who demonstrated impulsive and verbally aggressive behavior; failing to explore placement options for the infant before placing him in a shelter; failing to inform shelter staff about the medical condition of a fragile infant; and failing to make an effort to contact the mother after leaving her and her two children at a shelter.

The caseworker was disciplined.

3. The Department should provide non-disciplinary counseling to the child protection investigator and her supervisor for lapses in the investigation of the infant's substance-exposed birth including failing to investigate the presence of domestic violence in the home by not conducting a domestic violence screen, not completing a LEADS check on the father with whom the children were having contact and not following the paramour policy; and not attending a hand-off meeting with intact services, especially since the investigator had discussed the possibility of screening the case with court, indicating moderate to high risk was present.

The child protection investigator and supervisor were counseled.

4. Intact family services supervisors should have access to child abuse/neglect investigations in the SACWIS system on a "read only" basis to enable informed service planning and decision making.

The worker and supervisor should have had access to all investigations *linked* to participants in their case as this is the essence of like member security. Link is italicized because if the case was not appropriately linked to the correct family, follow-up would not have access to those individuals specific to this case. Whether or not there was a linking or other functionality issue with the application in this case is unknown. However, during the time this case was serviced by the supervisor in question (May 2004-April 2005), Child Welfare supervisors had like member security access to investigations in SACWIS.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION

A one day-old baby died from complications of a premature delivery likely precipitated by his mother's drug use. At the time of the baby's death, the mother and her two young children were receiving intact family services.

INVESTIGATION

The mother had an extensive history of substance abuse and mental illness dating back to her youth. She had been physically and emotionally abused by her stepfather and was a victim of sexual abuse by her biological father. She delivered her first child at the age of 13 and at 19 had two children permanently removed from her custody. Her third child, a boy, was born one-month premature and demonstrated developmental delays. The mother admitted using crack cocaine during the first two months of her pregnancy before she was aware she was carrying a baby. When she delivered her fourth child, another boy, the infant tested positive for cocaine. A child protection investigation was initiated and the case was referred for intact family services through a private agency.

At the outset of the intact family services case, private agency staff noted the mother's disclosure she had used cocaine and alcohol for five years and had never engaged in substance abuse treatment. During a substance abuse assessment the mother acknowledged smoking crack cocaine throughout the time she carried her youngest child. The mother also told the evaluator she had molested one of the children removed from her custody when he was two years old because she wanted him to experience the trauma she had been through. The evaluator concluded the mother needed to overcome issues of substance abuse and sexual victimization before she could be viewed as an appropriate caretaker for her children, however they remained in her custody. Shortly before the assessment was conducted the mother informed agency staff she was pregnant.

Since the case was opened, the mother and her two sons had moved out of the home they shared with her older son's aunt and the aunt's boyfriend and into their own apartment, after spending time in a shelter. The aunt had an extensive criminal history and private agency staff was aware she was a regular drug user. After the family moved the aunt was incarcerated for a brief period of time. Following her release she began going to the new apartment, making threats against the mother and demanding money to purchase drugs. The assigned intact family caseworker recorded in her notes that the mother struggled to manage her finances and routinely sent large amounts of money to her older son's father who was in jail. Although Department Rule provides for 90 days of intensive family preservation services, at the end of that period it was determined the mother had not made satisfactory progress and a 30-day extension was granted.

Just before the intact case was scheduled for closure, staff from a nursery where the brothers stayed while their mother underwent a dental procedure reported to the caseworker their concern regarding a rash on the younger boy's neck. Nursery staff reported that both boys were dirty and unkempt and described the seven month-old as a "very sick baby." The caseworker and the mother transported the infant to a hospital where he was immediately admitted. The boy was found to be dehydrated and the rash on his neck and diaper area was a yeast infection. After being held overnight, the baby was prescribed medication and a follow-up appointment was scheduled, however, there was no indication in the case file any additional medical visits were conducted. In anticipation of case closing, private agency staff prepared a treatment summary. The summary noted that although the mother had attended substance abuse treatment she had not applied what she learned. In addition, staff recognized the mother's susceptibility to the influence of her friends and associates and her high potential for drug relapse.

During the ensuing two-week period, while the case was being transferred to the Department for closure, the mother's behavior deteriorated. She was receiving food and clothing from the private agency after claiming she was out of money after paying rent when, in reality, she and the children had moved back into the aunt's

home. The caseworker was told by the mother's landlord she was being evicted for failure to pay rent and was informed by a colleague the seven month-old still had a severe rash on his neck. The caseworker called the family's pediatrician who stated the mother had not contacted him for follow-up and learned from the substance abuse treatment center she had ceased attending her appointments. The State Central Register (SCR) received a call regarding the instability of the family's situation and accepted the report for medical neglect. Meanwhile, on the same day, the mother submitted to a drug test requested by staff during a visit to the aunt's home. The test showed a positive result for the presence of cocaine. A second call was made to the hotline following the positive drug test. Although the SCR operator who took the second call could have used the report as the basis for an allegation of Risk Of Harm, the information was instead added to the initial medical neglect report. In an interview with the OIG, the caseworker stated she made the additional call to ensure the mother's drug use was considered as part of the child protection investigation.

A child protection investigator visited the family's home the following day and observed the rash on the baby's neck which she recorded in her notes as being, "beet red and raw." The mother told the investigator she had spoken to the pediatrician earlier in the day. By request, the mother then called the doctor's office in the presence of the investigator. In her case record, the investigator noted her belief it was unlikely the mother had previously contacted the office based on the mother's conversation with a nurse over the phone. The investigator instructed the mother to schedule an appointment for the following day. One week later the child protection investigator's supervisor contacted the doctor's office and confirmed the mother had brought her baby to the office. The investigator completed a Child Endangerment Risk Assessment Protocol listing all factors as safe. Although the mother and her children had moved back into the aunt's home, a criminal check of her background was not conducted by the investigator. In an interview with the OIG, the investigator stated she did not obtain the aunt's criminal history because the family had just recently moved into the home. The investigator stated she was unfamiliar with the family's history and questioned the relevance of such information to her investigation. The child protection supervisor spoke with private agency staff who informed her the mother had been encouraged to move out of the aunt's home because of the presence of substance-abusing adults. The supervisor was also told of the mother's recent positive drug tests and her failure to comply with requests to obtain medical treatment for her son's rash. Despite being provided with this information the supervisor met with the investigator nine days after the hotline call was made and instructed her to unfound the medical neglect report. According to the case record, the supervisor reasoned the infant's condition had not been life-threatening and he had been seen by the pediatrician. The record contained no indication the supervisor considered the mother's substance abuse or living arrangement in reaching her decision to unfound the report. In an interview with the OIG, the supervisor stated medical neglect cases are usually unfounded if a parent follows up with a physician or otherwise complies with an investigator's directive.

Three weeks after the report was unfounded the mother delivered a baby boy, three months before her due date. Both mother and child tested positive for cocaine. The baby died the following day. The mother told investigators she had been using crack cocaine on a daily basis during the final month of her pregnancy and had been smoking crack with the aunt in their home the night prior to the delivery. The mother said the two had exhausted their supply and the mother was on her way to purchase more drugs when she went into contractions. Two weeks after the baby's death the mother and the aunt were arrested for forgery, theft and burglary as a result of the pair's scheme to pose as friends of individuals they identified in local obituaries and then rob the homes of the deceased's relatives. The two surviving children were taken into protective custody following the death of their infant brother and placed in foster care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's services to substance abusing clients must match the client's presenting problem. In the past, the OIG has recommended that the Department appropriately address the problems that brought the family into the child welfare system. This recommendation is

reiterated, especially noting the need for long-term, uninterrupted child welfare services that are not available through private agency intact family programs as the contracts are currently written.

This recommendation is being addressed through private agency contracts and intact family procedures (P302.388), rather than through the substance affected family policy. The Intact Family Recovery program managed by the Service Intervention Division currently offers the long-term, uninterrupted child welfare and substance abuse services referenced.

2. The child protection supervisor should be counseled regarding her supervision of the investigation into the report of medical neglect of the seven month-old boy, specifically her assessment of medical neglect allegations, not adding a risk of harm allegation and her failure to ensure that investigative protocol was followed.

The supervisor is no longer employed by the Department.

3. Considering that the reporter indicated that substance abuse was present, the mother was being evicted, and the mother lied to and evaded the caseworker, the SCR operator should have added an allegation of risk of harm to the report. This report should be shared with the SCR administrator so this issue can be addressed and corrected.

This issue was addressed at an in-service meeting with SCR Call Floor staff.

4. Child protection investigators and supervisors should be instructed that a caregiver's adherence to a Department directive alone does not warrant unfounding an allegation.

The Department issued a memorandum to management staff statewide addressing this issue. The expectation is that managers will share the memo with supervisors for discussion in team meetings.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION

An eight month-old boy died of a subdural hematoma and cerebral injuries after being shaken by his father. The father was the subject of a child protection investigation of physical abuse that was unfounded three days prior to the infant's death.

INVESTIGATION

The family's involvement with the Department began after an anonymous caller contacted the hotline and reported observing multiple bruises on the then six-month old baby. It was also alleged the mother had confided to others she believed the father had injured the infant. A child protection investigator was assigned to the case and, utilizing specific information provided by the caller, made an unannounced visit to the family's residence in the basement of a home occupied by other relatives. An interpreter was dispatched to accompany the investigator to the home as English was not the family's first language and the investigator was not bilingual.

The investigator observed a mark on the baby's right cheek he described in his notes as being slightly discolored and swollen. The mother told the investigator the mark was the remnant of a heat rash and that the baby had been seen by his pediatrician who had prescribed an ointment. Although there was no record in the case notes, in an interview with the OIG the investigator stated the mother showed him the ointment. The investigator said he did not obtain the name of either the medication or the prescribing physician. The investigator expressed a familiarity with heat rashes and offered a description of their common physical characteristics. His description was inconsistent with his own account of the mark he observed on the boy. The investigator also took photographs of the boy and his one year-old brother, including a close-up of the infant's facial discoloration. An OIG examination of the photo found it to be of poor resolution and of little value in determining the nature of the mark.

In an interview with the OIG, the investigator stated that during the visit he spoke briefly with the family's relatives who lived upstairs but did not conduct interviews with them. According to the investigator, he addressed the relatives as a group through the interpreter on the importance of proper supervision of very young children. The investigator made no mention of the contact with the relatives in his case notes. In a separate interview with the OIG, the interpreter denied the investigator met with the relatives during the home visit. In addition, the interpreter stated the mother made no mention of a heat rash as the cause of the mark on the boy's face and told the investigator she had not noticed it until he brought it to her attention. The interpreter said she contacted the investigator after they had left the home and recommended he conduct an interview with the mother's brother and sister-in-law, who lived upstairs, outside the presence of the rest of the family. In his interview with the OIG, the investigator stated he arranged an interview with the couple but they did not appear at the scheduled time. The investigator was unable to provide a reason why the interview was not rescheduled.

Two days after the home visit, the investigator met with his supervisor who instructed him to conduct collateral interviews and confirm the infant's treatment for a heat rash with the family's pediatrician. The investigator began by interviewing the father, who had not been present during the home visit. With the assistance of a bilingual colleague, the investigator interviewed the father in the local Department field office. The father offered no concrete explanation for the baby's injury but expressed indignation at the Department's involvement with his family. During the meeting, the father signed consents for the release of medical information by the family pediatrician. The investigator faxed a request for information to the pediatrician, however an error in the recording of the fax number prevented the document from reaching the doctor's office. The mistake was not identified by the investigator and he made no other efforts to establish contact with the pediatrician.

The investigator again met with his supervisor who advised him to ensure the case was closed within the 30-day time period prescribed by the Department, a directive she reiterated during a second meeting one week later. The investigator conducted one more visit to the family home and spoke to the upstairs relatives, utilizing the mother's brother as an interpreter, but again did not attempt to conduct interviews. The investigator ultimately recommended to unfound the case and his decision was approved by his supervisor. In an interview with the OIG, the supervisor stated she felt secure in the determination the children were safe based on the photographs taken by the investigator and his observation the children had no apparent injuries. The supervisor said she did not consider it of critical importance the investigator had not followed her instructions to consult with the pediatrician to confirm diagnosis of a heat rash or conduct substantive interviews with the family's relatives who lived in the same home.

Three days after the case was unfounded the eight month-old baby was transported to the hospital presenting with severe Shaken Baby Syndrome. Thirty-six hours later the infant was pronounced dead. An autopsy performed by the county medical examiner determined the cause of death to be a subdural hematoma and cerebral edema caused by blunt force trauma to the head. The medical examiner also identified numerous old injuries including fractures, hemorrhaging and healing scars that appeared to be the result of burns. The father was arrested and charged with murder. Both parents were later indicated by the Department for multiple allegations against the baby as well as his one year-old brother. The surviving child was removed from the mother's custody and placed with her brother and sister-in-law who lived in the upstairs of the home.

Following the baby's death, OIG investigators learned numerous hospital staff members were familiar with the family as a result of frequent visits involving both children. Several nurses as well as the hospital social worker had observed behavior exhibited by the parents that raised concerns of possible child abuse or neglect. In addition, many of these concerns were expressed to the family's pediatrician who was a member of the hospital staff. Over time, the pediatrician had also developed his own concerns regarding the parents' treatment of their children, particularly the eight month-old. In separate interviews with the OIG, the pediatrician, the social worker and nurses described repeated miscommunications that resulted in a widespread belief among staff that one of them had called the hotline when, in reality, no such contact had been made.

In pursuing its investigation of this case, the OIG also identified the need for a greater emphasis to be placed on Department staffing decisions in the region as they pertain to the cultivation of resources to serve a growing population for whom English is not the first language. Data obtained from the most recent U.S. Census showed that for approximately one-third of families in the area, English is not the primary language spoken in the home. Burgos compliance reports produced by the Department do not provide enough substantive information to accurately determine the need for translators or bilingual staff in the region.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for failing to contact the child's physician, failing to conduct an investigation of the family's collateral contacts and demonstrating poor risk assessment.

The investigator was disciplined.

2. The child protection supervisor should be disciplined for approving a child protection investigation that did not include the required physician contact but a "faxed" contact and failing to ensure that her own instructions were followed.

The supervisor was disciplined.

3. Body charts should always be used when there is evidence of bruising and child protection investigators should be trained as to the appropriateness of the use of photographs when documenting bruising on non-Caucasian children.

The Department issued a memorandum to management staff affirming Department Procedure 300 and instructing investigators that photographs are not to be used in lieu of body charts.

4. The Department should review and analyze the Burgos Compliance Reports as tools to gather specific data to inform future staffing and hiring decisions.

The review has been completed and population shifts and cultural needs of client population are considered in hiring decisions.

OIG Note: The OIG review of the Burgos Compliance Reports found that the reports did not capture sufficiently specific data to enable informed decision-making.

5. A redacted copy of this report should be shared with the governing board of the hospital to inform training on mandated reporter responsibilities and better communication between professionals.

The Department agrees. The OIG shared the report.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

A 16 year-old girl was the victim of a rape she alleged was committed by her stepfather. The girl was murdered one month later. The girl's mother claimed that neither she nor her daughter were contacted by the Department despite the ongoing child protection investigation into the sexual assault.

INVESTIGATION

The child protection investigation was initiated after the hotline received a call that the girl had reported to hospital staff and local police she had been raped by her stepfather in her family's home. The child protection investigator assigned to the case made his initial contact with local police after an attempt to visit the family at home was unsuccessful. The investigator was told by the detective in charge of the criminal investigation that the girl had made "a good disclosure" to police and that the stepfather had refused to answer police questions regarding the accusation. Police had reached an agreement with the mother that the girl would reside temporarily with her maternal grandmother in another city until the mother moved into her new home. Although the new home had been purchased jointly by the mother and stepfather, the mother stated the stepfather would not be present and had agreed to instead stay with his sister. At the time of the incident, the couple had been married for four months and the detective stated that while the mother was outwardly supportive of her daughter, she confided to police she was conflicted as to whom to believe.

The grandmother's phone number was not included in the investigator's notes and, in an interview with the OIG, he stated it had never been obtained by him. The detective told the OIG he had provided the grandmother's number to the investigator, an assertion supported by the Sergeant who supervised the agency's youth division. The Sergeant stated he was familiar with the Department's need to assess the girl's safety and that the investigator's access to her and her mother was not restricted by police policy. The detective stated he told the mother to expect contact from the Department. In his interview, the investigator told the OIG he knew it was important for him not to speak with the girl or her family, although he acknowledged no such message was conveyed to him by involved law enforcement. The investigator stated he feared his attempts to reach either the alleged victim or alleged perpetrator might compromise the criminal investigation. The investigator's supervisor concurred with the investigator's belief that he was not to attempt to interview either party while the police investigation was pending. The investigator did not communicate with the girl or her mother and did not develop a safety plan for the girl's safety.

Less than a month after the rape was reported, the girl was found brutally murdered in the family's new home. While local police chose not to disseminate any information, the Department's office of communications responded to media inquires regarding the pending child protection investigation of the rape allegation and confirmed the stepfather was the focus. The office of communications does not have a protocol for responding to media requests regarding cases that also involve criminal investigations and no consideration is given to how disclosures may impact police activities.

Police were instructed by the local State's Attorney's Office to cease communications with all outside sources regarding their investigation of the rape or the murder. At the time, tests on physical evidence obtained from the girl and the stepfather had not yet been completed and the investigator had not reviewed the police report of the incident. The investigator did not learn of the girl's death until three days after the fact and had been unaware she was residing with her mother and not staying with the grandmother in another city.

Without access to any information that had been obtained by law enforcement and contact with the alleged rape victim an impossibility, the investigator and his supervisor, after extensive consultation with Department administrators, ultimately decided to indicate the report for Sexual Penetration by an unknown perpetrator and unfounded it against the stepfather. In his interview with the OIG, the supervisor stated the intention had

been to allow the report to remain open until information gathered by police became available. Once it became clear no information would be forthcoming, and the Department's 60-day time period for closing cases neared expiration, the determination was made. Following case closure, notices automatically generated by the State Central Register (SCR) were sent to the mother as well as the hospital where the girl was treated and local police. The letters simply related the indicated status of the report and did not state the perpetrator had been identified as unknown. As the parent of the victim of an indicated report, the mother was entitled to be informed of the perpetrators name, the allegation indicated and the amount of time the report would be retained by the Department, in accordance with Department Rule. Since the investigator neglected to update the mother's information in the Department system it was delivered to her previous address, delaying her notification.

An OIG review of the case loads handled by the two teams in the field office responsible for this case at the time these incidents occurred found both exceeded Department targets by significant margins. The OIG interviewed the Department's quality assurance administrator who qualified the data by explaining the available numbers did not distinguish investigations initiated by investigators in order to meet the Department's mandate to interview reporters and victims within 24 hours which are then transferred to other teams for completion. Exceeding recommended levels of case assignment places a burden on investigators to devote adequate time to conducting through investigation and encourages more rapid case closing.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Management should immediately review caseloads at the field office to determine critical positions that must be filled to bring the office in compliance with the B.H. consent decree.

The Department has reached an agreement with the union for the realignment of staff to areas of greatest need. Until such time as staff movement occurs, CPSWs from Cook County are still temporarily detailed to the Northern Region.

2. Child protection management should ensure that quality assurance is capturing necessary data to permit easy assessment of staffing needs. Specifically, current caseload assignment information should differentiate between full investigations and mandates.

SACWIS enhancements are in process. Target date of completion is September 2006.

3. The Department's office of communications should develop policy that requires contacting law enforcement when criminal investigations are pending to determine whether release of specific information may compromise criminal investigations.

The Department does not agree. The rationale is that it would impede DCFS' ability to provide general information about investigations in a timely manner to the media. Further, DCFS investigation personnel would be working collaboratively with local police and Communications would be made aware in situations that concerns are expressed about releasing.

4. Given the high caseloads and the time that has passed since the investigative interviews, the child protection investigator and his supervisor should receive non-disciplinary counseling regarding their failure to ensure that a safety plan was put in place and monitored as well as failing to formalize the pre-emption of the investigation to law enforcement and failing to update important contact information.

A practice and procedural memo as issued on August 9, 2005, requiring management staff to review and discuss with supervisors and front-line staff, Procedures 300.50 c)1) *Pre-empted investigations* and 300.50

c)2), *Delegated Initiation of the Investigation.* Report was reviewed and procedural deficits were discussed. A plan was put in place to complete a random weekly review of 1-2 cases for 60 days starting 10/01/05. The Regional Administrator will conduct the reviews to ensure objectivity and institute any requisite corrective measures. The case was reviewed with both the investigator and supervisor.

5. SCR should revise the Notice of Indicated Finding sent to parents to comply with Department Rule 336.60.

This recommendation is under review by the DCFS Legal Division due to the impact it may have on the DuPuy Federal lawsuit.

6. Child protection managers should reinforce, in monthly meetings and through evaluations, that when investigations remain open beyond 60 days for good cause, it will not be held against managers, supervisors or investigators. Supervisors and managers should ensure that evaluations limit negative feedback to investigations that are not closed within 60 days without good cause extensions.

A memorandum was issued to all staff on August 9, 2005 that contained the requirement for managers and supervisors to review the process for "good cause" extension requests and stated that when there are timely, good cause requests, these should lead to no negative impact on staff.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

A five year-old boy died from the intentional infliction of multiple blunt force injuries. At the time of the boy's death a child protection investigation of his mother was pending.

INVESTIGATION

The child abuse investigation was initiated after staff from a psychiatric hospital where the boy had been admitted contacted the hotline to report the boy's mother had removed him from the facility against medical advice. It was also alleged that in the past, the mother had forced the boy to eat hot peppers as a form of punishment and that her refusal to provide him with adequate water prompted him to attempt to drink from toilets. The report was accepted and a child protection investigator was assigned to the case. The following day, the investigator spoke with the mother who stated her son had been hospitalized for persistent behavioral problems that included cursing, intentionally soiling himself, banging his head against hard objects and threatening to drink bleach after saying he wanted to die. The mother attributed her son's acting out to his recent visit with his paternal grandparents outside the state. The mother believed the paternal grandparents had encouraged the boy to be defiant towards her and her current boyfriend, who was not the boy's father. The mother also hypothesized the boy felt overlooked in light of the birth of her first child with the boyfriend seven months earlier and the fact she was carrying the couple's second child. The mother explained to the investigator she made the decision to remove the boy from the hospital during a visit after another child exposed himself to her and her son claimed he was touched inappropriately by his roommate.

The investigator interviewed the boyfriend who reiterated the mother's beliefs regarding the paternal grandparents' influence, the boy's feelings of marginalization within the family unit and a lack of supervision at the hospital. The mother acknowledged feeding the boy a hot pepper in response to him cursing at her but both she and the boyfriend understood the practice to be a traditional form of discipline and stated it had only been employed on one occasion. The mother stated she did not deny the boy liquids but prevented him from drinking after 6:00 p.m. in accordance with a recommendation from his pediatrician to curtail his bedwetting. The investigator then spoke to the boy outside the presence of the mother and her boyfriend. The boy provided explanations consistent with those offered by his mother and stated he had only consumed water from the toilet in an attempt to garner attention. The boy told the investigator he understood the danger inherent in drinking bleach and agreed he would not do so. The boy stated he was well cared for and felt safe in the home. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) which listed no risk factors and determined the environment to be safe. The investigator had not completed a Law Enforcement Agencies Database System (LEADS) check to ascertain possible criminal histories for the mother and her boyfriend. Although the couple denied the existence of domestic violence issues between them during the interview, the investigator did not conduct a Domestic Violence Mini Screen. Following his visit to the home the investigator made an unsuccessful attempt to contact the hospital staff member who had called the hotline. The investigator performed no further work on the case until after the boy's death three weeks later.

In an interview with the OIG, the investigator stated he based his determination that the home was safe on the absence of obvious signs of abuse to the boy and the consistency of the statements provided by the mother, the boyfriend and the boy. The investigator said he intended to perform LEADS checks after completing work on other cases, although Department Procedure requires them to be completed immediately upon obtaining necessary information. A LEADS check conducted by the OIG found the boyfriend had been the subject of criminal charges related to incidents of domestic violence on four previous occasions. In addition, the boyfriend had been arrested for violating an Order of Protection entered against him on behalf of the mother six months prior to the hotline report that prompted the child protection investigation.

Three weeks after the investigator conducted his interviews with the family, the mother called 911 and reported she had found the boy unresponsive when she attempted to wake him from a nap. The boy was transported for treatment and later pronounced dead. An autopsy conducted by the county medical examiner detailed 44 sites on the boy's body illustrating recent external injuries and another 25 sites signifying recent internal injuries. The findings led the medical examiner to rule the boy's death a homicide. The mother and the boyfriend were both arrested and charged with first degree murder. The mother was convicted of endangering the life of a child and sentenced to four years in prison. The boyfriend is currently awaiting trial. Both individuals were indicated by the Department for Death by Abuse, Cuts, Welts and Bruises and Internal Injuries by Abuse to the boy as well as Substantial Risk of Physical Injury to his eight month-old sister. The mother was also indicated for Substantial Risk of Physical Injury to the boy stemming from the initial investigation. The eight month-old girl was removed from the mother's custody and placed in the home of a maternal cousin. Three months after the boy's death, when the mother delivered her third child, the infant was removed and placed in the same home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should amend procedures and the CERAP to require that LEADS checks be used to inform CERAP decision-making.

The CERAP Committee is reviewing this report to use in revising the CERAP.

2. The Department should amend the Domestic Violence Mini Screen to require the application of LEADS information.

A Policy Transmittal was issued. On-line training began this Fall.

3. Management should ensure that investigators are conducting LEADS checks immediately after sufficient information is obtained and during the initial investigation phase (first seven days), using the LEADS information to inform their CERAP decision-making, and applying LEADS information to the Domestic Violence Mini Screen.

The Department issued a memorandum stating the requirements for immediate requests for LEADS checks; using LEADS data to inform safety decision-making; and a review of the current version of AP#6 by all investigative staff.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION

A two year-old female ward died as a result of physical abuse inflicted by her foster mother. At the time of the girl's death, the foster mother was the subject of a pending child abuse investigation.

INVESTIGATION

The girl and her five year-old brother had been removed from the custody of their mother, who was also a ward, after she demonstrated symptoms of post-partum depression and expressed uncertainty of her ability to care for her children when the girl was just three months old. The children were placed in the home of first-time foster parents, a couple recently licensed through a private agency. The stated goal for the children was reunification with their mother, however the foster parents expressed a willingness to consider assuming permanent custody.

As part of the children's services, visits were scheduled with their mother, however the second visit with the mother was canceled because the foster parents and the children were not home at the planned time. A licensing worker from the private agency later spoke to the foster mother who told her they had taken the children out of state, with the caseworker's permission. The foster mother denied she had confirmed a visit between the children and their mother during her most recent conversation with the caseworker. The licensing worker consulted with her supervisor, who also oversaw the work performed by the caseworker on the case, and was instructed to conduct a home visit to address the discrepancy between the accounts of the caseworker and the foster mother. While visiting the home, the licensing worker observed that the girl had a black eye. The foster mother told the licensing worker the girl received the injury after tripping over exercise equipment in the home. The licensing worker accepted the foster mother's explanation but informed her of the importance of adherence to Department Rule requiring foster parents to notify caseworkers of any significant injuries or illnesses suffered by wards in their care.

Throughout the seven months the children were placed in the home, the girl suffered numerous injuries including multiple black eyes and other facial wounds. Although most of these injuries were observed by either the caseworker or the licensing worker, they were not consistently or thoroughly documented by either child welfare professional. After the caseworker observed the girl's third black eye during a home visit, the foster mother told her the licensing worker had already learned of the injury during her own visit. The caseworker did not speak to the licensing worker to corroborate the mother's claim. In fact the licensing worker was not aware of the girl's black eye as it occurred after she had been in the home. The supervisor responsible for monitoring both the caseworker and the licensing worker failed to ensure the colleagues, who operated out of the same building, shared the information they obtained individually regarding the family. In addition, no effort was made to include the independent consulting group that provided the girl with physical, developmental and speech therapy in a cohesive approach to addressing the girl's needs. It was not until after the girl's death that it was learned therapists in the consulting group had received explanations for the girl's injuries that differed from the ones provided to private agency staff. Other warning signs, such as the foster mother's utilization of hospital emergency rooms to treat the girl rather than seeking the consistent care of a pediatrician, went unrecognized.

Six months after the girl was placed in the home the foster mother called the caseworker to report the girl had been burned above the lip with a lit cigar. The injury had first been noticed by the girl's physical therapist while in the home. The therapist contacted the caseworker to report the injury, stating the foster mother claimed she had already notified the caseworker. In fact the caseworker had not been informed by the foster mother. After consulting with her supervisor, the caseworker contacted the hotline and a child protection investigation was initiated. Several months prior to the incident a four year-old boy, unrelated to the other two children, had also been placed in the foster home. Although the boy had asthma his medical condition was not considered as he was placed in a home with two adult smokers. In an interview with the OIG, the

licensing worker stated she had been unaware of the child's asthmatic status at the time he was placed. In previous reports, the OIG has emphasized the need to address the particular environmental needs of wards with asthma in light of their heightened risk of respiratory distress.

Six weeks after the girl suffered the burn to her lip, while the child protection investigation was still pending, the girl was brought to a hospital emergency room in cardiac arrest and presenting with retinal hemorrhaging. Hospital staff reported the girl's admission to the hotline and conveyed she was in grave condition. The following morning, the girl's mother gave doctors permission to remove the child from life support and she was pronounced dead soon afterwards. The county medical examiner determined the cause of death to be subdural hematoma due to blunt force trauma to the head and ruled her death a homicide. The two children remaining in the home were removed and taken into custody by the Department. The foster mother agreed to voluntarily cooperate with law enforcement and submitted to an interview by police. After offering several differing accounts of events the foster mother finally stated she had become agitated with the girl for repeatedly playing with a table supporting glass figurines and other decorations. The foster mother said that when the girl continued to play with the table, she grabbed her by the shoulders and shook her with sufficient force that the girl's head rocked back and forth. When she released the girl she began convulsing and her eyes rolled back in her head. The foster mother was arrested and charged with first degree murder. The case is currently pending.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. In cases where a child is receiving services from an outside service provider, the agency assigned to the child should convene quarterly case staffings. The case staffings should include supervisors, case managers, licensing staff and the service providers. For children whose special needs require therapeutic and supportive services, the staffings will ensure that service providers and foster parents are meeting the child's special needs and helping provide the child with an enhanced living environment.

Initial assessments are addressed with Integrated Assessment. Quarterly staffings are currently addressed in Rule 315 in which all involved persons are invited to attend the staffings. In an attempt to improve compliance with Rule, this will be required in performance-based contracts and quality reviews.

OIG Response: The OIG shared the report with the private agency and the President of the Board of Directors of the agency. The Inspector General met with agency executive staff and a member of the Board of Directors to discuss the findings and recommendations made in the report. The agency's specific responses to the recommendations are detailed below.

The agency developed and implemented a staffing procedure. The procedures include the inclusion of outside service providers in quarterly staffings and any additional staffings convened.

2. The private agency supervisor should be counseled for failing to ensure that information regarding the children was shared between the caseworker and the licensing worker or acting on the information provided by case management and licensing staff. Since she supervised both staff members, the supervisor could have assisted the staff in assessing and responding to the needs of the family and safety concerns of the children.

OIG Response: The employee identified in this report resigned. However, the agency has addressed this recommendation systemically be ensuring that all supervisors hold regular, documented supervision meetings, which include caseload review. As part of this process, all staff involved in the review of a case will meet monthly to discuss the case and coordinate services.

3. Private agency licensing staff approved the placement of an asthmatic ward into a home with foster parents who smoked. On January 24, 2002, and May 21, 2002, private agency staff received training on asthma and the implications for wards. The OIG's report, Asthma Management – Implications for Child Welfare Case Management, dated June 25, 1999, that was presented as part of that training should be reviewed with the private agency.

The agency will continue to follow DCFS Procedure 315.110 re: placement of foster children in licensed homes. In addition, the Department has implemented the Placement of Outside Agency Children in foster homes licensed by this agency. The Home Visit Form will ensure that caseworkers are regularly reviewing potential hazards in the home and sharing this information with outside service providers.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION

A six month-old boy died as a result of a fire in his family's trailer home. At the time of the infant's death, his family had an open case for intact services.

INVESTIGATION

The family came to the attention of the Department after a child protection investigator visited their home on other business. A translator accompanied the investigator as the parents spoke limited English. The investigator found the trailer home to be without operating gas or water and, as the visit occurred during the winter, noted the temperature was 20 degrees Fahrenheit. The worker also observed space heaters were being used to provide warmth to the home and that the electricity only appeared to be operational on one side of the structure. The investigator contacted the hotline to report the conditions in the home and, after the report was accepted, was assigned to the case.

The investigator returned to the home with the translator and interviewed the father, who stated the heating system had been disabled by the previous owner and the family could not afford the necessary repairs. A section of the home had never been wired for electricity. The father said three space heaters and a network of extension cords were employed to provide warmth to the home. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) which noted the use of space heaters as an environmental factor that posed a potential threat to the children's well-being. In her final analysis, however, the investigator determined the danger presented by the heaters did not rise to a level that the home could be considered "hazardous" to the children and determined that a safety plan was not required and that the children, a nine year old girl and six month-old male and female twins, were not placed in immediate risk of harm. Two other siblings, ages two and three, were out of the country visiting relatives. The investigator's conclusion was largely based on the opinion of the translator that the space heaters were safe.

The parents were indicated for Inadequate Shelter and the family was referred to receive intact services. The investigator's supervisor assigned the case to an intact family caseworker who was on vacation at the time, despite the fact a report had been indicated against the parents and the other worker on the team had more experience and was available to receive additional cases. Since the accepting caseworker was not present a formal case hand-off was not performed. The caseworker returned after her vacation to find the case file on her chair in the office.

During the caseworker's involvement with the family she noted concerns regarding the family's use of space heaters on several occasions. The caseworker documented conversations with the father, facilitated by the translator, about the proper use of the heaters and how to check the cords for overheating. The caseworkers original notes also showed she observed a fourth space heater being used in the home that was not equipped with "child safe" guards. The caseworker informed the father that heater should not be used in the home. Just more than three weeks after intact services were initiated, the family's home caught fire and as a result, the six month-old boy was killed. An investigation performed by the state fire marshal determined the fire was caused by an electrical system failure attributed to an overload at some point along one series of interconnected extension cords.

An OIG review of the case record found that multiple copies of the caseworker's notes existed, each substantively different from the other. While the caseworker's original notes made reference to the safety issues presented by the space heaters, in a second set contained in Department records those concerns were minimized or stricken altogether. A third set of notes appearing in the Statewide Automated Child Welfare Information System (SACWIS) restored some, but not all, of the originals' information pertaining to the heaters. All of the case notes share the same creation date, the day of the infant's death. In an interview with the OIG, the caseworker stated that later on the day the boy died a meeting involving the caseworker, her

supervisor, the site administrator and an assistant manager for the region resulted in a decision to alter the notes. In a separate interview, the supervisor stated the parties were concerned the original notes were not sufficiently descriptive and did not accurately reflect the caseworker's observations of the home. The caseworker said she created the third set of notes because she felt some of the excised information should have remained in the record. There was no indication in the Statement of File Integrity provided to the OIG that accompanied the notes that they had been revised or altered in any way.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. CERAP should be amended to require workers to note when a risk factor cannot be answered because of insufficient information. Under such circumstances workers should be required to perform diligent inquiry into relevant facts for assessment within 48 hours. The Department should develop procedures to ensure that there is follow-up and resolution of unknown variables.

A workgroup has been convened to review all CERAP/Safety Assessment recommendations from various entities assessing Department staff's use of this tool. This workgroup has the task of assessing the recommendations for incorporation into CERAP policy and procedures, revising the assessment tool, and developing training recommendations.

2. The Department's contract with housing advocates should be amended to include the development of resources, such as the expertise of journeymen, to assist investigators in resolving difficult questions about home safety issues, such as electrical wiring.

The Department is developing a training for Housing Advocacy Programs throughout the state to provide information to workers to better assess the safety of a home.

3. The site administrator should be counseled for failing to note on the OIG *Statement of File Integrity and Security* the changes that had been made to the record after the death.

The site administrator received an oral reprimand.

4. All Department supervisors should have access to the internet for evidence-based research to develop a knowledge base on relevant issues.

The Department agrees. Target date: September 2006.

5. The Department should institute a lock down procedure for SACWIS case entries and pending investigation notes when it is informed that a child involved with the Department has died. The State Central Register could initiate this process upon notification of a child death.

Because SACWIS revisions are not scheduled until September 2006, a temporary measure was initiated. Upon notification of an impound by the OIG, supervisors use the "COMPLETE" command in SACWIS application to preserve the historical record.

6. The supervisor should be counseled for handing off an indicated case to the caseworker while she was on vacation when another worker with more experience was available and had a similar caseload.

The supervisor was counseled.

7. The assistant regional administrator, the site administrator, the supervisor and the caseworker

should engage in a "grand rounds" discussion of problems in this case, including a joint determination of how notes clarification issues should be handled in the future.

The case was discussed in Grand Rounds.

8. A Spanish-speaking worker should be hired by the Department to service the region. This worker should be cross-trained in investigations and child welfare services and, in addition to their regular duties, would assist on an emergency basis with investigations and intact family services until the case can be transferred to a contracted agency that has intact bilingual employees.

The Department agrees and actively pursues hiring Spanish-speaking staff for each region.

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION

A three week-old girl died from complications of her premature delivery. Both the girl and her mother tested positive for cocaine at the time of her birth. At the time of the girl's death her family had an open intact family services case.

INVESTIGATION

The initial hotline report regarding the family was made after the mother and her two year-old son were admitted following a domestic disturbance. Police responding to a 911 call to the family's home arrived to find the mother bleeding from the mouth and holding her son, whose clothing was covered in blood. The boy's father complained of an injury to his hand. The father was arrested and charged with domestic battery while the mother and son were transported to the hospital. Tests conducted on the mother showed her blood alcohol level was more than three times the legal limit to operate a vehicle. In addition, tests showed she was 16 weeks pregnant. An examination of the boy revealed he had not been injured but had been sprayed with residual blood during the altercation between his parents. Hospital staff determined the mother's inebriated state precluded her from serving as a caretaker for her son at that time. Upon their release the mother agreed to take a taxi to the home of the boy's paternal grandmother, however, the mother grabbed her son and jumped from the cab before it reached the destination.

The child protection investigator assigned to the case interviewed the mother at the family home later the same day. The mother stated she had decided not to go to the grandmother's house and instructed the cab to take her home. In describing the incident, the mother said she and the boy's father had been drinking together before he left with his uncle. She stated she fell asleep while he was gone and was awakened by a punch in the mouth when he returned. The mother said the two had fought in the past but several years had elapsed since a similar incident occurred. In response to questions regarding the family's history, the mother affirmed police had been to the home previously in response to allegations of domestic violence and that the father had been physically violent towards her in the past. The mother told the investigator she had been in a relationship with the father for 20 years and would not leave him. She stated she had been unaware of her pregnancy until informed by the hospital, but the knowledge was adequate motivation for her to discontinue drinking until the baby was delivered. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) which listed domestic violence as a factor but did not identify substance abuse as an issue. The investigator then recommended the family receive intact family services provided through a private agency.

Two days later, the investigator and private agency staff met with both parents in their home to initiate intact family services. The mother agreed to the service plan however the father refused, stating he would wait until final disposition of his court case to engage in services. In an interview with the OIG, the private agency caseworker stated that during the meeting the mother's speech was slurred and she smelled strongly of alcohol. The caseworker said all of the child welfare professionals present made the same observations, although none of them documented the mother's condition in their notes. The caseworker later informed her supervisor of the possibility the mother was intoxicated at the meeting. In an interview with the OIG, the private agency supervisor stated many alcoholics continue to smell of alcohol for several days after they stop drinking. The supervisor did not alternatively consider whether the mother might have been drinking prior to the meeting.

One week later, the investigator and the caseworker returned to the home and developed a safety plan for the family. Prior to the meeting, the investigator learned both parents had extensive criminal records as well as a long history of alcohol-fueled physical confrontations and were well known to local police for repeated domestic disturbances. Violence in the home was the impetus for Department involvement. Yet, the safety plan was reliant upon the parents to exercise self-control to a degree all available information suggested was impossible. The safety plan required both parents to refrain from drinking in the presence of their son. If one

parent became drunk, the other was to take the boy to the paternal grandmother's home. Both parents also agreed to refrain from committing acts of domestic violence. Additionally, the mother was to submit to a drug screening and comply with any resulting recommendations. The safety plan developed at the meeting was woefully inadequate to address the myriad issues plaguing the family. Despite the fact the plan called for the boy to be taken to the grandmother's home in a time of crisis, the grandmother was never informed she was to serve in this role. In an interview with the OIG, the investigator stated she did not believe the boy was at immediate risk of harm because of her confidence in intact family services staff to monitor conditions in the home. The child protection investigator's supervisor agreed with the assessment and approved the plan.

Although the child protection investigator's supervisor received an oral criminal history report from local police, she failed to initiate a Law Enforcement Agency Database System (LEADS) check or obtain underlying police documents, as instructed by her supervisor. An OIG review of law enforcement documents related to the couple's criminal histories found a record of physical violence involving the couple and other family members spanning a 15-year period. The father had been arrested for assault 23 times, the mother 20, and each had four convictions. Narratives of police involvement detailed chronic domestic abuse by both parties and included repeated references to the use of weapons and the presence of children when the incidents occurred.

As the intact family case progressed the mother continued to agree to engage in services but consistently resisted performing required tasks, postponing or canceling numerous scheduled appointments to complete drug testing and assessment. The father continued to refuse to participate in any services. The intact family services caseworker and her supervisor learned the father was subject to a no-contact order while his criminal case was pending, however they did not inform law enforcement he was in violation of the order or reconsider the decision to allow the boy to remain in the family home. Six weeks after the case was opened the mother delivered her baby. The infant was born three months premature and weighed less than one and-a-half pounds. Both mother and baby tested positive for cocaine. A second child protection investigation was initiated and the same investigator assumed responsibility for the case. While the investigation was pending, the infant died from complications of her birth, prompting a third investigation. The boy was taken into protective custody and placed in the paternal grandmother's home. Ultimately, both parents were indicated for Substantial Risk of Physical Injury to their son and the mother was indicated for Substance Misuse and Death By Neglect related to their daughter.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for developing an unrealistic safety plan, for not contacting the paternal grandmother in relation to the safety plan, for not obtaining police reports as directed by her supervisor and for not requesting LEADS information in a timely manner.

The child protection investigator was disciplined.

2. The child protection supervisor should be counseled for signing off on an unrealistic safety plan in a home with extreme domestic violence and substance abuse issues.

The child protection supervisor was counseled.

3. The administration of the private agency should review this case with the intact family services supervisor for her failure to instruct the worker to explore the possibility that the mother was drunk during a meeting in the family home and permitting a non-cooperating parent, who was the subject of a no-contact order, to remain in the home.

The Department agrees.

OIG Response: The OIG shared the report with the private agency and the President of the Board of Directors of the agency. The agency's Chief Executive Officer and Clinical Director discussed the report and the recommendations made with the Family First Program Director. The agency's CEO also discussed the report with the Board President.

DEATH AND SERIOUS INJURY INVESTIGATION 11

ALLEGATION

A two month-old boy died of lung disease resulting from his premature birth. Eleven months earlier, the boy's mother had been the subject of an indicated report of abuse against her nine month-old daughter.

INVESTIGATION

The investigation into possible abuse of the daughter began after the hotline was contacted to report the mother had brought the nine month-old girl to the doctor's office with an injury to the back of her head. The mother stated the infant had fallen off of a bed in the family's home onto a hard tile floor. The pediatrician, the family's primary care physician, sent the mother and her baby to a hospital emergency room for x-rays which showed the girl had suffered a skull fracture. The hotline accepted the report and a child protection investigator was assigned to the case.

Five days later, the investigator met with the family in their home and observed the bedroom where the mother said the incident occurred. The investigator took photographs of the bed but did not measure the height from which the infant would have fallen. Although Department Procedures require children who suffer facial or head injuries to be taken into protective custody unless the treating physician determines abuse was unlikely, the investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) and determined the baby was not at risk in the home without obtaining a medical opinion. Department Procedures also require contact with the treating physician within seven days of case opening, however the investigator did not make her first attempt to speak with the pediatrician until twelve days after the hotline call. The investigator's initial efforts to establish contact with the pediatrician consisted of four messages left on the office answering system. In an interview with the OIG, the investigator stated she paid infrequent attention to her own voice mail and, for a period of time while the case was open, her mailbox was full which prevented callers from leaving messages. In separate interviews with the OIG, both the pediatrician and the pediatric nurse stated they regularly returned telephone messages. The investigator never attempted to make an appointment with the pediatrician or visit his practice though it was located only two miles from the investigator's field office.

Throughout the investigator's involvement with the case she consulted with her supervisor, however an OIG review of the case record found the supervisor's notes were vague in nature and frequently conflicted with facts presented to her by the investigator. An OIG review of randomly selected cases handled by investigators under the supervisor's direction during two distinct time periods found a pattern of similar entries that often employed standard phraseology with limited regard for its relevance to the specifics of a given case. The OIG did find that more recent supervisory notes were of greater quality and depth.

Three months after the case was opened, the investigator spoke with the pediatrician for the first time to inform him she did not suspect child abuse. Six weeks later, the investigator called again to ask the pediatricians opinion of the infant's injury. The pediatrician explained he had referred the baby to the hospital at the time of the incident for more thorough examination and analysis. In the interim, the investigator had spoken with the infant's maternal grandmother who told her the baby had received initial treatment as well as a follow up visit from a home nurse through a hospital. However the grandmother incorrectly named another medical institution in the area rather than the hospital that had provided the care. The investigator made fruitless attempts to obtain records of the follow-up visit from several hospitals in the region. Although the hospital that had treated the infant inaccurately told the investigator they had no records pertaining to her, the investigator did not speak with the pediatrician to verify the information he provided to her or make a second attempt to secure documentation. The OIG contacted the hospital and obtained a copy of a child protection consultation report conducted after the baby was admitted which found the infant's injury was consistent with the mother's explanation. However, the explanation provided by the mother varied somewhat from the explanation offered to the investigator. The mother asserted to the investigator the baby had received all

recommended medical attention but said she had disposed of the paperwork from the hospital.

Five months after the case was opened, the investigator indicated the report against the mother for Head Injuries By Abuse based on the absence of proof of a follow-up visit. In her interview with the OIG, the investigator stated that although her observation of the bedroom where the incident took place led her to determine the injury was consistent with the mother's explanation, she decided to indicate the report because of the mother's apparent failure to take the infant for a follow-up visit. The investigator acknowledged that the rationale for her determination would have been better represented as an indicated finding for medical neglect rather than a head injury. Since records of indicated abuse reports are maintained for up to 50 years it is vital that investigations and their outcomes accurately reflect the facts and evidence collected during cases.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be counseled for her failure to investigate this case.

This employee has been on leave since the recommendation was made. Counseling will occur upon her return.

2. The child protection supervisor should be counseled for her failure to supervise the investigator and ensure she investigated this case. In addition, the supervisor should be counseled concerning the importance of providing substantive supervision. Her supervision should be reviewed for the next six months.

The supervisor was counseled.

3. Child protection training materials should include that investigators ask doctors' staff for an appointment time to call or come into the office to talk to the doctor, rather than just leave messages.

A memorandum directing staff to request optimal times to contact professionals (specifically doctors) was distributed to statewide management staff. Managers were to distribute the memorandum to supervisors and front-line staff. The memo required CPSWs to request the best time to call or visit the professional, and to make contact at the times provided.

CHILD DEATH REPORT (FY 2005)

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.[2]

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 2005, the OIG received notification from SCR of 139 child deaths meeting criteria for review. In 21 cases preliminary investigations were conducted. In 106 cases records were reviewed. In 3 cases reports were sent to the Director. Nine full investigations are still pending. 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 139 child deaths received by the OIG in FY 05 as well as summaries of the individual cases. The first part of the summary presents child deaths by age and manner of death, case status and manner of death, county and manner of death, and substance exposure status and manner of death. The second part presents a summary of deaths classified in the five manners: homicide, suicide, accident, undetermined, and natural.

Key for Case Status at the time of OIG investigation:

Ward……... Deceased was a ward
Unfounded DCP……Family involved in an unfounded DCP investigation within a year of the death
Pending DCP…….. Family involved in a pending DCP investigation at time of the death
Indicated DCP ……. Family involved in an indicated DCP investigation within a year of the death
Child of Ward…….Deceased was a ward's child, but not a ward themselves
Open Intact…….Currently open intact family case
Open Placement……. Death of baby (who never went home) whose mother has children in foster care
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)
Preventive Services Case ……..Family case opened to assist family but not as a result of indicated report
Return Home…….…….. Child or sibling was returned to the parents from foster care within a year of the death
Extended Family Support……...Case opened to assist extended family members caring for children as a result of a safety plan or child welfare need

[2] The limitations of this information should be noted. SCR relies on coroners, hospitals and law enforcement in Illinois to report child deaths, even when the deaths are not suspicious for abuse or neglect. The reports are not always made. Therefore, true statistical analysis of child deaths in Illinois is difficult because the total number of children that die in Illinois each year is unknown. The Illinois Child Death Review Teams have requested that individual county registrars forward child death certificates to SCR to compile a list of all the children who die in Illinois. The Cook County Medical Examiner's policy is to report the deaths of all children autopsied at the Medical Examiner's office. The OIG acknowledges all the coroners and Sharon O'Connor at the Cook County Medical Examiner's Officer who have assisted us in obtaining autopsy reports.

Table 5: CHILD DEATHS BY AGE AND MANNER OF DEATH

Child Age		Homicide	Suicide	Undetermined	Accident	Natural	TOTAL
MONTHS OF AGE	At birth	1	0	0	0	7	**8**
	0 to 3	3	0	4	9	20	**36**
	4 to 6	0	0	3	3	13	**19**
	7 to 11	0	0	1	2	5	**8**
	12 to 24	3	0	1	3	10	**17**
YEAR OF AGE	2	0	0	0	2	4	**6**
	3	0	0	0	1	3	**4**
	4	0	0	0	0	2	**2**
	5	0	0	0	0	1	**1**
	6	0	0	0	3	3	**6**
	7	0	0	0	0	0	**0**
	8	0	0	0	0	1	**1**
	9	0	0	0	0	0	**0**
	10	1	0	0	0	0	**1**
	11	0	0	0	0	2	**2**
	12	0	1	0	0	1	**2**
	13	1	0	0	0	2	**3**
	14	1	0	0	0	3	**4**
	15	1	0	0	0	2	**3**
	16	1	0	0	0	2	**3**
	17	1	1	0	0	1	**3**
	18 or older	3	1	0	1	5	**10**
TOTAL		**16**	**3**	**9**	**24**	**87**	**139**

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

Reason for OIG investigation		Homicide	Suicide	Undtmn	Accident	Natural	TOTAL
Ward		5	3	0	1	28	**37**
Open Placement		1	0	0	0	2	**3**
Open Intact		2	0	1	5	23	**31**
Split Custody		0	0	0	1	1	**2**
Child of Ward		0	0	0	0	2	**2**
Child of Former Ward		0	0	0	0	1	**1**
Return Home		1	0	0	0	2	**3**
Preventive Services		2	0	2	4	5	**13**
Extended Family Support		1	0	0	0	1	**2**
DCP	Indicated	0	0	0	0	1	**1**
	Unfounded	1	0	3	8	17	**29**
	Pending	3	0	3	5	4	**15**
TOTAL		**16**	**3**	**9**	**24**	**87**	**139**

Table 7: CHILD DEATHS BY COUNTY OF DCFS SERVICE AND MANNER OF DEATH

County*	Homicide	Suicide	Undetermined	Accident	Natural	TOTAL
Champaign	0	0	0	0	1	**1**
Christian	0	1	0	0	0	**1**
Cook	9	1	5	6	58	**79**
DeKalb	0	0	0	0	1	**1**
Douglas	0	0	0	0	1	**1**
DuPage	0	0	0	1	4	**5**
Effingham	0	0	0	0	1	**1**
Fayette	0	0	1	1	0	**2**
Hancock	1	0	0	1	0	**2**
Kane	1	0	0	0	1	**2**
Kankakee	0	0	0	1	2	**3**
Kendall	0	0	0	0	1	**1**
LaSalle	0	0	0	0	1	**1**
Lawrence	0	0	0	1	0	**1**
McHenry	0	0	0	0	1	**1**
McLean	2	0	0	0	0	**2**
Macon	1	1	0	0	0	**2**
Macoupin	0	0	0	1	1	**2**
Madison	0	0	0	2	0	**2**
Marion	0	0	0	0	1	**1**
Massac	0	0	0	0	1	**1**
Peoria	0	0	1	0	4	**5**
Rock Island	0	0	0	0	1	**1**
St. Clair	1	0	0	4	1	**6**
Saline	0	0	0	1	2	**3**
Sangamon	0	0	1	0	0	**1**
Tazewell	0	0	0	0	1	**1**
Vermilion	0	0	0	1	1	**2**
Will	0	0	0	3	1	**4**
Winnebago	1	0	1	1	1	**4**
TOTAL	**16**	**3**	**9**	**24**	**87**	**139**

* Some children died in counties outside of their DCFS service.

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	1	1	13	**16**
Mother has history of substance abuse	1	1	0	5	22	**29**

FY 2005 DEATH BREAKDOWN BY MANNER OF DEATH

HOMICIDE:

Sixteen deaths were classified homicide in manner.

Cause of death	Number
Gunshot wounds	7
Blunt head trauma	5
Multiple injuries due to blunt trauma/assault	1
Abdominal injury due to blunt trauma	1
Asphyxia due to facial bone fractures	1
Poisoning	1
TOTAL	**16**

PERPETRATOR INFORMATION:

Perpetrator	Number of deaths
Father	4
Mother	2
Mother's boyfriend	2
Boyfriend of victim	1
Brother	1
Unrelated peer	2
Unsolved	4

Perpetrator sex	Perpetrator age range
Male: 8	19-36 years
Female: 2	22-36 years

In 16 death cases, 12 individuals have been criminally charged, including a mother who pleaded guilty to child endangerment for leaving the child in the care of a father she knew to be abusive. One teen was killed in the commission of a robbery and no one is being charged with the crime. Four cases remain unresolved.

Criminal charge status	Number of individuals
Convicted	4
Awaiting trial	8

SUICIDE:

Three deaths were classified suicide in manner.

- A 17-year-old ward shot himself in the head. The case was in Christian County.
- A 12-year-old ward hanged himself. The case was in Cook County.
- An 18-year-old ward died of fatal cardiac arrythmia due to ingestion of prescription medication. The case was in Macon 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.

Nine deaths classified undetermined in manner.

- 5 children also had an undetermined cause of death.
- 3 children died of asphyxia.
- 1 child had a cause of sudden unexpected death due to co-sleeping with a parent and viral pneumonia.

ACCIDENT:
Twenty-four deaths were classified accident in manner.

Cause of death	Number
Asphyxia/sleep related deaths	11
Fire related deaths	5
Drowning	3
Motor vehicle related deaths	2
Injuries due to fall	2
Stress due to physical exertion	1
Total	**24**

NATURAL:
Eighty-seven deaths classified natural in manner.

Cause of death	Number
Sudden Infant Death Syndrome (SIDS)	14
Complications from premature birth	5
Complications of multiple medical problems	2
Cardiac disease or complications from heart problems	14
Pneumonia or respiratory illness	13
Progressive illness	10
Cerebral abnormalities or neurological disease	14
Stillborn	5
Viral illness	5
Sepsis	2
Cancer	3
TOTAL	**87**

Homicide

Case No. 1	DOB October 2002	DOD July 2004	Homicide
Age at death:	21 months		
Substance exposed:	No		
Cause of death:	Cerebral injuries due to blunt trauma		
Perpetrator:	Father		
County:	Cook		
Reason For Review:	Child returned home from foster care within a year of his death		
Action Taken:	Records reviewed		

Narrative: Twenty-one-month-old former ward was beaten to death by his 26-year-old father in his father's home. The child's 22-year-old mother left the child and his 2-1/2-year-old half-brother with the child's father despite a protective order prohibiting any contact with the father. The children had been returned to their mother's custody from foster care 6 months earlier. The father was charged with first-degree murder and is in jail awaiting trial. The mother pleaded guilty to child endangerment and is serving three years in prison. Both parents were indicated for the child's death. The surviving child reentered foster care and was placed with his previous foster parent, with whom he remains.

Prior History: In March 2003 the mother brought the deceased to the emergency room with a second-degree burn on his foot. The child's sibling was also examined because of the severity of the burn and the fact that the child's father was said to have accidentally caused the burn, despite the mother having an order of protection against him because of domestic violence. Medical personnel discovered a burn scar on the sibling's thigh, a small fracture to his leg, and a healed skull fracture. The mother and father were indicated for the injuries and the children were taken into protective custody and placed in a foster home together. The mother participated in services, including domestic violence counseling, parenting classes, and individual counseling, which she successfully completed. The father was also offered services, but declined to participate. The mother reported that she was no longer involved with the father. In January 2004 the children were returned by the court to the mother's custody under an order of protection that they have no contact with the father. The family continued to be monitored by a worker who noted that it appeared the mother was complying with the order. The mother continued to report that she had no contact with the father. Her family reported the same. The children attended day care while their mother was at work, and the family lived with the maternal grandmother who was supportive. After her son's death, the mother admitted that she had been taking the boys to the father's home since April, but said she left them alone with him on only three occasions.

Case No. 2	DOB May 1985	DOD August 2004	Homicide
Age at death:	19 years		
Substance exposed:	Unknown		
Cause of death:	Asphyxia due to multiple facial bone fractures with possible contribution by manual strangulation and/or drowning		
Perpetrator:	Boyfriend		
County:	Macon		
Reason For Review:	Teenager was a ward within one year of her death		
Action Taken:	Records reviewed		

Narrative: Nineteen-year-old former ward was found fully clothed floating in a pond. Her hands and feet had been tied with a telephone cord. The teenager's on-again, off-again 19-year-old boyfriend confessed to beating her in the head with a crowbar and throwing her into the pond. He was convicted of first-degree murder in July 2005 and is serving a forty-year sentence. The teenager had previously been a victim of domestic violence at the hands of the boyfriend.

Prior History: The teenager's wardship ended four months prior to her death. The teenager wished to

move to Ohio with her 1-year-old daughter to live with her mother and the court released her guardianship in April 2004 as all parties believed the move was in the teenager's best interest. The teenager had been a ward since 1993, but the family's involvement with DCFS dated to 1984. In April 2003 the teenager gave birth to a daughter and the following day the teenager's sister was murdered in a drive-by shooting. In June 2003 the teen entered a supervised independent living program but failed to make progress in the program. While in the program, the teenager was indicated twice for inadequate supervision of her daughter. The teen and her daughter were in Ohio for approximately a month prior to returning to Illinois in May 2004. Ohio social services visited them and reported they were doing well. Upon her return to Illinois, the independent living program (in which her younger sister also participated) attempted to involve the teenager in services, including domestic violence court intervention and counseling. During her last visit with workers, 9 days before her death, the teen maintained she was no longer involved with the boyfriend. The teenager's daughter entered foster care following her mother's death.

Case No. 3	DOB February 1988	DOD August 2004	Homicide
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unknown, believed to be gang-related		
County:	Cook		
Reason For Review:	Teenager was a ward		
Action Taken:	Records reviewed		

Narrative: Sixteen-year-old ward, who was a gang member, was leaving a party with a friend when he was shot during a drive-by gang shooting. The homicide remains unsolved; there is an open investigation with the Chicago police department.

Prior History: The ward entered foster care for the first time in March 1998 because of his mother and maternal grandmother's neglect. He was returned to his father's care in September 1999. In August 2003 the teen reentered foster care after police discovered he was living on the streets after being repeatedly abused by his father. The teen was placed at a shelter but ran from it regularly. At the time of his death, the teen's whereabouts were unknown to family and DCFS. His worker regularly filed missing person reports with the police.

Case No. 4	DOB August 2004	DOD September 2004	Homicide
Age at death:	1 month		
Substance exposed:	No		
Cause of death:	Cerebral injuries due to blunt trauma		
Perpetrator:	Father		
County:	Kane		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-five-year-old father called 911 stating his one-month-old son had stopped breathing. The father claimed he had just finished feeding the infant and that he had been crying 15 minutes earlier. Paramedics, however, observed the infant to be cyanotic and cold to the touch, with bruising. The infant was taken to a local hospital where a CT scan revealed severe head injuries. The infant was air lifted to a trauma center where he died later that day. The father confessed to throwing the infant on the floor after he peed on the father's shirt. The infant's twenty-four-year-old mother was not home at the time of the incident as she was at the hospital with the infant's twin brother. The surviving twin and his 2-year-old half brother were examined and no abuse was found. The father was charged

with manslaughter and his case is pending. He also was indicated for the infant's death. The father had been indicated on a March 2003 report for substantial risk of physical injury to his 3-year-old daughter by another woman because of an episode of domestic violence against the woman while she was holding the child. The deceased's mother denied domestic violence between herself and the father. An intact family case was opened following the infant's death. It was closed in September 2005.

Prior History: Three days prior to the infant's death the hotline was contacted with an allegation of cuts, bruises, welts to the infant's twin brother. The mother brought the baby to the hospital with a distended stomach and thin linear bruises on the stomach for which doctors had not yet medically explained. The baby was hospitalized and following several tests, including abdominal and chest scans, the baby's condition was determined to be organic in nature, possibly due to Hirschsprung's disease (a serious digestive disorder). No abuse was detected and the report was ultimately unfounded. The DCP investigator saw the baby in the hospital, spoke with medical personnel, and made 2 attempts to see the deceased, his brother, and the father prior to the infant receiving his fatal injuries.

Case No. 5	DOB October 2004	DOD October 2004	Homicide
Age at death:	0		
Substance exposed:	Yes, cocaine		
Cause of death:	Blunt trauma to the head		
Perpetrator:	Mother		
County:	St. Clair		
Reason For Review:	Open foster care case on a sibling		
Action Taken:	Preliminary investigation		

Narrative: Thirty-six-year-old mother said she was walking home from a friend's house when she felt cramping, went to the bathroom and a baby fell out of her and landed on his head on a concrete walkway. There was no evidence that the mother gave birth where she said she did. An autopsy revealed that the infant died from inflicted severe head injuries. The mother was indicated for the child's death. She has been charged with first-degree murder and is awaiting trial.

Prior History: The mother, who has given birth to five children, has a history of neglect and substance abuse dating to 1991. Her children were in foster care from October 1999 to December 2000. They were placed in foster care again in May 2001. In October 2003 parental rights were terminated and workers had no further contact with the mother. In May 2004 three of the children were adopted by an aunt and uncle. The fourth is in foster care with a paternal relative. Her father appealed the termination of his parental rights and is working to gain custody of her.

Case No. 6	DOB January 1985	DOD October 2004	Homicide
Age at death:	19 years		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unknown		
County:	Cook		
Reason For Review:	Teenager was a ward		
Action Taken:	Preliminary investigation		

Narrative: Nineteen-year-old ward was shot and killed while committing a robbery. No one will be charged in his death, and the case was closed.

Prior History: The teenager and his six siblings entered foster care in 1995 because of the mother's chronic neglect. The teenager had a history of delinquency dating to the age of 11. In September 2004 the teen was paroled from the Department of Corrections into an approved self-selected placement where he was supposed to remain on house arrest. Two weeks later the teen went on run from his placement, violating his parole. The teen's worker had been trying to involve him in services prior to his

running. He was killed two and a half weeks after leaving his placement.

Case No. 7	DOB October 1990	DOD November 2004	Homicide
Age at death:	14 years		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unknown, believed to be gang-related		
County:	Cook		
Reason For Review:	Open preventive services case at time of child's death		
Action Taken:	Records reviewed		

Narrative: Fourteen-year-old child and his father were searching on foot in their neighborhood for the child's 15-year-old sister when a vehicle pulled up by them and the driver jumped out and opened fire on the child, striking him multiple times. The child and father would routinely search the neighborhood for the sister, who had a history of running away from home. No one has been charged in the child's death; there is an open investigation with the Chicago Police Department.

Prior History: The family's first contact with DCFS was two months prior to the child's death when the hotline was contacted with allegations of inadequate shelter and environmental neglect. The father and his two children were living in an apartment that frequently flooded and had mold. The report was unfounded, but a preventive services case was opened to help the father obtain a new apartment and get family counseling. The father, who had health problems, was raising the children alone because the mother left the family 10 years earlier to return to Mexico. Following the child's death, the father reported that he and his daughter were moving to California to be near his parents and get away from death threats he was receiving. The family's case was closed in January 2005.

Case No. 8	DOB March 1991	DOD November 2004	Homicide
Age at death:	13 years		
Substance exposed:	No, though mom has a history of substance abuse		
Cause of death:	Gunshot wound to head		
Perpetrator:	Brother		
County:	Cook		
Reason For Review:	Child was a ward		
Action Taken:	Records reviewed		

Narrative: Thirteen-year-old boy was at home in his room at his grandmother's house with his 18-year-old brother and his brother's friend when he was accidentally shot in the head while his brother showed them a gun. The 18-year-old pled guilty to involuntary manslaughter and was sentenced to 90 days in jail and 4 years probation. He was also indicated by DCFS for death by neglect. The maternal grandmother, who did not know there was a gun in the home and who did not allow the children to play with toy guns, was not charged or indicated in the child's death.

Prior History: The family has been involved with the Department since 1993 when the 21-year-old mother gave birth to her sixth child, who was born substance-exposed. The mother went on to have three more children, all born substance-exposed. The first seven children entered foster care in August 1995; two others followed after their substance-exposed births. The deceased and his sister were in the subsidized guardianship of their aunt. When she became ill, the father petitioned the court for custody and guardianship. The children had lived with their father and his wife for five months when he relinquished guardianship of the children to DCFS. In September 2004 the deceased was placed with his maternal grandmother (who had subsidized guardianship of four of his siblings) and his sister was placed in a non-relative foster home. The sister remains in foster care; one child is with his father; and the other six have been adopted or are in subsidized guardianship.

Case No. 9	DOB April 1989	DOD November 2004	Homicide
Age at death:	15 years		
Substance exposed:	No		
Cause of death:	Gunshot wound to head		
Perpetrator:	Unknown		
County:	Cook		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Records reviewed		

Narrative: Fifteen-year-old girl was walking down the street one evening with her 17-year-old male cousin when she was approached by a man with a gun and shot in the head. Police believe the bullet was intended for her cousin. The teenager was living with her grandmother, and the shooting occurred in the neighborhood. The homicide remains unsolved; there is an open investigation with the Phoenix police department.

Prior History: The teenager and her three siblings were in foster care from February 1996 to June 2003 when they were returned to their mother's care under an order of protection. Their cases were closed in February 2004. Between March and August 2004 there were four unfounded reports involving the family. In March 2004 police reported that the teenager was out of control and locked out of the home by her parents. A DCP investigation was unfounded because the teen was living with an adult cousin. In June 2004 the hotline was contacted with a report that the teen was struck in the mouth by her father. The father and daughter reported the incident was an accident that occurred while the father was trying to wake her. The DCP investigator did not observe any injuries. In August 2004 the deceased contacted the hotline to report that her family was homeless. The report was unfounded because the deceased was living with her grandmother and the rest of the family was staying with family and friends while searching for an apartment. The investigator provided the family with housing referrals. Later that same month, the police called the hotline to report a lockout, stating that the deceased was refusing to return home and her parents did not want her. The report was unfounded. The parents denied locking the teen out, but said that she came and went at will and was currently on run. The teen was not staying with her grandmother at the time and could not be located.

Case No. 10	DOB August 1994	DOD November 2004	Homicide
Age at death:	10 years		
Substance exposed:	No		
Cause of death:	Poisoning by Oxycodone		
Perpetrator:	Father		
County:	Hancock		
Reason for review:	Open service case within one year of child's death		
Action Taken:	Records reviewed		

Narrative: Thirty-six-year-old father poisoned his ten-year-old son with a large dose of crushed Oxycodone medication that he put into a glass of soda. The father confessed to putting the medication in a glass and watching his son drink it. He said that he and his only child planned to commit suicide together. School officials became concerned when the child was absent from school for a week. Investigation led police to the home where the child was found dead and the father was found with self-inflicted stab wounds. The father was charged with murder, and his case is pending.

Prior History: This family first came to the attention of the Department in July 2004, four months prior to the child's death, when police responded to a domestic violence call at the family's home. An allegation of substantial risk of physical injury to the child was unfounded, but a short term services case was opened for two months to provide support to the father and child as the child's forty-four-year-old

mother moved out of state. The mother left the child with his father, with whom he wanted to live, despite having legal custody of him. During the two months she was involved with the family, the caseworker observed the father and child to be well-bonded. The father reported a history of depression for which he took medication. The father and son both attended counseling and the father engaged in parenting instruction with the worker. The father never displayed any suicidal or homicidal behavior. No one involved with the family, including the father's probation officer and the child's school, had raised any concerns about the child's welfare prior to his death. The mother had called the child's counselor in August 2004 to inform him of the father's domestic violence, suicidal tendencies, statements to the mother that both he and the child could wind up dead, and the mother's belief that the father had turned the child against her. The counselor shared the information with the worker who felt that the mother was trying to cause problems for the father. There was hostility between the parents and the worker encouraged the father to limit his contact with the mother to matters that involved the child. The service case was closed in September 2004, two months prior to the child's death.

Case No. 11	DOB November 2004	DOD January 2005	Homicide
Age at death:	2-1/2 months		
Substance exposed:	No		
Cause of death:	Malignant cerebral edema due to shaken impact infant syndrome		
Perpetrator:	Father		
County:	Winnebago		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-four-year-old mother brought her 2-1/2-month-old infant to the emergency room, stating that she left the infant with the 19-year-old father while she went to work and when she returned home she found the infant unresponsive and having trouble breathing. The infant was diagnosed as having been shaken. She died in the hospital four days later. The father confessed to police that he shook the infant. He pleaded guilty to involuntary manslaughter and was sentenced to 14 years in the Department of Corrections. He also was indicated for the infant's death. The mother obtained an order of protection against the father.

Prior History: A month prior to her death, the infant's doctor contacted the hotline to report that an x-ray revealed that the infant had a skull fracture. The doctor had received a call from the infant's mother the night before after she picked up the infant from the babysitter's and noticed that she had a swollen bump on the side of her head. The sitter claimed she knew of nothing that might have caused the injury. The infant did not appear to be in any distress so the doctor had the mother bring the baby in the next morning. The infant had a soft, mushy spot on the side of her head, but no other outward injury. An x-ray showed the baby had a skull fracture. The hotline took a report against the 25-year-old babysitter for head injuries by neglect. During the investigation, the father confessed to the mother that he had been feeding the baby and he fell asleep, dropping the baby on the hard floor in the basement. The investigator observed the area where the injury was said to have occurred and had the father reenact the incident. The doctor opined that the injury could have occurred in the manner described. The mother's 6-year-old son and his paternal grandmother were interviewed. The boy reported liking his sister's father and said he had to go to his room when he got in trouble. The paternal grandmother reported she had no concerns about abuse. Following the infant's death, the investigation was indicated against the father for head injuries by neglect and medical neglect.

Case No. 12	DOB November 2004	DOD February 2005	Homicide
Age at death:	2-1/2 months		
Substance exposed:	No		

Cause of death:	Closed head injuries due to blunt force trauma
Perpetrator:	Mother
County:	McLean
Reason For Review:	Open intact family case at time of child's death
Action Taken:	Records reviewed

Narrative: 22-year-old mother claimed to find her 2-1/2-month-old son unresponsive when she got up to feed him. An autopsy revealed he died from blunt force trauma. The mother confessed to police that she beat her son and tried to smother him. She told police she hated the infant. The mother was arrested and charged with murder. Her trial is pending. The mother was indicated for death by abuse and the 28-year-old father was indicated for death by neglect because he allowed the mother to continue caring for the infant despite her being stressed and knowing that she had a tendency to become violent under stress, and because he was home at the time of the fatal injuries but did nothing to intervene. The couple's 13-month-old child was placed in foster care where she remains.

Prior History: In February 2004 the parents were investigated for environmental neglect. The investigation was unfounded because the parents improved the living conditions in their studio apartment. The investigator referred the family for short-term services to assist them further with correcting environmental concerns. In April 2004 the family was investigated again for environmental neglect. The investigation was indicated because the apartment was unsanitary and unsafe for the couple's 4-month-old daughter. An intact family case was opened. The family moved into a new, 2-bedroom apartment. The intact family worker met with the family on a weekly basis. The parents cooperated with services, and most of the time maintained a clean living environment for their daughter. The mother reported a history of bipolar disorder for which she took medication and the father reported a hospitalization years earlier for a nervous breakdown. The father completed a domestic violence assessment and sporadically attended group counseling sessions. He also periodically attended individual counseling. He was employed through a temporary employment agency. The mother stayed home to care for their child. She did not participate in counseling. The deceased was born in November 2004. The parents ensured that he, as well as his sister, received regular medical care. The infant appeared to have some breathing problems for which his doctor suggested he sleep upright. The infant ate well and appeared to be developing on target. The parents had the support of the mother's grandmother, their church, and family friends. The worker observed no signs that the infant was at risk for abuse.

Case No. 13	DOB October 2003	DOD February 2005	Homicide
Age at death:	16 months		
Substance exposed:	No		
Cause of death:	Hemoperitoneum due to laceration of the liver due to blunt force trauma		
Perpetrator:	Mother's boyfriend		
County:	McLean		
Reason For Review:	Open preventive services case within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Sixteen-month-old toddler was beaten to death by his mother's 22-year-old boyfriend while she was at work. The 30-year-old mother had been dating the man for two months before he moved in with her and her five children, ages 14 months to 11 years. They made the financial decision that she would work and he would watch the kids. The toddler was killed two months later. The boyfriend was charged with murder and is awaiting trial. He was also indicated for the toddler's death and substantial risk of physical injury to the surviving children. The mother was not indicated because she was not home when the abuse occurred, and there were no prior indications that the boyfriend might seriously harm one of her children. Still, the Department was awarded temporary custody of the children and they were placed with their mother and grandmother under an order of protection. The

mother cut off all contact with the boyfriend after her son's death, and the children's court cases were closed in July 2005.

Prior History: The family's only prior involvement with the Department was from August 2004 to January 2005 when a preventive services case was open. The mother requested help obtaining housing after relocating to the area from Chicago where she left an abusive relationship. A preventive services case was opened with a private agency and the mother received help obtaining housing, furniture, and clothing, and received referrals to other community resources. The case was closed the month before the toddler's death.

Case No. 14	DOB December 2003	DOD June 2005	Homicide
Age at death:	18 months		
Substance exposed:	No		
Cause of death:	Multiple injuries due to assault		
Perpetrator:	Mother's boyfriend		
County:	Cook		
Reason For Review:	Extended family support case open within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-five-year-old mother was staying overnight at her 20-year-old boyfriend's home with her 7, 5, and 1-year-old twin daughters. The couple had been seeing each other for 9 months. In the morning, while the mother was still sleeping, the boyfriend took the deceased twin into a room and closed the door. The siblings heard their sister crying. When the mother awoke later she went into the room and found the child unresponsive. An autopsy revealed multiple internal and external injuries, including a large rectal tear consistent with penetration. The other children were examined and no abuse was found. The boyfriend was charged with first-degree murder and is in Cook County Jail awaiting trial. The boyfriend was indicated for the child's death and sexual penetration. The mother was indicated for substantial risk of physical injury to her surviving daughters because of a history of domestic violence between the mother and boyfriend that was witnessed by the girls. The mother lives in Indiana and during the investigation, the Department requested that Indiana open a case on the family.

Prior History: In November 2004 the maternal grandmother contacted the hotline requesting assistance obtaining guardianship of her four granddaughters. She stated that the mother frequently left the children with her or other relatives, and they never knew when she would return. The hotline made a referral to the Extended Family Support Program. A worker made several attempts to contact the grandmother. When the grandmother did not respond the case was closed in January 2005.

Case No. 15	DOB July 1985	DOD June 2005	Homicide
Age at death:	19 years		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Rival gang member		
County:	Cook		
Reason For Review:	Teen was a ward		
Action Taken:	Preliminary investigation		

Narrative: Nineteen-year-old ward was sitting in a parked car one evening with a friend when a man drove up in another car and got out and shot the ward. The ward was gang-involved and the shooting is believed to have been in retaliation for a shooting that occurred the day before. A rival gang member has been charged in the offense.

Prior History: The ward and his two older sisters entered foster care in 1994 because of their mother's

neglect. The ward was living with a relative with whom he had been placed since May 1997. He was the father of two children. The ward's sisters have aged out of the foster care system.

Case No. 16	DOB October 1987	DOD June 2005	Homicide
Age at death:	17 years		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unknown, believed to be gang-related		
County:	Cook		
Reason For Review:	Pending DCP investigation at time of teen's death		
Action Taken:	Records reviewed		

Narrative: Seventeen-year-old boy was walking down the street at approximately 10:00 p.m. when a car pulled up beside him and an unknown gunman shot him multiple times. The homicide remains unsolved; there is an open investigation with the Harvey police department.

Prior History: There was a pending DCP investigation at the time of the teen's death alleging inadequate supervision of the teen by his 34-year-old adoptive mother. According to the reporter, the mother was a chronic drug user who was never home, and the teen was staying in homeless shelters and with friends. Investigation revealed that the teen had been staying with his grandfather who wanted him to remain there, and the investigation was unfounded following the teen's death. In August 2004 the grandfather had contacted DCFS requesting assistance to care for the mother's 9 and 12-year-old children, and an extended family support services case was opened. In January 2004 a child welfare services referral was made when the teen told a neighbor that he had been put out of his home by his 34-year-old adoptive father. The father denied putting him out and said he was free to come home at any time. The father was sent a letter advising him who to contact if he was having trouble with the teen.

Suicide

Case No. 17	DOB October 1986	DOD September 2004	Suicide
Age at death:	17 years		
Substance exposed:	No		
Cause of death:	Gunshot wound to the head		
County:	Christian		
Reason for Review:	Child was a ward		
Action Taken:	Full investigation pending		

Narrative: Seventeen-year-old ward found the keys to the locked gun cabinet in his foster parents' home and shot himself in the head. The ward had stayed home sick from school that day. The teenager had a history of mental health issues including major depression. The ward had seen his therapist the night before and had not voiced suicidal ideation. It was suspected that a break-up with his girlfriend contributed to the suicide. The OIG is investigating this case for inclusion in a cluster report about the suicide of children involved with DCFS.

Prior History: The ward's biological family has an extensive history with the Department. In October 1992 DCFS initiated two investigations, days apart, because the then six-year-old child and eight-year-old sister came to school with multiple bruises. The children indicated their thirty-two-year-old stepfather and twenty-six-year-old mother had inflicted the injuries. The children, along with their four-year-old half sibling, were taken into custody. The parents participated in services and the children were returned home in March 1994. In August 1995 the children were taken into custody again because of numerous allegations of abuse and neglect. The deceased ward was psychiatrically hospitalized and was then placed in residential treatment. In June 1998 the children were returned home to their parents. In

March 2000 they were taken back into custody for physical abuse. The child was hospitalized for suicidal ideation. Upon release from the hospital he was placed in the foster home where he remained until his death. The child's siblings were returned to their parents in July 2001. The deceased was diagnosed with oppositional defiant disorder, conduct disorder, post traumatic stress disorder, physical abuse as a child, major depressive disorder (in partial remission), ADHD by history, and enuresis. The teenager had significant behavior problems at school, including verbal and physical aggression and school failure. He attended weekly therapy and reportedly liked his foster home. He had a behavior plan at school. In the year prior to his death, the ward's behavior had improved.

Case No. 18	DOB January 1986	DOD September 2004	Suicide
Age at death:	18 years		
Substance exposed:	No		
Cause of death:	Fatal cardiac arrythmia due to ingestion of prescription medication		
County:	Macon		
Reason for Review:	Child was a ward		
Action Taken:	Full investigation pending		

Narrative: Eighteen-year-old ward was found unresponsive on the floor of her room at her paternal grandmother's home. Her grandmother went to check on her when she did not get up in the morning. The family reported that she was in a car accident the previous day, received a citation and had been agitated about the incident. Empty medication bottles with fill dates from mid August were found on her dresser. The family reported the bottles had not been there the day before. The ward had a history of depression and bipolar disorder. She was often non-compliant with her medication. The OIG is investigating this case for inclusion in a cluster report about the suicide of children involved with DCFS.

Prior History: The Department's first contact with the family was in March 1999 when the then thirty-one-year-old mother was indicated for cuts, welts and bruises to the ward's younger sibling. The Department opened an intact family case, although in September 1999 the mother voluntarily allowed the child to move in with her grandmother. In January 2000 the children reported that their mother's boyfriend had sexually molested them. The children were formally taken into custody. The deceased ward remained in the home of her grandmother. In March 2000 the ward was arrested for aggravated battery after twice assaulting a teacher. In September 2000 she was sentenced to imprisonment at the Department of Corrections Youth Center where she remained until April 2004. The teenager was reportedly not cooperative with therapy or treatment while incarcerated. While incarcerated the ward reported that DOC staff sexually abused her twice. The Department investigated; one case was unfounded and one case was indicated. Upon release from prison, the ward went to live with her paternal grandmother and was linked to psychiatric services. The caseworker visited the ward regularly. In June 2004 she was hospitalized after she told her parole officer that she had taken a bottle of her medication. The ward engaged in therapy and seemed to be doing well.

Case No. 19	DOB January 1993	DOD January 2005	Suicide
Age at death:	12 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Hanging		
County:	Cook		
Reason for Review:	Child was a ward		
Action Taken:	Full investigation pending		

Narrative: Twelve-year-old ward was found hanging from a rod in his closet by his foster parent. The foster parent reported that the child had become upset earlier in the day when told that he could not go outside. The child had been diagnosed with ADHD and exhibited symptoms of anxiety, depression

and post-traumatic stress disorder. He had participated in psychiatric and therapeutic services. The OIG is investigating this case for inclusion in a cluster report about the suicide of children involved with DCFS.

Prior History: The family's involvement with the Department dates to January 1988 when the then seventeen-year-old mother was indicated for neglect on the deceased ward's two-month-old sibling. An intact family case was open until December of that year. The mother, who has a history of mental illness, allowed relatives to raise the child. In August 1994 the mother was indicated for substance misuse after she gave birth to a substance exposed infant. In May 1995 the mother and her then boyfriend were indicated for burns, cults, welts and bruises and sexual molestation of the deceased ward's then four-year-old sibling. That sibling was placed with relatives and adopted in 1998. The mother had another indicated report for abuse in May 1997 when she came to the maternal grandmother's home with her boyfriend who physically abused the children. During the course of the investigation, the mother separated from the boyfriend and engaged in substance abuse treatment. The case was referred for intact family services. In August 2003 the ward and younger sibling were placed in traditional foster care after being sexually abused by their mother's boyfriend. The mother was indicated for substantial risk of physical injury because of the sexual abuse and for not consistently providing the child's psychotropic medication. In August 2004 the child was moved to a specialized foster home. The mother was inconsistent with services and generally uncooperative. She would visit with the ward, but frequently cancelled or was late, spoke negatively and acted inappropriately. She was often verbally abusive to the child and the workers who would then have to terminate visits. The child was exhibiting behavior problems in school, but was cooperating with weekly therapy. He had last seen his therapist four days prior to his death. The mother's boyfriend is currently serving five years in prison for aggravated criminal sexual abuse.

Undetermined

Case No. 20	DOB June 2003	DOD July 2004	Undetermined
Age at death:	13 months		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Cook		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-year-old mother found her one-year-old daughter unresponsive in her crib. The child's cause and manner of death were undetermined given the child's medical history of a prior hypoxic event with severe subsequent brain damage, the presence of ethanol in the blood and bile without apparent explanation, and no follow-up scene investigation. A DCP investigation of the child's death was unfounded.

Prior History: In September 2003 the mother awoke to find her daughter unresponsive. 911 was called and the 3-month-old infant was brought to the hospital in respiratory distress. A CAT scan showed the infant suffered from cerebral edema consistent with suffocation or loss of oxygen. She had severe brain damage. Following investigation, the mother was indicated for head injuries by neglect because the mother and infant slept on a makeshift bed consisting of pillows, blankets and crib mattresses thought to cause the infant's suffocation. While the mother did not appear to intend to harm the infant, she used poor judgment in placing the infant on an inappropriate sleeping surface. An intact family case was opened; it was closed in February 2005. A 4-year-old daughter remains in the mother's custody.

Case No. 21	DOB August 2004	DOD October 2004	Undetermined
Age at death:	2 months		

Substance exposed:	No
Cause of death:	Undetermined
County:	Cook
Reason For Review:	Pending DCP investigation at the time of child's death
Action Taken:	Records reviewed

Narrative: Two-month-old, who had been sleeping in a twin-sized bed with his 23-year-old mother and 27-year-old father, was found unresponsive by his father. He was taken by ambulance to the hospital where he was pronounced dead. The infant's cause and manner of death was undetermined because the parents reported the infant had had prior episodes where he stopped breathing and because of the sleeping arrangements of the family, making it likely that one of the parents overlayed the infant.

Prior History: The family's first contact with DCFS occurred five days before the infant's death when an anonymous reporter called the hotline to state that she had seen the family's four children in a clinic that day and they were dirty and had head lice and rotting teeth. A report was taken for environmental neglect. Allegations of inadequate food, inadequate shelter, inadequate clothing, and inadequate supervision were added when the family's landlord called stating he was evicting the family for nonpayment of rent, the family had no gas or stove, the home had roaches, the children were outside in their underwear, the children had been left unsupervised, and one of the children asked for food, stating the family had none. The day after the initial report, an investigator saw the three oldest children in the home. They were being babysat by their aunt while their parents were at the hospital with the infant who had been having difficulty breathing. The children were in need of dental care and had lice, which the parents were treating with lice shampoo. While the home did not have hot water, there was electricity and a hot plate to heat water. There was also plenty of food in the apartment. The investigator interviewed both parents the following day and saw the infant in the hospital. The report was ultimately unfounded, as was an investigation of the death of the infant. A preventive services case was open for three months following the infant's death to help the family with housing and employment issues, dental referrals and counseling.

Case No. 22	DOB February 2004	DOD November 2004	Undetermined
Age at death:	9 months		
Substance exposed:	No		
Cause of death:	Asphyxiation due to aspiration of formula combination		
County:	Fayette		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Thirty-three-year-old father found his 8-month-old infant unresponsive. The father reported that around midnight he gave the infant a bottle of formula mixed with baby carrots while they laid on a mattress on the living room floor. The father said he fell asleep and awoke about an hour later to find the infant unresponsive. An autopsy revealed numerous bruises to the infant that the pathologist did not believe were caused by normal exploratory behavior. In addition, he believed the infant was likely force-fed, causing him to aspirate on the contents of the bottle. Protective custody was taken of the infant's 2-year-old sister, however, she had no injuries and the State's Attorney's Office refused to take the case to a temporary custody hearing. The parents were indicated for cuts, bruises, welts and substantial risk of physical injury. DCFS opened an intact family case. The child entered foster care in February 2005 after domestic violence and drug abuse by the parents became apparent.

Prior History: The family first came to the attention of DCFS in April 2004 when the mother was arrested for felony theft. The mother reported that she did not know where her children were and that she needed to find them. A report was taken against the mother for substantial risk of physical injury. The report was unfounded after the mother confessed to knowing where the children were and that they were safe. She reported that she said she did not know where her children were because she thought the judge would let her out of jail to find and care for them. The children had been in the custody of their father, staying with the

paternal aunt and grandmother.

Case No. 23	DOB September 2004	DOD December 2004	Undetermined
Age at death:	3 months		
Substance exposed:	No		
Cause of death:	Sudden unexpected death due to co-sleeping with mother and mild viral pneumonia		
County:	Peoria		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Records reviewed		

Narrative: Thirty-one-year-old mother found her 3-month-old son unresponsive. He had been sleeping in bed with his mother and 4-year-old sister. The family did not have a crib for the infant. An investigation of the infant's death was unfounded.

Prior History: The family first came to the attention of DCFS in February 2003 when the police called the hotline to report that the mother had been arrested 3 times in one week for a DUI, domestic violence, and disorderly conduct. Police said the father did drugs and the mother drank alcohol. They suspected there was drug dealing from the home. The parents were indicated for substantial risk of physical injury, and an intact family services case was opened. The case was closed in December 2003 when the mother filed for divorce and moved to Peoria to be near her mother. The father was in prison on a drug charge, and the mother had recently been released from a 3-month jail stay for the same charge. The mother had participated in services in jail and before being incarcerated. She was reported to be clean at the time of case closure. The family's next contact with DCFS was in October 2004 when a reporter, who gave her name but wished to remain anonymous, called the hotline alleging the mother was giving the infant Benadryl to make him sleep. The investigation was pending at the time of the infant's death. The reporter said the family was living with the maternal grandmother, but she did not know the address. The investigator was attempting to locate the family. The investigation was ultimately unfounded because the mother denied giving the infant Benadryl, no Benadryl was found in the home, and a toxicology screen for Benadryl after the infant's death was negative.

Case No. 24	DOB July 2004	DOD December 2004	Undetermined
Age at death:	4 months		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Cook		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Thirty-four-year-old aunt, who was babysitting the 4-month-old infant while her 18-year-old mother was at school, found the infant blue and unresponsive. The infant had been napping face up on a couch. 911 was called and the infant was taken by ambulance to the hospital where she died three days later. No cause of death could be determined. An autopsy revealed three abrasions and a bruise on the back of the infant's head, as well as three posterior subgaleal hemorrhages within the infant's scalp. However, these injuries did not cause the infant's death.

Prior History: In April 2004 a school social worker called the hotline to report that the mother, then 17 years old, told her that she missed a day of school because her mother punched her, and her lip was swollen and bleeding. An investigation for substantial risk of physical injury was unfounded. The teenager had no evidence of injury and, while the mother admitted to hitting her daughter in the mouth, both mother and daughter agreed the mother was justified because the teenager had been "smarting off".

Case No. 25	DOB July 2004	DOD December 2004	Undetermined
Age at death:	4-1/2 months		
Substance exposed:	No		
Cause of death:	Asphyxia due to aspiration of regurgitated gastric contents		
County:	Sangamon		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-four-year-old mother found her 4-1/2-month-old son unresponsive facedown in a pile of vomit. The mother had taken the infant to his 27-year-old father's trailer home, in violation of a safety plan, and placed him down for a nap on a cot with an egg-crate foam mattress. The mother and father were indicated for death by neglect because they violated a safety plan prohibiting contact between the child and father and because they placed the infant in an unsafe sleep position in which he was unable to move his head. The mother's 2 and 4-year-old children from a previous relationship were placed in foster care and released to their father's custody in January 2005. A second child born to the mother and father in September 2005 entered foster care following her birth. She is placed in the home of a relative.

Prior History: The family's first contact with the Department occurred approximately three weeks prior to the infant's death, when the local police department contacted the hotline to report that earlier that day the deceased's 27-year-old father took his family hostage, threatening to beat them to death if they tried to leave. The police diffused the situation and brought the father to the hospital where he was involuntarily committed to the adult psychiatric unit and diagnosed with a drug-induced psychosis. The father was bipolar. The police reported that the home was unfit for children with junk everywhere, deer carcasses in the yard, and jars of deer blood within the children's reach. While DCP was investigating, the mother agreed to a safety plan whereby she and her children would stay with her mother and have no contact with the father. The mother violated the safety plan by bringing the infant to the father's trailer for a visit.

Case No. 26	DOB March 2005	DOD May 2005	Undetermined
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Undetermined		
County:	Cook		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-seven-year-old father found his 2-month-old son unresponsive and called 911. The father reported to hospital staff that the baby had been asleep in the father's bed when he found him. He later told Medical Examiner staff that he found the baby lying face up in his crib. He also told hospital staff the baby did not have a mother, but a short time later the 25-year-old mother arrived at the hospital. A cause of death could not be determined for the baby following a complete autopsy and scene investigation. The baby's death was ruled undetermined because the father had a violent criminal history which he lied about, was the last person with the baby, and gave an inconsistent history of where the baby was sleeping.

Prior History: The father was an alleged perpetrator on two reports involving his 1-year-old son with another woman. In June 2004 the hotline was called with a report of substantial risk of physical injury to the 1-year-old based on the father's history of violence, drug use, and gun possession. The report was unfounded because the mother agreed to not leave her child alone with the father, and her worker and guardian ad litem vouched for her good care of her son. In August 2004 a second report was made that the mother had been beaten by the father because she flushed his marijuana down the toilet. The father was arrested. The mother ended the relationship and obtained an order of protection. The child was not present during the beating, and the investigation was unfounded for substantial risk of physical injury. The mother was referred for domestic

violence services.

Case No. 27	DOB January 2005	DOD June 2005	Undetermined
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Asphyxia		
County:	Winnebago		
Reason For Review:	Open preventive services case within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-eight-year-old mother found her 5-month-old infant unresponsive in the morning. The infant had been sleeping in an adult bed with her mother and 2 of her 3 siblings.

Prior History: The mother has a history dating to 2000 of leaving her two sons, now 10 and 11, home alone for periods of time while she worked. In May 2004, following an unfounded report of inadequate supervision, a preventive services case was opened to assist her with her 9-year-old son's behavior problems from ADHD. The son was linked to a psychiatrist and counseling, and his behavior improved. The case was closed 2 weeks after the infant's birth.

Case No. 28	DOB April 2005	DOD June 2005	Undetermined
Age at death:	2-1/2 months		
Substance exposed:	Yes, methadone		
Cause of death:	Undetermined		
County:	Cook		
Reason For Review:	Open preventive services case within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Thirty-one-year-old mother found her 2-1/2-month-old infant unresponsive in the morning. Although there was a crib in the home, the infant slept with the mother. The infant was last seen alive approximately 5-1/2 hours earlier.

Prior History: From April 1997 to March 1998 there was an intact family services case open on the mother and her three children. The family's next contact with DCFS was in April 2005 when the deceased was born. The hospital requested child welfare services for the family when the infant tested positive for methadone. The mother reported that she had been enrolled in substance abuse treatment for the past two years and was taking methadone as part of her treatment. The infant was hospitalized for several weeks after her birth for respiratory problems. A child welfare services worker linked the mother to community services. The family moved prior to the infant's discharge from the hospital and the worker was unable to locate them. The mother has five surviving children in her care, ages 2 to 13 years.

ACCIDENT

No. 29 30	DOB March 2001 May 1998	DOD July 2004 July 2004	Accident
Age at death:	3 years & 6 years		
Substance exposed:	Unknown		
Cause of death:	Inhalation of smoke and soot due to house fire		
Case County:	Joliet (fire); Will (residence)		
Reason For Review:	Pending DCP investigation at time of children's death		
Action Taken:	Records reviewed		

Narrative: Six-year-old child and his 42-year-old adoptive mother died in a house fire. His 3-year-old

brother was maintained on life support until he died six days later. Three brothers survived the fire. The fire occurred in the home of a maternal aunt with whom the family was staying. The cause of the fire was undetermined, but appeared to have started with a living room couch.

Prior History: Four days before the fire the police called the hotline to report substantial risk of physical injury to the 6-year-old by his mother. The 6-year-old had been crying in the car with his mother and she made him get out of the car on the side of a major highway. The mother was in the final stages of a terminal illness and was disoriented by her numerous medications. The maternal aunt agreed that she and other family members would take responsibility for the boys, and the mother would no longer drive them or care for them by herself.

Case No. 31	DOB January 2003	DOD July 2004	Accident
Age at death:	17 months		
Substance exposed:	No		
Cause of death:	Thermal burns and smoke inhalation		
County:	St. Clair		
Reason For Review:	Open intact family services case at time of child's death		
Action Taken:	Records reviewed		

Narrative: Seventeen-month-old child died in a fire in his family's mobile home. He was the last of his four brothers, ages 3 months to 4 years, to be rescued from the fire. The fire is believed to have started from a candle placed on a shelf too close to the ceiling. The 21-year-old mother had gone outside to investigate a noise. When she returned to the front of the trailer she saw that the living room was on fire. She was able to rescue two of her children from the living room; a neighbor rescued a third; and the 21-year-old father, who arrived home during the fire, rescued the 17-month-old child. The mother and four children were hospitalized with injuries. The child died from his injuries five days after the fire.

Prior History: The family's first contact with DCFS was a January 2002 report of substantial risk of physical injury that was unfounded and kept on file for evidence of harassment. In May 2003 a second report was unfounded. In December 2003 the family was indicated for inadequate shelter and an intact family case was opened. A March 2004 investigation for inadequate food and environmental neglect was unfounded. At the time of the child's death, the parents were making improvements to their trailer home. The intact family case remains open.

Case No. 32	DOB October 2003	DOD July 2004	Accident
Age at death:	9 months		
Substance exposed:	No		
Cause of death:	Drowning in a bathtub		
County:	Lawrence		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Twenty-six-year-old mother found her 9-month-old son submerged in the bathtub. The mother reported she left the infant in the bathtub for a minute to go get something. She did not call for an ambulance until 1-1/2 hours after discovering him. The mother and 28-year-old father admitted to using methamphetamine earlier that day, and the mother tested positive for the drug. The mother has been charged with child endangerment.

Prior History: In October 2001 the parents were indicated for environmental neglect, and an intact family case was opened until July 2002. The family had no further DCFS involvement until June 2004 when the hotline was contacted with another report of environmental neglect against the parents. The family had been seen in the emergency room for bites all over their bodies from living in a home infested with bugs.

Hospital staff reported they believed the parents were using methamphetamine because of their behavior and the sores on their bodies. The report was unfounded.

Case No. 33	DOB July 2004	DOD August 2004	Accident
Age at death:	5 days		
Substance exposed:	No		
Cause of death:	Asphyxia due to probable overlay		
County:	Vermilion		
Reason For Review:	Unfounded DCP investigation involving father within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-four-year-old mother found her 5-day-old infant unresponsive, lying under her 27-year-old husband. The mother had placed the baby to sleep with the father, who had been drinking all day. The parents were indicated for death by neglect to the infant and substantial risk of physical injury to the mother's surviving 6-year-old son, who spent two months in relative foster care following his sister's death.

Prior History: Almost a year earlier, the father was an unfounded perpetrator in a report involving his 7-year-old brother. The brother's mother accused him and the child's father of injuring the boy in order to report her to DCFS. The parents were in the process of a bitter divorce and custody dispute and the report was determined to have been made in retaliation for an earlier report the father made against the mother.

Case No. 34	DOB July 2002	DOD August 2004	Accident
Age at death:	2 years		
Substance exposed:	No		
Cause of death:	Drowning		
County:	Saline		
Reason For Review:	Open intact family case and pending DCP investigation at time of child's death		
Action Taken:	Records reviewed		

Narrative: While visiting his paternal grandparents, 2-year-old child fell into a hole that was being dug for a new septic system. It had filled with water due to recent rains. The paternal grandfather, paternal uncle, and 19-year-old mother were present at the time of the incident; none of them had seen the child for approximately thirty minutes before he was found. The child's parents took him off life support the day following the incident. The mother was indicated for death by neglect. The child's surviving siblings entered foster care on the day of their brother's death. They were placed back in their parents' care in February 2005 and their court cases were closed in October 2005.

Prior History: In December 2003 an anonymous reporter contacted the hotline to report that the parents and their three children were living with the paternal grandfather who was a registered sex offender. An investigation was initiated for risk of sexual abuse to the children. During the investigation, the mother admitted that she was the reporter. She said the children were never left alone with their grandfather, but she wanted DCFS to assist her family in obtaining their own housing. The grandfather was indicated for substantial risk of sexual injury and an intact family case was opened. In July 2004, while the intact family case was open and eight days before the child drowned, a neighbor in the apartment complex to which the family moved, contacted the hotline to report that on two occasions in the past week neighbors had been out looking for one of the children after they disappeared. A report was taken for inadequate supervision and substantial risk of physical injury, and an investigation was pending at the time of the child's death. The parents were ultimately indicated for inadequate supervision.

Case No. 35	DOB September 1984	DOD August 2004	Accident
Age at death:	19 years		
Substance exposed:	No		
Cause of death:	Cardiac arrhythmia due to myocardial fibrosis with stress due to physical exertion significantly contributing		
County:	Will		
Reason For Review:	Child was a ward		
Action Taken:	Preliminary investigation		

Narrative: Nineteen-year-old ward went into respiratory distress following a physical altercation with his girlfriend. The girlfriend had an order of protection against the ward, but violated it by going to the ward's home. Police took the teenager to the hospital where he died.

Prior History: The teenager had been a ward of DCFS since 1989 because of neglect by his mother. The ward had a history of at least 20 placements. At the time of his death, he lived with a foster parent. The ward knew he had a heart condition and did not regularly attend his cardiology appointments or take his heart medication. He had recently been incarcerated for domestic violence against his girlfriend, and pursuant to a court order, had been cooperating with service requests by his worker.

Case No. 36	DOB May 2004	DOD August 2004	Accident
Age at death:	2-1/2 months		
Substance exposed:	No, however, mother had a history of alcohol abuse		
Cause of death:	Overlaying		
County:	Cook		
Reason For Review:	Referral for child welfare services within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Thirty-one-year-old mother slept with her 2-1/2-month-old son on a mattress on the floor in her bedroom. When she awoke in the morning, she found the infant under her unresponsive. The infant normally slept in a crib in a back bedroom with his 7-year-old sister. That night, however, the 7-year-old child slept out of the house, and the mother was afraid she would not hear the infant if he cried.

Prior History: In August 2003 the mother's daughter was removed from her custody in New Jersey because of alcohol abuse. The mother engaged in treatment and the child was returned to her in December 2003. In April 2004 New Jersey closed the family's case and paid for them to return to Illinois where they had family support. The New Jersey caseworker called Illinois to request services for the pregnant mother and her daughter. The mother was offered services, but declined them because she was moving to another county in Illinois and said she would request services there. DCFS provided the mother with referrals for substance abuse treatment and grief counseling following the infant's death.

Case No. 37	DOB February 1998	DOD September 2004	Accident
Age at death:	6-1/2 years		
Substance exposed:	No		
Cause of death:	Severe head trauma due to a motor vehicle accident		
County:	Washington County, Missouri (death); St. Clair (residence)		
Reason For Review:	Unfounded DCP investigation within a year of the child's death		
Action Taken:	Records reviewed.		

Narrative: Six-and-a-half-year-old child was a passenger in a car that was hit by a semi truck. The car flipped over and the child was killed. No drugs or alcohol were involved and the child was wearing a seat belt.

Prior History: This family first came to the Department's attention in July 1998 when the 25-year-old mother was indicated for environmental neglect of the child. In August 1999 the mother was indicated for inadequate supervision and substantial risk of physical injury to the child and an intact family case was opened for three months. In May 2001 the mother was indicated for substantial risk of physical injury to the child and a second intact family case was opened for a few weeks. In January 2004 the mother alleged that her son was sexually abused by a former boyfriend. A hotline report was taken and investigated for sexual penetration. The report was unfounded. The boyfriend denied the allegation, the boy did not disclose any abuse when interviewed by Child Advocacy Center staff, and the mother had made similar unfounded allegations against the boyfriend at the time of their breakup. The mother was provided with counseling referrals for herself and the child.

Case No. 38	DOB July 2004	DOD September 2004	Accident

Age at death:	2 months
Substance exposed:	No
Cause of death:	Overlaying
County:	Cook
Reason For Review:	Unfounded DCP investigation within a year of child's death
Action Taken:	Records reviewed

Narrative: Two-month-old infant was found unresponsive in the morning by his 15-year-old mother. The infant had been sleeping in an adult bed with his mother and her best friend.

Prior History: In February 2004 the mother's father contacted the hotline to report substantial risk of physical injury to the mother because she became pregnant by an 18-year-old male her mother allowed her to date. The report was unfounded after it was determined that the mother did not know her daughter had a boyfriend until after she became pregnant.

Case No. 39	DOB May 2004	DOD September 2004	Accident

Age at death:	4 months
Substance exposed:	No
Cause of death:	Bronchopneumonia due to blunt head trauma due to fall from heights
County:	Kankakee
Reason For Review:	Open intact family services case at time of child's death
Action Taken:	Records reviewed

Narrative: Four-month-old infant was found unresponsive by his mother, who called paramedics. The coroner pronounced the infant dead at his home. At autopsy the infant was found to have blunt force trauma and a skull fracture to his head. Investigation revealed that the infant had fallen out of a shopping cart at the grocery store onto the floor. The incident was captured on the grocery store's surveillance tape. The mother never sought medical attention for the infant. The mother was indicated for the child's death and head injuries and for substantial risk of physical injury to her five surviving children, ages 2 to 7 years. The children entered foster care and were placed with their maternal grandparents, with whom they remain.

Prior History: In July 2004 the hotline was contacted with an allegation of failure to thrive to the infant. The mother brought the infant, who was born six weeks prematurely, to the pediatrician for a 2-month check-up and he had gained less than a pound since birth. The infant was immediately admitted to the hospital where he gained a significant amount of weight in a short time. There was no medical reason for the infant's lack of weight gain, and he was diagnosed with non-organic failure to thrive. It was believed the mother was not spending enough time feeding the infant because she was overwhelmed caring for her six children alone (the father was reported to be in California in a substance abuse treatment program). An

intact family case was opened to assist the mother. The worker saw the infant in his home the day before his death, and he did not appear ill.

Case No. 40	DOB September 2004	DOD November 2004	Accident
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Traumatic asphyxia combined with smothering due to overlay		
County:	Macoupin		
Reason For Review:	Unfounded DCP investigation within a year of the child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-five-year-old mother found her 2-month-old infant unresponsive in the morning. The infant had been sleeping in a double bed with his mother, 25-year-old father, and 16-month-old sister. His 2-1/2-year-old brother reportedly slept on the floor. The parents were indicated for death by neglect to the infant because of the sleeping arrangements. They were also indicated for substantial risk of physical injury, inadequate supervision, and inadequate shelter to their two surviving children. Investigation revealed that the children had been found by a neighbor in the street by themselves and the trailer in which the family was living was being heated by four gas burners. Less than a month later, while an intact family worker was gathering information from the mother, the worker witnessed the children get into laundry detergent and bleach while their father played video games. Following this incident, the parents consented to the Department taking temporary custody of their children. The children were placed together in the care of a relative and they have a goal of return home.

Prior History: The family's first involvement with the Department was in February 2004 when a paternal relative contacted the hotline alleging that the parents dressed the children inappropriately for the cold and grabbed and threw the children around during fights. The investigation was unfounded as the investigator witnessed the children outside dressed appropriately, the parents denied domestic violence, local law enforcement reported no history of domestic violence, and family members believed the report may have been made in an attempt to get some of the deaf father's SSI money. The family was living with a relative and following the investigation, the family agreed to the opening of a preventive services case to assist them with housing, budgeting, and parenting issues. In April 2004 the family decided they did not want services and the case was closed. In July 2004 the relative with whom the family had been living contacted the hotline alleging the 2-year-old child almost drowned in a kiddie pool while the father was not paying attention. The report was unfounded because other relatives who witnessed the incident, including the reporter's sister, stated that the father was supervising the child and responded immediately after the child slipped and fell in the pool. In addition, the incident was not reported until a week after it happened and only after the relative kicked the family out of his home and tried to press charges against them for taking some items with them.

Case No. 41	DOB July 2003	DOD November 2004	Accident
Age at death:	16 months		
Substance exposed:	No		
Cause of death:	Subdural hematoma due to blunt force trauma to the head		
County:	Winnebago		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-three-year-old mother left her son in the care of her 22-year-old live-in deaf boyfriend while she and his mother ran to the store. They returned to find the pair lying at the bottom of the stairs. They called 911 and the child was taken to the hospital where he later died. The boyfriend reported that he was holding the child and going down the stairs when the 80 pound family dog knocked

him down, causing him and the child to fall down the stairs onto cement and tile flooring. The boyfriend sustained injuries during the fall for which he was treated. Medical personnel, the coroner, and law enforcement concurred that the incident was a tragic accident.

Prior History: Two weeks following the child's birth, the mother's adoptive mother contacted the hotline to report that the mother was deaf, bipolar and off her medication, and drank alcohol and smoked marijuana during her pregnancy. A report of substantial risk of physical injury was unfounded because the mother attended follow-up medical appointments for the baby and cooperated with visiting nurses and was reported to be taking good care of the baby. In addition, there was no evidence the mother was using drugs or alcohol, and she had been successfully off her bipolar medication for the past three years. The adoptive mother contacted the hotline again in May 2004 to report environmental neglect. She said she was contacted by the mother's landlord who reported the house was dirty with dog feces and the child was crawling around in it. An investigator visited the home and found it to be cluttered, but not dirty, and there was no evidence of dog feces in the house. The investigation pending at the time of the child's death alleged that the mother's birth mother caused a bruise and knot to the child's head while she kept him overnight. The doctor who examined the child found the injury consistent with a fall and the investigation was ultimately unfounded.

Case No. 42	DOB October 2004	DOD November 2004	Accident
Age at death:	1 month		
Substance exposed:	No		
Cause of death:	Suffocation due to entrapment in couch		
County:	Cook		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Full investigation		

Narrative: Thirty-nine-year-old mother found her 1-month-old son unresponsive in the morning. She had placed him to sleep alone on a couch after his 4:00 a.m. feeding.

Prior History: Five days after the infant's birth, the hotline received an anonymous report of substantial risk of physical injury to the infant because his mother might be experiencing post-partum depression. The mother had been taken by ambulance to the hospital for a psychiatric exam. Investigation revealed that the report was made by the mother's husband, who was the father of the infant and his 11-year-old brother. The mother had kicked the father out of the home and asked him for a divorce, but since the report was made, allowed the father back in the home. The investigation was pending at the time of the infant's death because the investigator was trying to get the mother's consent to obtain her hospitalization records. The OIG sent a report to the Director on September 19, 2005 addressing the use of administrative subpoenas in child protection investigations.

Case No. 43	DOB July 2004	DOD November 2004	Accident
Age at death:	4 months		
Substance exposed:	No, however, mother was rumored to have smoked marijuana while pregnant		
Cause of death:	Asphyxiation due to overlay		
County:	St. Clair		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Records reviewed		

Narrative: Four-month-old infant, who was born at 32 weeks gestation, was found unresponsive by one of the children with whom the infant's family was staying. He had been sleeping in bed with his 21-year-old mother.

Prior History: In September 2001 the mother was indicated for environmental neglect of a two-month-

old daughter. There was no further involvement with the Department until July 2004 when the hospital where the deceased was born requested child welfare services for the family. The hospital believed that the 21-year-old mother, who had six children, needed parenting classes and other services. While attempting to meet with the family for an intake evaluation, the worker found the mother's 3-year-old daughter wandering outside of the home alone. The worker contacted the police and made a report to the hotline of inadequate supervision of the child by her mother. During investigation it was learned that the child was staying with friends and an 18-year-old who was in charge that morning had left the child and her own older brothers home alone sleeping while she ran an errand. The investigation was unfounded against the mother, but indicated against the 18-year-old. After the infant was released from the hospital at one month old, the family continued staying with the friends while the worker assisted the family in finding their own housing. Prior to his death, the infant was gaining weight well and was seen by his doctor for regular medical care. The intact family case remains open.

Case No. 44	DOB November 2004	DOD December 2004	Accident
Age at death:	5 weeks		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Suffocation		
County:	Cook		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Twenty-eight-year-old father awoke to find his 5-week-old daughter unresponsive between him and the back of the couch. The father had fallen asleep on the couch with the infant. The infant's 22-year-old mother was incarcerated at the time for possession of a controlled substance.

Prior History: The mother and father have had four children together. While the mother was a ward of the state, the oldest child was removed from her care because of neglect. He was adopted by a foster parent in September 2002. The mother aged out of the system in February 2003 with custody of her other two children. In June 2004 a report was made against both parents for inadequate clothing for the children. The family did not live at the address provided by the reporter. The investigator was unable to locate the family, and the investigation was unfounded.

Case No. 45	DOB August 2004	DOD December 2004	Accident
Age at death:	4 months		
Substance exposed:	No		
Cause of death:	Positional asphyxia		
County:	Cook (pronounced in Lake County, IN)		
Reason For Review:	Open preventive services case within one year of child's death		
Action Taken:	Records reviewed		

Narrative: Four-month-old infant was found unresponsive. She had been sleeping in a twin-sized bed with her 22-year-old mother.

Prior History: The family's first contact with DCFS was in March 2004 when a nurse contacted the hotline with allegations of burns and medical neglect to the mother's 3-year-old son. The nurse reported that the child was missing medical appointments for his burn injury. The investigation was unfounded because the mother's history of the injury, that the child put his foot in a grease can on the side of a stove at a home in which they were staying, was consistent with the injury. Further, because the mother did not have transportation, the child missed one appointment for treatment. Following the investigation, the mother contacted DCFS requesting assistance with housing. In August 2004 a child welfare intake evaluation was completed, and a preventive services case was open from October to November 2004. The

mother found an apartment and received Norman funds from the Department.

Case No. 46	DOB December 2003	DOD December 2004	Accident
Age at death:	12 months		
Substance exposed:	No		
Cause of death:	Smoke inhalation from a house fire		
County:	Hancock		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Records reviewed		

Narrative: Twelve-month-old child died in a house fire. His family was staying with relatives over the holidays. The child was asleep in an upstairs bedroom of the home. His uncle and two teenage cousins were home and escaped the fire, which was believed to have started in the basement.

Prior History: In November 2004 police contacted the hotline after responding to a domestic disturbance at the family's home. The parents had a physical altercation while the then 11-month-old child was present. DCP investigated. Both parents reported that the child was in a playpen during the incident and was not in harms way. The 4-year-old child was at school during the altercation. The father was arrested because he pulled the mother's hair, grabbed her face, and picked her up and threw her out of the house. The mother called the police from a neighbor's home. The mother reported that she had left the father in the past because of similar incidents, but during the past six months things had been going well. After the incident, the mother left and took the children to stay with her parents. She said she had no plans to reconcile with the father, and she denied any assistance. The investigation for substantial risk of physical injury was ultimately unfounded.

Case No. 47	DOB June 2004	DOD January 2005	Accident
Age at death:	7 months		
Substance exposed:	No		
Cause of death:	Mobile home fire		
County:	St. Clair		
Reason For Review:	Open preventive services case at time of child's death		
Action Taken:	Full Investigation		

Narrative: Seven-month-old boy died in a fire that occurred in his family's mobile home. The State Fire Marshall determined that the fire was accidental in origin and in all probability the result of a failure in the trailer's electrical system. The infant's twin sister, 9-year-old sister, and parents escaped the fire.

Prior History: In December 2004 a DCP investigator went to the family's home to advise the parents about an investigation involving their 9-year-old daughter's teacher. While in the home, the investigator noticed that the trailer felt very cold and had no furnace. The family was using electric space heaters to heat the home. The investigator advised the family that she would have to make a hotline report. An investigation ensued and the parents were indicated for inadequate shelter. A preventive services (intact family) case was opened. The infant died a month later. In the month the case was open, no corrections were made to the family's heat source. A report about this case was sent to the Director on March 1, 2005.

Case No. 48	DOB November 2004	DOD February 2005	Accident
Age at death:	3 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Smothering asphyxia due to obstruction of mouth and nose due to sleep position		

County:	Madison
Reason For Review:	Open intact family case
Action Taken:	Records reviewed

Narrative: Twenty-seven-year-old mother awoke to discover her 3-month-old son unresponsive. The mother was sleeping on a couch with the infant and had laid him on his stomach on a pillow.

Prior History: The mother, who has given birth to six children, was unfounded on three neglect reports prior to being indicated for substance misuse after the birth of the deceased infant. The two oldest children live with relatives through agreements the mother made prior to DCFS involvement. The third child died from SIDS when she was 3 weeks old. Following the substance-exposed birth of the deceased, an intact family case was opened. The mother was monitored regularly by the worker, but the mother failed to follow through with substance abuse treatment. In September 2005 the 21-month-old child remaining in the mother's care entered foster care because of the mother's lack of participation in services. In November 2005, the mother gave birth to her sixth child and the hotline was contacted. While the mother tested negative for substances at birth, she had a positive toxicology screen a month earlier and admitted to cocaine use a week before delivery. The child entered foster care. He and his older brother are in the same relative foster home.

Case No. 49	DOB December 2004	DOD March 2005	Accident
Age at death:	2-1/2 months		
Substance exposed:	No, however, mother tested positive for cocaine at child's birth		
Cause of death:	Suffocation (from bedding)		
County:	Madison (pronounced in St. Louis, MO)		
Reason For Review:	Open preventive services case at time of child's death		
Action Taken:	Records reviewed		

Narrative: Two-and-a-half-month-old infant was found unresponsive in his bassinet by a family friend. The infant was found lying on his stomach with his face in a pillow. The infant was transported to an area hospital by ambulance where he was maintained on life support and transferred by helicopter to a hospital in St. Louis. The infant died the following day. DCFS investigated the infant's death. The 38-year-old mother, who had a history of bipolar disorder, was indicated for inadequate supervision because she had not checked on the infant between 4:00 a.m. and 1:00 p.m. when her mother's friend came over to visit. A visiting nurse had educated the mother about SIDS and advised her not to place the infant on his stomach or in the crib with loose bedding such as pillows.

Prior History: The family's first contact with DCFS was in December 2004 when a request for child welfare services was made after the mother tested positive for cocaine at the infant's birth, but the infant did not. The infant was born prematurely at thirty-three weeks gestation. A home health nurse worked with the mother and monitored the infant's weight gain. During January 2005 there were two unfounded investigations involving the family. The first investigation was unfounded for allegations of inadequate food and substantial risk of physical injury. The investigator observed adequate formula for the infant, as well as WIC coupons, and the home health nurse reported the infant was gaining weight. Eleven days after the first report was made, the hotline was contacted again with a report of substantial risk of physical injury to the infant. The investigation was unfounded because the infant appeared well-cared for, and the infant's doctor and the visiting nurse did not suspect any abuse or neglect of the infant. The mother agreed to DCFS services and a preventive services case was opened

Case No. 50	DOB December 2004	DOD March 2005	Accident
Age at death:	3 months		
Substance exposed:	No, however, parents had a history of marijuana and methamphetamine use		

Cause of death:	Mechanical asphyxia (overlay)
County:	Fayette
Reason For Review:	Unfounded DCP investigation within a year of child's death
Action Taken:	Records reviewed

Narrative: Twenty-six-year-old mother awoke to find her 28-year-old boyfriend sleeping on top of their baby, who was unresponsive. The parents had previously been advised against sleeping with their infant. Investigation revealed that the parents went to bed intoxicated and the mother placed the infant in bed between herself and the father. The parents admitted to marijuana and methamphetamine use and police found a large quantity of marijuana in the home, along with drug paraphernalia. The mother was charged with endangerment of a child, and both parents were indicated for death by neglect and substantial risk of physical injury to the mother's 4-year-old son. The surviving boy entered foster care where he remains with a goal of return home.

Prior History: The infant was the subject of a hotline report in January 2005 alleging cuts, bruises, welts and substantial risk of physical injury to him by his parents. A hospital social worker made the report, stating the infant had red circular marks on the inside of both his knees that the mother said were from the covers he slept on while in bed with her and the father, and the mother had been giving the infant cough syrup. The investigation was unfounded. The infant underwent a full body skeletal survey which was negative; a physician treating the infant felt the spots on his knees could have occurred as the parents explained; and the mother had been advised in writing to give the child cough syrup by a hospital emergency room. A hospital social worker talked to the parents about SIDS and the dangers of the infant sleeping in an adult bed. The investigator gave the parents a pack and play crib and they agreed to stop sleeping with him. The investigator also referred the parents to a Nurturing Parent program.

Case No. 51	DOB November 1998	DOD May 2005	Accident
Age at death:	6-1/2 years		
Substance exposed:	No, however mother has a history of substance abuse		
Cause of death:	Multiple injuries due to an automobile striking a pedestrian		
County:	Cook		
Reason For Review:	Siblings of child were in foster care at time of child's death		
Action Taken:	Records reviewed		

Narrative: Six-and-a-half-year-old and 5-1/2-year-old sisters were hit by a hit and run driver while they were waiting to cross the street with their uncle. They were on the way to the store to get ice cream. The 6-1/2-year-old died. The 5-1/2-year-old suffered a broken leg. The driver was apprehended.

Prior History: The 43-year-old mother has a history with DCFS dating to 1986. She has had 13 children. The ten oldest children have all been in foster care. Four have reached adulthood and six remain in the foster care system. The mother was allowed to retain custody of her three youngest children, the deceased and her twin, and the 5-1/2-year-old sister. DCFS monitored them in the home and by all accounts, the mother was taking good care of them.

Case No. 52	DOB December 2002	DOD June 2005	Accident
Age at death:	2-1/2 years		
Substance exposed:	No		
Cause of death:	Drowning in a retention pond		
County:	DuPage		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Records reviewed		

Narrative: Two-and-a-half-year-old child climbed out of his bedroom window in his family's basement

apartment at approximately 7:30 p.m. and drowned in a retention pond near the family's apartment complex. The child had moved bars intended to keep the window from opening more than a few inches and pushed the window screen out. The child had been at home with his 3-1/2-year-old brother, father and paternal grandparents. A DCP investigation of the child's death was unfounded because the father had taken precautions to prevent the child from climbing out of the window.

Prior History: In August 2004 the police reported to the hotline that the child had been found wandering outside by himself in the late afternoon. The police went to the family's apartment to find that the 26-year-old father and 3-year-old child had been sleeping, and the father thought the 2-year-old child was sleeping as well. A DCP investigator went to the home the following day and observed that the father had already attempted to secure the window by placing iron bars on the window tracks to keep the window from opening more than a few inches. The father stated that he also moved a toy box that had been placed under the window. The investigator noted that the window screen pushed out easily, and he observed the child climbing on furniture while he was at the home. The investigation was unfounded.

Natural

Case No. 53	DOB January 2004	DOD July 2004	Natural
Age at death:	5-1/2 months		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Neurologic dysfunction with deterioration due to central diabetes insipidus due to seizure disorder		
County:	Tazewell		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Five-and-a-half-month-old medically complex infant died in the hospital. The infant had an abnormal brain and suffered from near-constant seizures.

Prior History: In January 2002 the twenty-one-year-old mother was indicated for inadequate supervision of her then three-year-old son. The mother had a substance abuse problem, and the child was placed in the custody of his father. Upon the deceased infant's birth in January 2004, the hospital called the hotline to report substantial risk of physical injury to the infant because of his mother's history of substance abuse. The report was indicated. The infant was released to his father's custody, and an intact family case was opened.

Case No. 54	DOB January 1989	DOD July 2004	Natural
Age at death:	15 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Cardiac arrhythmia		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Fifteen-year-old ward playing softball hit a home run. After reaching home plate, she began cheering and then collapsed. She was taken to the hospital where she was pronounced dead.

Prior History: The ward entered foster care in 1994 because of her mother's substance abuse and neglect. The ward was obese, but had a physical exam in May 2004 okaying her for physical activity. The ward's foster parent had been pursuing guardianship of her. Three older siblings have aged out of the system. Two remain in foster care, one with a goal of guardianship and the other with a goal of independence.

Case No. 55	DOB July 2004	DOD July 2004	Natural
Age at death:	0		
Substance exposed:	No		
Cause of death:	Stillborn		
County:	Cook		
Reason for review:	Mother of child is ward		
Action taken:	Preliminary investigation		

Narrative: Sixteen-year-old ward gave birth in the hospital to a stillborn boy. It appeared that the baby suffocated because the umbilical cord was wrapped around his neck.

Prior History: The mother entered foster care with her four siblings in 1998 because of their mother's neglect. The ward lives with an aunt. She received routine prenatal care and was never made aware of any problems with her pregnancy.

Case No. 56	DOB July 2003	DOD July 2004	Natural
Age at death:	12 months		
Substance exposed:	No		
Cause of death:	Pulmonary Hemorrhage and Liver Failure		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: 12-month-old medically complex child died while hospitalized. The child was born prematurely at 24 weeks gestation and suffered from chronic lung and liver disease. She spent most of her life in the hospital.

Prior History: In May 2004 a hospital social worker called the hotline to report substantial risk of physical injury to the child because of her mother's refusal to comply with the child's discharge plan and recommendations for her follow up care. The child was fed by NG-tube because of her medical problems and the mother wanted to feed her with a bottle. The child was at risk of choking and dying if fed by bottle. The child had been released to her parents' care after being hospitalized for months, but was only home for nine days before being hospitalized again. The child was released again to her parents with the father's assurance that the discharge plan would be followed. DCFS planned to indicate the mother and open a case for intact family services, however, protective custody was taken of the child two weeks later because of the mother's continued non-compliance with the child's treatment plan. The child had been hospitalized again, and she remained hospitalized until her death.

Case No. 57	DOB December 1999	DOD July 2004	Natural
Age at death:	4-1/2 years		
Substance exposed:	Yes		
Cause of death:	Cardiac arrhythmia due to marked cardiomegaly and hydrocephalus		
County:	Cook (pronounced in Lake County, IN)		
Reason for review:	Child was a ward and pending DCP investigation at the time of child's death		
Action taken:	Records reviewed		

Narrative: Foster mother observed her four-and-a-half-year-old autistic, nonverbal foster child having what appeared to be a seizure. She called her foster care agency to report the behavior and that hospital staff, upon the child's discharge the day before after a seven-day stay, thought the actions were more behavioral than medical in nature. The foster mother eventually called for an ambulance because the child appeared in distress. The child was transported to the hospital where he was pronounced dead.

An investigation of the child's death was unfounded.

Prior History: The deceased was his 36-year-old mother's ninth child and fourth substance-exposed infant. He was placed in foster care following his birth. The mother does not have custody of any of her children. In February 2004 the child was placed in the foster home in which he died. At the time of his death, there was a pending DCP investigation on his foster parents for cuts, bruises, welts. Eight days prior to the child's death, his school called to report that he had gashes on his head that appeared to be in different stages of healing. The investigation was unfounded following the child's death because the child's doctor had seen the injuries on the child the day before the report and said they did not come from abuse, but rather the child's own behavior.

Case No. 58	DOB October 2003	DOD July 2004	Natural
Age at death:	9 months		
Substance exposed:	No		
Cause of death:	Leigh's Disease		
County:	Kankakee		
Reason for review:	Indicated DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Nine-month-old infant died from Leigh's Disease, a rare inherited neurometabolic disorder characterized by the degeneration of the central nervous system. Her death was expected.

Prior History: There was one prior investigation involving this family. In May 2004 the infant's 22-year-old mother and 22-year-old father brought her to a local hospital where she was diagnosed with failure to thrive. The local hospital called the hotline with a report of failure to thrive and medical neglect. The infant was transferred to a hospital in Chicago at the request of her parents. There, the infant was diagnosed with Leigh's Disease and the failure to thrive was determined to be organic. The parents were indicated for medical neglect because they had been asked a month earlier to complete lab work for the child, which they did not. The lab work may have led to an earlier diagnosis, but would not have prevented the child's death. The child was released from the hospital in June, and home health care nursing services were initiated. The child died the following month. The parents have a 3-1/2-year-old son who remains in their care.

Case No. 59	DOB December 2003	DOD July 2004	Natural
Age at death:	7 months		
Substance exposed:	No		
Cause of death:	Extreme prematurity		
County:	Cook		
Reason for review:	Unfounded DCP investigation within one year of child's death		
Action taken:	Records reviewed		

Narrative: Seven-month-old infant, who was born prematurely, died in the hospital.

Prior History: In October 2003 a hospital social worker contacted the hotline to report that the 30-year-old mother was having an outpatient procedure performed and near the end of it stated that she left her 5-year-old son and 7-year-old nephew home alone. Police responded and found the 5-year-old at home with a 17-year-old cousin. English is not the family's first language and investigation revealed that the social worker misunderstood the mother's 17 as a 7.

Case No. 60	DOB July 2004	DOD August 2004	Natural
Age at death:	2-1/2 weeks		

Substance exposed:	Yes, cocaine
Cause of death:	Sudden Infant Death Syndrome
County:	Cook
Reason for review:	Open intact family services case at time of child's death
Action taken:	Full investigation

Narrative: Nineteen-year-old mother called 911 after she awoke from a nap to find her 2-1/2-week-old daughter unresponsive.

Prior History: The family's first involvement with the Department was in April 2004 when an investigation was initiated after the mother took her 8-month-old son to the hospital with a head injury. An allegation of head injury by abuse was indicated to an unknown perpetrator. The family's next contact with DCFS was in July 2004 when the infant was born substance-exposed. The mother was indicated for substance misuse, and an intact family case was opened. The intact family case was closed after the infant's death, despite there being another child in the home. Three months later another investigation involving the family was unfounded. The OIG submitted a report to the Director about this case on August 18, 2005.

Case No. 61	DOB December 1992	DOD August 2004	Natural
Age at death:	11 years		
Substance exposed:	No		
Cause of death:	Bronchopneumonia due to cerebral palsy		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of the child's death		
Action taken:	Records reviewed		

Narrative: Eleven-year-old child with cerebral palsy was at home, uncomfortable and crying. While changing his position in bed to make him more comfortable, the mother noticed he was turning yellow. She called 911 and the child was taken to the hospital where he was pronounced dead.

Prior History: The family's only involvement with DCFS was in August 2003 when a neighbor contacted the hotline to report that the parents were drug addicts who left their young children home alone unsupervised and that after doing drugs the mother would scream at the six children and hit them with a belt. The report was unfounded after investigation. The parents and the children, ages 5 to 15, denied the allegations; criminal history checks on the parents were negative; a social services worker who was in the home weekly to help with the disabled child reported having no concerns; and one of the children's teachers and the disabled child's doctor had no concerns about the children's safety or well-being.

Case No. 62	DOB June 2001	DOD August 2004	Natural
Age at death:	3 years		
Substance exposed:	No, however, mother has a history of alcohol abuse		
Cause of death:	Congenital heart disease		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of the child's death		
Action taken:	Records reviewed		

Narrative: Twenty-eight-year-old mother brought her 3-year-old medically complex son to the emergency room because he had a fever and was vomiting. He died in the hospital a short time later. The child was born two months prematurely with congenital heart problems. He had cerebral palsy, a feeding tube, and had some of his toes amputated because of poor circulation. A DCP investigation of the child's death was unfounded; medical and service providers reported that the mother took good care

of the child.

Prior History: The mother, who has given birth to five children, has a history with DCFS dating to 1994. The three oldest children live with their father. The fourth was adopted by a relative in December 2000. The deceased came to the attention of the Department in October 2002 when a nurse contacted the hotline with an allegation of inadequate supervision and substantial risk of physical injury. The mother brought the 1-year-old child to the emergency room to have his feeding tube reinserted, and she was drunk. Investigation revealed that the mother had a history of alcohol abuse. The mother was indicated, and the investigator recommended that a case be opened for services. A case was not opened, however, and in August 2003 the hotline was called with a report of environmental neglect and substantial risk of physical injury. The report was unfounded because the family could not be located at the address provided. In October 2003 the mother requested services from a DCFS-contracted private agency. The agency assisted the mother until March 2004 when the mother declined further help.

Case No. 63	DOB November 1987	DOD August 2004	Natural
Age at death:	16 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Aspiration due to seizure disorder due to cerebral palsy		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Sixteen-year-old medically complex ward experienced trouble breathing in her nursing care facility, where she had lived for the past ten years. She was taken to the hospital where she was pronounced dead.

Prior History: The deceased and her two siblings entered foster care in 1991 because of their mother's substance abuse and resulting neglect. Three others followed after their births. All of the surviving siblings have been adopted or are in subsidized guardianship.

Case No. 64	DOB April 2003	DOD August 2004	Natural
Age at death:	15 months		
Substance exposed:	No		
Cause of death:	Congenital heart disease due to Down's Syndrome		
County:	Cook		
Reason for review:	Open preventive services case within one year of child's death		
Action taken:	Records reviewed		

Narrative: Fifteen-month-old child born prematurely with Down's Syndrome, chronic lung disease, a club foot, and who was ventilator dependent was found having difficulty breathing by his 43-year-old mother. She called 911 and the child was taken to the hospital where he was pronounced dead.

Prior History: The family came to the attention of the Department in July 2003 when a hospital social worker called the hotline stating that the mother and her child had inadequate shelter and were in need of housing assistance. A case was opened with a housing advocacy agency that assisted the mother in applying for and obtaining Section 8 housing. The case was closed in February 2004.

Case No. 65	DOB August 2002	DOD August 2004	Natural
Age at death:	2 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	hypoxic ischemic encephalopathy due to ventricular peritoneal shunt malfunction		

	due to congenital hydrocephalus
County:	DuPage
Reason for review:	Open intact family services case at time of child's death
Action taken:	Records reviewed

Narrative: Two-year-old medically complex child was found unconscious and not breathing. She was taken to the hospital where she was put on a respirator to aid her breathing. During her hospitalization doctors determined that she could not breathe on her own, and she had no brain function. Five days later, her parents removed her from life support.

Prior History: An intact family services case was opened on the family following an October 2003 indicated report of inadequate supervision and environmental neglect to the deceased and her 2-year-old sibling by their mother. The mother had issues of substance abuse and bipolar disorder, but met the deceased's medical needs. The mother refused to participate in substance abuse services, and the worker planned to pursue an order for the mother's participation. Prior to the hearing, however, a divorce court granted custody of the girls to their father. After the court hearing, the mother left her 13-year-old daughter with the maternal grandmother. A week later, the juvenile court granted DCFS temporary custody of the 13-year-old, and she was placed in foster care with her grandmother where she remains.

Case No. 66	DOB March 2003	DOD August 2004	Natural
Age at death:	17 months		
Substance exposed:	No		
Cause of death:	Microcephaly		
County:	New Hampshire (death); Kane (services)		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Seventeen-month-old medically complex child died while on vacation with her family in New Hampshire.

Prior History: In June 2004 DCFS investigated a report of cuts, bruises, and welts to the 38-year-old mother's 16-year-old daughter. The report was the culmination of escalating conflict between the mother and daughter. Following the report, an intact family case was opened. The case remains open.

Case No. 67	DOB March 2004	DOD August 2004	Natural
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	St. Clair		
Reason for review:	Open preventive services case within a year of child's death		
Action taken:	Records reviewed		

Narrative: Five-month-old infant was found unresponsive by her mother.

Prior History: In May 2004 the Department opened a preventive services case on the infant and her 33-year-old mother. The infant was being released from the hospital where she had been treated since her premature birth and hospital staff had concerns about the mother's care of the infant. Concurrently, a DCP investigation was conducted for substantial risk of physical injury to the infant based on reports the mother visited the infant in the hospital while drunk and said things that caused staff to be concerned about the infant's welfare. The investigation was unfounded because the mother's caseworker, a weekly visiting nurse, and the infant's doctor were not concerned about the infant's care, the infant was growing, and a drug/alcohol assessment conducted on the mother did not indicate the need for substance abuse treatment services. The infant was being seen weekly by a visiting nurse, was receiving in-home

physical therapy, and was monitored by an intact family worker. The infant was the mother's second child to die. In December 2001 an infant daughter delivered at 24 weeks gestation died at birth.

Case No. 68	DOB December 2003	DOD August 2004	Natural
Age at death:	8 months		
Substance exposed:	Yes, alcohol		
Cause of death:	Hypoplastic lung, diaphramatic hernia		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Eight-month-old medically complex infant was hospitalized since June 2004. At the end of July she had surgery to reinsert a g-tube for feeding. Following surgery she was in the pediatric intensive care unit where she was on a ventilator. The infant developed pneumonia and died in the hospital.

Prior History: In November 2002 the 26-year-old mother was indicated for substantial risk of physical injury to her 2-month and 3-year-old children because of her substance abuse. An intact family case was opened from January 2003 to October 2003. In May 2004 the hotline was contacted with allegations of failure to thrive and medical neglect to the deceased. The mother was indicated for medical neglect because she had missed two follow-up appointments for the infant. An intact family case was opened, however, the mother refused to participate in services. Twice, protective custody was taken of the infant and her two siblings, but the case was rejected by the State's Attorney's Office and the siblings were returned to their mother, while their sister remained hospitalized. Following the infant's death, the hotline was called in April 2005 with allegations of inadequate supervision and substantial risk of physical injury because of the mother's continued drug and alcohol use. The mother was indicated and the surviving siblings entered foster care in May 2005. They are placed together in the home of a relative.

Case No. 69	DOB May 2004	DOD August 2004	Natural
Age at death:	3 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Viral syndrome		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Three-month-old ward was found unresponsive by his foster mother when she went to wake him in the morning.

Prior History: The deceased was the 28-year-old mother's sixth child and fourth substance-exposed infant. After the infant's birth, he was placed in a foster home where two of his siblings already resided. The mother's involvement with DCFS dates to 1995. None of her children are in her care. One has been adopted; two are in the process of being adopted; and two have goals of guardianship with their foster parent.

Case No. 70	DOB August 2004	DOD August 2004	Natural
Age at death:	0		

Substance exposed:	Not tested, but twin sister tested positive for cocaine and barbiturates
Cause of death:	Stillbirth
County:	Cook
Reason for review:	Open foster care case on a sibling
Action taken:	Records reviewed

Narrative: Thirty-nine-year-old mother gave birth to twin girls at 32 weeks gestation. One of the twins was stillborn. The other was born substance-exposed. The mother was indicated for substance misuse and agreed to enter residential substance abuse treatment. The mother did not stay in treatment and a few weeks after the baby's birth the mother surrendered her parental rights to allow the infant to be adopted through a private adoption agency.

Prior History: The mother has a history with DCFS dating to 1989 when her first child was removed from her care because of inadequate supervision and substantial risk of physical injury due to her substance abuse. The mother went on to have five substance-exposed infants prior to giving birth to the twins. All of the children were removed from her care directly or shortly after their births. The mother's parental rights were terminated on the six children and all have been adopted, except for the oldest who remains in foster care in an independent living program.

Case No. 71	DOB February 2003	DOD August 2004	Natural
Age at death:	18 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Myocarditis		
County:	Cook		
Reason for review:	Open intact family services case within a year of child's death		
Action taken:	Records reviewed		

Narrative: Eighteen-month-old child was being cared for by his 18-year-old sister when he began coughing and choking. He had a history of asthma. The sister called 911 and the child was taken by ambulance to the hospital where shortly after arriving he was pronounced dead.

Prior History: The 43-year-old mother has a history with DCFS dating to 1986. She has had 10 children, four of whom were born substance-exposed. Prior to the child's birth, eight of his siblings were placed in foster care and one was voluntarily placed with a relative after her birth. All of the children achieved permanent living arrangements prior to the child's birth. After the child's substance-exposed birth, the mother entered an inpatient substance abuse treatment program and an intact family case was opened. The case was closed in January 2004 because the mother completed substance abuse treatment, was meeting her son's needs, and had family support. She was referred to the Department of Human Services for aftercare.

Case No. 72	DOB June 2004	DOD September 2004	Natural
Age at death:	3 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Twenty-nine-year-old mother was sleeping with her 3-month-old baby on a mattress on the floor. She awoke at 4:00 a.m., fed the baby, and went back to sleep. A couple of hours later she found the baby unresponsive. The baby had been seen at the hospital two days earlier for a cold.

Prior History: In May 2004 an anonymous reporter called the hotline stating that the 2-1/2 year old child had burns on his left foot and right arm that were said to have been caused by an iron and for

which the 25-year-old father did not seek medical attention. A DCP investigation revealed that the child did have burns that were almost healed. The father reported that the child was burned by an iron that had been left on. The parents did not take the child for medical treatment because they were afraid DCFS would be called and they would lose their 2 children. Also, they were treating the burns at home and they were healing well. The investigator had the child examined at the hospital. No signs of abuse or neglect were noted; the parents treated the burns appropriately; and they appeared truthful about how the burns were caused. The investigation was unfounded.

Case No. 73	DOB December 1992	DOD September 2004	Natural
Age at death:	11 years		
Substance exposed:	Yes		
Cause of death:	Pulmonary hypertension		
County:	Cook (residence) Lake County, Indiana (death)		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Eleven-year-old ward who suffered from pulmonary hypertension requiring 24-hour nursing care went into respiratory arrest at his foster home. A home health nurse and the foster parent administered CPR while waiting for an ambulance. The child was taken to a hospital in Indiana where he was pronounced dead. The ward had been on a lung transplant list since July 2003.

Prior History: The ward was one of nine children. The family first came to the Department's attention in August 1990 when the four oldest children entered foster care. The subsequently born children entered foster care shortly after their births. The deceased ward had a goal of adoption with his foster parents with whom he had lived since June 1999. Two of his siblings aged out of the system and the other six siblings were adopted.

Case No. 74	DOB August 2003	DOD September 2004	Natural
Age at death:	13 months		
Substance exposed:	No		
Cause of death:	Bronchopneumonia with a contributing factor of Bronchopulmonary dysplasia due to prematurity		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: A 13-month-old medically complex child was found unresponsive 20 minutes after being fed by her 26-year-old mother.

Prior History: The family's first contact with the Department was in April 2004 when the child's 12-year-old half sister alleged that her father and the child's mother mistreated herself and her half siblings and drank and used drugs around the children. A DCP investigation was unfounded when no evidence was uncovered to support the allegations and the 12-year-old admitted lying because she was angry. A month later a second call was made to the hotline alleging medical neglect and failure to thrive to the medically complex child. Hospital staff reported that the child, who was born prematurely, was released from the hospital six weeks earlier with a contract for follow-up, but the mother had missed four out of five follow-up appointments and the child had not gained weight. Two days prior to the hotline call a visiting nurse went to the home, discovered the baby was sick, and instructed the mother to take the child to the hospital. The nurse returned the following day; the child had gotten worse and the mother had not taken her to the hospital. The nurse arranged for the child to go to the hospital. The mother was indicated for medical neglect and an intact family case was opened. The case had been open for about six weeks when the child died. The worker had arranged for homemaker and transportation services, parenting classes, in-home counseling, and medical care for the child's three siblings. The child's

medical appointments were kept, she was gaining weight, and a visiting nurse felt the mother was caring for the baby well. The intact family case remained open through January 2005. The Department has had no further contact with the family.

Case No. 75	DOB September 2004	DOD September 2004	Natural
Age at death:	10 days		
Substance exposed:	No		
Cause of death:	Congenital cardiac abnormalities		
County:	Cook		
Reason for review:	Mother of child is ward		
Action taken:	Preliminary investigation		

Narrative: Ten-day-old infant, who was born prematurely, died after undergoing surgery for a mass on his heart.

Prior History: The infant's 20-year-old mother has been a ward since 1995. She lived in a foster home and received prenatal care throughout her pregnancy. The pregnancy was considered high risk because the mother has bulimia.

Case No. 76	DOB September 2004	DOD September 2004	Natural
Age at death:	7 days		
Substance exposed:	No		
Cause of death:	Shock, presumed sepsis		
County:	Sangamon (death); Macoupin (services)		
Reason for review:	Open return home case within a year of child's death		
Action taken:	Records reviewed		

Narrative: Seven-day-old infant died in the hospital. The infant was discharged to her 22-year-old mother's care two days after birth. Four days later the mother took the infant to the hospital because she was jaundiced. The infant died the following day from infection.

Prior History: The family's first contact with DCFS was in February 2004 when the hotline was called with a report of neglect to the mother's and 21-year-old father's 14-month-old son. The father went to the police station drunk and suicidal. He reported that he could not take care of his son, and he would leave him in the playpen all day while the mother worked. The father was indicated for substantial risk of physical injury to the child and the mother was indicated for inadequate supervision of the child for leaving him with the father despite knowing the father was not caring for him. The child was taken into custody and spent two months in foster care. In May 2004 he was placed with his mother. Guardianship was returned to her in September 2004. A case remained open until September 2005.

Case No. 77	DOB September 2004	DOD September 2004	Natural
Age at death:	0		
Substance exposed:	No		
Cause of death:	Intrauterine fetal demise		
County:	Cook		
Reason for review:	Extended family support case open at time of child's death		
Action taken:	Records reviewed		

Narrative: Fourteen-year-old girl delivered a stillborn baby girl in the hospital. The baby's father was a 17-year-old boy who lived in another state. The girl was seen by her doctor the day before the birth, and no problems were detected.

Prior History: In June 2004 the teen's maternal aunt called the hotline requesting assistance in filing

for legal guardianship of the teen for whom she had been caring for the past six weeks. The teen's mother and grandmother were deceased and the teen's father was unknown. The teen's mother had been addicted to drugs for several years prior to her death and the teen had lived with different relatives for most of her life. A worker was assigned to assist the aunt and teen with applying for TANF, medical, and WIC benefits, and to make referrals for school and community-based programs. The case was closed shortly after the infant's death.

Case No. 78	DOB May 2004	DOD October 2004	Natural
Age at death:	Four-and-a-half months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of the infant's death		
Action taken:	Records reviewed		

Narrative: Twenty-seven-year-old mother found her four-and-a-half month-old infant unresponsive in the morning after sleeping in bed with him.

Prior History: In October 2003 the Department investigated an allegation of cuts, bruises, and welts by the mother to her eight-year-old son. The son had a bruise on his ear that he reported was inflicted by his mother with a belt because he did not complete his homework. The investigation was unfounded because the bruise was not severe, there was no history of abuse, school personnel had no concerns, the ten-year-old sibling had no injuries, and the children were not afraid of their mother. The mother admitted to disciplining the child, and the child demonstrated for the investigator how he shifted from side to side to avoid the punishment intended for his buttocks, causing him to be hit accidentally on his ear and arm. The child was described as learning disabled and the mother wanted him assessed for special education. School personnel agreed to speak with the mother about available services.

Case No. 79	DOB September 2004	DOD October 2004	Natural
Age at death:	3 weeks		
Substance exposed:	Yes, marijuana		
Cause of death:	Viral illness		
County:	Will		
Reason for review:	Pending child welfare services referral at the time of child's death		
Action taken:	Records reviewed		

Narrative: Thirty-seven-year-old mother found her 3-week-old baby unresponsive when she went to check on him during a nap.

Prior History: The mother has given birth to 3 children. She never cared for her first child and, in January 1992, her second child, then 4 months old, entered foster care because of neglect and was adopted by a foster parent in March 1993. In September 2004 the mother gave birth to her third child and a hospital social worker contacted the hotline. The mother was schizophrenic and hospital staff were concerned about her ability to parent a newborn. The mother had the support of her physician and family, and hospital nursery staff found the mother's interaction with the baby appropriate. The hotline referred the family for child welfare services. The baby died thirteen days later, prior to the family being seen by the caseworker. The caseworker had attempted to reach the mother unsuccessfully by phone and the supervisor had attempted a home visit, but could not locate the street on which the family lived.

Case No. 80	DOB May 2004	DOD October 2004	Natural
Age at death:	4-1/2 months		
Substance exposed:	No		

Cause of death:	Cerebral Dysgenesis
County:	Fulton (death) Peoria (residence)
Reason for review:	Child was a ward
Action taken:	Records reviewed

Narrative: Four-and-a-half-month old medically complex ward died at her nursing home where she had been placed a day earlier after an extended hospital stay.

Prior History: The family first came to the attention of the Department in June 2004, approximately two weeks after the baby's birth, when a relative contacted the hotline to report that the eighteen-year-old mother was developmentally delayed and did not have the capacity to care for the infant. The report of substantial risk of physical injury to the baby was unfounded because hospital and home health care staff reported that the mother was able to follow directions and meet the child's medical needs with assistance from the infant's maternal grandmother and maternal uncle. A second hotline report was made in August 2004 when the baby was hospitalized with seizures and weight loss and it was learned that the mother and infant had moved out of the maternal grandmother's home and were living with friends. The mother was indicated for substantial risk of physical injury and inadequate food as it was determined that she had not been feeding, giving medication, and using medical equipment as instructed by hospital staff. The baby entered foster care and was initially placed with her maternal grandmother, but after two weeks was hospitalized, where she remained until her transfer to a nursing home the day before she died.

Case No. 81	DOB September 2004	DOD October 2004	Natural
Age at death:	1 month		
Substance exposed:	No		
Cause of death:	Aspiration pneumonia		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: One-month-old ward was found unresponsive by her foster aunt while being cared for in the day care home of her foster grandmother. The foster aunt found the infant unresponsive while checking on another child. 911 was called and the foster aunt performed CPR. The infant was taken to the hospital where she was pronounced dead. The foster mother had expressed interest in adopting the infant and the mother was considering this option.

Prior History: The family first came to the Department's attention in July 2003 when an 8-month-old infant was brought to the hospital with head injuries. During investigation the 26-year-old father admitted to police that he got angry and shook the infant. Examination of her four siblings revealed that three of them were also victims of child abuse. All five children entered foster care and were placed with their maternal grandmother. The deceased entered foster care after her mother abandoned her in a building hallway a day after her birth and called police. The infant was in a car seat, nourished, and had a change of diapers next to her. The 26-year-old mother concealed her pregnancy from her caseworker and family members. Police tracked the baby to the mother by showing photos of the infant at area hospitals. The infant was placed in a non-relative foster home because the maternal grandmother was unable to care for another child. The mother is working, unsuccessfully, toward the return of her surviving children.

Case No. 82	DOB July 1999	DOD October 2004	Natural
Age at death:	5 years		
Substance exposed:	No		

Cause of death:	Pneumonia due to viral encephalitis
County:	Cook
Reason for review:	Child was a ward
Action taken:	Full investigation pending

Narrative: Five-year-old medically complex ward was checked by her night nurse and found to be unresponsive.

Prior History: The child entered foster care in December 1999 after her parents were indicated for head injuries to her and a broken leg to her twin brother. The child was believed to be a victim of Shaken Baby Syndrome. At autopsy the child was found to have viral encephalitis, not Shaken Baby Syndrome. The parents, however, were indicated for the child's death. Three of the family's four children were adopted by their foster parents. The fourth remains in foster care.

Case No. 83	DOB January 1990	DOD October 2004	Natural
Age at death:	14 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Pneumonia due to encephalopathy		
County:	DuPage		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Medically complex 14-year-old child was taken to the emergency room from his nursing care facility. He was admitted to the hospital where he died 5 days later.

Prior History: The deceased was one of four children. The 31-year-old mother has a history with DCFS dating to 1993 when she gave birth to a substance-exposed infant. The deceased and his two sisters entered foster care in 1994 as a result of their mother's neglect because of substance abuse. The mother gave birth to her fourth child, her second substance-exposed infant, in January 1998. The two older girls were adopted by the same family in 1998. The other sister was adopted by another family in August 2000. The deceased had lived in his nursing care facility since September 1997.

Case No. 84	DOB June 2004	DOD October 2004	Natural
Age at death:	4-1/2 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Twelve-year-old girl found her 4-1/2-month-old brother unresponsive in the morning. They had been sleeping in the same bed. The infant was born 3 months prematurely and had recently been taken off a heart monitor.

Prior History: In August 2004 an anonymous reporter called the hotline alleging environmental neglect and inadequate shelter of the family's six children, ages 2 months to 12 years. A DCP investigation was unfounded after 2 investigators observed the home and found the conditions to be livable. The family was noted to have all the necessities it needed to maintain the children in the home. Two collateral contacts vouched for the mother's good care of the children and the children's primary care physician reported no medical concerns for them. The family has had no further DCFS involvement.

Case No. 85	DOB June 2004	DOD October 2004	Natural

Age at death:	4 months
Substance exposed:	No
Cause of death:	Sudden Infant Death Syndrome
County:	Cook
Reason for review:	Open intact family services case at time of child's death
Action taken:	Records reviewed

Narrative: Four-month-old infant was found unresponsive by his 31-year-old father at noon. The infant had been sleeping in bed with his father and 30-year-old mother. He was last seen alive around 2:00 a.m.

Prior History: The father had 3 boys from a previous relationship. Their mother was shot to death in May 2000 and her family cared for the children after her death. The boys, ages 11, 12, and 13, went to live with their father shortly before the hotline was called in February 2004 to report that the father had thrown the 13-year-old out of the home. The father admitted to telling his son to leave the home and to not knowing where his son stayed. While the investigation was pending, another incident of inappropriate discipline happened with the 12-year old son and all 3 boys ended up going to live with their maternal grandmother. The father was indicated for substantial risk of physical injury, inadequate shelter, and inadequate supervision. An intact family services case was opened to assist the grandmother with obtaining public aid and appropriate housing. The boys continued to see their father on a regular basis. The intact family services case was closed in June 2005.

Case No. 86	DOB August 1984	DOD October 2004	Natural
Age at death:	20 years		
Substance exposed:	No		
Cause of death:	Sickle cell anemia		
County:	Cook		
Reason for review:	Teenager was a ward		
Action taken:	Preliminary investigation		

Narrative: Twenty-year-old ward was admitted to the hospital because of a sickle cell anemia crisis. The same day, but prior to admission, the Chicago Police arrested the ward for possession of marijuana. He was taken by ambulance to the hospital from the police station because he was complaining of chest, back, and leg pain. He died in the hospital two days later.

Prior History: The ward was the oldest of six children. Both parents have a history of substance abuse and three of the six children were born substance-exposed. The family's contact with DCFS dates to 1992. The family has been involved with the juvenile court since November 2000 and four of the six children were in foster care from January 2001 to October 2001 when they were returned to their mother's care (the fifth child was born in May 2001 and allowed to remain with his mother and the deceased remained in foster care with a paternal aunt). In March 2005 the deceased's siblings reentered foster care when their mother relapsed. The mother, who was ill and undergoing dialysis, died in July 2005. The children remain in foster care with a relative.

Case No. 87	DOB May 1998	DOD November 2004	Natural
Age at death:	6-1/2 years		
Substance exposed:	No		
Cause of death:	Long QT syndrome		
County:	LaSalle		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Six-and-a-half-year-old child died when her heart stopped beating. The child suffered from Long QT syndrome which is a hereditary disorder of the heart's electrical rhythm. Persons with the syndrome are susceptible to an abnormally rapid heart rhythm. If the heart doesn't regain it's normal rhythm, it may go into spasms that lead to a deadly arrhythmia called ventricular fibrillation, that without immediate emergency treatment, leads to death within minutes.

Prior History: The parents have four children. Between December 2002 and October 2004 the family has been investigated by the Department four times. In December 2002 the father was indicated for bruises to his 11-year-old son's face. The father admitted to hitting his son in the face and drinking alcohol on the night of the incident. The father was arrested for the incident and as a condition of bond, he was not allowed to be present in the home when the boy was there. An intact family case was open until October 2003. In June 2003 a report of inadequate supervision of the boy by his mother was unfounded. Another report in June 2003 alleged medical neglect and substantial risk of physical injury to the deceased by her parents. A nurse alleged that the child required around the clock nursing care, but since the parents were divorcing the father refused to renew the nursing contract through his health care policy. At the same time, the father alleged that the mother was leaving the child in the care of unqualified caregivers. The father was indicated on the allegations, but he was later unfounded on appeal. In October 2004 the father contacted the hotline again to report that the mother left the child with an unqualified caregiver. The investigation was unfounded. While the child received 120 hours of nursing care, the mother sometimes had to leave the child in the care of her niece while she worked. The niece was certified in CPR and the nursing agency had no concerns about the child's care. There have been no further reports to the hotline since the child's death.

Case No. 88	DOB November 2004	DOD November 2004	Natural
Age at death:	0		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Stillborn		
County:	Cook		
Reason for review:	Mother was a ward within a year of the child's death		
Action taken:	Preliminary investigation		

Narrative: Twenty-one-year-old former ward delivered a stillborn infant by cesarean section at 26 weeks gestation.

Prior History: The mother was a ward from 1996 until she turned 21 years old in March 2004. She has given birth to three children; the first was born when she was 18 years old. When the infant was five months old, the mother was indicated for inadequate supervision after she left the infant with an unwilling caregiver who left the child home alone. The infant entered foster care and was adopted by her foster parent in June 2005. In July 2003 the hotline was contacted with a report of substantial risk of physical injury to the mother's second child, born in May 2003, because of the mother's history. The report was unfounded because the 2-month-old infant was living with the mother's aunt.

Case No. 89	DOB April 2000	DOD November 2004	Natural
Age at death:	4-1/2 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Congenital heart disease		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Four-and-a-half-year-old child died in the hospital from complications 9 days after she had heart surgery to have a shunt replaced. The child was born with heart disease and had her first

surgery shortly after birth.

Prior History: The Department became involved with this family shortly after the premature birth of the child to a 15-year-old mother and 18-year-old father. The hospital contacted the hotline to report that the mother was not learning how to care for her daughter's special needs. The mother was indicated for substantia l risk of physical injury and an intact family case was opened. The case was closed after two months because the mother had the support of her mother and grandmother with whom she lived, and the grandmother agreed to ensure the child's needs were met. In June 2004 a second intact family case was opened after the mother was indicated for inadequate supervision of the child. Services included monitoring the child's medical care, obtaining stable housing for the family, and enrolling the mother in parenting classes. The case was closed in October 2005. A 2-1/2-year-old son remains with the mother.

Case No. 90	DOB November 2004	DOD November 2004	Natural
Age at death:	0		
Substance exposed:	Yes, cocaine		
Cause of death:	Extreme prematurity		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Twenty-two-year-old mother gave birth to a baby boy at 22-23 weeks gestation. The mother tested positive for cocaine and marijuana and admitted that she had last used cocaine the day prior. The baby lived for approximately thirty minutes. The mother was indicated for substantial risk of physical injury to her two surviving children.

Prior History: The family's first contact with DCFS was in September 2004 when a relative called the hotline to report that the mother's 38-year-old boyfriend was beating her, and the relative feared he was beating the mother's girls, ages 1 and 2, as well. During investigation, the mother admitted that her boyfriend had been violent with her, oftentimes with her children witnessing the incidents. The mother also admitted that she did not want the child she was carrying. She and the boyfriend were indicated for substantial risk of physical injur y to the children, and an intact family case was opened. A safety plan was developed with the mother agreeing to obtain an order of protection, not allow her children to be around her boyfriend, and have her children reside with an aunt until her home was safe. The boyfriend requested referrals for parenting classes and domestic violence. Approximately a week and a half after her children were returned home, the mother went into labor. The surviving children's biological father obtained custody of them in May 2005, and the case was closed.

Case No. 91	DOB November 2003	DOD November 2004	Natural
Age at death:	12 months		
Substance exposed:	No		
Cause of death:	Cerebral anomalies due to encephalitis		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Twelve-month-old child was born with herpes and encephalitis with severe brain damage. She suffered from uncontrollable seizures. While hospitalized for increased seizures, she went into cardiac arrest, leading to coma and brain death. She was removed from life support and died.

Prior History: The family first came to the attention of the Department in March 2004 when the hotline was called with a report that the baby's 20-year-old father had slapped the baby's 22-year-old mother

while she was holding the baby. The father was charged and pled guilty to battery. The mother obtained an order of protection. While the report of substantial risk of physical injury was being investigated, the investigator discovered the father in the home in violation of the order. Both parents were indicated on the report. The father said he was willing to attend domestic violence counseling, and an intact family case was opened. The parents separated. The mother participated in domestic violence counseling, as did the father albeit inconsistently. The mother cared for the child adequately and was monitored and assisted by a visiting nurse. The case was closed shortly after the child's death. There has been no further contact with either the mother or the father.

Case No. 92	DOB October 2004	DOD November 2004	Natural
Age at death:	3 weeks		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Forty-six-year-old father awoke at 8:30 a.m. to find his three-week old daughter unresponsive. The infant had been sleeping in bed with her parents after a 3:00 a.m. feeding.

Prior History: The 34-year-old mother has given birth to four children. She has a history with DCFS dating to 1994 for neglect of her first child because of her substance abuse. That child has lived primarily with his maternal grandmother. In February 2000 the mother gave birth to twins who tested positive for cocaine. She was indicated for substance misuse and an intact family case was opened. The mother participated in substance abuse treatment, but eluded agency workers after completion. Further reports of neglect were made to the hotline and in March 2004 the private agency handling the case screened the case with the Cook County State's Attorney's Office for court involvement. The State's Attorney's Office declined to pursue a petition in court. Despite diligent searching, the private agency was unable to locate the mother and twins for several months prior to the infant's birth and death. The mother was offered services after the infant's death, but she declined. The twins were reported to be doing well in her care, and the intact family case was closed.

Case No. 93	DOB April 2004	DOD November 2004	Natural
Age at death:	7 months		
Substance exposed:	No		
Cause of death:	Encephalopathy due to hypoxic brain injury		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: Seven-month-old medically complex ward died in the hospital where he was being treated for increased seizure activity. He had been hospitalized for four months after birth and lived in a nursing care facility for the final 3 months of his life.

Prior History: The 28-year-old mother and 54-year-old father have a history with DCFS dating to July 2003 when a report was made alleging physical abuse to the 2-1/2-year-old son. The report was unfounded. Five months later, in December 2003, the Department received a report of physical abuse to the 6-year-old daughter. Investigation revealed domestic violence by the father against the mother and 2 children. The investigation was indicated, the mother obtained an order of protection, and an intact family case was opened. The intact family worker contacted the hotline the next month to report that the son had a black eye and the mother had scratches on her face. The worker stated that the mother was

allowing the father in the home and had not gone to court to get an extension on the order of protection. The children entered foster care and were placed together in a foster home. After the deceased's birth, the parents were indicated for substantial risk of physical injury to him and he entered foster care prior to his discharge from the hospital. In June 2005 the siblings were placed in the home of a relative where they remain.

Case No. 94	DOB February 2003	DOD November 2004	Natural
Age at death:	21 months		
Substance exposed:	No		
Cause of death:	Pulmonary hypertension		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Full investigation pending		

Narrative: Twenty-one-month-old child suffered cardiac arrest after a cardiac catheterization. She was resuscitated and placed on life support which the parents removed two days later. The child had a history of heart problems, emesis, and failure to thrive for which she was being treated.

Prior History: The family became involved with DCFS in June 2003 when a hospital where the child was being treated contacted the hotline with a report of failure to thrive to the child and substantial risk of physical injury to her 18-month old sister. The report was indicated based on the medical opinion of the attending physician. Protective custody was taken of the 4-month-old, but the court denied temporary custody, finding that the child had numerous medical problems that could have contributed to her failure to gain weight. The court placed the parents on pre-adjudicatory supervision and an intact family case was opened. The infant gained weight at a slow rate, she attended her medical appointments regularly, and she received early intervention services. The family's court case was closed in July 2004 after the parents completed services. The intact family case remained open until June 2005. The OIG is investigating this case for inclusion in a cluster report about services to medically complex children.

Case No. 95	DOB March 2002	DOD November 2004	Natural
Age at death:	2-1/2 years		
Substance exposed:	No		
Cause of death:	Myocarditis. Congenital heart disease due to Down's syndrome was a significant contributing condition.		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Twenty-two-year-old mother got up at 6:00 a.m. and discovered her 2-1/2-year-old daughter unresponsive. The child had Down's syndrome and a heart condition.

Prior History: In August 2004 the child's father and paternal grandmother called the hotline alleging the mother had missed several necessary medical appointments for the child. The mother produced documentation that proved she had attended the child's appointments. Further, the child's doctor reported that while the mother had been inconsistent in the past in keeping appointments, the mother had been sent a letter and was compliant with appointments afterward. The doctor had no concerns. The mother has a surviving child, a year older than the deceased. There have been no further reports involving the family.

Case No. 96	DOB August 2004	DOD November 2004	Natural

Age at death:	3 months
Substance exposed:	No
Cause of death:	Sudden Infant Death Syndrome
County:	Peoria (death); Vermilion (services)
Reason for review:	Open intact family services case at time of child's death
Action taken:	Full investigation pending

Narrative: Twenty-three-year-old developmentally delayed mother awoke in the morning to find her 3-month-old son unresponsive. DCFS investigated the infant's death. The mother was indicated for substantial risk of physical injury to her surviving 2-1/2-year-old son because she admitted to smoking marijuana while caring for her children, her developmental delays placed the child at risk because she had poor decision-making abilities, and the mother used intimidation and unreasonable discipline with the child. The child was placed in foster care. In September 2005 the mother gave birth to a daughter. She entered foster care at her birth and is placed in the same foster home as her brother.

Prior History: The mother was a ward from March 1983 until April 2002 when she reached majority. She is developmentally delayed. In May 2002 the mother was indicated for inadequate supervision of her 3-month-old son after leaving him unsupervised for 15 minutes while she went to buy beer. An intact family case was opened until November 2002. A second neglect report in August 2004 was unfounded. When the deceased was born a substantial risk of physical injury report was made because the doctor felt the baby would be at risk in the mother's care. The report was unfounded, but an intact family case was opened. Three subsequent reports by staff at the shelter at which the mother was residing were unfounded. Three weeks before the infant's death, intact family staff assisted the mother in moving to the Peoria area to be near family. The intact family case had not yet been transferred to Peoria at the time of the infant's death.

Case No. 97	DOB January 1986	DOD December 2004	Natural
Age at death:	18 years		
Substance exposed:	No		
Cause of death:	Kidney failure due to renal disease		
County:	Cook		
Reason for review:	Teenager was a ward		
Action taken:	Records reviewed		

Narrative: Eighteen-year-old with renal disease that required dialysis three times a week had been hospitalized for two weeks due to complications with the shunt used for dialysis. She was discharged from the hospital with instructions that she be taken directly for her dialysis treatment. The teenager became unresponsive during the treatment and was rushed back to the hospital where she was pronounced dead.

Prior History: The teenager was one of eleven children. Her family has a history of neglect dating to 1991. In July 2002 the teenager and her five minor siblings entered foster care. The teenager lived in a group home at the time of her death and was on a strict diet and weight loss program to enable her to be placed on the kidney transplant list.

Case No. 98	DOB August 2004	DOD December 2004	Natural
Age at death:	4 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Twenty-three-year-old mother of four children ages four and under found one of her 4-month-old twins unresponsive. The mother had laid the twins on their stomachs on a couch at the infants' 41-year-old father's house while waiting for a ride to take them home. The mother said she laid the babies on their stomachs because they would cry when they were put on their backs.

Prior History: The family's first involvement with DCFS was in March 2004 when an anonymous reporter called the hotline alleging the mother had left her 1 and 3-year-old children home alone overnight and the home was uninhabitable and had no food. The Department was unable to locate the family for two weeks; they were evicted from their apartment and were staying with the maternal grandmother. The investigation was unfounded. In August 2004 the mother gave birth to twins at 27 weeks gestation. She had no prenatal care. The twins remained hospitalized. In September 2004 a hospital social worker contacted the hotline to report that the twins were ready for discharge, but the mother failed to visit the children for the past two weeks or attend training to learn how to care for their special needs resulting from their premature birth. The mother reported that she was unable to go to the hospital because she had no childcare for her two other children, and they were not allowed in the hospital. The mother and children were living with her stepfather who confirmed the family could stay with him. The investigation was unfounded, but an intact family case was opened to provide services to the family. The case was closed in May 2005.

Case No. 99	DOB March 1996	DOD December 2004	Natural
Age at death:	8-1/2 years		
Substance exposed:	No		
Cause of death:	Myocarditis		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Eight-and-a-half-year-old child, who had a history of asthma and a hole in her heart, was not feeling well and was taken to the hospital by her mother. The child died while in the care of hospital staff.

Prior History: In May 2004 a hospital nurse called the hotline to report alleged sexual abuse of the child and her 8-year-old aunt by a 12-year-old uncle while in his home after school. The child was taken to the hospital by her mother. Neither girl had any physical findings, the uncle denied touching either girl inappropriately, another child in the home denied seeing anything bad happen, and an uncle in a downstairs apartment did not hear anything on the day in question. The investigation was unfounded, however, police theorized that the children may have engaged in sexual experimentation while their caregiver ran to the store. The girls were referred for counseling and the uncle was referred for assessment. In addition, the family agreed to an aftercare plan that the children would not be left home alone unsupervised.

Case No. 100	DOB May 2004	DOD December 2004	Natural
Age at death:	7 months		
Substance exposed:	No, however, parents have a history of substance abuse		
Cause of death:	Chronic active peritonitis		
County:	Effingham		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: Seven-month-old ward, born prematurely, had medical problems necessitating a g-tube. The foster mother, checking on the infant in the early morning, found the infant fussy with a 103 degree fever. The fever started to subside with medication, but the infant began to experience respiratory

difficulties. The infant was rushed to the hospital where it was discovered that air and fluid leaking from her g-tube had led to a pressure build up in her abdomen causing a perforation of her bowel. Surgery was attempted to correct the situation, but the infant died during the procedure. The infant had spent 5 months in the hospital prior to being released to the foster parent.

Prior History: The 26-year-old mother and 31-year-old father's first contact with DCFS was in August 1999 following the death of their 3-year-old son. The parents were indicated for death by neglect after a pet python got out of his cage and wrapped itself around the child asphyxiating him. In June and October 2003 the parents were indicated for inadequate supervision of their 2-year-old son. The parents were offered services, but refused. In June 2004, a month after the infant was born, the hotline was called with another report of inadequate supervision. During the investigation, drug use and domestic violence by the parents was revealed, and they were indicated for substantial risk of physical injury to the children. In July 2004 the hospital where the infant was being treated following birth called the hotline to report the parents were not visiting the child. During a worker's visit to the home, the mother was observed to be under the influence, and the mother admitted to methamphetamine use. The three children were taken into custody, and the two boys were placed in a foster home together. Their infant sister joined them upon her release from the hospital. The boys remain in their foster home.

Case No. 101	DOB November 2003	DOD December 2004	Natural
Age at death:	12 months		
Substance exposed:	No		
Cause of death:	Peroxisomal Disorder		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: Medically complex ward, born with a terminal genetic disorder, died in the hospital. She lived in a nursing care facility. Her 9-month-old sibling, who was also a ward, died a year earlier from the same disorder.

Prior History: The ward's 21-year-old mother was herself a ward from 1992 until 2004 when she aged out of the system. She was one of 8 children removed from their mother's care because of drug addiction. The 21-year-old has one surviving child, a 4-year-old son, who has been in foster care since August 2003 because of the mother's involvement in a violent relationship. The mother is no longer in that relationship and is undergoing domestic violence counseling. Her son lives with a relative and has a goal of return home.

Case No. 102	DOB July 1989	DOD January 2005	Natural
Age at death:	15 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Multiple medical problems		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Fifteen-year-old severely medically complex child died at the hospital after being taken there from his nursing care facility.

Prior History: The child's 39-year-old mother has given birth to 8 children. She has a history with DCFS dating to 1985 because of abuse and neglect. Her last three children were born substance exposed. The deceased entered foster care in April 1990 and had been living in his nursing care facility since January 1991. None of the children are in the mother's care. Four of the children were adopted by

a maternal aunt, one was adopted by his foster parent, and two are in a specialized foster home with an "out of home" goal.

Case No. 103	DOB August 2004	DOD January 2005	Natural
Age at death:	5 months		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Pulmonary hypertension due to AV canal malformation due to trisomy 21		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: Five-month-old medically complex infant died in the hospital. She had been hospitalized since birth because of her medical problems.

Prior History: The deceased was one of seven children, including a twin brother. Her mother had an intact family services case open from April 1995 to January 1996. There was no further DCFS involvement until September 2003 when the mother gave birth to a substance-exposed infant. The mother was indicated for substance misuse and the baby girl entered foster care. The four older children were in the guardianship of their maternal grandmother. The mother did not participate in services to regain custody of her daughter, and the caseworker was unaware that the mother had given birth to twins. In November 2004 the mother left the infant's twin brother with a babysitter and did not return. The babysitter contacted the maternal grandmother who picked up the baby and took him to a hospital stating she could not care for him. The infant was placed in foster care, where he remains. His older sister was adopted in September 2005.

Case No. 104	DOB November 2004	DOD January 2005	Natural
Age at death:	1-1/2 months		
Substance exposed:	No		
Cause of death:	Viral pneumonia and gastroenteritis		
County:	Peoria		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: One-and-a-half-month-old infant died in the emergency room after being brought there by his 22-year-old mother and 25-year-old father. The infant had been irritable that day, was not eating normally, and had vomiting and diarrhea. The infant arrived at the emergency room unresponsive and could not be resuscitated.

Prior History: The father was the alleged perpetrator on one report from March 2004. An ex-girlfriend called the hotline to report that her 4-year-old daughter returned from visiting her father with a bruise to her right hip that the 4-year-old said was caused by her father kicking her. An investigation was unfounded. While the child did have a small bruise, it did not appear to be from a kick. The father denied kicking the child, and his girlfriend and wife (from whom he was separated and going through a divorce) stated they had never seen anything concerning about the father's behavior with children (he had one child with his wife and his girlfriend had a child). The investigator referred the family to a program to provide counseling/behavioral intervention for the child, but at the end of the investigation, the 4-year-old moved out of state with her mother.

Case No. 105	DOB November 2001	DOD January 2005	Natural
Age at death:	3 years		

Substance exposed:	No
Cause of death:	Quadraplegia due to cerebral palsy
County:	Cook
Reason for review:	Open preventive services case within one year of child's death
Action taken:	Records reviewed

Narrative: Medically complex 3-year-old, with cerebral palsy and quadriplegia, was found unresponsive in his home.

Prior History: The family's only involvement with DCFS was for preventive services. In November 2003, a social worker at the hospital where the child was being treated contacted the hotline requesting housing assistance for the family because the home in which they were living was too small for all of the child's medical equipment and nursing staff. The Department opened a preventive services case and referred the family to a housing advocacy program which assisted the mother in obtaining appropriate housing. The case remained open until July 2004 to monitor the family. The 27-year-old mother has one surviving child, and there has been no further involvement with the Department.

Case No. 106	DOB November 2004	DOD January 2005	Natural
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Congenital heart disease		
County:	DuPage		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: Two-month-old infant was taken to the emergency room by his maternal grandmother, his foster parent, because he was having difficulty breathing. He was stabilized and transferred by ambulance to another hospital, where he later died.

Prior History: The 19-year-old mother has a history of depression and has attempted suicide on multiple occasions. Her first contact with DCFS was in June 2004 when she attempted to commit suicide by ingesting antibiotics in the presence of her 1-1/2-year-old son. The mother was indicated for substantial risk of physical injury and an intact family case was opened. A couple of weeks after the infant's birth, in December 2004, medical staff contacted the hotline to report that the mother had missed 2 appointments for the infant for follow-up of a suspected heart condition. The infant and his older brother entered foster care at that time because of the mother's instability and the intact family worker's inability to monitor the mother's care of the children and compliance with medical appointments. The children were placed with their maternal grandmother, where the surviving sibling remains.

Case No. 107	DOB October 1998	DOD January 2005	Natural
Age at death:	6 years		
Substance exposed:	No		
Cause of death:	Brain cancer (Pontine glioma)		
County:	Peoria		
Reason for review:	Unfounded DCP investigation and open preventive services case within a year of child's death		
Action taken:	Records reviewed		

Narrative: Six-year-old child died six months after being diagnosed with a brain tumor. The day before she died she had been discharged from the hospital where she was treated for pneumonia. Hospice care was supposed to have begun the day of her death.

Prior History: The mother was appropriately unfounded on reports alleging neglect in December 2003,

April 2004, and July 2004. During the course of the July 2004 investigation of environmental neglect, the child was diagnosed with an inoperable brain tumor. A preventive services case was opened to assist the mother, who moved with her four children, ages 1-5, to another town to obtain treatment for her daughter. The case was closed in September 2004 after the family was stabilized and made aware of local resources.

Case No. 108	DOB September 1991	DOD January 2005	Natural
Age at death:	13 years		
Substance exposed:	No		
Cause of death:	Seizure disorder		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Forty-two-year-old father returned home late after having been in a car accident to discover his 13-year-old mentally retarded and epileptic son unresponsive with foam coming out of his mouth. He had been in the care of his 15-year-old sister.

Prior History: The father was the custodial parent of the deceased and his 3 siblings. The father's only prior DCFS involvement was an unfounded investigation from August 2004 when the mother of the 2 youngest children called the hotline alleging the children were left unsupervised while the father was at work. The report was unfounded. The 2 younger children attended day care next door to the home, the children denied being left home alone, the father named multiple caregivers for his children in his absence, and a family member vouched for the father's excellent care of the children.

Case No. 109	DOB May 1988	DOD January 2005	Natural
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Anoxic encephalopathy due to muscular dystrophy		
County:	Kankakee (residence) Cook (death)		
Reason for review:	Teenager was a ward		
Action taken:	Preliminary investigation		

Narrative: Sixteen-year-old ward with muscular dystrophy was hospitalized for 10 days after he stopped breathing in his foster home. He never regained consciousness and life support was removed after consultation with his foster and biological families. He died shortly thereafter.

Prior History: The family has a history of neglect dating to 1987. The parents have had 11 children together, four of whom were diagnosed with muscular dystrophy. Another son died from muscular dystrophy in January 1998. The OIG submitted a report to the Director about that child's death. Following the first child's death, the surviving children entered foster care. The deceased and another brother with muscular dystrophy were placed together in a specialized foster home. The brother remains in the home with a goal of guardianship. The other siblings have been adopted or are in subsidized guardianship.

Case No. 110	DOB December 2004	DOD February 2005	Natural
Age at death:	2 months		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		

Reason for review:	Open return home case within a year of child's death
Action taken:	Records reviewed

Narrative: Thirty-one-year-old mother found her 2-month-old infant unresponsive on her back in her crib during a nap.

Prior History: The family has a history with DCFS dating to 1995 when the mother's two children were removed from her care because of neglect. These children were adopted by their foster parents in June 2000 and January 2001. The mother went on to have 3 more children. All 3 shared the same father. In December 2001 the mother gave birth to a substance-exposed infant. The mother was indicated for substance misuse and an intact family case was opened. The mother was incarcerated at the time of case opening. The infant was placed with her father under an order of protection and the case was closed in May 2002. In August 2003 the mother gave birth to her second substance-exposed infant, who was born prematurely. The mother was indicated for substance misuse, and the child entered relative foster care. The father obtained custody of the child in December 2003. DCFS monitored the father until December 2004.

Case No. 111	DOB July 1987	DOD February 2005	Natural
Age at death:	17 years		
Substance exposed:	No		
Cause of death:	Hemolytic anemia		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of teenager's death		
Action taken:	Records reviewed		

Narrative: Seventeen-year-old was taken to the emergency room by her mother because she complained of being sick. The teen was jaundiced and anemic. She was being given blood in the hospital and died. There were no signs of abuse or neglect.

Prior History: The family's only involvement with the Department was in September 2004 when a hotline report was made alleging substantial risk of physical injury to the deceased and her 3 siblings, ages 5, 10, and 16. The deceased reported that her father was an alcoholic who became violent when he drinks and that 2 days prior he grabbed her and threw her into a chair and bounced her head against a wall. DCP investigated and unfounded the report. All family members were interviewed. They reported that the teen's boyfriend was told at 9:30 p.m. to go home because it was a school night, and he refused. The father yelled at him and the teen. The family denied that the teen was hit, and she did not have any bruising. The father was reported to drink, but not to be an alcoholic.

Case No. 112	DOB January 2002	DOD February 2005	Natural
Age at death:	3 years		
Substance exposed:	Yes, cocaine		
Cause of death:	Microcephaly		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: Foster parents took their 3-year-old medically complex foster daughter to the emergency room with a fever. While at the hospital, the child's temperature increased. She was given medication, but her temperature continued to increase, and the child was transferred to another hospital that could better treat her. She died the next morning.

Prior History: The mother gave birth to a substance-exposed infant in October 2000, and an intact family case was opened. In September 2001, the child and her older sister entered foster care. The

deceased was the 32-year-old mother's second substance-exposed infant. Upon her release from the hospital, the child was placed in the home of a relative where she was still living at the time of her death. The child had numerous medical problems and received in-home nursing services. There were two hotline reports against the foster parents, in September 2003 and October 2004, both of which were appropriately unfounded. The child's siblings remain together in another relative's home with a permanency goal of substitute care pending court decision on termination of parental rights.

Case No. 113	DOB December 1992	DOD March 2005	Natural
Age at death:	12 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Leukemia		
County:	Douglas		
Reason for review:	Unfounded DCP investigation within one year of child's death		
Action taken:	Records reviewed		

Narrative: Twelve-year-old child with leukemia was admitted to the hospital for complications from a bone marrow transplant. While in the hospital the child became septic and died.

Prior History: Almost a year earlier the child's 31-year-old mother was reported to the hotline for substantial risk of physical injury to the child based on statements the child made to hospital staff. The report was unfounded because the child was in the sole custody of his father, whose divorce from the mother was finalized in the month prior to the report. The mother was allowed only limited visitation, and the child was refusing to see her. The Department had no further contact with the family.

Case No. 114	DOB January 2003	DOD March 2005	Natural
Age at death:	2 years		
Substance exposed:	No		
Cause of death:	Complications of prematurity		
County:	St. Louis, MO (death); Massac (residence)		
Reason for review:	Pending DCP investigation at time of child's death		
Action taken:	Records reviewed		

Narrative: Medically complex 2-year-old child, who was born prematurely at 26 weeks, died while in the hospital, where he had been for 3 weeks. After the child's death, a short-term service case was opened to provide the family, including a 4-1/2-year-old sibling, with brief preventive services.

Prior History: The family first came to the Department's attention in October 2003 when an allegation of medical neglect was made against the child's 23-year-old mother and 20-year-old father. A DCP investigation was unfounded because the child's primary care provider and other doctors involved in his care had no concerns about the child's care. A second report was made in August 2004 for substantial risk of physical injury to the child because his parents allegedly smoked in the home, propped the child's bottle causing him to lose the ability to suck, and failed to give the child his antibiotic medication for an infection. The investigation was unfounded because a home health nurse, who spent 24 hours a week in the home, had no concerns about the parents' care of the child, witnessed no smoking, and attributed the child's lack of sucking to his medical condition. At the time of the child's death there was a pending investigation for medical neglect of the child. Again, it was unfounded because the child had 40 hours a week of nursing care and the in-home nurse reported that both parents did an excellent job of caring for the child.

Case No. 115	DOB March 2005	DOD March 2005	Natural
Age at death:	2 days		

Substance exposed:	Probably (could not be tested), mother tested positive for heroin and admitted to alcohol abuse throughout pregnancy
Cause of death:	Congenital abnormalities
County:	Cook
Reason for review:	Open intact family services case within a year of child's death
Action taken:	Records reviewed

Narrative: Two-day-old infant died in the hospital. The baby girl was born with numerous congenital abnormalities and was not expected to live. The 38-year-old mother used heroin and alcohol throughout her pregnancy and had no prenatal care. The mother was indicated for substantial risk of physical injury/environment injurious to the two surviving children, ages 5 years and 22 months, in her care. An intact family case was opened. The children's father, who does not use drugs and has no criminal history, ensures that the children's needs are met. The mother's three oldest children live with their father and paternal grandmother.

Prior History: The two children in the mother's care were both born substance-exposed. Intact family cases were opened after each child's substance-exposed birth. The mother has been unsuccessful in her attempts to get clean; she has participated in detox and methadone maintenance treatment programs, but she has continued to use heroin. The last intact family case was open for a year. It was closed because, in addition to their mother, the children lived with their father who was supportive of his wife's substance abuse treatment and who had ensured that his children's needs were met.

Case No. 116	DOB December 2004	DOD March 2005	Natural
Age at death:	2-1/2 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cape Girardeau, MO (death); Saline (residence)		
Reason for review:	Child welfare services referral within one year of child's death		
Action taken:	Records reviewed		

Narrative: Maternal aunt, who wanted to visit with her niece, found the two-and-a-half-month-old infant unresponsive, lying on her stomach in her bassinette. The family called 911 and the child was air-lifted to a hospital in Missouri where she was pronounced dead.

Prior History: Three days after the infant's birth, a hospital social worker called the Department requesting that services be offered to the 18-year-old mother about how to care for a newborn. The social worker was concerned because the mother did not appear to have family support. A DCFS worker interviewed the mother in her home to determine her needs. The worker observed that the home was clean and the child was dressed appropriately and sleeping in a bassinette. The mother reported an appropriate feeding schedule, involvement with the WIC program, a scheduled well baby check, and having completed classes for teen mothers through the Illinois Department of Public Aid. She also reported the support of the 20-year-old father's family. The mother was not interested in DCFS services and the intake evaluation was closed.

Case No. 117	DOB February 2005	DOD February 2005	Natural
Age at death:	6 weeks		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Rock Island		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Twenty-three-year-old mother awoke in the morning, fed her infant daughter, and fell back to sleep with her on the couch. When she awoke a few hours later, the mother found the infant unresponsive, wedged between herself and the back of the couch.

Prior History: The mother, who has two older children, ages 4 and 5, has been involved with Illinois DCFS and Iowa DHS since 2003 when she was indicated for inadequate supervision, environmental neglect, and inadequate food. On two occasions, workers attempted to visit the family and found the mother asleep in the home while the two young children were hungry, surrounded by raw and spoiled food. In December 2003 the children were placed in foster care in Iowa. Their foster care case was closed in January 2005, but the mother agreed for the children to continue to live with their paternal grandmother. When the deceased was born, the hospital called the hotline alleging substantial risk of physical injury to the infant because of her mother's prior history. The investigation was unfounded because the baby was healthy, the mother had all the supplies she needed to care for the baby, the home appeared appropriate with no environmental problems, the mother appeared to be bonding appropriately with the baby, and the hospital expressed no concerns about her caretaking. Since the infant's death, the mother gave birth to another daughter in November 2005, a day after she filed a police report that she was assaulted. The baby was born prematurely at 28 weeks gestation. A report was made to the hotline alleging substantial risk of physical injury because of the mother's prior history. The investigation is pending.

Case No. 118	DOB October 2004	DOD March 2005	Natural
Age at death:	5 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Pneumonia due to chest deformity due to short-limbed dwarfism		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Foster parent, who was the infant's paternal grandmother, laid the medically complex infant down for a nap. Approximately 30 minutes later, she heard the infant's heart monitor beeping and found the infant turning blue. Her teenaged son called for an ambulance which took the infant to the hospital where he was pronounced dead.

Prior History: The deceased was the 7th child born to his 28-year-old mother. He was the 3rd child born substance-exposed. His mother abandoned him in the hospital. Two months after his birth, when he was ready for discharge, he was placed with his paternal grandmother who was already the foster parent for two of his siblings. The mother has a history with DCFS dating to 1995. All of her children have been in foster care. One is in an independent living program; two have been adopted; one is in subsidized guardianship; and two remain with their paternal grandmother with a goal of guardianship.

Case No. 119	DOB January 2005	DOD March 2005	Natural
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Bronchopneumonia		
County:	Cook		
Reason for review:	Split custody		
Action taken:	Records reviewed		

Narrative: Twenty-one-year-old mother found her 2-month-old infant unresponsive in her crib. The infant was the mother's third child. Five days before her death, the mother brought the infant to her pediatrician's office wheezing and coughing. The infant was diagnosed with Bronchitis and prescribed antibiotics and asthma medication. The following day the mother reported the infant was doing much

better.

Prior History: The mother came to the attention of the Department in March 2002 when the hotline was called with an allegation of medical neglect to her medically complex 9-month-old son. The boy was born prematurely with multiple medical problems and was hospitalized for six months following his birth. Three months after leaving the hospital he was readmitted with apparent failure to thrive. The mother failed to visit the baby consistently or cooperate with the hospital's requests. She was indicated for medical neglect, and the infant was placed in foster care with a relative. In December 2003 the mother gave birth to her second child, and the hotline was contacted. The mother was indicated for substantial risk of physical injury to the infant because of her history and her failure to participate in services to regain custody of her son. The case was screened with the State's Attorney's Office for custody of the child, but the State's Attorney's Office refused to pursue the case. The agency servicing the child in placement also monitored the child at home. In February 2004 the agency called the hotline with a report of medical neglect to the child at home. The investigation was unfounded. The mother's parental rights on her first child were terminated in July 2004. The agency continued to monitor the child at home until April 2005.

Case No. 120	DOB March 2005	DOD April 2005	Natural
Age at death:	2 weeks		
Substance exposed:	Yes, cocaine		
Cause of death:	Respiratory failure due to hypoxic ischemic encephalopathy		
County:	Cook		
Reason for review:	Pending DCP investigation at time of child's death		
Action taken:	Records reviewed		

Narrative: Two-week-old substance-exposed infant, who was born with multiple anomalies, died in the hospital where she had been since birth.

Prior History: The Department's first contact with the 18-year-old mother and 24-year-old father was the substance-exposed birth of the deceased. The parents were indicated for substantial risk of physical injury/environment injurious to health and welfare of the infant because of their drug use.

Case No. 121	DOB September 2003	DOD April 2005	Natural
Age at death:	18 months		
Substance exposed:	No		
Cause of death:	Acute respiratory distress syndrome and pneumonia		
County:	Saline		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Full investigation pending		

Narrative: Eighteen-month-old medically complex child was hospitalized in intensive care for 2 months for complications from her medical problems. She died while hospitalized. The child had a history of organic failure to thrive.

Prior History: The family came to the attention of DCFS in November 2003 when the 21-year-old mother and 18-year-old father were reported for medical neglect of the child. The report was unfounded, but an intact family case was opened. A second report in January 2004 for inadequate food was unfounded. The father had a history of substance abuse, including methamphetamine use. The intact family worker monitored the family's adherence to medical appointments and provided transportation to appointments. The child was receiving early intervention services. The parents have a 3-year-old son, and the intact family case remains open.

Case No. 122	DOB November 2004	DOD April 2005	Natural
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Multiorgan failure due to congenital heart disease		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Records reviewed		

Narrative: Five-month-old infant died in the hospital where she was recovering from heart surgery.

Prior History: In December 2004 the hospital, where the infant had been since birth, contacted the hotline to report that the medically complex infant's 28-year-old mother was not visiting her or learning how to care for her. The mother was indicated for inadequate supervision and the infant entered foster care. When not hospitalized, she lived with a foster parent trained to care for her. The deceased was the mother's fourth child. None of the three older children live with their mother. One was adopted by her mother's godmother, one lives with his father, and one is in the guardianship of her paternal grandmother.

Case No. 123	DOB March 2005	DOD April 2005	Natural
Age at death:	3 weeks		
Substance exposed:	Yes, cocaine and opiates		
Cause of death:	Sudden Infant Death Syndrome		
County:	DeKalb		
Reason for review:	Pending DCP investigation at time of child's death		
Action taken:	Records reviewed		

Narrative: Maternal grandmother fed her 3-week-old grandson and put him back to sleep before going to work. The infant's 14-year-old sibling found him unresponsive, lying on his stomach, approximately 3 hours later.

Prior History: At the time of the infant's death, there was a pending DCP investigation because of the infant's substance-exposed birth. During the investigation the mother turned herself in for an outstanding warrant and was put in jail. She placed her son in the care of the maternal grandmother, who was already the legal guardian for the mother's 14-year-old daughter. The day before the infant's death, the mother had been released from jail and ordered into a drug treatment program. The Department was in the process of opening an intact family case with a program that specializes in services to substance-abusing mothers.

Case No. 124	DOB April 2005	DOD April 2005	Natural
Age at death:	0		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Intrauterine asphyxia, etiology unknown		
County:	Cook		
Reason for review:	Intact family case open at time of child's death		
Action taken:	Records reviewed		

Narrative: Thirty-four-year-old mother gave birth to her fourth child in the bathroom at home. The baby's 38-year-old father assisted. The baby was taken by ambulance to the hospital where he was pronounced dead.

Prior History: The family's first contact with the Department was in July 2002 when the mother

delivered her second child, who was born substance-exposed. The mother was indicated for substance misuse and an intact family case was opened. The mother was not cooperative with substance abuse services, however, the family lived with paternal relatives who ensured the children were cared for appropriately. The mother gave birth to her third child, also substance-exposed, in February 2004. The mother entered inpatient substance abuse treatment with the infant and successfully completed the program. Once released, however, the mother did not follow through with outpatient treatment and appears to have relapsed. Her whereabouts are unknown. The surviving children live with their father and paternal relatives and the intact family case remains open.

Case No. 125	DOB December 2004	DOD April 2005	Natural
Age at death:	4 months		
Substance exposed:	No		
Cause of death:	Cardiac failure due to multiple congenital heart defects		
County:	Winnebago		
Reason for review:	Intact family case open at time of child's death		
Action taken:	Records reviewed		

Narrative: Maternal grandmother noticed that her 4-month-old grandson, who had multiple congenital heart defects, was having trouble breathing. She called 911 and the infant was taken to the hospital where he died. The infant had only been home from the hospital for two weeks. He had been hospitalized for the prior six weeks and underwent several procedures including surgery.

Prior History: The infant was born to a 13-year-old girl who was having sex with a 23-year-old man. Following the infant's birth, a hospital social worker contacted the hotline with a report of medical neglect against the mother and maternal grandmother because the infant had not been brought to any of his scheduled medical appointments. Both were indicated and a Family First intact family case was opened to assist the family with keeping medical appointments. While the case was open, the 13-year-old mother ran away to be with the 23-year-old father and was unavailable to consent to medical procedures. In March 2005 the grandmother went to court and obtained temporary custody of the infant. The mother and father were located together. The father has since been convicted of predatory criminal sexual assault of the 13-year-old. He was sentenced to 9 years in prison.

Case No. 126	DOB December 2002	DOD April 2005	Natural
Age at death:	2 years		
Substance exposed:	Yes, cocaine		
Cause of death:	Mitochondrial disorder		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Two-year-old ward with numerous congenital and acquired illnesses, including cerebral palsy, developmental delays, failure to thrive, hypertrophic cardiomyopathy, hypertension, seizure disorder, hydrocephalus, chronic respiratory failure, and mitochondrial disorder, died in his preadoptive foster home where he had been placed since he was 10 days old. The child had a do not resuscitate order in place and was receiving hospice care.

Prior History: The 38-year-old mother of 8 children has a history with DCFS dating to 1988. Her last five children were born substance-exposed. The mother has no children in her care. Five of the children have been adopted; one is with her father; and the youngest is in the preadoptive home of the foster parents who cared for the deceased.

Case No. 127	DOB June 1989	DOD April 2005	Natural
Age at death:	15 years		
Substance exposed:	No		
Cause of death:	Myocarditis		
County:	Cook		
Reason for review:	Open intact family services case within a year of child's death		
Action taken:	Records reviewed		

Narrative: Fifteen-year-old girl was taken to the hospital for shortness of breath that required intubation. She suffered cardiac arrest seven hours later. The teenager had been seen at the hospital earlier in the day for a headache and abdominal pain. She tested positive at the hospital for marijuana and alcohol after staying out all night the day before.

Prior History: The family's first contact with DCFS was in May 2003 when the deceased's father was indicated for substantial risk of sexual injury to a step-daughter. The father moved out of the home and agreed to participate in services. An intact family case was opened. The father was allowed to return home after a psychosexual evaluation determined him to be at low risk for offending against the children. Meanwhile, the parents had difficulty controlling the teenager's behavior. In November 2004 the teen required psychiatric hospitalization for out of control behavior and depression. The worker linked the family to community resources for assistance, and the intact family case was closed in January 2005.

Case No. 128	DOB June 2004	DOD April 2005	Natural
Age at death:	4 months		
Substance exposed:	No		
Cause of death:	Sudden Unexpected Death in an Infant with viral pneumonia		
County:	Peoria		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Four-month-old infant, who was sleeping in bed with her parents, was found unresponsive.

Prior History: There was one prior report involving this family. In March 2005 the hotline was contacted with a report of substantial risk of physical injury to the infant by her 28-year-old mother because the mother was arrested for hitting the 29-year-old father over the head with a pot. Investigation revealed that the mother had actually slapped the father in the face and the reporter had misread the mother's writing. The mother had filed for an Order of Protection, which a judge granted, because the father threatened to take the infant away from the mother. The investigation was unfounded. The mother and maternal grandmother reported that such an incident had not occurred previously. The mother's 7 and 10-year-old boys, who were not home at the time of the incident, appeared healthy and well-cared for, and the mother allowed the Order of Protection to lapse.

Case No. 129	DOB June 2003	DOD April 2005	Natural
Age at death:	22 months		
Substance exposed:	No		
Cause of death:	Community-acquired atypical pneumonia		
County:	DuPage		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Records reviewed		

Narrative: Twenty-three-year-old mother and 23-year-old father found their 22-month-old child unresponsive following a nap.

Prior History: The family's first contact with DCFS was in December 2004 when the child's doctor contacted the hotline to report that the child had a fractured clavicle, bruises on his face, and a large bruise in the middle of his back. A report was taken for investigation of bone fractures and cuts, bruises, welts. The investigation was unfounded because the parents' explanation for the injury was consistent with the injury. In January 2005 the child was taken to the hospital with a broken leg, and the father was indicated for bone fractures. An intact family case was opened with a safety plan in place that the aunt and uncle, with whom the family lived, would supervise the father's contact with the child. Homemaker services were put into place, and the intact family worker was monitoring the child in the home and setting up parenting classes and counseling. The mother gave birth to a baby girl two weeks before the boy's death. The intact family case remains open, and the parents are participating in services.

Case No. 130	DOB January 2005	DOD April 2005	Natural
Age at death:	3-1/2 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
County:	Cook		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Records reviewed		

Narrative: Twenty-six-year-old mother laid her 3-1/2-month-old daughter face down for a nap. She checked on her two hours later and found her unresponsive.

Prior History: In June 2004 the hotline received a report of substantial risk of physical injury to the mother's four-month-old son. The mother brought the baby to the hospital alleging that her boyfriend's 13-year-old son punched the infant in the chest. The boy denied hitting the baby, and a thorough medical evaluation of the infant revealed no injuries. The 13-year-old boy lived with his paternal grandmother and had been visiting his father when the incident was alleged to have occurred.

Case No. 131	DOB May 1990	DOD May 2005	Natural
Age at death:	14-1/2		
Substance exposed:	No		
Cause of death:	Bronchial asthma		
County:	Cook		
Reason for review:	Pending DCP investigation at time of child's death		
Action taken:	Records reviewed		

Narrative: Fourteen-and-a-half-year-old child had an asthma attack while at home. His 35-year-old mother and 5-1/2 year-old brother arrived home during the attack and called 911. The child was taken to the hospital where he was pronounced dead. The child, who was obese and smoked cigarettes, had a history of refusing to take his medication. His mother was indicated for death by neglect because the child had no currently filled prescriptions for his asthma medication.

Prior History: The mother had three prior indicated reports for inadequate supervision in June 2001, April 2003 and September 2003. The family had an intact family case open from October 2003 through April 2004. At the time of the child's death there was a pending DCP investigation alleging substantial risk of physical injury to the deceased and his brother by their mother and substantial risk of physical injury to the brother by his father. An anonymous reporter contacted the hotline alleging that the father and teenager regularly hit the 5-1/2 year old. The boy denied being hit by his father, but admitted to being hit by his older brother. The teenager admitted to hitting his brother for discipline, at the request

of his mother. The teenager and mother agreed that the teen would no longer discipline his brother. The investigation was unfounded.

Case No. 132	DOB November 1998	DOD May 2005	Natural
Age at death:	6-1/2 years		
Substance exposed:	No		
Cause of death:	Pneumonia secondary to muscular dystrophy		
County:	Marion (but died in the hospital in St. Louis, MO)		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Full investigation pending		

Narrative: Six-and-a-half-year-old child with muscular dystrophy was brought to the hospital by her 24-year-old mother because she was having problems breathing, stopped talking, and went limp. The child was stabilized and then flown to another hospital for further care. The following day the child was pronounced brain dead and life support was withdrawn.

Prior History: The family has a history with DCFS dating to April 2003 when the mother was indicated for inadequate supervision of the 4-year-old child and her 2-year-old sibling for allowing them to play outside unsupervised. In July 2004 the mother was indicated for medical neglect of the child for failure to follow-through on therapy evaluations and medical appointments for the child. An intact family case was opened. Three subsequent DCP investigations (one for risk of harm and two for cuts, bruises, welts) were unfounded. Following the child's death, the three surviving siblings entered foster care in August 2005 when their mother was indicated for environmental neglect. Another child entered foster care after his substance-exposed birth in October 2005. The OIG is investigating this case for inclusion in a cluster report about services to medically complex children.

Case No. 133	DOB December 1991	DOD May 2005	Natural
Age at death:	13 years		
Substance exposed:	No		
Cause of death:	Carcinoma		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Thirteen-year-old ward, diagnosed 6 months earlier with carcinoma, a form of cancer, died in the foster home in which he had lived since February 2001. A do not resuscitate order was in place, and he had been receiving 24 hour home hospice care.

Prior History: The ward and his 5 siblings entered foster care in 1996 after his 31-year-old father was indicated for sexually molesting his 2 older half-sisters. A sixth sibling, born later in 1996, entered foster care in August 2003 after her mother and grandmother were indicated for substantial risk of sexual abuse for allowing the father to have unsupervised access to her. Neither parent completed services to get the children returned. Three of the children have aged out of the system; one was adopted; and two remain in foster care with goals of substitute care pending court decision on termination of parental rights.

Case No. 134	DOB January 1985	DOD May 2005	Natural
Age at death:	20 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Seizure disorder		

County:	Cook
Reason for review:	Deceased was a ward
Action taken:	Preliminary investigation

Narrative: Foster parent found the 20-year-old ward unresponsive in the morning when she went to wake him. He had had a seizure the night before, but reported feeling okay. The ward had lived in his foster home since July 1997. He was being followed by a neurologist for his seizures and recently had an MRI.

Prior History: The ward and his two younger brothers entered foster care in December 1991 as a result of their mother's neglect because of drug abuse. The brothers were released to their father's custody the following month. The ward, who had a different father, remained in foster care. He had a goal of independence.

Case No. 135	DOB April 2005	DOD May 2005	Natural
Age at death:	5 weeks		
Substance exposed:	Unknown because not tested. Mother has a history of substance abuse		
Cause of death:	Complications due to prematurity		
County:	Cook		
Reason for review:	Open foster care case on a sibling		
Action taken:	Records reviewed		

Narrative: Five-week-old infant and his twin were born extremely premature and were still in the hospital when the infant died from complications of his premature birth. In July 2005 the surviving sibling was discharged from the hospital and placed in a specialized foster home.

Prior History: The family's first contact with DCFS was in October 2004 when the 36-year-old father and 26-year-old mother were indicated for substantial risk of physical injury to their 2-month-old because they were using drugs and had been staying in a drug infested apartment. The family was difficult to locate because they were homeless. While the investigation was pending, in December 2004, a second report was made to the hotline when the infant was found to have a cigarette burn on his forehead. The mother was indicated for burns by neglect; she admitted that she picked up the infant forgetting that she had a lit cigarette in her mouth. The infant entered foster care in January 2005. Until the twins' birth, the mother's whereabouts were unknown and the worker was unable to provide services.

Case No. 136	DOB October 1984	DOD May 2005	Natural
Age at death:	20 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Pneumonia due to sepsis		
County:	Cook		
Reason for review:	Child was a ward		
Action taken:	Preliminary investigation		

Narrative: Twenty-year-old ward died in the hospital after a two-week hospitalization. He suffered from Adult Respiratory Distress Syndrome.

Prior History: The family has a long history with the Department beginning with intact family services from January through May 1989 because of abuse. The mother has a history of substance abuse. The next contact with the family occurred in May 1991 when the 28-year-old mother was indicated for inadequate supervision of her four children, ages 1, 5, 6, and 7. In July 1991 the mother was indicated again for inadequate food and shelter, and her children were placed in foster care. The deceased had multiple group home placements beginning in 1994 coupled with multiple hospitalizations. The

deceased lived in a group home prior to his last hospitalization in May 2005. The mother had two more children who were placed in foster care in 1995. Four of the deceased's siblings have been adopted. One sibling remains in foster care with a goal of adoption.

Case No. 137	DOB May 1987	DOD May 2005	Natural
Age at death:	18 years		
Substance exposed:	No		
Cause of death:	Respiratory failure due to encephalopathy		
County:	Cook		
Reason for review:	Teenager was a ward		
Action taken:	Records reviewed		

Narrative: Eighteen-year-old ward died in the hospital after a three-month hospitalization with numerous occurrences of respiratory, heart, liver and kidney failure. The teen had been in an induced coma to control seizures and optimize body function. He had been admitted to the pediatric intensive care unit for candida sepsis, acute respiratory distress syndrome, and septic shock.

Prior History: The family came to the Department's attention in February 2004 when the hotline was called with an allegation of medical neglect to the then sixteen-year-old teen by his mother who missed appointments for treatment of third degree burns the teen received three weeks earlier. The reporter believed the burns may have been self-inflicted because the teen had attempted suicide the previous fall that left him blind and paralyzed. The mother was indicated for medical neglect. The hotline received a second call two months later after the mother brought the teen to the hospital after he fell down ten stairs. During an exam, the reporter noticed new burns on the teen's legs. The mother explained the teen put his legs next to a hot radiator; however, the pattern of the burns did not fit the explanation. The mother was indicated for burns and protective custody was taken of the teen. The Department was granted custody of the teen, and he was placed at a rehabilitative facility. He later disclosed abuse by his mother and his 19-year-old sibling.

Case No. 138	DOB January 2005	DOD June 2005	Natural
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Microcephalus		
County:	Kendall		
Reason for review:	Child was a ward		
Action taken:	Preliminary Investigation		

Narrative: Five-month-old ward was born with microcephalus and suffered numerous medical problems as a result. He died in his foster home where he was receiving hospice care. His mother, foster mother, and worker were present.

Prior History: The 21-year-old mother had planned to give the child up for adoption upon his birth. With the child's medical problems, however, adoption was not an option. The mother felt she could not care for the baby, and the hotline was called when she would not take him home from the hospital. The mother was indicated for abandonment, and the infant entered foster care in February 2005 upon his release from the hospital. He was placed in a specialized foster home where his mother frequently visited him.

Case No. 139	DOB June 2005	DOD June 2005	Natural
Age at death:	0		

Substance exposed:	Unknown, however, mother tested positive for marijuana
Cause of death:	Prematurity
County:	Champaign
Reason for review:	Open intact family services case and unfounded DCP investigation within one year of child's death
Action taken:	Records reviewed

Narrative: Thirty-nine-year-old mother went to the hospital with high blood pressure. An emergency cesarean section was performed at thirty weeks gestation. The baby lived for only two hours.

Prior History: The family has an extensive history with the Department. Between April 1999 and December 2002 the parents were indicated 3 times for environmental neglect of their 6 children, with two intact family cases being opened. In July 2003 the mother and her 23-year-old boyfriend were indicated for environmental neglect. In April 2004 the mother was indicated for substance misuse after smoking marijuana with her 15-year-old daughter. A third intact family case was opened. The worker assisted the family with housing and clothing and provided referrals for substance abuse counseling. The case was closed in November 2004. In January 2005 an investigation for neglect was unfounded. The family has had no further contact with the Department.

GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

ALLEGATION

A child protection investigator falsified an investigation of possible sexual abuse and failed to interview either the alleged perpetrator or the alleged victim.

INVESTIGATION

The child protection investigator was assigned to the case following a hotline report regarding a 14 year-old girl who alleged she had been sexually abused by her grandfather approximately 8 years earlier. According to the case record, the investigator conducted interviews with the girl, her mother, her brother and the grandfather. The investigator also documented collateral contacts with the grandfather's niece, his friend, and his building manager as well as the police officer assigned to conduct the criminal investigation. After one month, the investigator determined there was insufficient evidence to support the allegation and recommended the case be unfounded. The investigator's supervisor concurred and the case was closed.

In interviews with the OIG, the girl, her mother and the grandfather all denied ever being interviewed by the investigator. The mother stated she and the girl were present at a medical appointment during the time the investigator claimed to have spoken with them. The OIG verified the mother's report. The girl said she had not seen her grandfather in one year, in contrast to the investigator's report that their most recent contact occurred three months earlier. The investigator provided an inaccurate first name for the girl's brother.

The investigator's notes reported the girl's parents, who were divorced, had previously lived with their children in the grandfather's home. The investigator identified family strife related to family issues, particularly the grandfather's decision to allow another son rather than the father to handle his finances, as a destabilizing force. In support of this conclusion, the investigator cited her conversation with the manager of the grandfather's building, claiming he told her he had to intervene on multiple occasions when the family's volatile behavior became disruptive to other tenants. All family members denied the parents and their children had ever lived in the grandfather's home. In addition, the father stated he was an only son and there had been no family conflict over finances. In an interview with the OIG, the manager of the grandfather's building confirmed the family had never lived there and stated the grandfather was an exemplary tenant who had never been the source of any complaints. The manager stated he had encountered the investigator at the building on one occasion and allowed her access in order to knock on the grandfather's door. The manger said he had a brief, vague conversation with the investigator before she left after being unable to meet with the grandfather. In her notes, the investigator recorded an interview with an individual she identified as the building manager, though the name provided does not correspond.

Although the grandfather speaks passable English it is not his first language and the OIG secured the services of a translator in order to conduct an interview regarding a complex, sensitive issue such as child sexual abuse allegations. The manager told the OIG the grandfather asked him for assistance in reading a letter he received from the Department regarding the investigation. There was no record in the case notes the investigator utilized the services of a translator in order to communicate effectively with the grandfather nor did she note any barriers to their verbal interaction.

In her interview with the OIG, the investigator was unable to provide adequate explanations for the multitude of inconsistencies contained in the case file. She offered inaccurate physical descriptions of parties she supposedly interviewed and could not provide information about the homes she claimed to have visited. Event though the mother's home displayed unique characteristics such as brightly colored walls and the

prominent display of a large musical instrument, the investigator gave a highly generic description of the premises. Both the OIG and local police pursuing a criminal investigation of the case were unsuccessful in their attempts to locate either the niece or the friend. In an interview with the OIG, the girl's father denied the family had another relative in the area and stated he had never heard of the friend attributed to the grandfather.

Throughout her interview with the OIG the investigator maintained she had in-person contact with all the individuals she identified. She attributed the numerous errors involving dates, times, names and phone numbers to her practice of entering information into the record long after contacts had occurred. An OIG review of the record found that 60 percent of the investigator's entries were made on the day the case was officially closed. Furthermore, the OIG recognized the case closing date entered in the Statewide Automated Child Welfare Information System (SACWIS) was one month earlier than the actual case closing occurred. With the assistance of a Department computer specialist, the OIG was able to identify the investigator as being responsible for entering the inaccurate closing date.

In an interview with the OIG, the investigator's supervisor stated the workers in her charge were responsible for covering a large geographic area and as such often conducted their duties from remote locations. The supervisor stated she frequently utilized electronic means of communication, email and monitoring entries into SACWIS, in order to conduct supervision. The supervisor acknowledged she was aware the investigator had a history of tardiness regarding the entry of case notes and admitted she had not ensured the investigator completed all tasks she had been instructed to perform.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discharge the investigator and the OIG should pursue revocation of her child welfare license.

This employee has resigned from the Department. The employee relinquished her Child Welfare Employee License.

2. The Department should counsel or discipline the investigator's supervisor for her inadequate supervision of the investigator in this case.

The supervisor was counseled.

3. The Department should formally apologize to the girl and the grandfather for mishandling the investigation into allegations of abuse.

DCP conferred with DCFS Legal Division. As a result, a letter will not be forwarded to the family.

4. The Department should review the allegation in light of law enforcement findings and determine if the investigation should be reopened.

DCP conferred with DCFS Legal Division. As a result, the investigation will not be re-opened.

5. The Department should preserve an electronic copy of the investigation, a printout and any original investigation paperwork to support discharge of the investigator. The substance of the investigation in SACWIS should be purged.

Documents related to the discharge of the investigator were retained and used during the discipline process.

6. Alterations to the 'finding" and "finding date" fields on the Decision tab in SACWIS should be

restricted to supervisors and administrative staff. Case closure requires supervisory approval and investigators should not have access to change these fields at any time during an investigation.

A change was implemented in the SACWIS application at the request of DCP. The final finding date is no longer an editable field, but now system driven and based upon investigation approval by the supervisor or Child Protection Manager.

7. The Department should conduct an administrative and investigative review of the investigator's cases for the time period surrounding this investigation to verify that listed contacts were made. The review should be conducted by Quality Assurance and an experienced child protection supervisor or administrator. Particular attention should be paid to unfounded investigations and investigations where the investigator entered more than 50 percent of her investigative notes in a single day.

Management reviews of investigations meeting the criteria were completed.

GENERAL INVESTIGATION 2

ALLEGATION

A private agency caseworker was the subject of pending felony theft charges for defrauding the state of $330,000.

INVESTIGATION

An OIG review of the caseworker's personnel files and documents obtained from law enforcement found she had an extensive history of deceptive behavior and misrepresentation. The caseworker had been employed by several private agencies, however her applications were inconsistent in the inclusion or omission of previous employers and her criminal history. The applications were directly contradictory in regards to where or when she was employed at a given time during the previous seven years. On her applications the caseworker acknowledged a prior criminal conviction in another state for theft, however she characterized the incident as involving her and the children she was babysitting eating fruit in a grocery store before checking out. The OIG obtained underlying documents related to her arrest and conviction and found she had been charged with felony attempted theft after trying to establish a line of credit at an electronics store in another state under an assumed name.

The caseworker's previous employment at one of the private agencies had been terminated after it was determined she had engaged in fraud. In her position at the agency, the caseworker was responsible for the disbursement of childcare funds to eligible parents. The supervisor described a system that assigned various teams to oversee requests from parents that were divided between two agencies according to the families' geographic location in the county and then grouped together alphabetically by surname. During a routine check, agency staff found the caseworker had approved childcare payments to herself during the hours that she was paid to work at the agency.

The OIG also learned that a forged deed had been submitted to the court during her divorce proceedings that appeared to give the caseworker unfettered sole title to marital property. The judge ruled the deed a forgery and required the caseworker to execute a quit claim deed back to the marital estate. The deed appeared to have been notarized by a notary public who worked at the same private agency as the caseworker. However, notary's name was misspelled on the document and she denied the signature that appeared was hers.

The OIG met with the caseworker, however she was largely uncooperative with investigators, repeatedly citing her poor memory for her inability to answer even basic questions or declining to respond altogether. Department Rule requires employees of private agencies that contract with the Department to comply with OIG investigations. The OIG subsequently filed charges calling for the revocation of the caseworker's child welfare license, which resulted in a full hearing before an administrative law judge. The caseworker continued to assert an inability to recall simple facts, such as her ex-husband's name or the year she graduated from college. The judge found the caseworker was not forthright or credible and recommended the caseworker's license be revoked. The Child Welfare License Board accepted the judge's recommendation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG and the Department should distribute an informational pamphlet alerting Purchase of Service (POS) agencies' personnel departments of safe hiring practices.

The Department and the OIG will jointly issue a pamphlet.

2. The Department must develop a protocol for assisting its own personneloffice as well as those of POS agencies in retrieving underlying criminal documents to assess truthfulness and suitability for child welfare employment.

The Department and the OIG have convened a work group to develop the protocol and address other issues

associated with criminal background checks. The protocol should be completed by June 2006.

3. The Department should develop a tracking mechanism for reviewing multiple Authorizations for Background Checks and alerting private agencies when inconsistent information has been provided.

The BC09 screen has been modified to accommodate additional information about employees/applicants/ licensees who are required to complete a background check. The following Fields were added:
Have you ever been indicated as perpetrator in a child abuse/neglect investigation? Y N
Have you ever been convicted of anything other than a minor traffic violation? Y N

A modification has also been made to allow multiple uses of a single provider number to enable us to run reports.

The Consent to Redisclose form will be revised to include consent to allow DCFS to disclose to appropriate child welfare agencies.

Inconsistent responses on the Background Check Authorization forms will be forwarded to the OIG for investigation.

GENERAL INVESTIGATION 3

ALLEGATION

During a routine review of Economic Interest Statements, the OIG noted that a Department manager had disclosed accepting a gift worth several hundred dollars.

INVESTIGATION

The OIG researched the company that had provided the gift and learned that while it did no business with the State in the name provided in the Economic Interest Statement, it was closely related to a company that did do business with the State. The two businesses were so closely related that they were housed at the same address and had the same phone number. The company that did business with the State had received its first contract with the Department soon after the manager had started working for the Department.

The company's contract provided that it would act as fiscal agent for another entity [the "Provider"] that had a contract to provide services to children. As fiscal agent, the company would approve payments and issue checks on behalf of the Provider. Through interviews, the OIG learned that the fiscal agent company had also made payments directly to the manager, for products allegedly delivered to the Provider. The checks were made to a company with a name similar to a company owned by the Department manager. The OIG learned the checks were deposited into an account over which the Department manager had full control. As a result, the OIG recommended the Department place the employee on administrative leave, pending the completion of the investigation, and referred the matter to both the Executive Inspector General (for investigation and possible referral to the Ethics Board for a violation of the Gift Ban Act) and to federal law enforcement (for criminal investigation of possible misuse of federal funds.)

After the referrals, the OIG completed a follow-up report to the Department that recommended financial controls to ensure better monitoring of public funds in the future.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department must develop a reliable Contract Monitoring process that would provide checks and balances and separation of functions to prevent the abuses identified in this Report. The process must include:

- Quarterly review of expenditures to ensure that expenditures were related to the Contract;
- Quarterly review of services, to ensure that the goods or services were provided;
- Contractual and Rule requirement that any contractual spending for services or items not specifically covered under the Contract must be approved, in writing, by the Contract Division;
- Lapsed funds and deobligation of funds must be approved in writing by the Contract Division.

The Department agreed and is implementing the recommended changes.

2. The Department must develop specific guidelines for disbursement when Fiscal Agents are used. The guidelines must include checks and balances to ensure that Fiscal Agents ascertain that the services or goods for which they issue checks have been provided. The use of Fiscal Agents must also be monitored by the Contracts division to ensure separation of functions. Fiscal Agents must understand that their role is not limited to check-writing and that they maintain fiduciary responsibility for expenditure of public funds.

The Department agreed and is implementing the recommended changes.

3. The Department needs to systematically track public monies spent by contractors through subcontracts. The Department must be able to track who is ultimately responsible for providing

services and who is ultimately receiving DCFS funds, in order to guard against conflicts of interest and double-billing.

The Department agreed and is implementing the recommended changes.

4. The Department must develop a conflict of interest protocol, whereby entities are identified that the Department should not be contracting with, because of conflicts of interest, and the Department must purchase anti-conflict software that would identify Department funds expended on prohibited entities, similar to the practice at law firms.

The Department agreed and is implementing the recommended changes.

GENERAL INVESTIGATION 4

ALLEGATION

The former accountant for a private agency embezzled funds from the agency.

INVESTIGATION

The Acting Chair of the Board for the child welfare agency, shortly after being asked to serve in that capacity, learned that the accountant for the agency was the wife of the Director of the agency. She informed the agency that this was a conflict and the accountant had to be terminated. Shortly thereafter the Acting Chair was made aware that the accountant had transferred agency funds into a personal bank account. The OIG subpoenaed bank records that confirmed the transfer of money from the agency into a personal bank account in the name of the accountant that was opened for the transfer. The child welfare agency receives all of its funding from DCFS. DCFS is no longer placing children with the agency. The case was referred to the State's Attorney's Office.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The acting Board Chair of the Agency should be commended for her immediate recognition and action to resolve a conflict of interest relationship at the agency and for referring the apparent embezzlement to the OIG.

A commendation letter was sent.

2. The Department's Licensing Standards for Child Welfare Agencies (Rule 401) and Child Care Institutions (Rule 404) should be amended to prohibit familial relationship between the Director and Financial Officer/Accountant at the same agency.

Rule 401 First Notices were placed on the Department website for public comments. Rule 404 is complete and was adopted in July, 2005. The policy transmittal will be distributed in January 2006 for implementation.

GENERAL INVESTIGATION 5

ALLEGATION

A Department employee used her position in order to fraudulently secure government funds intended to assist low-income residents residing in a Local Area Network (LAN).

INVESTIGATION

Local Area Networks (LANs) are comprised of private agencies and service providers grouped together in common geographic areas. LANs assist low-income residents by disbursing vital state funds for both traditional and non-traditional services. The Department funds LANs to assist families where children are at risk of removal if needed services are not provided. Local fiscal agents disbursed funds approved by a local Steering Committee. Within the boundaries of the particular LAN, more than 40 percent of children under the age of 5 live below the poverty level.

The OIG received a complaint that alleged that funds in a particular LAN were being diverted for the benefit of the LAN Liaison, a Department employee. Through an analysis of funding records and interviews, the OIG determined that over $10,000 of LAN funds had been deposited in a mortgage account for property owned by a relative of the Department employee. An additional $3,600 had been paid directly to relatives of the employee. The investigation also found that the employee had approved LAN payments totaling over $10,000 to employees of a private agency that is a member of the Steering Committee and to another DCFS employee. Many of the irregularities had been concealed by submitting requests for payments in the name of needy families in the LANs. Several family members interviewed confirmed that they had never received the funds, nor had knowledge that funds had been applied for in their names. The LAN accepted signatures by proxy but both the family members and the LAN Chair stated that they had never given authorization for their names to be signed.

The investigation found that the LAN system was plagued with lack of controls that provided opportunities for corruption. Signatures were not verified; payments were ostensibly made to landlords without verification of rent or relationship; there was no separation of functions to ensure that the needy families received the funds; the system did not provide for verification that the family actually lived in the LAN or needed the services requested. Many of those who received LAN funds did not live in the LAN, some used the address of the private agency at which they were employed to show LAN residence. Moreover, the system permitted funds to be disbursed without LAN approval for "emergency" purposes – this system had so few controls and limits that it was easily exploited.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department employee should be terminated. She has been referred to the State's Attorney's Office for prosecution.

The employee has been terminated and referred for prosecution.

2. The OIG should seek revocation of the Employee's Child Welfare Employee License.

The employee relinquished her Child Welfare Employee License.

3. The other LAN Liaison should be disciplined violating Rule 437, Conflict of Interest, for accepting funds from the LAN.

The employee was disciplined.

4. Portions of this report should be shared with the Board of Directors of the Steering Committee

Agency, several of whose employees accepted or applied for LAN funds. The OIG recommends that the employees be terminated and should pay restitution from their retirement funds.

OIG Response: *The OIG shared portions of the report and met with the Director and the Board, along with a representative of the Executive Inspector General's Office, since the Steering Committee Agency agent is not funded by DCFS.*

5. The DCFS employee and her relatives should pay restitution and legal action should be considered.

The OIG referred the case to the State's Attorney's Office for prosecution.

6. The other fiscal agent for the LAN should be advised to require that requests for domestic violence funding be accompanied by a police report or an order of protection.

A new policy for LANs funds has been developed. Funds will be used for education programs.

7. The Department should issue a letter of gratitude to persons who brought the misuse of funds to light.

The Department issued the letters.

8. To ensure that future disbursement of Flexible Funds is justified, the Department should immediately ensure that all LAN Liaisons, Fiscal Agents and Co-conveners have copies of the Program Plan and the Guideline for Application for Flexible Funds.

Commencing with the FY 06 contract year, copies of the program plan and flexible funds guidelines are sent to the LAN Liaisons, fiscal agents and co-conveners.

9. Immediate interim measures should be instituted and the Program Plan for all LANs must be amended to reflect the following checks and balances:

- **The Program Plan must specify that all disbursements must be approved at LAN meetings;**
- **The fiscal agents for all LAN must be required to ensure that all Requests are supported by LAN minutes of approval (if an emergency exists, the Fiscal Agent must ensure that the LAN approves the disbursement at the next meeting.)**
- **All emergency request approvals outside of a LAN meeting must be documented;**
- **The LAN must designate a person to contact the parent to ensure receipt of funds and the person designated must not be the facilitator;**
- **If any signature appears to have been signed by proxy, the Fiscal Agent must contact the signor and verify that the signature was authorized;**
- **The facilitator cannot sign the approval;**
- **The Fiscal Agent must maintain a current list of all employees of LAN agencies to ensure that checks are not issued to LAN employees;**
- **Any requests for rent payments or security deposits should be accompanied by a lease or a notarized statement from the landlord.**

The Department agrees. The contract and program plan for LANS flex funds have been revised for 06 in the following ways:

- A standard program plan will be used for all Flex Funds contracts.
- Addendum #2 to the contract requires that the wrap-around plan be approved at a LAN meeting and that such approval be recorded in the meeting minutes.

- Addendum #2 further requires that all requests for emergency funds be documented.
- Addendum #2 requires that the fiscal agent to contact the signor and verify authorization of any signatures obtained by proxy.
- Addendum #2 states that the facilitator cannot sign the approval.
- Addendum #2 provides that the fiscal agent must certify that an employee of a LAN/private agency is not reimbursed for the provision of any services that are already provided and funded by the agency of employment.
- Furthermore, any employee of a LAN/private agency must sign on the designated section of the wrap plan certifying that they will not submit billing for flex funding for any services funded/provided by their employee.
- Flex funds are to be used to assure that children and youth are not truant, suspended or expelled from school.
- Flex funds will not be used for rent payments or security deposits.

The Department is currently working on development of an audit plan and on identifying staff who could perform the audits. A planning meeting is scheduled for December 2005. Target completion date for plan is March 2006.

OIG Note: The OIG reiterates that proxy signatures and receipt of funds must also be verified.

GENERAL INVESTIGATION 6

ALLEGATION

During an OIG investigation into a DCFS employee's misappropriation of Department funds through a Local Area Network [LAN], the OIG learned that the employee was also submitting questionable requests for payment to another fiscal agent, authorized to disperse payments through the LAN.

INVESTIGATION

The OIG found similar patterns of falsification by the employee and lack of financial controls by the LAN Board and the fiscal agent. As in the OIG investigation of disbursement of funds by the other fiscal agent, the OIG found that the employee had caused the LAN to issue payments into a relative's mortgage account. In addition, and also consistent with the prior LAN investigation, the OIG found that significant amounts of LAN funds ended up benefiting employees of one of the private agencies that ran the LAN. The investigation also found that funds alleged to be for the benefit of families were funneled through a third party, without any documentation showing that the families ever received the funds.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG reiterates the need for a statewide audit of all of the LANs funding operations and to establish strict accountability procedures, if funding is to continue. Procedures should require the authorization of several persons for the release of funds and issuance of checks.

The Department agrees. The contract and program plan for LANS flex funds have been revised for FY 2006 in the following ways:

- A standard program plan will be used for all Flex Funds contracts.
- Addendum #2 to the contract requires that the wrap-around plan be approved at a LAN meeting and that such approval be recorded in the meeting minutes.
- Addendum #2 further requires that all requests for emergency funds be documented.
- Addendum #2 requires that the fiscal agent to contact the signor and verify authorization of any signatures obtained by proxy.
- Addendum #2 states that the facilitator cannot sign the approval.
- Addendum #2 provides that the fiscal agent must certify that an employee of a LAN/private agency is not reimbursed for the provision of any services that are already provided and funded by the agency of employment.
- Furthermore, any employee of a LAN/private agency must sign on the designated section of the wrap plan certifying that they will not submit billing for flex funding for any services funded/provided by their employee.
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The Department is currently working on development of an audit plan and on identifying staff who could perform the audits. A planning meeting is scheduled for December 2005. Target completion date for plan is March 2006.

OIG Note: The OIG reiterates that proxy signatures and receipt of funds must also be verified.

GENERAL INVESTIGATION 7

ALLEGATION

The Department allowed a six year-old boy to reside in a home for nine months with a convicted sex offender with a history of abuse against juveniles. The Department also had knowledge that a second man, who was an indicated sexual perpetrator, also had access to the household.

INVESTIGATION

Law enforcement first became aware of the situation after receiving multiple reports of a juvenile living in a home with a registered sex offender. A local deputy sheriff visited the home and confirmed the presence of a man who had previously been sentenced to 15 years in prison for Aggravated Criminal Sexual Assault against a 10 year-old girl. The man had initially been charged with several counts for engaging in sexual, ritualistic behavior with numerous prepubescent girls in the area which included dressing in white robes and standing amongst circles of candles. The man served half of his sentence before being released. A hotline call was made and a child protection investigation was opened.

Since the hotline received the report over a weekend, an on-call worker was assigned to conduct the mandatory home visit within 24 hours. The on-call worker went to the home and found the man, the six year-old boy, the boy's two aunts, a second man who identified himself as the roommate of the boy's mother and a female visitor. The first man confirmed his status as a registered sex offender with the worker and discussed some of the circumstances of the case, conducting the conversation while the man was wearing boxer shorts. During the conversation the worker noticed that the man's genitals were exposed and eventually requested that he cover himself. The worker observed that the aunts both had speech impediments and demonstrated developmental delays. The aunts explained to the worker that one of them had previously been married to the man and he was now engaged to the other. They stated their younger sister, the boy's mother, had left him with the adults in the household because she was unemployed and homeless. One of the aunts stated one of her children had been removed from her custody by the Department and she did not want the same thing to happen to the boy. The mother's roommate told the worker he had once been arrested for suspicion of sexual abuse against his then-ten year-old sister and that criminal charges had been dropped although he had been indicated by the Department.

Despite the presence in the home of two individuals with indicated reports for sexual abuse against children, the on-call worker determined the boy would be safe in the home and formulated a safety plan. The plan made the aunts responsible for ensuring the boy's safety plan even though they demonstrated difficulty articulating their comprehension of its requirements and had each expressed their belief neither man presented a risk to the boy. The plan prohibited either of the two men from being alone with the boy and stipulated they must be fully clothed whenever he was present. The on-call worker spoke only briefly with the boy, who slept through most of the visit. The worker discussed the plan with her acting supervisor who granted her approval. The case was then re-assigned to a child protection investigator for further examination. On the next business day, the assigned investigator went to the home and found the first man and the aunts who told her the boy's mother had taken him and left, along with her roommate. They stated they had no knowledge of her whereabouts or how to contact her.

The investigator obtained a possible address for the mother in another town and a second child protection investigator from that area was designated to conduct a parallel investigation. The parallel investigator was informed of the histories of both men regarding sexual perpetration against minors and was instructed to locate the mother and son and arrange for the boy to participate in an interview with the Children's Advocacy Center (CAC). The parallel investigator went to the address provided, along with a police officer and an intern from the office, and found the mother's roommate home alone with the boy. The roommate stated he was watching the boy for a few days while the mother was out of town and that he had no way to reach her.

All of the parties returned to the parallel investigator's field office and waited while she conferred with the acting supervisor. The acting supervisor told the parallel investigator to postpone the boy's interview since the mother was not available. The second investigator then asked the roommate if he felt it was safe for the boy to remain in his care. The roommate assured her it was and the two were allowed to return home. In an interview with the OIG, the second investigator stated that prior to going to the home she had not reviewed information contained in the Statewide Automated Child Welfare Information System (SACWIS) that showed the safety plan's restriction against the roommate being alone with the boy. SACWIS also provided information regarding the indicated findings against the first man for torture and sexual molestation, however the entry could not be found in connection with his name, only through a search of the case number. The second investigator had been aware, however, of the roommate's past sexual abuse of his sister. When the second investigator returned to the home one week later she found the house was vacant and a 'for sale' sign had been placed in the yard. The second investigator was unable to make any further contact with the mother, her roommate or the boy.

Ten weeks later, the first child protection investigator found the boy living in the home that was the subject of the initial hotline report along with the first man and the two aunts. The following day the investigator met with the acting supervisor and decided to indicate the report against the boy's mother and the two men for Substantial Risk of Sexual Injury. The case record shows the investigator and the supervisor determined the mother had placed her son at risk by placing her son in frequent contact with two indicated sexual perpetrators. The decision was reached even though Department personnel had repeatedly allowed the boy to remain in the care of these individuals and no involved child welfare professional had made any successful contact with the mother. The report was indicated against the mother and the two men and the case was referred for intact family services. In separate interviews with the OIG, both the first child protection investigator and the acting supervisor expressed their belief it was unlikely the State's Attorney's Office would have moved to take protective custody of the boy even if the Department had initiated the process since he had never made an outcry alleging abuse.

An intact family services caseworker began working with the family, including the mother who had returned to the primary home. The intact worker pre-arranged all of her visits to ensure the mother would be present, relinquishing her ability to arrive unannounced and possibly observe typical conditions in the home. The intact worker's case notes showed she spoke with the boy on each visit to the home and that she had to reprimand the first man for being inappropriately dressed when child welfare workers were in the home. Five months after services were initiated, the hotline received a report of physical abuse by the aunts against the boy. The boy denied being abused, however four days later law enforcement contacted the Department regarding complaints they had received involving lack of supervision. The boy was visited at school by a worker and told her his aunts frequently left him home alone with the first man who gave him baths. The boy was subsequently taken into protective custody by law enforcement officials. After being removed from the home, the boy told child welfare professionals that the first man, who claimed he was god, and his aunts would dress in white robes and stand inside circles lit with candles. The Department assumed guardianship of the boy and he was placed in a traditional foster home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue disciplinary action against the acting supervisor for failing to take protective custody of the boy following the allegation of risk of sexual abuse - sex offender has access.

The case manager was disciplined.

2. The Department should pursue disciplinary action against the second child protection investigator for failing to read the case information contained in SACWIS when assigned the parallel investigation.

The investigator was disciplined.

3. The on-call worker should be counseled for failing to properly apply rules and procedures in assessing the risk to the boy and for developing an inadequate safety plan.

The investigator was disciplined.

4. The first child protection investigator should be counseled for failing to properly apply rules and procedures in assessing the risk to the boy.

The investigator was disciplined.

5. The intact family services worker should be counseled on the inability to effectively monitor the safety plan for the boy by conducting only announced home visits.

The worker is making announced and unannounced home visits.

6. SACWIS should be corrected so that the first man's indicated finding for the sexual molestation of children can be retrieved through a name search. Currently, the indicated finding can only be retrieved with the SCR number.

The man had been indicated in 1989 for torture and sexual molestation. In 1989, the law permitted for a shorter time period for retention of indicated findings. Therefore, the Department could not correct the record.

GENERAL INVESTIGATION 8

ALLEGATION

A mother testified during a child protection hearing that the private agency caseworker who had previously managed the family's case could be the father of her youngest son.

INVESTIGATION

At the time the caseworker was initially assigned to the family case, the mother's five children were in placement after having been taken into protective custody by the Department. The mother was a diagnosed schizophrenic and presented other mental health issues that contributed to her inability to provide adequate care for her children. In an interview with the OIG, the mother stated it was during the 15-month period the caseworker was directly responsible for handling the family's case that they began an intimate relationship, which then continued for several years after his professional responsibilities to the family ended. The mother's parental rights were ultimately terminated and all five of her children were adopted. The mother stated that even after her relationship with the caseworker ended, he would periodically arrive at her home and continued to do so at the time this investigation took place.

In light of the mother's testimony during the child protection hearing the caseworker was subpoenaed to appear in court. In his testimony, the caseworker acknowledged having a physical relationship with the mother and provided a timeframe for the relationship that coincided with the period when he managed the family's case. A DNA test ordered by the court found the caseworker was not the boy's father. In his interview with the OIG, the caseworker contradicted his testimony in court, stating his relationship with the mother did not begin until two years after he managed her case.

Five years earlier, the OIG had investigated the same caseworker regarding his romantic involvement with another client. The client, a mother of four children in Department custody, was developmentally delayed and demonstrated cognitive limitations that adversely affected her ability to care for her children. During the earlier investigation, the caseworker had admitted engaging in a sexual relationship with the client while managing the family case. The caseworker had been assigned both women's cases on the same day. The OIG had recommended the caseworker be discharged, however he resigned his position prior to the matter being resolved. The caseworker had since been hired by another private agency.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be discharged from the private agency where he is currently employed as he should not be working in child welfare.

Employee was discharged effective July 21, 2005.

OIG Response: The OIG has initiated proceedings to revoke the caseworker's license.

2. The OIG should share the prior report on the caseworker as well as the present report with the private agency.

The OIG shared the reports with the private agency.

GENERAL INVESTIGATION 9

ALLEGATION

The OIG was alerted by federal investigators that a child welfare employee with critical responsibility for children was accessing a significant volume of child pornography from his home.

INVESTIGATION

The OIG was contacted by agents of the Federal Bureau of Investigations (FBI) regarding an ongoing investigation concerning the employee. During a consensual search of the employee's home, the agents discovered a compact disc containing a video of child pornography involving a pre-pubescent child. While the agents were present in the home the employee acknowledged to them he had a "problem" related to such material and expressed an intention to seek professional help. The FBI's initial search of the employee's computer found a record of a significant number of erased images designated with a tag of "Lolita," many of which had titles suggesting violence against children. The FBI agents informed OIG investigators that such tags are used by file sharing services to facilitate retrieval of desired documents. The "Lolita" tag is commonly used to designate files containing child pornography.

The OIG recommended the employee be placed on administrative leave pending the completion of the OIG investigation. The OIG was informed the employee had taken medical leave and did not return to work until 10 days after the recommendation was made. The employee was placed on administrative leave upon his return.

Two days before the employee returned from medical leave he was arrested for breaking into the apartment of a female neighbor. Police responding to a report of breaking glass encountered the employee in an apartment building hallway with a bloody sweater wrapped around his hand. Officers reported the employee admitted forcibly entering the apartment and offered numerous explanations for his actions they characterized as "increasingly bizarre." Police interviewed the resident of the apartment who stated she was acquainted with the employee as a neighbor, but she had recently been staying with her sister in response to his "bizarre and aggressive" behavior. Officers then placed the Department employee under arrest, at which time he became belligerent, referred to himself as the "demon of death," and alternately claimed he planned to assassinate the President of the United States and that he had shot the President. The employee was charged with Residential Burglary and Resisting/Obstructing a Police Officer.

A further analysis of the employee's computer completed by the FBI was provided to the OIG. The analysis found evidence of hundreds of computer files with graphic and explicit names suggesting child pornography and sexual violence against children. A record of additional files of similar nature was found in another directory separate from the employee's hard drive.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department employee should be discharged for off-duty conduct that makes him unfit for child welfare practice and brings disrepute to the Department.**

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

GENERAL INVESTIGATION 10

ALLEGATION

A foster mother pressured a 14 year-old girl in her care to have an abortion after the girl became pregnant by the foster mother's 22 year-old son.

INVESTIGATION

The girl entered foster care following a two-month period when her biological mother refused to allow her into the family home. After a brief stay in a temporary arrangement the girl was placed in the home of the foster mother, who also lived with her 22 year-old son.

Six months after the girl was placed in the home, the hotline received a call alleging the girl was two months pregnant and that the foster mother's son was the father. The caller further stated the two had been sexually involved since shortly after the girl moved into the home and the foster mother had been aware of the relationship. The caller also contacted the girl's caseworker who went to the home and spoke with her. The girl confirmed she was pregnant but refused to state definitively whether the foster mother's son was the father. The caseworker filed an Unusual Incident Report (UIR) and both the Department and local law enforcement initiated investigations.

At the outset of the investigations, the girl denied the foster mother's son was responsible for her pregnancy during separate interviews with a child protection investigator and a police detective. Four days after the interviews were conducted, the foster mother transported the girl to a medical clinic where her pregnancy was terminated. The Department was unaware the pregnancy had been terminated until the stepfather called a second child protection investigator one month later. That same day, the second investigator went to the foster home and met with the girl. The girl stated the foster mother's son had indeed been the father and that the foster mother was aware of his paternity and had taken her for the abortion. According to the girl, the foster mother said her son could be imprisoned and she would lose her foster home license if the girl told anyone how she had become pregnant. The girl also said she continued to engage in a sexual relationship with the son and would not make any statements to police that might implicate him. The second investigator relayed the information to the caseworker who had the girl removed from the home that day.

The second investigator interviewed the foster mother who admitted taking the girl to the clinic but denied knowledge of the father's identity. The foster mother stated that during a conversation regarding the situation the caseworker told her she should take the girl to the clinic and allow her to make her own decision. The investigator then spoke to the caseworker who denied encouraging the foster mother to take the girl to the clinic but acknowledged telling her the decision whether to terminate the pregnancy rested with the girl. Ultimately a decision was reached by the investigator and approved by her supervisor to indicate the foster mother for Substantial Risk of Physical Injury based on their determination the foster mother had illegally consented to the girl's abortion and usurped the Department's role as guardian for the minor. In fact, Department Rules and Procedures state pregnant minors do not have to obtain the consent of a parent or guardian for medical treatment, a policy in accordance with Illinois state law. In response to the child protection investigation the foster mother surrendered her foster home license and did not appeal the indicated finding against her. Police were unable to pursue criminal charges due to insufficient evidence and the girl's refusal to cooperate.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should ensure that the respective divisions of Child Protection and Licensing be trained on Illinois law and Department Rules governing a pregnant minor's right to consent to medical procedures without the need to obtain consent or permission from the Department's Guardianship Administrator.

Training materials were updated and the trainings were conducted.

2. The Department should ensure that, once the Teen Parenting Service Network (TPSN) is notified by UIR of a pregnant or parenting ward who is 14 years of age or younger, it must arrange for Title X counseling of that ward within 48 hours.

OIG NOTE: *Subsequent to the investigation, the OIG learned that although the UIR appeared to have been sent to the TPSN, it was never received.*

Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available.

3. This report should be shared with the Juvenile Court.

Information contained in the report has been shared with Juvenile Court.

4. The girl should be referred to the local Children's Advocacy Center's counseling program to address possible issues of sexual abuse.

The ward was referred to an agency for sexual abuse counseling. The waiting list was 2-3 months, therefore she was referred to another agency. The ward has not been participating in the counseling. She was also referred to a third agency for a family assessment regarding the incest, but she failed to participate.

GENERAL INVESTIGATION 11

ALLEGATION

A private agency supervisor left a four year-old boy in the care of his grandmother despite the woman's bizarre behavior and disclosure that she began drinking alcohol at 5:00 a.m. that day.

INVESTIGATION

The family's involvement with the Department was initiated after a caller to the hotline reported that the boy's mother and maternal grandmother, who shared the same home, were alcoholics who fought violently with each other when they were intoxicated. The report also stated the boy complained to neighbors of being hungry and thirsty, had open sores on his legs and had not received his immunizations. A subsequent investigation conducted by the Division of Child Protection (DCP) resulted in an indicated finding against the mother for Medical Neglect. The family's case was referred to a private agency and an intact family caseworker was assigned to provide services. After 10 months, the caseworker left her position and her supervisor assumed responsibility for monitoring the case.

One month after the supervisor began working directly with the family she arrived at the home for an unannounced visit at 11:00 a.m. The grandmother was initially reluctant to allow the supervisor into the home, explaining that it was, "not a good time." The grandmother then began to cry and told the supervisor that her boyfriend had been missing for three days and she believed her neighbors were involved in his disappearance. She also suggested the same neighbors were somehow responsible for the mother's incarceration a week earlier following a traffic accident. When questioned by the supervisor, the grandmother acknowledged she had been drinking beer at 5:00 that morning but stated, "I am allowed to have fun," and said she had ceased drinking at 6:00 a.m. The supervisor then observed a scratch on the boy's shoulder and inquired how the injury occurred. After the boy stated his grandmother had pushed him, the grandmother yelled at the boy, "Go ahead and tell her I beat you. I don't feed you and you were raped. They will put me in jail like your momma. You want me to go to jail." The grandmother went on to tell the supervisor that three months earlier the boy had reported being sexually abused by the brother of his mother's boyfriend. In her case notes, the supervisor recorded her belief the boy had a desire to relate information to her but was discouraged from doing so by the grandmother's overbearing, intimidating behavior towards him. Despite the grandmother's admitted drinking and erratic behavior, the boy's visible injury and the revelation of a previously unreported allegation of sexual abuse, the supervisor determined the boy was not at immediate risk of harm and left the home after arranging for another visit the following week. The supervisor contacted the hotline upon her return to the field office but left the boy in the grandmother's care.

The family had a history of non-compliance with required services throughout their involvement with intact family services. In addition, a safety plan developed by the caseworker prior to the supervisor's direct involvement with the family prohibited the boy from being left alone with the grandmother because of her alcohol and mental health issues. Despite the existence of the safety plan, the supervisor had allowed the boy to remain with the grandmother as his primary caregiver following his mother's incarceration and had offered to assist the grandmother in obtaining guardianship.

Later the same day, a police officer and a Department child protection investigator arrived at the family home in response to the hotline call. The officer noted in the police report the grandmother was disoriented and unable to provide direct responses to questions. Numerous knives were found throughout the home under beds and in jacket pockets as well as in locations identified by the officer as being, "easily accessible to the [boy]." Present in the home were two maternal great uncles who, according to the officer, were clearly under the influence of alcohol and the grandmother's boyfriend she had earlier reported as missing. Police removed the boy from the home and, after the Department was granted custody, he was placed with his maternal aunt. The grandmother was indicated for Inadequate Supervision and Cuts, Welts and Bruises. The Department was unable to collect sufficient credible evidence to substantiate the allegation of sexual abuse.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency should discipline the supervisor in accordance with their personnel policies and procedure. The supervisor failed to take immediate action to ensure the child's safety when presented with a risk of imminent harm to the child. Contrary to a safety plan prohibiting the child from being left alone with his grandmother, the supervisor initiated assistance to the child's grandmother to obtain custody of her grandson.

The Department agrees.

OIG Response: The OIG shared the report with the private agency. The Inspector General met with the agency executive staff and a member of the Board of Directors to discuss the findings and recommendations made in the report. The supervisor was disciplined.

GENERAL INVESTIGATION 12

ALLEGATION

The adoptive mother of two sisters, ages 14 and 16, abandoned the girls but continued to receive subsidy payments. The adoptive mother had been approved to care for the girls by a private agency despite her extensive criminal history.

INVESTIGATION

The sisters' involvement with the Department began while the girls were infants after allegations of neglect were made against their mother. Two years later, when the girls were ages two and four, they were permanently removed from their mother's custody. Over the ensuing nine years, the sisters moved through eleven foster homes before being placed with their paternal aunt. The aunt expressed a desire to adopt the girls and the caseworker for the private agency handling the sisters' case reported that the rest of their family supported the plan.

In anticipation of the adoption, the caseworker conducted a criminal background check on the aunt. The check found the aunt had 11 previous arrests on charges including theft, prostitution, criminal damage to property and trespass to residence. The aunt had twice been convicted of theft and, in the second case, had violated her probation and was sentenced to 80 days in jail. The aunt's most recent arrest had occurred only six months prior to the girls being placed in her home when, during a dispute with a neighbor, she was alleged to have unleashed her dog and instructed the animal to attack the neighbor's 10 year-old daughter. The neighbor intervened and sustained a bite to the foot which prompted police to file a charge of battery against the aunt.

The OIG found the caseworker had neither examined the dog attack incident or obtained police reports or any other underlying documentation regarding the aunt's numerous previous arrests and convictions. The pre-adoptive investigative report completed by the caseworker includes her account of a discussion of the criminal background check with the aunt. The aunt told the caseworker her history of arrests was the result of her short temper as well as her previous lifestyle and the individuals she associated with during that period of time. The aunt stated she had altered her life and was committed to settling down. The case file also included a hand written statement by the aunt regarding her second theft conviction in which she wrote she had taken money from the register during her shift working at a gas station in a misguided attempt to exact retribution for her employer's persistent sexual harassment. The police report related to the arrest, reviewed by the OIG, presented a different set of facts. The gas station owner stated the aunt, who was unknown to him, arrived at the station and asked the owner for $100 on behalf of one of his employees whose baby was ill. Two days later when the employee returned to work, she informed the owner she did not know the aunt and had not asked her to request money. Later that day the aunt entered the gas station and the owner called the police.

In an interview with the OIG, the caseworker stated she had never received training regarding pre-adoptive investigations and had used an earlier report composed by the agency for another case as a guide. The caseworker said she was unfamiliar with how to obtain underlying documents from law enforcement and had only been instructed to evaluate criminal history based on how much time had elapsed since incidents occurred and whether children were involved. The caseworker stated she believed the aunt would be an appropriate caretaker because she appeared invested in the sisters and the girls wanted her to adopt them. The caseworker stated that when the girls had previously run away from other placements they were often found at the aunt's home.

While the adoption was pending, the aunt and her 14 year-old son were arrested and charged with domestic battery against the older sister, who was 15 at the time. The girl reported to police that during a family argument the aunt placed a gun against her head and hit her on the legs with a hammer. The girl's then 13 year-old sister corroborated the account. While a child protection investigation into the incident was unfounded, the aunt ultimately pled guilty to the charge of domestic battery and was placed on conditional

discharge for one year. In reviewing the case record, the OIG found no indication the assigned child protection investigator obtained the police report or shared the full details of the incident with the caseworker. In her interview, the caseworker stated she was unaware of a gun being involved in the incident and only recalled receiving notification that the case would be unfounded just prior to finalization of the adoption. In a separate interview, the Department's Adoption Coordinator told the OIG that the Department routinely relies on the involved adoption worker's recommendations and self-reports to evaluate criminal history. Generally the Department does not procure and review arrest reports.

One month after the adoption was finalized the aunt was evicted from her home, at which time she disappeared and abandoned the 14 and 16 year-old sisters. The girls stayed with various friends and relatives before an older cousin allowed them to move into her home. The aunt repeatedly returned to her former home to pick up the adoption subsidy checks mailed to the address by the Department. The Department finally became aware of the situation after the 14 year-old sister, who had concealed her pregnancy, delivered a baby into a toilet at her high school and disposed of the body in a trash receptacle.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department must implement procedures for accessing underlying arrest reports to comply with Administrative Procedure 6. The Department should utilize the Law Enforcement Liaison in the Office of the Director when implementing these procedures.

The LEADS protocol committee is currently meeting to revise AP#6 and incorporate all outstanding practice-related OIG recommendations. Members of this workgroup have also been meeting with the OIG on this issue as it relates to accessing underlying arrest reports. The workgroup anticipates completion by the end of the first quarter of 2006.

GENERAL INVESTIGATION 13

ALLEGATION

The Department usurped the rights of the parents of a medically complex five year-old girl and denied them from visiting her while she was hospitalized without cause.

INVESTIGATION

Due to complications of her birth, the girl had extraordinary medical issues that required full time care and assistance in every facet of life. Her parents, who had three other children, two boys, ages six and nine and an eleven year-old girl, had been the subject of four previous child protection investigations which had all been unfounded. The fifth report involving the family was related to the five year-old girl's care. It was alleged the parents were failing to follow doctor's orders, had neglected to properly maintain essential medical equipment and allowed her hygiene to deteriorate to the point the girl showed signs of infection. The call was accepted and a child protection investigator was assigned to the case. The investigator had performed one of the earlier unfounded investigations of the family and was familiar with ongoing disagreements between the parents and some health care providers over what constituted appropriate care.

The investigator's first activity on the case was to meet with her supervisor. The supervisor instructed the investigator that if the allegations of the report were confirmed the girl should be taken into protective custody. Five hours after being assigned the case, the investigator took the girl into custody with the assistance of law enforcement and medical personnel without having spoken to the reporter, a violation of Department Rule. Prior to taking the girl into custody the investigator conducted four telephone interviews. Two were with home health care nurses who had recently discontinued their involvement with the family. The nurses made statements that supported and added upon the initial allegation, one of them going so far as to claim the girl's lack of proper hygiene had resulted in her becoming infested with insects. The was no information provided in the case notes to substantiate who witnessed these incidents, when they occurred or whether they had been documented by the in-home nursing staff.

The investigator's other two contacts were with the coordinator of a state program for medically fragile and technology dependant children and the girl's primary physician. The coordinator stated the parents provided their daughter with proper care and that while their decision not to comply with certain medical recommendations created conflict with some of the nurses, the alternatives they employed achieved acceptable standards of care. As an example the coordinator offered that the girl struggled to maintain an adequate body temperature and heating pads had been recommended. However, after the girl suffered burns when the pads were utilized, the parents sought other means to keep her warm, such as modifying the heating system in her room. The investigator did not address specific orders for medical treatment with girl's physician but rather presented him with a hypothetical question as to what outcome might result if orders were not followed. In response, the physician supposed such a scenario might result in the girl's death. The investigator did not request a copy of the orders for treatment from the physician or obtain records from the coordinator related the specialized program. Contained in the program record was a letter from the physician, dated just prior to the hotline call, which offered a favorable view of the care provided by the parents. The physician was not asked about the specific allegations made in the report until after the report was indicated against the parents. At that time he expressed his view the nurses' concerns were minor and stated his belief the parents did not abuse or neglect the girl.

After completing these contacts the investigator met again with her supervisor who advised her to take the girl into custody and have her transported to a hospital for observation. In an interview with the OIG, the supervisor stated she believed the girl was in imminent danger because the previous unfounded reports demonstrated a risk of harm and since the nurses were no longer present in the home, the threat posed to the girl by the parents was unmitigated. The girl was the only one of the parent's four children placed at risk

because of her medical condition. While the investigator was at the home, in the process of taking custody, she did not interview the parents. In her notes the investigator recorded her observations of the girl and the home that directly contradicted the conditions alleged in the report.

The hospital the investigator and her supervisor arranged to accept the girl following her removal was not equipped to treat the girl's medical needs and, in fact, did not have a pediatric unit. Furthermore, the father rode in the ambulance from the home to the hospital to assist with her care at the request of the paramedics because they were not qualified to handle the extent of her condition. In her interview, the supervisor stated all children taken into custody in the area are required to be taken to that hospital for an initial screening. The supervisor was unaware of the hospitals limitations until she was apprised by the OIG during her interview. Upon the girl's admission to the hospital, the supervisor signed consents for medical treatment, however the girl was not in the guardianship of the Department and the right to make decisions regarding the girl's medical care legally remained with the parents. The following day the girl was transferred to another hospital, however the father's request to accompany the girl in the ambulance was denied by the investigator. The investigator also contacted the staff social worker at the receiving hospital and instructed her the parents were not to be permitted to visit the girl.

On the evening of her admission to the second hospital the girl suffered second and third degree burns after hospital staff placed heated bags on her body, actions referred to by the treating doctor as "drastic measures," in order to raise her body temperature which had plummeted, causing her heart rate to fall. After four days at the second hospital the girl was returned to the custody of her parents and taken home. The investigator continued her work on the case by consulting with a Department nurse. The Department nurse reviewed the case file and recommended to the investigator she obtain both the physician's notes as well as any documentation from the in-home nurses regarding their concerns. She also encouraged the investigator to secure more detailed descriptions of the physical injuries the girl allegedly suffered as a result of neglect. The investigator did not pursue any of the Department nurses recommendations. With the approval of her supervisor, the investigator indicated the report against the parents for Medical Neglect.

The parents appealed the indicated finding and an administrative hearing was held. Presented at the hearing was a letter of support for the parents written by the girl's primary physician. After considering evidence and testimony, the Administrative Law Judge concluded the indicated finding was unsubstantiated and the report should be unfounded. One week later, the Department's division of quality assurance reviewed the investigation and noted the investigator's good work on a complicated case.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Due to the increased complexity of technology-dependent children, the Department's protocol for investigations of medically complex cases must include a standard of investigation that addresses:

A. Situations where the reporter of the hotline call is a home health professional working in the family's home. Because multiple parties are involved in the child's care in the home and in an effort to minimize bias possibly rooted in relationship conflict, the child protection staff should be expected to get an independent medical evaluation to help determine abuse or neglect. The independent medical assessment should take into account the comparative risks and benefits of home care and out-of-home care for each child under the circumstances of each case.

B. Child protection staff investigating families involving children with a Home Waiver should make it standard practice to (1) identify the family's UIC Division of Specialized Care for Children (DSCC) Care Coordinator as a primary source of historical and current information regarding the child, family, the child's care, the home environment, the parents' relationship with health care professionals,

and (2) request the DSCC Guidelines to understand the parent-service provider relationship, including role boundaries and parental rights.

This report should be shared with the DCP Administrator who is the Chair of the work group that is developing a protocol for investigations involving medically complex children.

The Medically Complex Protocol is in its final review with workgroup members. It is expected the protocol will be distributed to staff within the first quarter of 2006.

2. The Department's draft definition of "medically complex" or "medically fragile" children should be consistently applied in rule, procedures and policy, and in all documents that refer to medically complex children.

See Response to Recommendation 1, above.

3. The Department should amend Procedure 300.80 Taking Children in Protective Custody to include a section on Medically Complex Children detailing:

- Procedures to enable workers to arrange for transport of medically complex children to the most appropriate HealthWorks facilities that can accommodate technology-dependent children and are equipped to handle the child's needs during the initial health screening and admission, unless it is a medical emergency situation. Children with a severe disability or medical condition are referred to a specialist for evaluation and treatment.

- Children ages 30 days old to 18, with history of severe medical conditions have special arrangements made to prepare for taking protective custody. The child protection investigator should involve a Department registered nurse to assist with planning and preparation to take protective custody, including but not limited to, securing the child's care plan to follow the child, transportation arrangements, hospital admission, and placement issues.

- Primary care providers must be interviewed when considering protective custody, and the interviews should be specific to reported allegations. If possible, child protection workers should ask the primary care physician for a home visit or assessment of the circumstances.

- When a Department nurse recommends review of medical information or identifies sources to interview, the recommendations must be followed prior to concluding an investigation.

See Response to Recommendation 1, above.

4. The draft Policy Guide 2005: Referrals to Department Regional Nurses should be revised to: require that Department nurses be immediately consulted in investigations of medically complex children; require an immediate response to referrals for investigations of medically complex children, instead of the current five-day referral response time; require that medical records be retrieved in an expedited manner.

DSI-Health Services Staff have participating in meeting of the medically complex protocol committee. This committee is chaired by DCP. Several meetings were held throughout the summer and early fall. A final draft has been circulated to committee members for their review and comment.

5. The Department should conduct an independent review of the Quality Assurance's review of this

investigation. This report should be shared with Quality Assurance.

After diligent review and investigation, the Department was unable to confirm that a Quality Assurance review was conducted in this case; the worker ID presented on the form was invalid. The Department agrees to develop a training for Quality Assurance staff, using a redacted copy of the report as a teaching tool.

6. The Department should discipline the child protection supervisor for signing consent for emergency medical treatment for a non-ward without seeking parental consent; directing protective custody be taken without evidence of the presence of imminent danger to the child; not making reasonable efforts to prevent removal of a medically fragile child from her home and; not ensuring adequate care after taking protective custody.

The supervisor was disciplined.

7. The Department should discipline the child protection investigator for denying the parents the right to visit their child without cause while she was in the hospital. In addition, the investigator should be counseled about the flawed investigation. The discipline and counseling should be convened by management.

The investigator was counseled and disciplined.

8. The hospital where the girl was first transported after being taken into Department custody should not be used for initial health screenings or comprehensive health evaluations of medically complex or technology-dependent children. The Department should review all HealthWorks medical providers statewide to determine which ones are equipped to handle these special children and ensure that child protection staff utilizes HealthWorks providers accordingly.

The Medically Complex Protocol will provide that prior to sending a medically complex child to a medical provider, the Department will contact the provider to ensure that the provider has the capability to care for the child.

GENERAL INVESTIGATION 14

ALLEGATION

A private agency failed to adequately address the risks posed to a newborn girl, the third substance-exposed infant delivered by her mother. The baby tested positive for HIV soon after birth but did not begin receiving treatment until six months later.

INVESTIGATION

The mother had an extensive history of substance abuse and her three older children, two of whom tested positive for drugs at birth, had been removed from her custody and placed with their maternal grandmother. Upon delivery of her fourth child, who was born three weeks premature weighing less than four pounds, hospital staff contacted the hotline to report the infant's substance-exposed status. During the ensuing child protection investigation, hospital staff related the mother's admission she had used cocaine, heroin and methadone the day before the baby girl was born. The infant presented symptoms of withdrawal as well as periods of labored breathing. The baby was taken into custody by the Department and placed in the care of her maternal uncle and his wife who were living in the maternal grandmother's home. The baby was vulnerable to numerous risk factors as a result of her respiratory issues, the presence of drugs in her system and her premature birth to a mother with well documented drug issues and two older children born substance exposed. Nonetheless, in accordance with Department policy the case was assigned to a private agency based on their position as next in line on a rotating list of agencies available to accept cases.

Despite the baby's fragile condition, her aunt and uncle did not bring her to either a follow-up appointment at the hospital or the rescheduled visit. The infant received no routine medical care while in the relative placement. When after four months it was determined the family's living situation was untenable because of overcrowding in the home and a lack of heat or hot water, the baby was removed and placed with a couple in a traditional foster home. Two months after the baby was placed, the foster parents were informed her mother was positive for the HIV virus. The fact the infant was the mother's third child born substance-exposed had prompted the hospital to test the baby for HIV, but the lab results were never shared because the relatives failed to bring the infant in for a follow-up appointment. The infant has since begun receiving anti-viral medications and is responding well to treatment. Her case has been transferred to a specialized foster care program administered by another private agency.

The private agency caseworker assigned to the family demonstrated a substandard level of effort in providing services to the infant throughout his involvement in the case. After a Department nurse alerted the private agency to the conditions in the aunt and uncle's home and expressed concern the baby's breathing was constricted by the blankets she was bundled in, the caseworker visited the home. The aunt told the caseworker the family would reside with another relative who lived nearby before leaving to travel out of state the following day. The caseworker did not obtain any information regarding the relative. Furthermore, at a court hearing on the case two days later, he did not advise the court the baby had been taken out of state. At the time the baby was placed with the traditional foster parents the caseworker was aware there was no crib in the home. The caseworker did not assist the couple to secure one but promised they would receive a voucher for its acquisition. The foster parents bought two cribs, first used, then new, as well as a car seat but were never reimbursed by the agency despite submitting receipts.

An OIG review of the case record found the caseworker chronically neglected to document important contacts with medical personnel, child welfare workers or the family. In an interview with the OIG, the caseworker admitted falsifying time sheets, billing the agency for hours he spent working at another job. Prior to being hired by the private agency, the caseworker had received a positive reference from his former supervisor at another agency where he had an extensive history of warnings and reprimands addressing many identical shortcomings in his work.

In a separate interview with the OIG, the caseworker's current supervisor acknowledged a lack of oversight at the private agency she attributed to widespread problems related to issues of finances and employee retention. In an interview with the OIG, the foster parents expressed their frustrations regarding their dealings with the caseworker as well as other agency staff monitoring the case of another child placed in their home. The foster parents requested that their other foster child's case also be transferred to the private agency now monitoring the baby's services**.** Although the agency's organizational deficiencies were documented by the Department's Agency Performance Team (APT) liaison, no efforts were initiated to ensure the systemic issues plaguing the agency were addressed. In an interview with the OIG, the APT liaison stated that his duties were limited to monitoring and did not include ensuring that problems identified in APT record reviews were addressed.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Third or above substance-exposed infants requiring substitute care cannot be assigned to private agencies through the regular case assignment rotation system. These children require the services of private agencies that have the capability and expertise to provide necessary critical services. Families with second or above substance-exposed infants that are referred for intact families services should be referred for specialized intact family services such as the Intact Family Recovery program.

As a component of the Department's Program Improvement Plan, Policy Guide 99.13 was evaluated by Quality Assurance. Quality Assurance met with the Program Improvement Plan sub-committee to discuss results of their review and the steps to follow. The charge of the sub-committee is to make recommendations based upon the review that insure the best possible provision of service to this client population and compliance with the policy.

Procedures 302-Appendix O (Intact Family Services) was distributed. These procedures address differential services based upon family circumstances (e.g. substance misuse as an underlying condition.)

The Case Assignment Unit shall notify the receiving agency that the particular case is a substance exposed child/children case. The agency then will accept or deny the case. If they accept the case, they are responsible for providing necessary and appropriate services, including specialized services, if needed.

Case reviews are conducted by DCFS every six months to ensure children are receiving appropriate care. A monitoring system is being developed that should address how each case is monitored by the private sector.

OIG Response: The OIG disagrees. A system that depends on the agency's decline is not sufficient. The Department retains the fiduciary responsibility to ensure that only agencies that have the capabilities to service families are assigned.

2. The Department's AIDS Project should establish a tracking system that includes monthly identification of second and above substance-exposed infants with consultations to the foster care or intact providers to assure competent services and necessary testing. For intact families, parental consent should be sought for any necessary medical tests or procedures along with consent for results to be shared with the Department. Refusal of consent should prompt review for court screening for an order of protection or temporary custody.

Health Services staff is now receiving a weekly report of identified SEI cases and conducting follow-up to ensure that these infants are screened for HIV and referred for appropriate services (system is for wards only.)

3. The Department's consent form for release of information of a child's medical records should

specify HIV test results for all substance exposed infants and children.

Written procedures still need to be developed for distribution to HealthWorks Lead Agencies. Target completion date: February 2006. Re: Procedures for intact families - Policy Transmittal 2005.09 was issued October 20, 2005. It is Procedures 302, Section 302.388, Intact Family Services. Requirements related to consents for/handling of HIV information is addressed in Sections e)2) and i)1.

OIG Response: While the Procedures identify the need for specific consent for HIV information, they do not educate workers that with Substance Exposed Infants, it is good casework practice to include a specific request for any HIV related information.

4. The private agency should discipline the case manager in accordance with the agency's personnel policies and procedures.

The employee was placed on probation and receives weekly supervision to monitor compliance with probationary terms.

5. The private agency's Board of Directors should analyze and develop corrective actions to address the agency's staff turnover rate and deficiencies in its supervisory and timekeeping systems.

The private agency's Board Chairman, Executive Director and the majority of the Board Members met with the Deputy Director and the issues raised in this recommendation were discussed. The agency is under a corrective action plan to address those concerns as well as many other critical concerns.

Agency Response: The agency reviewed the turnover rates for the past three years and found that the turnover percentage has dropped from 52% to 38%. The agency considers this rate as consistent with industry standards.

6. The Department should develop procedures for APT monitoring of agencies and APT monitors should be trained to competently carry out monitoring responsibilities. Procedures should provide guidelines for, but not be limited to, substantive reviews of children's case records, verification of agency compliance, reviews of foster parent license files when necessary, development of corrective action plans, and formal exchange of information with other monitoring units of the Department's Purchase Of Service Monitoring Division (Agency and Institution Licensing, Office of Field Audits, Contract Compliance Unit) to achieve an integrated assessment of a private agency for appropriate action.

The Department has standard operating Procedures for APT monitoring of agencies, and training is extend to APT staff on new initiatives, and on a necessary basis. A monitoring guide is drafted for Cook POS monitoring and is awaiting review and approval of the Deputy Director. Anticipated date of publication: 1-31-06. The monitoring guide for downstate is still in the draft form. Anticipated release date: 6-30-06. Competent reviews of foster home files are to be done by licensed and certified licensing staff. It is done by A&I licensing staff. Monthly Associate Deputy directors meeting is primarily meant for information sharing, and developing intra unit action plans.

OIG Response: The OIG reviewed the draft APT Monitoring Guide; it is a compilation of forms and does not, as yet, include any substantive procedures or guidelines for monitoring private agencies. The OIG will work with the Department in further developing the guide.

7. A redacted copy of this report should also be shared with the agency where the caseworker was

previously employed for discussion with the agency's Board on ethical duties of agencies providing candid employee references.

OIG Response: The OIG shared the report with the private agency and the President of the Board of Directors of the agency.

8. The baby's foster parents' license should immediately be transferred to the private agency responsible for monitoring the baby's case. Case management responsibility for the couple's other foster child should also be transferred to the agency.

Both child cases and the licensing files have been sent to another agency.

GENERAL INVESTIGATION 15

ALLEGATION

A Department caseworker providing services to the mother of five young children, four of whom were wards of the Department, failed to note the mother's increasing non-compliance with substance abuse treatment and signs of relapse.

INVESTIGATION

The family became involved with the Department one year earlier after the mother delivered her fifth child. Tests conducted on the newborn girl returned positive for cocaine and cannabanoids, prompting hospital staff to contact the hotline. The assigned child protection investigator interviewed the mother who acknowledged using those substances during her pregnancy. The investigation was indicated against the mother for Substance Abuse by Neglect and the family was referred to intact family services.

The mother's intact family services caseworker had been in her position for only two months at the time she was given the case and her previous experience consisted of a nine-month internship with the Department. The mother had a long history of substance abuse which began during her teenage years. The caseworker developed a service plan that required the mother to complete a drug assessment, participate in substance abuse counseling and comply with random drug screenings. The caseworker contacted the mother's physician but did not divulge that her involvement was related to the mother's delivery of a substance-exposed infant. The physician had been prescribing the mother significant amounts of potentially addictive painkillers.

For the first nine months the family case was open, the mother was compliant with services. After that time, however, local police contacted the caseworker and informed her the mother had filed charges against a friend. The mother alleged the friend had been fraudulently filling the mother's prescriptions while the friend contended she had been assisting the mother by picking up her prescriptions while keeping a few pills from each bottle for herself. The friend also stated the mother made frequent trips to hospital emergency rooms throughout the surrounding area, complaining of recurrent pain from a previous surgery in order to obtain prescriptions for painkillers. The following day the friend contacted the caseworker directly and told her the mother used urine obtained from another source in order to successfully pass her drug tests and bragged about her ability to circumvent the system. After attempting unsuccessfully to meet with the mother later the same day, the caseworker went to the family home a week later to discuss the situation with the mother. The mother stated she had obtained the painkillers legitimately and that they were necessary to ease her persistent pain related to a medical procedure she had undergone three months earlier. The caseworker requested documentation of the prescriptions and asked the mother to complete a drug screen by that evening. The caseworker also contacted the drug screening facility and requested that all of the mother's future drug tests be monitored. However, she did not share the information obtained from the police or the friend with the mother's drug abuse counselor. The supervisor did not instruct the caseworker to verify the prescription or her treatment program.

The mother's first monitored drug test returned a positive result for valium. In her interview with the OIG, the caseworker stated she did not consider the positive result to be a failure because valium was one of the drugs the mother was prescribed by her doctor. The caseworker stated she had been told by the mother's physician she was prescribed valium but the mother never complied with her request to provide documentation. The mother failed to appear for each subsequent drug test over the following three months although she was required to do so as part of her service plan.

After the first failed drug screen, the caseworker provided a letter to the attorney representing the mother in a case involving the father of one of her children's attempt to obtain custody of his son. In the letter, the

caseworker wrote the mother had been cooperating with all requirements of her service plan and had no positive drug tests since her involvement with intact family services began. In reality, the mother had provided two positive samples and failed to appear for another test. In her interview, the caseworker told the OIG the elements of the mother's case were nearly identical to those of another family in the same town who were also receiving services. The caseworker hypothesized that in her haste to arrive at court on time she transposed the facts of the two cases but acknowledged she should not have written the letter as it could have been used as evidence in the hearing. Although the father demonstrated a willingness to care for his son and had previously been deemed a suitable parent by the court, the OIG found no indication the Department identified him as a potential caretaker for the mother's only child who had not been adjudicated a ward of the state.

An OIG review of the mother's public aid records found that during a 13-month period while she was receiving services from the Department, she obtained 73 prescriptions for various painkillers from 21 different doctors. The mother's ability to manipulate the system was aided by a lack of coordination and communication between involved service providers. The caseworker relied on the mother's self-reports but obtained scant documentation and neglected to check the veracity of her statements. The mother's primary physician provided requested information but was never informed of the mother's substance abuse problems. There was no contact between the agency conducting the drug testing and the mother's substance abuse counselor. As such, the counselor's only understanding of the mother's progress was based on her presentation during sessions. The disconnect between medical and social work professionals allowed the mother to continue her substance abuse unabated and placed her children at unnecessary risk.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The mother should be referred to the Illinois Department of Public Aid Recipient Restriction Prescription Program to ensure she is not abusing prescription painkillers.

The Department agrees.

2. All information relevant to the mother's substance abuse treatment should be shared with her substance abuse counselor, including a complete and timely record of her drug screens and prescriptions. The caseworker and supervisor must ensure that the mother renews all consents necessary.

The Department agrees and the supervisor will ensure that all necessary consents are renewed.

3. The attached report should be shared with the court prior to the hearing of the parents' custody case.

The court case is closed.

4. The Department's legal division should monitor the custody case. In the event that it becomes necessary to remove the boy from his mother's custody, the father should first be considered as a potential guardian before granting guardianship to the Department. The Department's legal division should assist in responding to the State's Attorney's petition for guardianship.

The father was awarded custody of the minor on 01/19/05.

5. Future management of this case should reflect the basic tenets of the Intact Family Recovery Project, which include:
- Immediate and increased communication and collaboration between child welfare and substance

abuse treatment workers
- Comprehensive services offered to the entire family
- Intensive home visits by both child welfare and substance abuse providers
- Cross training in both disciplines
- Extended case management (18 to 24 months) in recognition of the difficult process of addressing drug dependency.

The Department agrees.

6. The caseworker should be disciplined for failing to provide full information about the mother's service compliance to the mother's attorney with the knowledge that this information would likely be relied upon by the court.

The worker was disciplined.

7. The caseworker and her supervisor should be counseled concerning this case and the necessity of working collaboratively with service providers, sharing full information and corroborating all critical self-report information. This report should be used in the counseling session regarding how to access information concerning possible abuse of prescription drugs by substance abusing parents.

The caseworker and the supervisor were counseled.

8. The OIG renews its previous recommendations that the Department must recognize that specialized knowledge is required to work with drug abusing parents and must implement training and programs to enable coordinated and collaborative drug abuse interventions.

The work group to revise the substance affected family policy has been meeting and revised procedures have been submitted to OCFP. The revised procedures address previous recommendations from the OIG and the case review completed by Quality Assurance. The work group will continue meeting to develop the training plan for DCFS and POS staff. The revised procedures are scheduled to be disseminated by OCFP by February 06 and the training developed and begun by June 06.

OIG Response: The revised procedures do not address limiting assignment to agencies that have the requisite knowledge of substance abuse issues. The Department and the OIG will continue discussion regarding this issue.

GENERAL INVESTIGATION 16

ALLEGATION

Two caseworkers for a 17 year-old female ward withheld critical information regarding the girl's mother from the court, placing six younger children in the mother's care at risk.

INVESTIGATION

The girl's family had an extensive history of involvement with the Department that included 18 abuse and neglect investigations, 5 of which were indicated, over the course of more than a decade. The OIG's review of the case record found that while no tangible evidence existed to support claims of intentional deception on the part of the two caseworkers, their poor understanding of Department Procedure combined with a consistently low level of communication between child welfare professionals involved with the family and substandard record-keeping prevented the optimal delivery of intended services.

The eighteenth child protection investigation concerning the family was related to an allegation against the mother that she had repeatedly failed to adequately manage the girl's epilepsy, specifically, maintaining compliance with the girl's medication schedule to manage her frequent seizures. The girl also had developmental delays and exhibited advanced sexual behavior. The girl was taken into protective custody by the Department although her five younger siblings as well as her own three year-old daughter remained at home in the mother's care. Despite the high volume of previous abuse and neglect investigations involving the family and the fact that they had been receiving intact services from the Department for five years, the caseworker completed two social histories of the family that contained no details regarding the incidents that precipitated the inquires or the disposition of the investigations. In an interview with the OIG, the first caseworker exhibited a remarkable ignorance of Department Procedure as it pertains to the system for designating, recording and reporting child abuse and neglect investigations. The first caseworker stated he was unaware that any of the prior abuse and neglect reports against the family had been indicated because he erroneously believed a determination affirming a report would have resulted in the removal of the children from the home and precluded the family from engaging in intact services. Since the younger children remained in the home and the family was involved in an intact service case, he assumed none of the prior reports had been indicated.

An OIG review of the case file found the first caseworker was unaware the mother had experienced the accidental death of a two year-old daughter seven years earlier, even though a family therapist's notes about the mother's response to the incident were contained in the case record. Although documents produced by the Statewide Automated Child Welfare Information System (SACWIS), which would have clearly delineated the family's history of indicated reports, were not required to be included in the case file provided to the caseworker when the girl was taken into protective custody, data from the Child and Youth Centered Information System (CYCIS) should have been utilized to ensure a clear picture of the family's previous involvement with the Department was developed. Even after becoming aware of prior indicated reports, including an incident in which the girl was burned when her mother held her hand over an open flame as punishment, the first caseworker did not reevaluate the potential risks to the children who remained in the home. The girl had given birth to a daughter when she was only 13 years old and although an adult male who resided in the family home admitted engaging in sexual relations with the girl, DNA testing showed he was not the father of her child. Issues related to the girl's sexual victimization and ongoing sexualized behavior were not addressed and no effort was made to engage her in counseling. Furthermore, the caseworker failed to assess new information, such as reports from the younger children's school that when they attended they were often disheveled or from the girl's foster parents who noted a dramatic improvement in her health and performance after being placed in their home, as it related to the mother's suitability as a caretaker.

Neither of the involved caseworkers referred the family to any local social services agencies familiar with the

treatment of epilepsy. Targeted service is necessary to effectively manage disease, particularly in cases such as this where the girl's mother had repeatedly demonstrated an unwillingness or inability to provide the girl with prescribed medications to control her serious seizure disorder. In addition, the caseworkers did not make an effort to engage the family, who did not speak English as a first language, in bilingual or cultural-specific counseling related to the girl's medical issues. The mother's refusal to allow personnel at the girl's school to administer medication, based on an ongoing contentious relationship with staff, was never rectified and served to place the girl at additional risk. Referrals were made for assistance from the Department's Nursing Division, however the requests elicited no response. Although the girl has experienced great advancements medically and educationally since being placed in the foster home, the long-term requirements related to her medical condition, behavioral issues and developmental delays could place a financial strain on the foster parents now administering her care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The first caseworker should be required to receive training on the numbering and sequences system for allegations when there are multiple hotline reports on a family.

The training was provided.

2. Department management should review and assure that the first caseworker understands Department Procedure 300 and closely monitor the caseworker's work products for thoroughness and accuracy.

The Procedures have been reviewed with the worker and the worker is being closely monitored.

3. The first caseworker should meet with a representative of the Attorney General's Disabilities Information Division to develop his knowledge about resources for Hispanic developmentally delayed and epileptic clients.

The Attorney General's Office provided the worker with information about agencies that provide services for children with disabilities, specifically seizure disorder youth.

4. The SACWIS screen of prior indicated reports and the packet used for screening with the State's Attorney's Office should be included in the Division of Child Protection's hand-off packet to the follow-up worker at the temporary custody hearing.

A memorandum was distributed to all management staff requiring investigative staff to include a copy of the complete screening packet in the case hand-off documents for intact and placement cases. Juvenile Court screening documents include a copy of prior involvement.

5. The SACWIS screen of prior indicated reports should be part of the hand-off packet for indicated cases.

A memorandum was distributed to all management staff requiring investigative staff to include a copy of the complete screening packet in the case hand-off documents for intact and placement cases. Juvenile Court screening documents include a copy of prior involvement.

6. A representative from the OIG and the Department's Liaison to the County Medical Examiner's Office should attend Division of Child Protection supervisors' and managers' meetings to discuss and assist them in developing a rapid retrieval system for information on a child's death. A representative from the Children's Advocacy Center should discuss the specialized counseling referral process for

young girls at risk of sexual exploitation.

The Department agrees. The presentations were made.

7. A redacted copy of this case should be used for case discussion in the implementation of the Referral to Nurses Policy Guide.

The Department does not believe including a redacted copy in any implementation activities for the nurse referral policy guide would be appropriate. The draft nurse referral policy guide will be revised to include aspects of this case where it would improve the policy, e.g. referencing nurses' use of the internet to identify additional resources that may be helpful for a particular child's situation. When the Nurse Referral Policy Guide is finalized, Division of Service Intervention staff will work closely with the Division of Child Protection, Field Operations, Monitoring/Quality Assurance and Clinical Practice and Professional Development in implementing the guide. The OIG identified information from the case to be included in the guide.

8. The Department should review the foster payment rate of the girl's foster parents to assure they are receiving payments equitable for the care they are providing this medically complex, developmentally disabled young adult.

A Child And Youth Investment Team (CAYIT) review was conducted and recommended that the girl be placed in a group home setting that meets her medical and psychological needs.

GENERAL INVESTIGATION 17

ALLEGATION

A private agency caseworker and a Department attorney withheld critical information from the court in a family case.

INVESTIGATION

The family had an extensive history of involvement with the Department. The mother was the subject of her first hotline call alleging neglect of her five month-old son when she was just 13 years-old. The baby's grandmother had been investigated by the Department three years earlier for possible abuse of the mother and her older brother. Both children were taken into Department custody at that time, however the mother was returned to the grandmother while her brother remained in foster care until the age of 21. The grandmother admitted an addiction to heroin and cocaine. In later years, the mother told therapists that while growing up in the grandmother's home she was the victim of frequent physical and sexual abuse by family members and others, beginning at the age of five. The mother believed her former stepfather might have been responsible for the two children she had given birth to before she turned 15. By the age of 20, the mother had been the subject of five indicated reports for abuse and neglect of her three children. Her two oldest sons had been adopted after her parental rights were terminated and the third was removed from her custody after she was arrested for assaulting him, a charge on which she was later convicted. The boy was placed in a foster home and the family's case was assigned to a private agency for services.

The myriad presenting issues and complexity of the family's case necessitated extensive involvement from numerous child welfare workers, mental health professionals and medical personnel. In order to manage the network of individuals and organizations, the Department's legal division referred the case to the Department's HELP Unit to serve as a neutral, stabilizing influence. A family court decision to change the boy's goal to return home after he was removed from an unsuitable foster placement had polarized those involved in the case, with private agency staff and representatives of the Department's legal division supporting the mother's reunification with her son while the boy's Guardian ad Litem (GAL) and the Assistant State's Attorney opposed his return to her custody. Several of the professionals involved made statements to the OIG describing escalating tensions between the two sides as the case progressed, creating a distrustful, combative atmosphere.

While the family case continued, the mother, who had given birth to two more children who remained in her care, informed private staff she was pregnant. She also notified staff the grandmother had moved into her home to assist with the care of the children during her pregnancy. The family's assigned private agency caseworker conducted a background check on the grandmother and noted several arrests on charges related to a drug lifestyle, none of which had occurred during the previous four years.

Regularly scheduled meetings were convened by the HELP Unit to discuss the case and all parties were invited to attend. The meetings were attended by representatives of all involved entities, with the exception of the Assistant State's Attorney and the GAL. The mother and grandmother also attended the meetings but were excluded from some discussions that took place. At the next meeting that followed the grandmother's move into the home, it was determined both she and the mother's boyfriend should submit to random drug testing. The caseworker completed a Child Endangerment Risk Assessment Protocol (CERAP) that noted the presence of risk factors related to the mother and grandmother's histories of child abuse and neglect as well as the mother's present compliance with services and appropriate care of her children.

One month after the CERAP was completed, a urinalysis test of the grandmother returned a "presumptive positive" result for cocaine metabolites. A HELP Unit staffing was convened five days later. The grandmother insisted she had not relapsed and believed the numerous medications she was prescribed were

responsible for her failure of the test. In an interview with the OIG, a Department attorney stated those present at the meeting feared news of the grandmother's positive drug test, which they perceived as being unconfirmed at that point, would harden the stance of the Assistant State's Attorney and the GAL against the mother. The Department attorney said she "suggested" to private agency staff that they confirm the test result prior to notifying the court.

A consensus was reached among those in attendance that the private agency would obtain confirmation of the positive result before any information regarding the test was shared with the court. It was also resolved that a safety plan would be developed prohibiting the grandmother from any unsupervised contact with the children. Although the safety plan was verbalized to the mother and grandmother, who were waiting outside the meeting room, it was never put into writing. Several of the involved professionals expressed their beliefs to the OIG that some other member of the group had taken responsibility for documenting the plan. A HELP Unit clinician placed on the team to assist in making such decisions arrived late to the meeting and was not present for the discussion related to the grandmother's failed test. The clinician had also not read the case file and was unfamiliar with the family's history of substance abuse and Department involvement.

By the time of a court hearing one month later regarding the mother's requests for unsupervised visits with her son who remained in Department custody, private agency staff had been unsuccessful in their attempts to communicate with either the laboratory that conducted the drug tests or outside agents as to whether the grandmother's medications could have caused her positive result. Although records from the lab obtained by the OIG showed confirmation of the presence of cocaine in the grandmother's system had been mailed to the private agency two weeks prior to the hearing, agency staff stated they did not receive the documentation. In court, the Department attorney spoke at length in response to concerns voiced by the Assistant State's Attorney and the GAL about the grandmother's fitness to supervise the mother's visits with her son. At no time did the attorney disclose to the court the fact the grandmother had failed a drug test. In response to a direct question from the bench asking if the grandmother had ever been assessed, the first attorney responded by stating the grandmother had not undergone, "anything like a mental health assessment." In her interview with the OIG, the attorney denied attempting to intentionally mislead the court, explaining the grandmother's positive drug test result was not on her mind at the time. The attorney stated she was aware she had erred in withholding the information from the court and resolved she would not repeat the mistake in the future.

As the mother's pregnancy progressed she experienced complications that required periodic hospitalization, leaving the children primarily in the grandmother's care for extended periods. One month after the hearing, while the mother was residing in the home, the grandmother stole the mother's bank card and car, disappearing for a week. Upon her return, the grandmother told the family she had been ill and would soon be undergoing a surgical procedure. As the date the grandmother stated her surgery would take place drew near, she eventually admitted she had fabricated the story. The private agency and the mother developed a plan calling for the grandmother to vacate the home soon afterwards. Almost three months after the grandmother's positive drug test, the Assistant State's Attorney and the GAL became aware of the result after the family's private agency caseworker was instructed by the HELP Unit to share the information. At a court hearing on the case two days later, the caseworker testified she had not previously divulged the grandmother's positive test result on the advice of the Department attorney. At the conclusion of the hearing, the judge ordered the private agency to be removed from the case.

The disruption in service proved to be traumatic for the family as the mother experienced a recurrence of her diagnosed post-traumatic stress disorder and ceased visitation with her son. Staff from the private agency that assumed responsibility for the case has reported the boy continues to progress in therapy but continually questions the discontinuation of contact with his mother.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's clinical division and the HELP Unit should develop a HELP Unit Face Sheet that includes present and historical information about the Department case involved in the staffings. The Face Sheet should include information about current and previous Department involvement; household compositions, alternative caregivers, paramours and criminal backgrounds; issues involving current or previous substance abuse, domestic violence, physical and mental health; school attendance and educational issues; any other concerns that directly impact the safety and well-being of the involved children.

The Help Unit Face Sheet was developed and approved for use effective September 2005. Policy Guide 99.11, The DCFS Help Unit - Cook County Juvenile Court is being revised and will be issued along with the Face Sheet, CFS 399-2. Target date is January 2006.

OIG Response: The OIG reviewed the face sheet and the new policy guide. The OIG notes that the face sheet and policy guide should also require inquiry into who is supervising the children when the parent or other caretaker is unavailable and that background checks need to be completed on those persons as well.

2. The HELP Unit should discontinue the practice of accepting oral safety plans and should require that all safety plans be documented and shared with all relevant parties.

The HELP Unit Face Sheet requires the worker to attach all past and current Safety Plans; Court Orders regarding visitation; and most current Service Plan. All staff will receive Policy Guide 99.11 and CFS 399 - 2. This will notify all supervisors/workers of the revisions and guide staff to provide all necessary documentation prior to the Help Unit staffing.

3. A transcript of the court hearing in which the first Department attorney addressed the court but did not disclose the grandmother's positive drug test result should be shared with management and used to counsel the first attorney on her failure to fully disclose information to the court; her "suggestion" that private agency staff withhold the information about the grandmother's positive urinalysis; her apparent active avoidance of the judge's question about an assessment of the grandmother during the hearing and; her failure disclose information about the verbalized safety plan during the hearing.

The employee resigned from the Department.

4. Child welfare staff should contact the Department's division of service intervention when they have substance related questions. The Department should send out a policy transmittal notifying child welfare staff of the specialist and how he/she can be contacted. Additionally, the transmittal should clarify that only two percent of presumptive positive results returned by the lab that conducted the grandmother's drug test are found to be incorrect upon confirmation.

The Division of Service Intervention will post a D-Net announcement that details contact information that workers can use for assistance and consultation on cases with substance abuse involvement. The announcement will include the updated DASA provider directory. Information will also be included on procedures for obtaining and confirming toxicology testing results from DCFS contracted sites.

5. A copy of this report should be shared with the Presiding Judge of the Child Protection Division.

The OIG shared the report with the Judge.

6. A redacted version of this report should be used as a learning tool.

The redacted report was used for Grand Rounds in all Department regions.

GENERAL INVESTIGATION 18

ALLEGATION

The father of an eight month-old boy complained the Department failed to return his son to his custody after the State's Attorney's Office decided not to screen the family's case into court.

INVESTIGATION

The family came to the attention of the Department after police responded to a report the then seven month-old infant had been left unattended in a locked car. Officers arrived on the scene and encountered the baby's mother and father who stated they had only left him in the vehicle briefly while they patronized a store. Witnesses' disputed the parents' claim and a responding officer noted he observed sweat on the infant when he first approached the car. The parents were arrested and charged with child endangerment. A pursuant child protection investigation determined the parents' had acted negligently and they were both indicated for risk of harm.

One month later the parents were again the subjects of an investigation after paramedics were called to a gas station to treat the father, who had passed out after injecting heroin in the bathroom. The mother had left the premises following a fight with the father, leaving their eight month-old son in his care. Prior to entering the bathroom the father had placed the infant on the floor outside the door. After the father was revived he fled the scene in an attempt to evade police, leaving his son behind. The father was apprehended and charged with possession of a controlled substance and endangering the life of a child. The infant was transported to a hospital for examination before being placed in the home of family friends. A safety plan was developed requiring a neighbor of the parents to move into the family home and serve as an additional caretaker. The parents were not to be alone with the baby outside of the neighbor's presence. One week after the plan was implemented, child welfare workers went to the family home for a scheduled visit but could not gain entry. Police were called to perform a well baby check and found the parents home alone with their son. Officers removed the baby from the parents and he was placed in the protective custody of the Department.

The parents had been the focus of criminal domestic violence investigations in the past and both the mother and father had histories of substance abuse. The Department received information the father was a heroin user while the mother's preferred drug was methamphetamine. The parents were not in treatment for their addictions and, while they were reported to be adequate caregivers on their own, they were susceptible to pressure from their friends and could not be trusted to abstain. A woman who had previously served as a foster parent to both parents volunteered to have the infant placed with her, however the parents were unwilling to agree to the baby remaining in the home beyond the hours the mother was at work. The assigned child protection investigator determined the parents posed too great a risk to the infant to initiate intact family services and attempted to screen the case into court through the State's Attorney's Office.

Despite the parents' history of domestic violence and substance abuse, two incidents within one month that resulted in criminal child endangerment charges and their disregard of the safety plan, the Assistant State's Attorney who met with the child protection investigator denied the request to screen the case into court. According to the investigator's case notes, the Assistant State's Attorney stated, "violating a safety plan and the father being 'high' are not enough reasons to take the case before the judge." The Assistant State's Attorney instructed the investigator to develop a new safety plan and gave her a list of actions to perform before again attempting to screen the case. Later the same day, the investigator met with the parents who refused to agree to the terms of the new safety plan. The investigator contacted her supervisor who in turn spoke with the Department's Legal Division. Following consultation between the Legal Division and the State's Attorney's Office a decision was reached to screen the case into court.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES	**1. The OIG should meet with the State's Attorney to discuss the problems encountered in attempting to screen this case.** The Department agrees.

GENERAL INVESTIGATION 19

ALLEGATION

A private agency caseworker failed to refer the 72 year-old foster parent of a 4 year-old girl for a permanency evaluation despite requests from the girl's Guardian ad Litem (GAL) to do so.

INVESTIGATION

The girl had been taken into custody shortly after her birth and was placed in the home of the foster mother at the age of one month. The girl's biological parents visited her in the home and participated with services, however after one year their involvement with the child ceased. At that time, the girl's caseworker proposed to the foster mother that she pursue adoption. The foster mother agreed and after the mother and father's parental rights were terminated, the girl's goal was changed to adoption by the foster mother. An OIG review of the case record found no indication either the caseworker or his supervisor considered the long-term viability of the girl's potential adoption by the foster mother in light of her advancing age and documented health issues related to diabetes, hypertension and restricted mobility. In addition, the caseworker accepted the foster mother's identification of her niece as a back-up caregiver for the girl in the event the foster mother was unable to care for her, however he did not meet with the niece or assess her willingness to accept responsibility for a young child if necessary.

As the case progressed towards adoption, the recognized back-up care provider changed several times as the foster mother identified various relatives to serve in that role. The foster mother also admitted to the caseworker she was not following her physician's instructions regarding her medicine regimen and expressed doubts about her ability to proceed with the adoption. The caseworker also learned the foster mother had experienced what he characterized as a "diabetic episode" which resulted in a fall in her home. Despite these revelations, the caseworker did not question the foster mother's ability to serve as a permanent caregiver or attempt to involve her relatives to develop a long-term plan. When the caseworker presented the girl's GAL with an interim adoption order during a status hearing he was informed the GAL had placed a hold on the adoption at the direction of her supervisor, an Assistant Public Guardian, who believed the foster mother needed to be engaged with senior services before the process could be finalized. The caseworker acknowledged he had previously been asked by the GAL to refer the family to the Older Caregivers Project, a program jointly operated by the Department and a private agency to provide support to elderly individuals with children in their care.

At the time the caseworker assumed responsibility for the case, he had been identified by the private agency as a problematic employee. In the previous four years, the worker had received at least seven disciplinary warnings related to providing inaccurate information regarding his whereabouts, consistently poor documentation and failure to adequately maintain his case records. During the OIG investigation, a comparison of the caseworker's notes with records of his testimony in court on this case found he had made false statements to the court, claiming to have performed tasks he had not completed. In addition, the OIG reviewed the caseworker's diploma included in his personnel file. The certificate, which had been bestowed by a foreign academic institution, was present along with a document purported to be an English translation of the degree. The OIG secured the services of a translator who reported the diploma had been granted in the field of Medicine and Surgery, not in Sociology and Social Medicine, as the accompanying translation claimed. The translator also noted the caseworker had received an overall grade of "fair" as opposed to "excellent" as was recorded in his personnel file. The OIG was unable to corroborate the validity of the caseworker's degree or determine its equivalency to one bestowed by an American university. While the OIG investigation was pending, the private agency terminated the caseworker's employment for failure to adhere to the terms of his probationary status within the agency. The caseworker was offered an opportunity to resign his position, which he accepted.

Prior to leaving his position, the caseworker's most recent work with the family had been overseen by a new

supervisor who joined the agency one month earlier. The supervisor had no previous experience monitoring employees. In an interview with the OIG, the new supervisor stated she did not believe the caseworker required much oversight since he was "veteran staff", having been employed at the agency for seven years. In a separate interview, the private agency administrator who placed the new supervisor in her position acknowledged she neglected to inform her of the caseworker's history of substandard performance. Both the new caseworker and the administrator were unfamiliar with the Older Caregiver Project. The administrator stated she believed the program only provided senior services and did not realize it could be used as a resource to facilitate collaboration between child welfare and aging services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency's foster care staff should immediately participate in training on the Older Caregiver Project.

The persons identified by the OIG have received Older Caregiver Training. The agency has arranged with the Older Caregiver Project to have additional training provided to the agency.

2. The private agency's quality assurance division should carefully review cases of foster children who are in the care of foster parents and pre-adoptive parents that are 60 years old and older to identify concerns regarding living arrangements and caregiver back-up plans and determine if the family should be referred to the Child Protection Mediation Program.

The private agency will assess cases on a quarterly basis to determine which foster parents are over 60 years old. All foster parents over 60 years old will then be assessed for need. When appropriate, a backup plan will be implemented.

3. The private agency administrator should be counseled on her responsibility to prepare and assist new supervisors working with employees whose performances are deficient.

The administrator was counseled.

4. As a prerequisite for employment, the private agency's human resources division should ensure that foreign academic credentials are verified and that job applicants, at their expense and prior to hire, produce an evaluation of their credentials to determine whether the person's education is equivalent to that of the U.S. education system.

The private agency has adjusted it personnel policies to ensure that foreign academic credentials are verified before a person's employment. That credential will then be evaluated to determine whether the person's education is equivalent to that of a US education system.

5. This report should be shared with the Department's Child Welfare Employee Licensure (CWEL) Division for the purpose of reassessing the caseworker's educational credentials if he seeks re-employment in child welfare.

The report was shared with CWEL. The caseworker relinquished his Child Welfare Employee License.

6. Pre-adoptive parents, ages 60 and older, and their back-up caregiver should be required to meet with the Department's adoption liaison for the purpose of providing them with an overview of the child and the adoption subsidy, to review the back-up plan, and to discuss the back-up caregiver's role and responsibility for the child. If the adoption liaison identifies concerns regarding the living arrangement or back-up plan, the liaison should refer the family to the Child Protection Mediation Program.

The implementation of the recommendation will go into effect on January 15, 2006.

7. When a foster parent's chronic illness becomes acute, licensing workers should consult with the treating physician with the consent of the foster parent.

Written procedures are being developed by the Office of Child and Family Policy to guide the decision-making process around when the discussion should be held with the foster parent requesting consent to discuss a chronic illness with their doctor.

8. When a medical report indicates that a caregiver, regardless of age, may not be capable of caring for a child into adulthood, the back-up caregiver should sign a statement that he/she is aware of that fact and is still willing to serve as the back-up caregiver.

Written procedures are being developed by the Office of Child and Family Policy to guide the decision-making process around when the discussion should be held with the foster parent requesting consent to discuss a chronic illness with the back-up caregiver.

GENERAL INVESTIGATION 20

ALLEGATION

An adoption attorney registered multiple complaints against two Department adoption liaisons. The complaints alleged the liaisons exhibited bias against the attorney, delaying the delivery of services to children and their potential adoptive families.

INVESTIGATION

The adoption attorney, who worked frequently with the Department on adoptions involving wards, filed several complaints against each liaison. An OIG review of the complaints found that each was related to adoption assistance applications that were not initially approved by the liaisons and had been returned to the attorney requesting additional information. The process of negotiating adoption subsidy applications can be complex and cumbersome and frequently entails prolonged interaction between both sides. The OIG found no evidence the requests for additional materials by the liaisons were unreasonable or inappropriate. In all of the cases cited, adoption assistance agreements were eventually signed and the adoptions were ultimately finalized.

The first adoption liaison, however, had exhibited unprofessional behavior and used profanity during a prior meeting with the complainant's assistant. In addition, a letter sent by the first liaison to the assistant, ostensibly as an apology, conveyed a confrontational tone and in reality leveled accusations of improper behavior against the assistant and the adoption attorney's practice.

The OIG found that the degree of assistive technology a child is entitled to was a frequent source of conflict in formulating adoption subsidy agreements. Questions regarding the necessary levels of service to be provided or the qualifications of those determining need often proved to be the source of contentious debate. Within Illinois, there are several organizations whose purpose is to accurately identify children's individual requirements for assistive technology and provide assistance in obtaining suitable materials. By availing itself of these resources, the Department could provide more consistent, specified services to children and alleviate a persistent problem between adoption attorneys and adoption liaisons.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The first adoption liaison should not be assigned to adoption cases involving the complainant.

The Department does not agree. The OIG found nothing in their investigation that indicates that requests for documents/materials were improper.

OIG Response: As stated in the report, the recommendation of reassignment was not based on a finding of wrongdoing, but a recognition that the worker's prior written sarcastic response could be viewed as evidence of future bias.

2. Adoption liaisons and caseworkers should be made aware of the assistive technology centers available to determine the appropriate level of assistive technology for a child.

A memo was issued to adoption team members on November 22, 2005, which provided them with technology center information to use as resources.

GENERAL INVESTIGATION 21

ALLEGATION

Staff at an elementary school alleged a Child Protection Investigator assigned to a case involving a possible injury to a student acted unprofessionally, accused them of racial bias and threatened their careers.

INVESTIGATION

During an in-school group counseling session, an eight year-old female student announced that a playground monitor had punched her in the stomach and knocked her off of a swing during recess earlier in the day. After dismissing the other children from the session the school social worker asked the girl to describe the incident. The social worker then escorted the girl to the school's administrative office to relate the story to the principal. In her interview with the OIG, the social worker stated that while en route to the office the girl changed her story, claiming the monitor struck her accidentally while attempting to stop the girl from swinging. The girl told both the social worker and the principal she was not hurt. The social worker told the OIG that the girl's varying accounts of the incident caused school staff to question her credibility and since she was not injured, a decision was made not to contact the hotline. School staff also did not inform the girl's mother of the incident.

Later that evening the girl's mother learned of her daughter's allegation from the parent of a classmate. The mother transported her daughter to the hospital for an examination, which found no injuries, and then to the local police station to file a report. The following morning the mother contacted the hotline and a child protection investigator was assigned to the case. Prior to the child protection investigator's arrival at the school, school staff met with the girl's mother and interviewed six children who were near the swings at the time of the alleged incident. Upon arriving at the school the investigator met with the principal, the social worker and a special education coordinator. In their interviews with the OIG, the school administrators said the investigator accused them of "obstructing justice" by speaking with the children before he could interview them and stated they had "contaminated" his investigation. The administrators contended it was their right and responsibility to ascertain the facts of the situation as soon as possible. The investigator concluded the meeting with an instruction to staff not to speak to any students regarding the incident.

In his interview with the OIG, the investigator stated school administrators had "tainted the investigation" by interviewing the students. The investigator also told the OIG the administrators had portrayed the girl in a negative light during his meeting with them and believed the staff's impression of the girl as an aggressive and disrespectful child contributed to their decision not to contact the hotline. The investigator expressed his belief that school staff, as mandated reporters, were required to contact the hotline after learning of the allegation and "broke the law" by failing to do so.

A week after the investigation was initiated, the investigator contacted the principal. The principal told the OIG that during the conversation, the investigator made statements suggesting he would seek to revoke the licenses of several school staff members and made specific reference to the social worker. The principal also stated the investigator implied he could not effectively target her for license revocation due to her impending retirement. According to the principal, the investigator then referenced a high-profile Department investigation involving a residential facility that resulted in its closure. The principal lodged a complaint with the school district office, which notified the school district's attorney. The attorney contacted the investigator and later claimed that during the conversation, the investigator stated the school was, "going to need a lawyer after I am done with them." In his interview with the OIG, the investigator denied making threatening statements to the principal and characterized any comments he made regarding employees' licenses as being in the interest of "full disclosure" so school staff was aware of all potential outcomes of the investigation.

The playground monitor had been assisting during recess because a parents' group had previously voiced concerns that racial tensions among students during the recess period placed students in danger. Animosity

between the girl's mother and the principal had required the intervention of other staff to manage earlier situations.

In interviews with the OIG, both the child protection supervisor and the manager of the child protection division described the investigator as employing an aggressive, confrontational approach when conducting his work but believed he comported himself in a professional manner. The supervisor stated investigators are frequently the focus of complaints by the subjects of investigations and that full disclosure statements are often misconstrued as threats. The supervisor stated that the behavior alleged by school staff would be considered unacceptable.

The supervisor explained he addressed all complaints with the individual investigators but kept records only of those submitted in writing. The supervisor stated he had never received a written complaint regarding the investigator except for the one stemming from this incident. The OIG found a second written complaint lodged against the investigator for unprofessional conduct as well as the supervisors' written response to the allegations. An OIG review of the investigators personnel file found no record of any complaints being lodged against him.

Over the objections of the investigator, the supervisor ultimately determined the investigation should be unfounded. Based on the subjective nature of the conversations between the investigator and school administrators and the absence of tangible evidence or impartial witnesses, the OIG was unable to substantiate the allegations made against the investigator.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection supervisor should be counseled to document oral complaints and to retain records of written complaints in supervisory files. The supervisor should also be counseled for providing misinformation to the OIG about whether he had received prior written complaints against the investigator.

The supervisor was counseled.

GENERAL INVESTIGATION 22

ALLEGATION

The Department failed to notify or consult the non-custodial father of two boys regarding the reestablishment of a post-adoption behavioral services contract with a service provider the father had previously objected to.

INVESTIGATION

The OIG has written two previous reports involving the family in this case. The father and the mother, a Department administrator, have been involved in contentious, on-going divorce proceedings for a period of four years. During that time the provision of post-adoptive services, specifically the services of an in-home behaviorist, has been a central source of disagreement between the mother and father. The father objected to the individual identified by the mother as her preferred choice to serve as a behaviorist as her family enjoys a close personal relationship with the mother. The mother has previously acknowledged the behaviorist is "biased" in her favor. In addition, the behaviorist's own mother is a foster parent support specialist and, as such, her position is indirectly affected by decisions the mother makes in her capacity as a Department administrator. Furthermore, the OIG had previously determined the behaviorist's relationship with the mother had allowed her to enter into contracts with the Department despite not possessing the requisite educational training to do so, although she has since attained the necessary degrees. Despite the father's objections to the behaviorist's professional involvement with his children and an earlier decision by the Department to terminate the service, the OIG learned the contract with the behaviorist had been reestablished. The father had not been informed by the Department that negotiations to resurrect the contract had taken place.

The original contract for an in-home behaviorist called for services to cease once the boys began attending school full-time. The boys have been attending school full time for four years and, according to school staff, function well in separate classrooms presided over by a single teacher and teachers' aides. Despite their involvement in normal special education classroom activities the mother has continued to receive payments from the Department for therapeutic day care. When the cost of reimbursements for therapeutic care is combined with the amount of monthly adoption subsides the mother receives, the total is more than $90,000 paid annually by the Department to a Department administrator.

In order to ensure due process for non-custodial parents is preserved, the Department must ensure that all parents are notified of potential changes to post-adoptive services contracts and are offered an opportunity to provide their input into the decision making process. Although the Department previously agreed to implementation of this process it is paramount that policy is followed to guarantee the effective delivery of services to children and protect the rights of non-custodial parents.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department must revise Rule 302 to provide that the Department has the burden to notify non-custodial parents of all post-adoption subsidy reviews and contract changes, before revisions are made and must allow time for response and input from that parent. The Post-Adoption Unit should not go forward with changes or continuation until this requirement is satisfied and it is noted in the record that it was satisfied, so that the Department can demonstrate it is in compliance with federal statues. The Department should send notice to the last known address of a non-custodial parent advising that the subsidy and/or contract is up for review and the parent should contact the Department. The notice should provide the name of the person to contact and their phone number. If the non-custodial parent does not want to participate and does not want to receive notice in the future, they should be required to put that in writing with their signature and date so that the Department can demonstrate that it is in compliance with federal statutes. If Post-Adoption receives no response from the non-custodial parent they must document in the record that notice was sent to the last known address.

Written notification to non-custodial parents has been incorporated into revisions of Rule 302. Revision of the accompanying procedures will provide additional details to workers and adoptive families.

2. The Department should return to negotiations on the post-adoption contract with notification to the father and give him an opportunity to have input into the contract. The Department should determine whether the requirements for such renewal were satisfied and whether the children need two therapeutic day care providers. Whatever the results of the re-negotiations, the Department should not contract with the previous in-home behaviorist to provide services to the children.

The parents were notified of the transferring of subsidy management responsibilities to another Region. Therapeutic daycare will be re-negotiated with the parents and a new provider obtained by January 2006.

3. A related OIG investigation pertaining to the mother's position as a Department administrator resulted in a request to the Department's legal division to present this case to the ethics committee

The Department's legal division presented the case to the Child Welfare Ethics Advisory Board on 12/20/04 and 04/04/05.

GENERAL INVESTIGATION 23

ALLEGATION

A private agency caseworker and her supervisor provided the findings of a psychological assessment conducted on a maternal grandmother serving as a relative foster parent for two children to their biological parents, in violation of confidentiality requirements.

INVESTIGATION

All three of the parent's children, ages seven, two and six months, were in the maternal grandmother's care. The grandmother had obtained legal guardianship of the oldest child through a private arrangement and had accepted the younger two in foster placements. The children's mother was diagnosed with bi-polar disorder but was non-compliant with her medication schedule while the father exhibited learning and developmental disabilities. Both parents acknowledged struggling with drug and alcohol abuse issues and a history of domestic violence. The mother and grandmother had a contentious relationship.

During an Administrative Case Review, the parents were given a copy of an Early Intervention Psychotherapeutic Services Assessment that contained assessments of both the two year-old girl as well as the grandmother. Although the parents were entitled to any information regarding their daughter and the grandmother had agreed for the release of information to the private agency, the grandmother's consent did not include sharing the results of her assessment with the mother. In an interview with the OIG the private agency supervisor responsible for overseeing the case stated the inclusion of the grandmother's evaluation in the materials provided to the parents was accidental and attributed it to an inadequate review of documents by him and the caseworker prior to the meeting. The supervisor said both he and the caseworker had apologized to the grandmother for their error and the agency had initiated a review of the Health Insurance Portability and Accountability Act (HIPAA) and Department Rules regarding the dissemination of confidential information. The OIG found that the Department does not currently offer training to caseworkers regarding the confidentiality of medical and mental health information.

During the course of this investigation, the OIG learned the parents had not been involved in a number of their children's assessments and therapy sessions conducted by outside care providers. It is imperative that biological parents have equal access and opportunity to engage in the services provided to their children. Regularly scheduled meetings involving parents, foster parents and child welfare professionals could help to ensure that all interested parties are apprised of service appointments.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should provide training for workers on the confidentiality of medical and mental health information and on obtaining consents for the release of information.

The Trainer Guide was developed and the training conducted. This training will be offered on an as needed basis. Spring 2006 is the target date for information to be available on the Web.

2. This report should be shared with the private agency supervisor and the family's current caseworker to address any intra-familial clinical issues raised as a result of sharing the grandmother's assessment with the parents.

The agency shared the report with the supervisor and caseworker. The report has also been shared with the current worker and the current supervisor and the clinical issues raised are being addressed. The parents have cooperated with attempts to educate them on the therapeutic needs of the children.

3. The private agency should conduct quarterly staffings with the parents, foster parents and therapists from outside agencies to ensure the parents are given the opportunity to be educated on how

to address their children's therapeutic needs. An example of an existing Quarterly Staffing Procedure Form used by another agency should be shared with the private agency as an example.

The Department agrees.

OIG Response: The OIG shared the report with the private agency and the President of the Board of Directors of the agency. The Inspector General met with the agency executive staff and a member of the Board of Directors to discuss the findings and recommendations made in the report. The worker and supervisor were counseled with respect to HIPAA requirements. The children were returned home and guardianship was returned to the parents. The foster mother and biological mother, who are mother and daughter, are attending counseling together and family visits. The parents are cooperating with services.

4. The service plan should document any lack of cooperation by the parents as to the education of their children's therapeutic needs.

The parents are cooperating.

5. A redacted copy of this report should be shared with the Department of Human Services to determine potential problems with their consent procedures.

The Department agrees. The OIG shared this report with DHS.

GENERAL INVESTIGATION 24

ALLEGATION

A Department caseworker alleged five children on her caseload were removed from their foster home and she was subjected to disciplinary action in retaliation for her claims of misconduct by her superiors.

INVESTIGATION

The caseworker monitored a foster home placement involving two sibling groups. Regional management, in consultation with Department Deputy Directors, had determined the children needed to be removed from the home after the hotline received a report alleging abuse by the foster mother. The couple had been licensed foster parents for four years without incident, however they had been investigated by the Department 10 years earlier for an allegation of risk of harm to their own children. The earlier investigation was not indicated, however the parents agreed to participate in services for one year. At the time of licensure, workers were unaware of the previous involvement since initial, unfounded reports are not included on the Child Abuse and Neglect Tracking System (CANTS) and Department licensing applicants do not require prospective foster parents to disclose all previous involvement with services. The caseworker strongly opposed management's decision to remove the children from the home. The caseworker utilized email to contact higher-ranking Department personnel and request their intervention in the case. The caseworker received a positive response and the children were returned to the home.

The contentious relationship that developed over time between the caseworker and two of her superiors was perpetuated by both sides and impeded the Department's ability to provide effective service to the children in the home. The caseworker believed the administrators were biased against the foster parents and sought to disrupt the placement unnecessarily. The administrators contended the caseworker had become overly enmeshed with the family and had abdicated her role as a service provider for the children in order to serve as an advocate for the foster parents. In conducting this investigation, the OIG found evidence that all involved parties allowed personal conflicts and the inconsistent application of Department Policy to obscure tangible issues regarding the foster parents' suitability as caretakers as well as the functionality of the local field office.

The caseworker repeatedly violated Department policy through her failure to submit Unusual Incident Reports (UIR) after learning of injuries suffered by the children. There was also evidence the caseworker may have attempted to persuade a mandated reporter not to contact the hotline despite concerns regarding the children's welfare. The caseworker routinely accepted the foster mother's account of how the children incurred injuries and did not report either the initial incident or her contact with the family to her superiors. The caseworker felt her actions were justified, as she believed the foster parents had been targeted by her superiors and did not want to contribute information that might be used to remove the children from what she determined to be a positive environment.

The site administrator and the regional administrator undermined the authority of the caseworker's direct supervisor by instructing the caseworker to report directly to the site administrator with concerns. The administrators allowed their personal conflicts with the caseworker to color their judgment and viewed all behavior they deemed incorrect as a deliberate challenge to their authority. Although the caseworker erred in performing her work, it could not be proven that the entirety of her actions were of malicious intent.
The administrators took particular exception to the caseworker's frequent use of email to protest decisions made on the field-office level to higher-ranking Department personnel. The caseworker disregarded repeated instructions from both of the administrators as well as Department personnel that received her emails to discontinue the practice and adhere to the chain of command when lodging complaints. However, as high-ranking Department personnel continued to address the caseworker's charges and, on more than one occasion, resolve situations to her satisfaction, they added merit to the practice and reinforced her behavior.

Throughout, both sides demonstrated a poor understanding of the "whistle blower" provision of the Illinois Ethics Act intended to protect employees against retaliation. The caseworker invoked her rights as a whistle blower to support her actions, as she believed the administrators were derelict in their duties. Alternatively, the administrators viewed the caseworker's frequent attempts to solicit the intervention of their superiors as acts of insubordination. Both sides overstated the degree to which the others' behavior impacted the workplace.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be permanently removed from all child and family cases involving the foster children.

All cases were transferred.

2. The caseworker should receive training on identifying and neutralizing bias.

The Department continues to search for appropriate training.

3. This report should be shared with the caseworker's current supervisor to assist in supervision and case management.

The report was shared with the caseworker's supervisor.

4. The caseworker and her current supervisor should jointly create a written agreement detailing guidelines for when the caseworker must consult with her supervisor regarding possible abuse and neglect of children on her caseload and calling the State Central Register (SCR).

An evaluation was conducted with worker and the supervisor.

5. Department management should review all disciplinary charges brought against the caseworker to determine their merit in light of this report.

The Department reviewed the disciplinary charges and determined that discipline was appropriate.

6. The foster home application license application form should be revised to include a question asking if the applicant has ever received child welfare services from the Department. The processing of the application should also require a Child and Youth Centered Information System (CYCIS) check to confirm this information.

The licensing application was revised to include the question of whether the applicant has previously received child welfare services. A memo was sent to staff notifying them that CYCIS database checks are required for all household members on all new Foster Home Licensing Applications. The Central Office of Licensing also completes CYCIS database checks when they receive and process Foster Home Licensing Applications.

GENERAL INVESTIGATION 25

ALLEGATION

The foster parents of a five year-old male ward failed to address his medical needs and had not developed an adequate back-up care plan, despite their advancing age.

INVESTIGATION

The boy had been living in the foster home for four years. The foster mother and father were 74 and 73 years old, respectively, and their adult daughter, who had been identified as the backup caregiver, expressed reservations about her willingness to care for the boy long-term after she became aware of the extent of his special needs. In addition, it was suspected the foster father suffered from dementia and had failed to report that he and the boy had been involved in an automobile accident.

The Older Caregivers Project is a joint program operated by the Department and a private agency to provide support and assistance to elderly foster and adoptive parents. The GAL had previously recommended to the boy's caseworker that she refer the family to the program. In an interview with the OIG, the caseworker stated she initiated the process of a referral but discontinued her efforts after she became aware the family lived outside the project's designated catchment area. The OIG contacted staff from the program and learned the project would consider accepting significant cases beyond the boundaries of the catchment area. The OIG referred the case to the Older Caregivers Program and it was accepted.

The boy's medical history showed he had a heart murmur and presented other cardiac abnormalities. He had also had numerous surgeries on his nose and throat, including the insertion of a ventilation tube. The boy also demonstrated speech delays and deficiencies with his motor skills. The foster parents had complied with all medical advice, ensuring he completed recommended neurological and multidisciplinary evaluations and maintaining his consistent attendance in speech and occupational therapy as well as an early childhood special education program. His medical records showed he had received annual checkups and his immunizations were up to date. His obesity, which had been identified as a significant health issue, was being addressed through consultation between the foster mother and a health care professional. An adult second cousin of the boy who had maintained involvement with him and the foster parents since he was placed in the home repeatedly expressed a desire to care for the boy and presented a viable option if either the foster parents or their daughter were unable to care for him.

Determining whether an individual suffers from dementia requires a comprehensive, professional assessment. It is vital that child welfare professionals who suspect dementia in a caregiver make a referral to the Department's HELP Unit for a geriatric assessment.

Failure by a foster parent to report a ward's involvement in an automobile accident, or any other incident that might affect the child's care and welfare, is a violation of Department licensing standards. The OIG referred this issue to the Department's Division of Agency and Institution Licensing in order for the private agency responsible for licensing the foster parents to conduct an investigation. The OIG secured assurances the results of the investigation would be shared with the Older Caregivers Project and the OIG.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should designate the Help Unit or a similar centralized unit that can recognize both the need for family conference mediation to address permanency issues and the need to refer more complex issues to the Older Caregiver Project, such as a caregiver demonstrating memory loss.

The designated units are the Regional Clinical Units. The Action Transmittal is in the process of being revised and rewritten.

GENERAL INVESTIGATION 26

ALLEGATION

The Department's Ethics Board requested that the OIG present additional information about factors that impact a teen-parent's ability to provide care and retain custody of their children.

INVESTIGATION

The OIG reviewed 118 case files to identify the prevalence of risk factors for teen-parent wards. Reviewed were cases of 62 teens that had lost custody because of abuse, neglect or dependency (Group A) and cases of 56 teens that retained custody (Group B). Nineteen areas of major concern were identified from both groups as well as differences.

Group A teens were younger, more troubled, had more children that experienced frequent heath problems and were more likely to be diagnosed with a severe mental illness than in Group B. In Group A there was a high rate of violence and aggression found. 81% of the teens had perpetrated at least one act of violence against a person. Slightly more than 25% of the teens in Group B had exhibited at least one form of aggression. There was a high prevalence of substance-related disorders and severe mental illness found in both groups. In Group A the percentages were 60% and 61% respectively. In Group B the percentages were 25% and 48% respectively.

Based on its review of the cases, the OIG suggests that (1) teen-parents' functional parenting capacities should be regularly assessed, (2) the Department must develop programming for substance-abusing and mentally ill teen-parents, (3) the Department must address the high prevalence of violence among this population, and (4) the Department should educate parents concerning chronic health problems among children. Dr. Karen S. Budd developed a psychosocial assessment tool to assess stable and changing risk and protective factors. The assessment tool is useful for developing individualized treatment plans. Further training on using the assessment tool is needed as supervisors reported that caseworkers were having difficulty differentiating between stable and changing risk factors.

The OIG in collaboration with the Chicago Department of Health developed and piloted a teen violence prevention program. The program focuses on preventing violence among this population and addresses victimization. The OIG developed a resource manual in collaboration with nurse-researchers at the University of Illinois at Chicago. The manual provides information about common chronic health problems like asthma, cerebral palsy and enuresis. The manual should be shared with teen-parents whose children experience physical health problems.

When the Department is considering custody of a teen-parent's child, the teen-parent's level of maturity and sense of responsibility must be considered along with the level of impulsivity and mental disability. The Department could advocate for a 6-months period when the child is removed from the parent's custody and work on treatment of the parent's problems.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. TPSN workers should be trained to: use the psychosocial assessment tool; be proficient at identifying stable and changing risk and protective factors; develop a specific parenting plan that builds on teen parents' social support and positive parenting skills; and monitor the progress of treatment to identify areas of weakness and deficiency.

Due to staff vacancies, the responses are not available at this time.

2. In cooperation with the National Alliance for the Mentally Ill (NAMI), supportive psychoeducational and peer support programming should be developed for teen parents with Major Depression, Bipolar

Disorder, and other psychotic disorders. Michelle Martin, from NAMI, has offered to work with the teen parent initiative to set up and pilot a short-term psychoeducational mental health and peer support group for appropriate teen parents with mental health problems.

Due to staff vacancies, responses are not available at this time.

3. All teen-parent wards with children who have a chronic health problem should receive specialized training on their children's health problems, using the Department's 2004 A Guide for Care Manual. The parents' caseworkers should baseline and plot parents' progress in applying the guidelines to the child's medical care.

The tip sheets have been online on the D-Net since August 2005. The Office of Training placed the complete manual into the DCFS resource library where it is available for circulation. This manual will be online also when the library goes online in FY 06.

OIG Note: The Department needs to develop procedures to ensure that D-Net information is used as a tool in casework activity.

4. The collaborative training by the Department of Health, TPSN, the Department, and the Park District on teen violence prevention should be replicated to serve all of the Department's teen parents. Similar programming should be developed for the rest of the State.

DSI-Behavioral Health Services staff and other members of the Department's Behavioral Health Team are developing a trauma curriculum which focuses on the following areas: understanding trauma; how to identify signs and symptoms of trauma; and how various partners within child welfare (substitute caregivers, caseworkers, child protection investigators, etc.) can respond to trauma.

5. Family mediation sessions should be initiated for teen-parent families to specify the voluntary terms of alternative or back-up caregiver arrangements.

Due to staff vacancies in Teen Parent Services, the responses are not available at this time.

6. The father and paternal grandmother of two children in this study should be referred for family mediation to formalize the care plan they established.

Due to staff vacancies in Teen Parent Services, the responses are not available at this time.

7. The Department should convene a panel of psychiatric, medical and child welfare practice clinicians to develop special criteria for assessing risk to children of wards where there are underlying conditions and a pattern of behavior by the parent that are problematic but have not yet resulted in abuse or neglect. The panel should consider recommending use of specialized counseling to determine the ward's desire to continue parenting or the use of the dependency provisions of the Juvenile Court Act to screen children of wards into court when the special criteria of risk specified by the panel are met.

Due to conflicts in scheduling, no meeting has yet been held. Target date: December 2005.

GENERAL INVESTIGATION 27

ALLEGATION A private agency continued to accept board payments for a 19 year-old male ward after he left his foster home to attend college. The private agency also failed to enroll him in the Department's Youth In College program which would have provided him with financial assistance.

INVESTIGATION The boy's case was transferred to the private agency at the beginning of his senior year in high school. The boy, one of nine siblings, eight of whom are or were wards of the state, had achieved moderate scholastic success and was accepted for admission to a state university. During the spring before the boy graduated his Assistant Guardian ad Litem (GAL) wrote to his caseworker to request that the agency facilitate securing available financial assistance for his education. The Assistant GAL had learned from the boy and his foster mother they were unaware he could receive funds from the Department. Although the deadline to apply for a scholarship had passed, the boy could apply to the Department's Youth In College (YIC) program which provides wards seeking higher education with grants for housing and school supplies as well as a monthly stipend. Despite the Assistant GAL's request, the private agency caseworker never completed the necessary measures to secure the boy's participation in the program. In an interview with the OIG, the caseworker stated she did not receive supervision during the time she serviced the boy's case. After repeated appeals by the boy's GAL to enter him into the YIC program, the matter was raised during a juvenile court status hearing on his case, one year after the initial request was made. According to court transcripts, a private agency supervisor incorrectly testified that the boy's high school grades were below the standard established for inclusion in the program. In fact, the boy exceeded the minimum academic requirements for eligibility and had been entitled to receive funds. The court ordered the private agency to immediately enroll the boy into the program.

An OIG review of the case record found the private agency had failed to reflect the boy's enrollment in college or change of address in official documents. As such the agency continued to receive payments for his care. Some of the payments were delivered to one of his former foster parents while others were retained by the agency. After the boy finally began receiving funds, midway through his second semester, the private agency neglected to provide him with the full amount available to him. An internal audit conducted by the agency determined the boy had not been given $142.78 in board payments that he was entitled to since he had been living independently. However, an OIG review of the audit found the agency did not consider a period of time the boy was living on his own when payments in the amount of $868.85 were delivered to his former foster parent. The boy's first year in college ultimately proved to be unsuccessful and he was dismissed at the end of the school year for failure to maintain adequate academic standards. In an interview with the OIG, the boy related his struggle to adjust to the university and acknowledged he had been unprepared for college life. The boy stated he had been placed on a bus alone and arrived on campus without any contacts with the exception of an acquaintance from high school. His sole interaction with his family while he was away consisted of a single visit by three of his siblings and another private agency caseworker.

While the OIG's investigation of this case was pending, the Office became aware of concerns regarding the private agency's handling of another case that had been transferred to the Department. A Department caseworker contacted the OIG to request a background check on a man identified as a self-selected placement for an 18 year-old male ward. The OIG learned the man had a criminal history that included multiple convictions for forgery and theft. The OIG reviewed the ward's case record and found a pattern of substandard service, perpetuated by his caseworker at the time. The ward, who had been diagnosed with developmental disabilities, had dropped out of school during the ninth grade and had repeatedly voiced his frustration regarding his inability to read. The ward also admitted to substance abuse problems and stated he had tried to address the issue on his own but was unsuccessful. The ward had resided with his grandmother from the age of 10 until he was 15 when she became critically ill. After his grandmother died the ward moved

in with his older sister, herself a former ward whose case had been closed following her twenty-first birthday. The sister's household included her own two year-old child, another brother and, periodically, the sibling's mother who had previously lost custody of her children as a result of her own substance abuse issues. The OIG attempted to review the sister's case file, however the private agency responsible for her case prior to closing reported it as lost.

In reviewing the ward's case the OIG found his most recent caseworker had failed to perform many basic functions of service provision. Despite the boy's academic deficiencies and acknowledged substance abuse, the caseworker did not ensure the ward followed through with any referrals for services or take steps to engage him in support programs or treatment. The caseworker repeatedly developed service plans that included required tasks for the ward to perform but did not maintain consistent contact with him or employ other measures to compel his compliance. In his case notes, the caseworker documented that during a visit to the sister's home he believed he smelled an odor associated with smoking drugs. Although the caseworker was aware of the boy's drug issues and that his mother, who had a long history of substance abuse, resided in the home, the caseworker's only action was to ask the ward's brother if anyone in the household was engaging in drug activity. The brother denied any drug use by residents.

Just before the ward turned 18 he visited the private agency and requested to be placed in the home of an adult male. The caseworker's supervisor approved the self-selected placement without performing a background check on the man or conducting a home visit. In an interview with the OIG, the caseworker stated he had conducted a background check on the man, however there was no evidence of such in the case record. The OIG found the man had prior convictions for aggravated assault and aggravated battery of a police officer.

The OIG determined that a lack of institutional controls and a high rate of staff turnover hampered the private agency's efforts to guarantee the delivery of effective services to wards. Through interviews with private agency staff and a review of personnel records the OIG learned that staff shortages and reliance on temporary workers prevented the agency from developing cohesive strategies for addressing the needs of individual clients and thwarted any attempts to establish consistency. The agency's staffing problems were exacerbated further by financial shortfalls that hindered its ability to recruit or retain additional workers. While the agency struggled to operate under the strain of these issues, the Department's Agency Performance Team (APT) charged with monitoring their operations documented the problems without assessing their effect on services. Previous OIG reports have cited APT's lack of written procedures, standardized forms or effective training for its liaisons as well as the need for follow-up when factors that hinder agency viability are identified.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department, in conjunction with the Office of Education and Transition Services, should; review the efficacy of the Youth In College program's early identification and enrollment of wards; eliminate the need for transfer between Youth In College and Youth In Employment during summer breaks and pursue a single seamless program; make relevant Youth In College documents available on-line to Department wards and; accept submission of documents electronically.

A Policy Review Committee was convened comprised of representatives from DSI-Education and Transition Services and various other Department Divisions. As a result, a revised Appendix G – Youth in college/Vocational Training requiring earlier identification of youth for the program and reducing the required documents needed for application has been through the Department's standard policy review/comment process. It is in the final stages of approval and is expected to be issued by December 31, 2005.

2. The Department should reimburse the 19 year-old boy $1,388.95 for his student loan costs, the difference between his YIC funding eligibility and what he actually received his first year in school. The Department should recoup from the private agency the $868.85 paid for the boy's board payments

after he went to school.

A pre-approved Court of Claims form has been mailed to the ward.

3. Agency Performance Team should track turnover at all agencies and forward to Agency and Institution (A&I) Licensing information about agencies with significant turnover rates to determine if A&I Licensing needs to intervene with the agency board's personnel committee. Turnover rates should be reviewed as potential signs of problems at an agency necessitating APT intervention.

The Department does not agree. Many times, staff turnover is due to the employee taking a position with another agency, including DCFS, who offer higher salaries.

OIG Response: While high turnover may be attributable to benign factors, high turnover remains a correlate to explore as a potential red flag or management concern.

4. The Department's Division of Monitoring and Quality Assurance should monitor the private agency's compliance with the agency specific recommendations discussed below in recommendations seven, eight and nine.

DCFS Monitoring and Quality Assurance will monitor the agency's compliance with recommendations 7, 8 and 9 through an information Corrective Action Plan by the Agency Performance Team on a quarterly basis.

5. A redacted copy of this report should be shared with the APT, specifically the liaison assigned to the private agency and his supervisor.

A redacted copy of the OIG report has been given to the agency and APT staff.

6. During the course of this investigation, OIG staff was unable to retrieve the 18 year-old ward's sister's closed case record because the agency archiving it had lost it. The Department is ultimately responsible for record retention for wards. Department Rules, Section 401.270(e): Records Retention. The Department should implement a mechanism by which child and family case files, once closed, are returned to the Department from agencies for archiving.

The Department is working in conjunction with the Child Welfare Advisory Committee to address this issue. Target date for resolutions of concerns is February 2006.

7. The private agency's Board of Directors personnel committee should review with agency management the problem of high staff turnover.

The issue of staff turnover has been discussed between the agency's management and the agency's Board of Directors. They believe that their turnover is consistent with industry statistics. The agency submitted to the OIG that their turnover rate was decreasing.

OIG Response: The OIG shared the report with the private agency and the Chair of the Board of Director of the agency. The Inspector General met with the agency executive staff and a member of the Board of Directors to discuss the findings and recommendations made in the report.

The OIG notes that a valid statistical analysis supports its finding that the agency's turnover rate for caseworkers was significantly higher than the industry standard. The Department has also noted the high turnover rate as a concern in the agency's Corrective Action Plan. The Department agrees that it will

continue to monitor this issue through the Corrective Action Plan.

8. The private agency's Board of Director's program committee should ask agency management for monthly reports regarding interventions for children with developmental disabilities, elevated school absenteeism rates or substance abuse problems.

The board meets quarterly. However, they will continue to provide regular supervision and collect the information monthly on children with developmental disabilities, high absenteeism and substance abuse problems and share this information with the board when they meet. The Director of Foster Care will devebp a tracking form for supervisors to monitor these issues and share with the Board committee.

9. The caseworker assigned to the 18 year-old ward's case requires direct and intensive case supervision. The private agency's supervisory staff should review the caseworker's case records for compliance with required home visits, clinical quality of his case service plans and follow-up on service referrals. The private agency should provide the caseworker with training on working with developmentally delaye d youth.

The caseworker was placed on probation and receives intensive supervision. The caseworker has been enrolled an early childhood development training. The agency will research training opportunities for servicing developmentally delayed youth.

GENERAL INVESTIGATION 28

ALLEGATION

A man and woman used false identities and misrepresented themselves as a married couple in order to become foster parents and later adopt four wards. The couple received post-adoption assistance subsidies from the Department.

INVESTIGATION

The OIG was alerted to an ongoing investigation of the couple conducted by the U.S. Postal Service and what was then the Illinois Department of Public Aid. The couple was suspected of creating fictitious identities in order to secure federal and state funds. Both individuals received Social Security payments as a result of their claimed significant physical and mental disabilities that prevented them from pursuing employment. Investigators learned, however, that the couple held jobs under assumed names and social security numbers while continuing to receive SSI payments. In addition, the woman had used her alias in order to bill the government for services she supposedly provided to herself and the man as a personal assistant. It was estimated that over the course of almost 20 years, the couple had defrauded the Federal government of more than $200,000. The couple had become foster parents and later adopted four wards and received post-adoption subsidies for their care, all under their assumed names.

The OIG conducted a review of the family's case record and found the couple had utilized the same fraudulent identities throughout their involvement with the Department. In addition, the couple had misrepresented their marital status as well as their biological relationship to the children. The OIG found the couple was continually permitted to provide information without efforts being made to substantiate the validity of their self-reports.

The OIG brought this case to the attention of the Department's Legal Division and the Illinois Attorney General's Office. Both offices agreed to attempt to notify the adoption court of the earlier misrepresentations made by the adoptive parents at the time of the adoptions of all four children.

The Department agreed.

GENERAL INVESTIGATION 29

ALLEGATION

An in-home daycare provider for three sisters living in a foster placement overbilled the state for her services. Concerns were also raised regarding the foster parents eligibility to receive daycare services.

INVESTIGATION

The foster parents provided a home for the three sisters, ages four, eight and twelve, for four years before a Department family support specialist recommended they apply for employment-related day care. The couple completed an application that outlined their respective work schedules as well as the foster father's scheduled leisure activities, and was clear in requesting day care while he participated in his bowling league. It was also noted the father engaged in odd jobs in the area including the repair of automobiles at the family home. The couple identified the foster mother's adult daughter, who lived next door, as a potential caretaker. The request was approved without question and the adult daughter began receiving payments as an in-home childcare provider.

The Department provided funds to the daughter for 10 months before payments were discontinued after questions arose regarding the amount of time she actually spent in the home and the foster parents' need for childcare services. Child welfare professionals involved with the family had received reports the daughter held a job as a waitress and was at work during times she had billed the Department for her services. It was also reported the foster father was frequently at home during the day and that, on occasion, both foster parents as well as the daughter were present in the home when the children arrived after school.

At the time the foster parents' application was submitted, the Department was in the process of revamping its system for childcare requests, partially in response to a previous OIG investigation which found flaws in the program's structure that allowed for errors and potential fraud. The previous forms did not require the foster parents to identify specific hours or substantiate the need for daycare.

Through interviews and a visit to the family home the OIG learned both parents had flexible work hours and continually adjusted their schedules based on weekly demands. Since the foster father frequently worked from home and the daughter providing day care lived next door, the children often moved freely between the residences depending on the adults' availability. The OIG obtained records from the restaurant where the daughter was employed. There was no evidence she had been at work during times she billed the Department for childcare services. Discrepancies between the foster parents' estimated and actual work hours could be attributed to fluctuations in the requirements of their jobs and unforeseen events, such as the foster mother's back surgery. The OIG determined the foster parents and the daughter providing day care had been forthright in their dealings with the Department and found no evidence to support allegations of fraud or deception for monetary gain. The OIG concluded the inherent inadequacies of the forms previously used to request daycare payments would be corrected through use of the new forms.

GENERAL INVESTIGATION 30

ALLEGATION

The OIG learned an 18 year-old male ward with a history of sexually inappropriate behavior was placed in the relative foster home of his grandmother. The boy's three female nieces, ages 9, 6 and 5, also resided in the home.

INVESTIGATION

The family had a history of involvement with the Department spanning more than 20 years. His mother had an extensive criminal history including 23 arrests for prostitution and numerous others on charges such as battery, theft, aggravated assault and possession of a controlled substance. She had been incarcerated on at least 21 separate occasions. The mother's two oldest children, both girls, had been the focus of child abuse investigations and were later adopted by their maternal grandmother. When the boy was four months old, his mother was indicated for inadequate supervision and he was placed with the grandmother in a private guardianship arrangement. The mother later gave birth to two more children who were subsequently adopted by relatives.

The grandmother was also the subject of indicated reports for abuse and neglect of the three children. The boy's oldest sister, who was ten years older, had five daughters of her own by the time she was 26. The middle three girls were also placed with the grandmother in private guardianship as a result of indicated reports against the boy's sister for Risk of Harm, Substance Abuse and Medical Neglect. When the boy was 10, the grandmother asked the Department to assume guardianship of him in order for her to receive additional assistance for his care. Later the same month, the hotline received a report the boy had attempted to penetrate his five year-old niece, who at that time was not in the grandmother's care but was frequently present in the home. An OIG review of the investigation of the allegation found family members offered varying accounts of events, all of which suggested a highly sexualized home environment inappropriate for young children. The niece who alleged abuse alternately asserted and retracted her accusation. The OIG found little evidence a comprehensive investigation of the incident occurred or that an assessment of the suitability of the grandmother's home as a residence for young children had been conducted. As a result of the investigation, the boy was indicated for Sexual Penetration and entered into the Department's Sexually Aggressive Children and Youth (SACY) program, which placed significant restrictions on his interactions with other children, particularly those who were younger or of the opposite sex.

Six months after the 18 year-old boy was placed with his grandmother the hotline received a call from his oldest sister alleging he had physically abused her three middle daughters who also lived in the home. The child protection investigator assigned to the case interviewed the girls who denied being whipped with a belt by the boy, as the allegation contended. The investigator spoke with the grandmother who stated the nine year-old girl was illiterate and suffered from a nervous condition that caused her to pull out her hair. The investigator observed the girl and noted her hair was short and patchy. The investigator learned from staff at the six year-old girl's school she had missed 44 days of class and would have to repeat the grade the following year. On the day the investigator visited the school the girl was not in attendance. The grandmother had called earlier that day and told staff the girl did not have a coat and it was too cold for her to walk to school. The investigator also met with the children's pediatrician who expressed a firm belief the grandmother should not continue to serve as the children's caretaker and inquired if other relatives were available to assume the responsibility. The investigator consulted with her supervisor who stated that since the children were placed through a private guardianship agreement the Department had no jurisdiction to intervene.

During the ensuing years following the boy's SACY designation he was involved with numerous mental health and child welfare professionals who noted his dramatically increasing weight, withdrawal from social situations, limited educational development and frequent behavioral problems. Throughout this time, he remained in the custody of his grandmother who was identified on multiple occasions as a substandard

caretaker and, potentially, as a perpetrator of abuse against the children in her care. When the boy was 14, the grandmother moved the family to another state, however they remained in contact with services in Illinois since the Department retained guardianship of the boy. When the boy's Guardian ad Litem (GAL) visited the family's new home out of state, she reported it was filthy and in a state of disrepair. The GAL also stated the boy was not attending school and that two of his nieces slept on the floor of his bedroom. The GAL brought the boy back to Illinois and he was placed in a traditional foster home, however the boy was ordered removed from the home since he was still designated as a SACY ward and a 12 year-old girl already resided in the home.

The Department's regional sexual abuse services coordinator reviewed the appropriateness of the boy's SACY designation. The coordinator found little information pertaining to sexual misbehavior attributed to the boy in his case record. The coordinator did find a therapist's report that raised the question of whether the boy was involved in a sexual relationship with his grandmother. The coordinator said his review found issues identified in recent progress reports, such as truancy, obesity and lethargy, as the central problems facing the boy and decided to rescind his SACY designation. The coordinator told the OIG he based his determination on the fact that five years had elapsed since the precipitating incident occurred and the boy was engaged in services and monitored by therapists. However, the Department failed to ensure that the other identified problems in the home were addressed. Following his removal from the SACY database the boy was placed in a residential group home, but was eventually returned to his grandmother's care.

Within the first year of being returned to his grandmother's care, the boy was arrested for predatory criminal sexual assault of his nine year-old niece. The boy was charged with 30 criminal counts including aggravated criminal sexual assault, criminal sexual assault and criminal sexual abuse. A nurse at the hospital where the nine year-old was examined reported the girl's hair was breaking off and she appeared not to have bathed in several weeks. The girl and her mother alleged the grandmother had been aware of the boy's sexual abuse of his niece. The grandmother admitted to Department investigators she had knowledge of the abuse and that the girl had told her the boy forced her to perform oral sex. The grandmother stated she did not want any of the children returned to her home. Immediately following the revelation of abuse the three girls were placed with their paternal grandmother before being moved to a residential facility.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This investigation should be redacted so that child welfare staff can learn how the absence of a thorough assessment of risks and the lack of services over time can lead to sexual exploitation and the possibility of a lengthy prison sentence for one Department ward.

The Department agrees to use a redacted copy of this report as a teaching tool with child welfare staff. The Office of Training will include portions of this redacted case in the following courses: Foundation and CERAP and Understanding Needs of Children and Youth with Sexual Behavior Problems - web course. The Department may include the redacted case as a genogramming example in upcoming Genogram/Ecomap web course.

2. The OIG will ask Dr. Barbara Bonne r from the National Center on Sexual Behavior of Youth (NCSBY) to assist the Department's Clinical Division on a review of the latest research on assessment and treatment of adolescent sexual offenders, including community safety and supervision issues.

Dr. Bonner was given the new standards to review and provide comments. Her comments were just provided to the Department.

3. The child protection investigator who responded to the oldest sister's report of physical abuse by the

boy should be counseled on her failure to recognize the risks to the children based upon the doctor's expert opinion as well as the grandmother's inadequate parenting abilities coupled with the squalid condition of her home.

The investigator was counseled.

GENERAL INVESTIGATION 31

ALLEGATION

During the course of an investigation, the OIG noted the presence of an unaddressed conflict of interest that may have influenced problems identified in an OIG death investigation.

INVESTIGATION

A Department employee recently promoted to the level of administrator had a relative working beneath them in a direct chain of supervision. Department personnel reporting to the administrator pursued counseling and discipline of the administrator's relative, resulting in the relative's termination.

The administrator's situation presented conflicts of interest on several levels. Department management was aware of the conflicts of interest and devised a solution whereby the administrator would have no direct supervision over the relative, however the relative continued to work in the same region and be supervised by staff who reported to the administrator. The supervisor required to implement the discipline of the relative still ultimately reported to the administrator.

The relative filed a grievance over the termination. While the relative's grievance was progressing, discipline was initiated on another worker for the same offense that led to the relative's termination. The administrator attempted to intervene in the discipline of the other worker. Because the charges were the same, the Department's response to each had to be consistent. Therefore, while the administrator did not seek to intervene in the discipline of the relative, the intervention on behalf of the other worker, charged with the same offense, could have indirectly affected the outcome of the relative's pending grievance.

While the above actions were ongoing, the administrator received a complaint regarding a poorly handled investigation. The supervisor that had been involved in the discipline of the administrator's relative was in a line of authority over the worker's who mishandled the investigation. After reviewing the pending investigation, the administrator instructed an administrative assistant to conduct disciplinary interviews of several staff members including the supervisor. The supervisor had no knowledge of the deficiencies with the investigation until after the mistakes had occurred. At that point, he consulted with Department management, including the administrator's assistant who had been directed to hold the disciplinary interviews. The assistant failed to disclose to the administrator that he had participated in discussions regarding how the investigation should be handled.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A redacted form of this report should be shared with Deputy Directors with the direction to seek professional ethical consults when similar rare but complex ethical conflicts are presented.

A redacted copy of the report was shared.

2. Disciplinary charges pending with the Office of Employee Services on staff that had implemented discipline of the relative regarding his handling of the child protection investigation case should be dismissed.

Formal charges were never filed or pursued on this employee.

3. The Department should issue a reminder on the D-Net of the availability of the Department's Conflict of Interest Committee to assist in resolving conflicts of interest.

A notice was posted on the D-Net and as an announcement.

4. The manager responsible for disciplinary interviews should receive ethics counseling to address his management failure to provide clear direction and assistance to the field and his failure to disclose his conflict in holding investigative interviews concerning acts that he had participated in.

The Department agrees. The OIG will provide the counseling.

GENERAL INVESTIGATION 32

ALLEGATION

Questions were raised regarding the OIG's ability to reference unfounded child protection investigation reports in pursuing discipline of Department employees.

INVESTIGATION

In two separate OIG interviews during child death investigations, union representatives objected to OIG investigators questioning workers regarding investigations that had been unfounded. The union representatives contended that the law, which requires identifying information to be deleted from the State Central Register when investigations are unfounded, also prohibits the Department from using an unfounded report to support an internal investigation or discipline. The union representative also relied on another provision of the Abused and Neglected Child Reporting Act [ANCRA] which prohibits *release* of information unless the report has been indicated.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should support legislative change of ANCRA to clarify that unfounded reports may always be used internally for disciplinary proceedings and may be shared with prosecuting authorities when necessary to support charges against employees.

ANCRA allows unfounded reports to be used internally for disciplinary proceedings and may be shared with prosecuting authorities when necessary to support charges against employees. ANCRA only mandates that "all information identifying the subjects of an unfounded report shall be expunged from the register…" ANCRA does not mandate that all copies of an unfounded report be destroyed. The OIG should challenge the Union's objection to the use of unfounded reports. If the challenge does not prevail, then the issue of amendments to ANCRA could be revisited.

GENERAL INVESTIGATION 33

ALLEGATION

A Department licensing worker who engaged in a personal business as a salesperson solicited orders from the operators of day care facilities she was responsible for monitoring.

INVESTIGATION

The licensing worker was an independent salesperson for a company that produces cosmetics, jewelry and home accessories. The OIG contacted staff from the 10 day care facilities the licensing worker visited during the time period in question. Of the 10, staff from 4 agencies affirmed they had had some discussion with the licensing worker regarding her outside business. Staff from three agencies stated they had given the worker money while the owner of a fourth said the worker had left a product catalogue behind following a monitoring visit.

In separate interviews with the OIG, the three day care staffers who reported providing money to the worker stated they had done so to support a project undertaken by the licensing worker to assemble care packages containing various products she sold for distribution to American military personnel stationed overseas. All three stated that while conversing during monitoring visits, the worker had inquired as to whether they would like to contribute funds to defray the cost of purchasing and shipping the products. The three uniformly stated they felt no pressure from the licensing worker to donate money to the effort and denied harboring any beliefs their decisions whether or not to offer money to the undertaking would affect the worker's evaluation of their facility.

The owner of the fourth agency told the OIG the worker did not attempt to solicit any sales from him during a monitoring visit but that after she left, a product catalogue was found on a table. Agency staff filled out order forms and faxed them to the licensing worker at her office the following day however, after the licensing worker's supervisor found the faxed order forms, the worker returned the orders and left a telephone message stating she would identify another sales representative to assist with any orders they might want to place.

In her interview with the OIG, the licensing worker stated she was aware of the impropriety of soliciting sales from staff at agencies on her caseload. She stated she identified the care package project as a charitable endeavor and did not regard asking for donations as inappropriate. The worker stressed that all money collected was directly used for purchase and shipping costs and denied making any profit from the transactions. In regards to the catalogue, the worker stated she did not intentionally leave the booklet behind but explained she might have inadvertently dropped it while looking through other documents.

All private agency staff lauded her work and denied she exerted any pressure upon them. Nonetheless, the worker must be more prudent in the future regarding the influence her outside business interests have on the performance of her duties as a representative of the Department. Even in the absence of ill intent, allowing for the intersection of private business interests with her responsibilities as a Department employee could be construed as a conflict of interest by the general public.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The licensing worker should be counseled for engaging in conflicts of interest by soliciting contributions for the care baskets from her clients. The responsibility of licensing workers to avoid any appearance of a conflict of interest should be addressed with her.

The worker was counseled.

2. A redacted version of this case should be incorporated into the training curriculum for licensing staff as an example of an ethical issue.

The redacted report has been incorporated into the training curriculum.

GENERAL INVESTIGATION 34

ALLEGATION

The OIG responded to an inquiry regarding the dissemination of information contained in the Law Enforcement Agency Database System (LEADS) to outside agencies or individuals.

INVESTIGATION

The Integrated Assessment program recently initiated by the Department may include criminal histories of family members. One of the Integrated Assessors requested that the Illinois State Police provide them with training on how to read LEADS printouts. The LEADS statewide Coordinator was concerned about the dissemination of LEADS printouts beyond the Department. LEADS: Law Enforcement Agencies Database System provides a criminal history based on identifying information such as name, date of birth, social security number, but is not based on fingerprints. LEADS depends on multiple reporting sources, and may not be accurate. Because of these limitations, LEADS printouts should not be disseminated beyond the Department. The criminal history information can be disseminated to outside providers. The Administrative Procedure and Rules and Procedures are not in agreement on what is to be disseminated, the raw data, a summary or the underlying documents. The underlying documents provide the pertinent information of arrests and are more useful in assessing risk to children and should be the documents disseminated. The details of the crime provide the assessor with a basis to evaluate the accuracy of the individual's explanation of the crime. Since closed arrest reports are public documents and more reliable, sharing the underlying documents does not raise the same confidentiality concerns that sharing a LEADS printout raises.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Administrative Procedure 6 should be amended to conform with Rule and Procedure 431, requiring workers to access underlying documents for the purpose of sharing relevant criminal history with outside service providers.

The LEADS protocol committee is currently meeting to revise AP and incorporate all outstanding practice-related OIG recommendations. Members of this workgroup have also begun meeting with the OIG on this issue as it related to accessing underlying arrest and case reports from police departments specifically and the state in general. The workgroup, chaired by DCP, projects completion by the first quarter of 2006.

2. The OIG reiterates its 2001 recommendation and recommends that the Department immediately develop law enforcement liaisons in each region to assist workers in procuring underlying criminal documents.

The Department's Law Enforcement Liaison has met with local police departments throughout the State to form or improve relationships with DCFS to facilitate procurement of underlying documents. County liaisons have been identified and are working on a protocol to define expectations. Upon completion of the statewide staff reorganization, 12 DCFS law enforcement liaisons will be identified for remaining regions.

3. The OIG will assist the Department's law enforcement liaison in developing and providing training around procurement of underlying public criminal documents and assessing criminal history.

The Office of Training is currently providing LEADS training in Foundation and Enhanced Training. The CPSW curriculum also includes LEADS training. The procurement of underlying criminal documents and assessing criminal history is included in SACWIS training, CPSW training, and the Family Development Specialist Training (Licensing Core).

4. The practice of disseminating the actual LEADS printouts should stop. LEADS Operators should

provide a verbal or written assessment of the LEADS printout, as provided in AP 6.

The LEADS protocol committee is currently meeting to revise AP and incorporate all outstanding practice-related OIG recommendations. Members of this workgroup have also begun meeting with the OIG on this issue as it related to accessing underlying arrest and case reports from police departments specifically and the state in general. The workgroup, chaired by DCP, projects completion by the first quarter of 2006.

GENERAL INVESTIGATION 35

ALLEGATION

A Department caseworker requested compensation after alleging that exposure to insects while conducting visits to a foster home resulted in the infestation of her own home.

INVESTIGATION

The caseworker was responsible for providing services to four children who resided in a relative foster placement with their maternal aunt. The caseworker complained that her visits to the family home brought her into contact with insects that had subsequently infested her home, office and car. The caseworker stated that in her efforts to combat the insects she was forced to bathe and clean her home with extraordinary frequency and she had been compelled to obtain the services of an exterminator to decontaminate her home.

The caseworker maintained the Department field office was infested and had repeatedly raised the issue with her supervisor and the regional administrator, who noted no other employees in the field office reported problems with insects, nor did the family's licensing worker who also made frequent visits to the home. The caseworker told the regional administrator that only individuals with particular complexions and hair coloring were susceptible to the insects. The regional administrator agreed to the retention of an exterminator to decontaminate the field office. Independently, the caseworker utilized "bug bombs" on several occasions to treat the field office although she never received permission from her superiors to do so. The caseworker stated she also sprayed her office frequently with pesticides, emptying the contents of a 10-ounce container every two to three days.

The caseworker submitted physician's notes stating she could not return to work until the infestation issue was resolved. She also obtained information from outside sources regarding the nature of the insects, however their opinions were speculative since they had not been provided with samples and no insects had been observed or captured other than by the caseworker. The OIG interviewed the acting state entomologist, who was familiar with the situation as he had previously been contacted by the caseworker. The entomologist stated that, given these events occurred during the winter in Illinois, he was unaware of any insect species that could survive transport from one location to another in the manner the caseworker described and was unfamiliar with any parasite that exhibited the characteristics she attributed. The entomologist also noted the inherent danger of prolonged exposure to pesticide, particularly within confined areas and recommended a more through examination of the caseworker's symptoms by a physician to identify other possible explanations related to factors of environment or toxicology.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should not permit the caseworker further use of pesticides at the Department offices.

The worker was instructed during a meeting with manager and the Union to stop the use of pesticides. Specific written warnings followed.

2. The Department should require the caseworker to submit to an independent medical examination to rule out differential diagnoses of her condition. The physician should have experiences with environmental agents and toxicology issues before.

The worker returned to work with a doctor's statement. An independent medical examination is being scheduled.

3. Department management should be provided with training to assist in resolving difficult environmental/employee issues.

A tip sheet has been drafted and will be incorporated into training.

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 Child Welfare Ethics Advisory Board met five times during FY 2005 to consider issues presented by child welfare professionals and by the OIG Ethics staff.[3] The Board welcomed new member Dr. Jennifer Clark, a psychologist and Child Protection Clinical Director at the Cook County Juvenile Court Clinic. Teresa Jacobson resigned from the Board in September. Commander Roberta Bartik resigned from the Board in December after accepting a position with DCFS.

The Board considered ethical issues that arose in the course of OIG investigations. Dr. Kane asked the Board to review a case in which a caseworker alleged she was being retaliated against for disagreeing with DCFS management on one of her cases. According to her superiors, the worker had a habit of complaining up the chain of command when she disagreed with her superiors. The question presented to the Board was whether the case constituted whistleblowing. The Board concluded that the case presented issues of communication problems between caseworkers and management. The Board recommended that DCFS management work to improve mechanisms for good communication between caseworkers, supervisors and management. They also recommended that the Department clarify the roles of each level of making and reviewing decisions, and not penalize workers who disagree in good faith with their superior's decisions and take the issue to a higher level in the agency.

The Board continued its discussion of ethical questions surrounding teen mothers who are also wards. The Board reviewed the OIG's report on teen mothers and discussed the ethical issues the report brought to light regarding the Department's responsibilities to the children of wards. Specifically, the report raised the issue of a ward's self-determination versus the Department's duty to protect. There is not universal consensus as to how to handle teenage wards who have children, and what the State's responsibilities are to those children. The Board was concerned with teenage wards retaining custody of their children even though they repeatedly engaged in high-risk behaviors or had a history of psychiatric problems. The Board recommended that DCFS convene a panel of specialists to develop criteria for assessing risk to the children of parenting wards. The Board further recommended that the Department

[3] 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
Jennifer Clark, Psy.D., Director, Child Protection Clinical, Cook County Juvenile Court Clinic
Michael Davis, Ph.D., Illinois Institute of Technology's Center for the Study of Ethics in the Professions
Armand Gonzalzles, M.D., pediatrician
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

should consider using a claim of dependency in these cases to protect the children of troubled or immature teens.

The Board was asked to discuss the case of a medically complex child who was taken into protective custody after a home health worker made a hotline call alleging medical neglect of the child. The Board discussed the ethical considerations that should be taken into account when an allegation of medical neglect is made regarding severely medically compromised children. The Board concluded that a generic response from DCFS is not effective in these types of cases, and that someone specialized in the care of medically complex children should be part of the investigative process.

The Board discussed a situation involving a DCFS senior employee who was receiving substantial adoption subsidies for her two adopted sons who have special needs. The employee was engaged in a contentious divorce, and her husband was questioning the need for the subsidies. The issues brought before the Board included how to handle adoption subsidies for DCFS employees, whether a previous conflict of interest with the in-home therapeutic day care provider had been resolved, and the issue of whether a DCFS employee may hire an attorney who often represents DCFS clients in litigation with the Department. The Board recommended that when adoption subsidies are awarded to DCFS employees the subsidies should be reviewed in another region, and that the Department develop procedures for handling situations in which DCFS employees hire attorneys to represent them before the Department.

The Board also discussed the DCFS AIDS Project after an article appeared in the Chicago Sun-Times. The article reported foster children were participating in government clinical trials of AIDS treatments without advocates being appointed for the children. The OIG contacted the director of the AIDS Project, who provided information for the Board to review. The Board felt there was a need to appoint advocates for these children, however they felt they needed more information about the project itself to fairly assess the situation. The Board composed questions for the director of the AIDS Project. The questions pertained to how the medical treatment of the wards was monitored, how the project unit advocated for the children involved, and what roles DCFS nurses and the project director played in the children's care. The Board agreed to discuss the issue further next year after these questions were answered.

OIG Ethics Staff Initiatives

In January 2005, the OIG, in conjunction with Loyola University Center for Ethics and Social Justice, presented a breakfast conference on ethics leadership for child welfare agency boards. The conference brought together board members and executive directors of purchase of service agencies. The conference addressed the role of not-for-profit board members in the ethical leadership of their organization. A panel, consisting of two lawyers and two ethicists, gave presentations on the legal and ethical aspects of the topic. After the presentations there was a discussion among attendees and panel members of ethical issues facing not-for-profit boards of directors and practical strategies for addressing these issues.

In May 2005, the OIG held an afternoon forum, again in conjunction with Loyola University Chicago Center for Ethics and Social Justice, entitled *Teen Parents and their Children: The State's Ethical Responsibilities*. Child welfare professionals and representatives of the judiciary attended the conference. There were two panels at the conference with a total of eleven presenters. Panel members were selected from a variety of different fields. The first panel discussed the ethical interests at stake for teen parents, their children and the state. The second panel addressed the question of how the courts can best serve these interests. The discussions were guided by a hypothetical case of a ward and her child. Audience questions and discussion followed the panel members' presentations.

The ethics staff continued interagency ethics discussions, which were initiated in FY 2004. Five discussions took place in FY 2005, on a bi-monthly schedule and covered ethical issues that the agencies

may have in common. Representatives from selected Chicago area purchase of service agencies attended the discussions. The goal of these meetings was to discuss practical ways for agencies to cooperatively address common ethical dilemmas. Such topics included: the appropriateness of placing a child in a group home, confidentiality and HIV/AIDS, addressing impaired colleagues, and bureaucracy and the values that it serves.

The ethics staff conducted several trainings at the request of purchase of service agencies. In each instance, ethics staff met with agency administrators to identify ethical issues that commonly arise in their agencies, constructed a series of hypothetical case scenarios to reflect those issues, and presented the cases at training sessions. Group discussions helped staff to recognize the ethical values at stake and obtain resolutions.

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. One case was referred to the Executive Office of the Inspector General for possible referral to the Ethics Board for a violation of the Gift Ban Act.

Annual Ethics Training

As required by the State Officials and Employees Ethics Act of 2003, state officials and DCFS continued ethics training for all new, contractual, seasonal, and temporary employees. The online ethics training for state employees consisted of lessons on various ethics topics including accepting gifts, conflicts of interest, and political campaigning. There were three one-month training periods for which the OIG Ethics staff was asked to notify those employees registered to complete the training and track their completion status. Upon conclusion of each period, the OIG submitted a report to the Executive Office of the Inspector General. Approximately 3,500 DCFS employees completed the ethics training in FY 2005. In addition to all DCFS employees, boards and commissions associated with DCFS were asked to have their members complete a similar ethics training. In FY 05, the Inspector General attended several board and commission meetings to answer questions arising from these trainings.

HOME AND FIRE SAFETY TRAINING

A home and fire safety training program was developed and implemented by the OIG Project Initiatives staff in FY 2003 in response to a number of child deaths and serious injuries resulting 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 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 general safety of intact families, wards and their child/ren. In FY 2004, the training curriculum was revised to also include 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. In June of 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 in an effort to reduce the risk of serious accident and injury to children. The curriculum also includes a manual entitled *A Helpful Guide for Parents and their Caregivers*. The manual and associated checklists are interactive tools to be used by workers during home visits with young parents and caregivers.

In FY 05, the Home Safety Checklists were revised in response to feedback from workers who had been using the checklists with families they serve. The revised checklists have been designed to clarify and facilitate the safety assessment process. *A Helpful Guide for Parents and their Caregivers* was also revised, and reformatted to a client/user-friendly 8.5 x 5.5 inch booklet. The content of the *Guide* was updated to include information on violence prevention adapted from the American Academy of Pediatrics by the Child Health Data Lab, Children's Memorial Hospital and provide a schedule for childhood immunizations. The OIG Project Initiatives staff also developed brochures for violence prevention and closed head trauma. The brochures and the *Guide* are required elements of the Home Safety Checklist assessment.

In FY 05, training on the home and fires safety curriculum continued. The OIG Projects Initiatives staff conducted Home and Safety trainings in Aurora and the Southern Region for 209 DCFS and 94 private agency administrators, supervisors, investigators and case managers. The training curriculum provided practical home and fire safety information as well as strategies to help parents and caseworkers ensure the health and safety of families, wards and their child/ren. The curriculum also covered scene investigation, early childhood development, bruising in children, and gun safety.

The OIG Project Initiatives staff also presented the home and fire safety training to pregnant and parenting teen wards and their case managers. The Chicago Fire Department joined in this training in April 2005 and has agreed to present at future teen ward trainings.

In an effort to better accomplish the goals of home safety and fire prevention, OIG Project Initiatives staff secured a donation of over 500 smoke detectors from the Chicago Fire Department. The smoke detectors were distributed to vulnerable families involved with the Department that lacked the financial means to afford a smoke detector. The Inspector General commends Chicago Fire Commissioner Cortez Trotter for his assistance in this effort. The Department's Division of Child Protection collaborated in this effort by coordinating inventory, identifying families, and distributing the smoke detectors.

OLDER CAREGIVER PROJECT

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. 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.

Currently, over 2,017 of DCFS children are in foster or relative homes where the caregiver/s are age sixty or older. Approximately 8,370 children are in the adoptive or subsidized guardianship homes of older caregivers. To better serve and support the Department's older caregiver families, the staff of the Older

Caregivers Project provided lifespan trainings to a cross section of child welfare professionals. The training integrated the skills needed for conducting geriatric and child assessments, accessing specialized services for the elderly, and arranging family conference mediation for cross-generational planning for the future needs of the children and their caregivers. The Department of Aging joined the project's staff as co-trainers and provided training to over two hundred supervisors, caseworkers, clinicians, and licensing/monitoring professionals within the child welfare field. Project staff is assisting DCFS' training division to incorporate key components of the curriculum "Kids and the Older Caregiver" into the DCFS expanded adoption curriculum. In addition to internal trainings, project staff has presented the essential elements of this lifespan approach to professional audiences across public services. Professionals from the Illinois Department on Aging Grandparents Raising Grandchildren Taskforce, Chicago Department of Aging Title II providers, elder abuse supervisors, and the Chicago Police Department senior citizen officers have received presentations geared to the citizens served by these departments.

In concert with the trainings, the Project is facilitating opportunities for child protection cases with concerns about older caregivers to receive family mediation services through the Child Protection Division of the Circuit Court of Cook County.

To further develop child welfare workers' professional knowledge in this emerging field, two additional training manuals are under development: *"Grandparents and Older Caregivers: Health Challenges While Caring for Kids*" and "*A Critical Thinker's guide to Home Safety and Maintenance*". The "*Grandparents and Older Caregiver: Health Challenges While Caring for Kids"* guide, co-produced by University of Illinois School of Nursing and the Office of Inspector General, provides information on general health care issues and chronic and common illness affecting the geriatric population with special consideration to the demands or stresses of caring for children. *"A Critical Thinker's Guide to Home Safety and Maintenance*" addresses housing issues facing older caregiver families, child welfare workers and Norman liaison housing specialists. Both guides should be ready for the Department's review in FY 06.

SYSTEMIC RECOMMENDATIONS

OIG investigative reports include both systemic and case specific recommendations. The systemic reform recommendations for Fiscal Year 2005 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. Recommendation categories are as follows:

- ADOPTION AND POST-ADOPTION
- CASEWORK PRACTICE
- CHILD PROTECTION INVESTIGATIONS
- CLINICAL
- COORDINATION BETWEEN SERVICE PROVIDERS
- CRIMINAL HISTORY CHECKS
- ETHICS
- FINANCIAL ACCOUNTABILITY
- INFORMATION TECHNOLOGY
- INTACT FAMILY SERVICES
- JUVENILE COURT
- LICENSING
- OLDER CAREGIVERS
- PERSONNEL PRACTICES
- PRIVATE AGENCY AND CONTRACTOR MONITORING
- SEXUALLY AGGRESSIVE MINORS
- STATE CENTRAL REGISTER
- TEEN PARENTS

ADOPTION AND POST-ADOPTION

Pre-adoptive parents, ages 60 and older, and their back-up caregivers should be required to meet with the DCFS Adoption Liaison, for the purpose of providing them with an overview of the child's needs and the adoption subsidy, to review the back-up plan, and to discuss the back-up caregiver's role and responsibilities for the child. If the Adoption Liaison identifies concerns regarding the living arrangement or back up care plan, the Liaison should refer the family to the Child Protection Mediation Program.

When a medical report indicates that a caregiver, regardless of age, may not be capable of caring for a child into adulthood, the back-up caregiver should sign a statement that he/she is aware of that fact and is willing to serve as the back-up caregiver.

The Department must revise Rule 302 to provide that the Department has the burden to notify non-custodial parents of all post-adoption subsidy reviews and contract changes, before revisions are made and must allow time for response and input from that parent. The Post-Adoption Unit should not go forward with changes or continuation until this requirement is satisfied and it is noted in the record that it was satisfied, so that the Department can demonstrate that it is in compliance with federal statutes. The Department should send notice to the last known address of a non-custodial parent advising that the subsidy and/or contract is up for review and the parent should contact the Department.

To avoid unnecessary disputes about the degree of assistive technology that special needs wards may require, Adoption Liaisons and caseworkers should be made aware of the assistive technology centers available to determine the appropriate level of assistive technology for a child.

Adoption Liaison staff should be trained in criminal history assessment and assistive technology.

CASEWORK PRACTICE

The Department's contract with housing advocates should be amended to include the development of resources, such as the expertise of journeymen, to assist investigators in resolving difficult questions about home safety issues, such as electrical wiring issues.

The Department should provide training for workers on the confidentiality of medical and mental health information and on obtaining consents for the release of information.

CHILD PROTECTION INVESTIGATIONS

Medically Complex Children

Due to the increased complexity of technology-dependent children, the Department's planned protocol for investigations of medically complex cases must include a standard of investigation that addresses situations where the reporter of the hotline call is a home health professional working in the family's home. Because multiple parties are involved in the child's care in the home and in an effort to minimize bias possibly rooted in relationship conflict, the child protection staff should obtain an independent medical evaluation to help determine abuse or neglect. The independent medical assessment should take into account the comparative risks and benefits of home care and out-of-home care for each child under the circumstances of each case.

Child protection staff investigating families involving children with a Home Waiver should make it standard practice to (1) identify the family's UIC Division of Specialized Care for Children (DSCC) Care Coordinator as a primary source of historical and current information regarding the child, family, the child's care, the home environment, the parents' relationship with health care professionals, and (2) request the DSCC Guidelines to understand the parent-service provider relationship, including role boundaries and parental rights.

The Department's draft definition of "medically complex" or "medically fragile" children should be consistently applied in rule, procedures and policy, and in all documents that refer to medically complex children.

The Department should amend Procedure 300.80, *Taking Children into Protective Custody*, to include a section on Medically Complex Children detailing: (1) Procedures to enable workers to arrange for transport of medically complex children to the most appropriate HealthWorks facilities that can accommodate technology-dependent children and are equipped to handle the child's needs during the initial health screening and admission, unless it is a medical emergency situation. (2) Special arrangements for taking children with severe medical conditions into protective custody. The DCP investigator should involve a DCFS registered nurse to assist with planning and preparation needed to take protective custody, including but not limited to, securing the child's care plan to follow the child, transportation arrangements, hospital admission, and placement issues. (3) Interviewing primary care providers must be interviewed when considering protective custody, and the interviews should be specific to reported allegations. If possible, child protection workers should ask the primary care physician to conduct a home visit for assessment of the circumstances. (4) When a DCFS nurse recommends review of medical information, or identifies sources to interview, the recommendations must be followed prior to concluding an investigation.

The draft Policy Guide 2005, "Referrals to DCFS Regional Nurses" should require that DCFS nurses be immediately consulted in investigations of medically complex children. The suggested five-day referral response time should not apply to investigations of medically complex children; instead, the response should be immediate. It should also require that medical records be retrieved in an expedited manner.

Coordination with Law Enforcement

The Office of Communications should develop a policy that requires contacting Law Enforcement when criminal investigations are pending to determine whether release of specific information might compromise the criminal investigation.

Investigations

Child protection training materials should include that investigators ask doctors' staff for an appointment time to call or meet with doctor in person, rather than leaving phone messages for the doctor.

Child Protection supervisors and investigators should be reminded that a caregiver's adherence to a Department directive does not warrant unfounding an allegation.

Body charts should always be used when there is evidence of bruising and child protection investigators should be trained as to the appropriateness of the use of photographs when documenting bruising on non-Caucasian children.

The Department should support a legislative change of ANCRA to clarify that unfounded reports may always be used internally for disciplinary proceedings and may be shared with prosecuting authorities when necessary to support charges against employees.

Management

Child Protection Managers should reinforce, in monthly meetings and through evaluations, that when investigations remain open beyond 60 days for good cause, it will not be held against managers, supervisors or investigators. Supervisors and managers should ensure that negative evaluations pertaining to a failure to close cases within 60 days are limited to cases without good cause extensions.

The Department should ensure that the Divisions of Child Protection and Licensing be trained on the Illinois Law and DCFS Rules governing a pregnant minor's right to consent to medical procedures without the need to obtain consent or permission from the DCFS Guardianship Administrator.

A representative from the OIG and the DCFS liaison to the Cook County Medical Examiner's Office should attend Cook County DCP Supervisors' and Managers' Meetings to discuss and assist them in developing a rapid retrieval system for information on a child's death.

A representative from the OIG and a representative from the Chicago Child Advocacy Center should attend Cook County Child Protection Supervisors' and Managers' Meetings to discuss the specialized counseling referral process for young girls at risk of sexual exploitation.

Risk Assessment

Child Endangerment Risk Assessment Protocol [CERAP] should be amended to require workers to note when a risk factor cannot be answered because of insufficient information. Under such circumstances workers should be required to perform diligent inquiry into relevant facts for assessment within 48 hours. The Department should develop tight procedures to ensure that there is follow-up and resolution of unknown variables.

The Department should amend procedures and the Child Endangerment Risk Assessment Protocol [CERAP] to require that Law Enforcement Agencies Database System [LEADS] checks be used to inform CERAP decision-making.

CLINICAL

The Clinical Division should develop a protocol for the utilization, monitoring, and supervision of student interns.

COORDINATION BETWEEN SERVICE PROVIDERS

In cases where a child is receiving services from an outside services provider, the agency assigned to the child's case should convene quarterly case staffings. The case staffing should include supervisors, case managers, licensing staff and all service providers. For children whose special needs require therapeutic and supportive services, the staffings will ensure that service providers and foster parents are meeting the child's special needs and helping provide the child with an enhanced living environment.

CRIMINAL HISTORY CHECKS

The Department needs to implement procedures for accessing underlying arrest reports to comply with Administrative Procedure 6. The Department should utilize the Law Enforcement Liaison in the Office of the Director when implementing these procedures.

The Department should amend the Domestic Violence Mini Screen to require the application of Law Enforcement Agencies Database System [LEADS] information.

Management should ensure that investigators are conducting LEADS checks immediately after sufficient information is obtained and during the initial investigation phase (first seven days), using the LEADS information to inform their Child Endangerment Risk Assessment Protocol [CERAP] decision-making, and applying LEADS information to the Domestic Violence Mini Screen.

Administrative Procedure 6 [AP 6] should be amended to conform with Rule and Procedure 431, requiring workers to access underlying documents for the purpose of sharing relevant criminal history with outside service providers.

The Department must immediately develop law enforcement liaisons in each region to assist workers in procuring underlying criminal documents. (*Recommendation reiterated from 2001*).

The OIG will assist the Department's law enforcement liaison in developing and providing training around procurement of underlying public criminal documents and assessing criminal history.

The practice of disseminating the actual LEADS printouts should stop. Instead, LEADS Operators should provide a verbal or written assessment of the LEADS printout, as provided in AP 6.

ETHICS
The Department should issue a reminder on the D-Net of the availability of the Department's Conflict of Interest Committee.

DCFS administrators should receive training on whistle blowing under the Illinois Ethics Act.

FINANCIAL ACCOUNTABILITY
To ensure that future disbursement of Flexible Funds is justified, the Department should immediately ensure that all Local Area Network [LAN] Liaisons, Fiscal Agents and Co-conveners have copies of the Program Plan and the Guidelines for Application for Flexible Funds.

Immediate interim measures should be instituted and the Program Plan for all LANs must be amended to reflect the following checks and balances:

- The Program Plan must specify that all disbursements must be approved at LAN meetings.
- The fiscal agents for all LANs must be required to ensure that all requests for funds are supported by LAN minutes of approval. If an emergency exists, the fiscal agent must ensure that the LAN approves the disbursement at the next meeting. All emergency request approvals outside of a LAN meeting must be documented.
- The LAN must designate a person to contact the parent to ensure receipt of funds and the person designated must not be the Facilitator. If any signature appears to have been signed by proxy, the Fiscal Agent must contact the signor and verify that the signature was authorized.
- The Facilitator may not sign the Approval for funds.
- The Fiscal Agent must maintain a current list of all employees of LAN agencies to ensure that checks are not issued to LAN employees.
- Any requests for rent payments or security deposits should be accompanied by a lease or a notarized statement from the landlord.

The Department should initiate a statewide audit of all of the LANs funding operations and establish strict accountability procedures for the disbursement of funds.

Private agencies should be advised to require that requests for public funds targeted for victims of domestic violence must be accompanied by a police report or an order of protection for verification.

The Department's Office of External Affairs should coordinate the solicitation and acceptance of cash and in kind donations from outside sources. The Department must implement procedures within the Office of External Affairs to provide financial accountability and controls.
NOTE: *Since the Office of External Affairs was abolished, the OIG clarified its recommendation to require centralized management and strict accounting of such donations.*

INFORMATION TECHNOLOGY
The Department should institute a lock down procedure for the Statewide Automated Child Welfare Information System [SACWIS] case entries and pending investigation notes when informed that a DCFS-involved child has died.

The SACWIS screen of prior indicated reports should be part of the "hand-off packet" for intact cases.

Alterations to the "finding" and "finding date" fields on the DECISION tab in SACWIS should be restricted to supervisors and administrative staff. Case closures require supervisory approval and caseworkers should not have access to change these fields at any time during an investigation.

Intact Family Services supervisors should have access to child abuse/neglect investigations in the SACWIS system on a “read only” basis to enable informed service planning and decision-making.

All DCFS supervisors should have access to the Internet for evidence-based research in order to develop a knowledge base on relevant issues.

INTACT FAMILY SERVICES

Substance Abuse

Cases in which a mother gives birth to a third substance-exposed infant should not be assigned to private agencies through the regular case assignment rotation system. These children require the services of private agencies that have the capability and expertise to provide necessary critical services to substance-affected families. Substance affected families referred for intact family services should be referred for specialized intact family services, such as the Intact Family Recovery Program.

The Department's AIDS Project should establish a tracking system that includes monthly identification of substance-exposed infants with coordination with the foster care or intact providers to assure competent services and necessary medical testing. For intact families with substance exposed infants, parental consent should be sought for any medical testing or procedures along with consent for results to be shared with DCFS. Refusal of consent should prompt review for court screening for either an order of protection or temporary custody.

The DCFS consent form for release of information of a child's medical records should specify HIV test results for all substance exposed infants and children.

In recognition of the difficult process of addressing drug dependency, intact family workers should receive cross training in both child protection and substance abuse, and case management services should be extended to at least 18 months.

The OIG renews its previous recommendations that the Department must recognize that specialized knowledge is required to work with drug-abusing parents and must implement training and programs to enable coordinated and collaborative drug abuse interventions.

The Department's services to substance-abusing clients must match the client's presenting problem. In the past, the OIG has recommended that the Department provide services that appropriately address the problems that brought the family into the child welfare system. This recommendation is reiterated, especially noting the need for long-term, uninterrupted child welfare services that are not available through private agency Family First programs, as the contracts are currently written.

Child welfare staff should contact the Division of Service Intervention when they have substance abuse related questions. The Department should send out a policy transmittal notifying child welfare staff of the specialist and how the specialist can be contacted. Additionally, the transmittal should clarify that only 2% of presumptive positive results are determined to be incorrect upon confirmation.

Education
The Department should extend the expectation that wards are immediately referred for pre-school education, including early intervention services, as identified in Procedures 314.70, to children at home with their parents.

The Department, in conjunction with the Office of Education and Transition Services, should 1) review the efficacy of the Youth In College Program's early identification and enrollment of wards, 2) eliminate the need for transfer between Youth In College and Youth In Employment during summer breaks and pursue a single seamless program, 3) make relevant Youth In College documents available on-line to DCFS wards, and 4) accept submission of documents electronically as an option.

Extended Cases
Cases with a goal of return home for more than three years should be reviewed by management to determine if management intervention is needed.

JUVENILE COURT
The OIG should meet with the Cook County State's Attorney's Office to develop solutions to continuing disagreements regarding safety concerns identified by the Department where the State's Attorney declined to screen the case into court.

The DCFS Southern Region should convene a workgroup of supervisors, managers, mental health professionals and states attorneys in the Southern Region to develop a collaborative approach to cases involving dependency and risk of harm to ensure that protective custody is taken when necessary.

The Statewide Automated Child Welfare Information System [SACWIS] screen of prior indicated reports and the packet used for screening with the State's Attorney's Office should be included in the DCP hand-off packet given to the follow-up worker at the Temporary Custody Hearing.

The HELP Unit is a division of DCFS that provides clinical assistance for complex, court-involved cases. The DCFS Clinical Division and the HELP Unit should develop a HELP Unit Face Sheet that includes present and historical information about the DCFS case involved in the staffings. The Face Sheet should include information about current and previous DCFS involvement; household compositions, alternative caregivers, paramours and criminal backgrounds; issues involving current or previous substance abuse, domestic violence, physical and mental health; school attendance, educational issues; any other concerns that directly impact the safety and well-being of the involved children.

The HELP Unit should discontinue the practice of accepting oral safety plans and should require that all safety plans be documented and shared with all relevant parties.

LICENSING
The Department's Licensing Standards for Child Welfare Agencies (Rule 401) and Child Care Institutions (Rule 404) should be amended to prohibit a familial relationship between the Executive Director and Financial Officer/Accountant at the same agency.

If a foster parent's chronic illness becomes acute, a licensing worker should consult with the treating physician with the consent of the foster parent to determine the foster parent's ability to continue caring for the child(ren).

The foster home license application form should be revised to question whether the applicant has ever received child welfare services from the Department. The processing of the application should also require a CYCIS check to confirm this information.

OLDER CAREGIVERS

The Department should inform child welfare staff and officers of the court to refer cases of suspected dementia to the DCFS Help Unit to ensure immediate and appropriate referrals for geriatric assessments (the OIG included a list of Geriatric health services in the Chicago area).

PERSONNEL PRACTICES

The OIG and the Department must distribute an informational pamphlet alerting POS personnel departments to safe hiring practices.

The Department must develop a protocol for assisting its own and POS personnel offices in retrieving underlying criminal documents to assess truthfulness and suitability for child welfare employment.

As a prerequisite for employment, a private agency's human resource department should ensure that foreign academic credentials are verified and that job applicants, at their expense and prior to hire, produce an evaluation of their credentials to determine whether the person's education is equivalent to that of the U.S. education system.

The Department should review and analyze the Burgos Compliance Reports as tools to gather specific data to inform future staffing and hiring decisions.

A Spanish-speaking worker should be hired by the Department to service the southern region. This worker should be cross trained in investigations and child welfare services, and, in addition to regular duties, would assist on an emergency basis with investigations and intact family services until the case can be transferred to a contracted agency with intact bi-lingual employees.

The Department should develop a tracking mechanism for reviewing multiple Authorizations for Background Checks and alerting private agencies when inconsistent information has been provided.

Management should immediately review caseloads at this local DCFS office to determine critical positions that must be filled to bring the office in compliance with the B.H. Consent Decree.

Child Protection Management should ensure that Quality Assurance is capturing necessary data to permit easy assessment of staffing needs. Specifically, current caseload assignment information should differentiate between full investigations and mandates.

Management should be provided with training to assist in resolving difficult environmental employee issues.

PRIVATE AGENCY AND CONTRACTOR MONITORING

The Department should develop procedures for Agency Performance Team monitoring of agencies and Agency Performance Team monitors should be trained to competently carry out monitoring responsibilities. Procedures should provide guidelines for, but not be limited to, substantive reviews of children's case records, verification of agency compliance, review of foster parent license files when necessary, development of corrective action plans, and formal exchange of information with other

monitoring units of the Department's POS Monitoring Division (Agency and Institution Licensing, Office of Field Audits, Contract Compliance Unit) to achieve an integrated assessment of a private agency for appropriate action.

Agency Performance Teams (APT) should track staff turnover at all agencies and forward to Agency & Institution (A & I) Licensing information about agencies with significant staff turnover to determine if A & I Licensing needs to intervene with the agency board's personnel committee. Turnover rates should be reviewed as potential signs of problems at an agency necessitating APT intervention.

The private agency's Board of Directors was required to analyze and develop corrective actions to address the agency staff turnover rate and deficiencies in its supervisory and timekeeping systems.

The private agency's Board of Directors' Personnel Committee should review with the private agency's management the problem of high staff turnover.

DCFS should implement a mechanism by which child and family case files, once closed, are returned to the Department from private agencies for archiving.

The Board of Directors' Program Committee of a private agency that demonstrated casework deficiencies with youths with developmental disabilities and substance abuse issues and school attendance for wards was asked to review monthly reports from agency management regarding interventions for children with (1) developmental disability, (2) high absenteeism rates (more than 10 days a semester), or (3) substance abuse problems.

Any private agency failing to provide adequate services for an older caregiver must require foster care staff participation in the Older Caregiver training.

Any private agency demonstrating deficiencies in services for older caregivers should be asked to carefully review cases of children who are in the care of foster parents and pre-adoptive parents who are 60 years old and older, and identify concerns regarding living arrangements and caregiver back-up plans in order determine if the family should be referred to the Child Protection Mediation Program.

The Department should cease using a HealthWorks medical provider for initial health screenings or comprehensive health evaluations of medically complex or technology-dependent children. The Department should review all HealthWorks medical providers statewide to determine which providers are equipped to handle these special children and ensure that child protection staff utilizes HealthWorks providers accordingly.

SEXUALLY AGGRESSIVE MINORS

The OIG will ask an expert from the National Center on Sexual Behavior of Youth (NCSBY) to assist DCFS clinical in reviewing the latest research on assessment and treatment of adolescent sexual offenders, including community safety and supervision issues.

The new standards being developed to address services to sexually aggressive children should contain information from empirical research concerning the sexual behavior of children from different developmental stages. The Standards should include as appendices the fact sheets published by the National Center on Sexual Behavior of Youth (NCSBY).

The new SAP (Sexually Aggressive Persons Protocol) must be amended to incorporate Integrated Clinical Assessment into the reporting structure.

Intake should be streamlined to be clinically coordinated within the Integrated Assessment process instead of creating a duplicative uncoordinated system of clinical intervention. A centralized trained person should be available to assist in assessing behavior and to ensure consistency across the state.

Children under the age of 8 who have problematic sexual behaviors should be referred for an initial or updated Integrated Assessment, specifically designed to account for different developmental stages.

Children age 8 and over should be referred for an initial or updated Integrated Assessment when problematic behavior occurs. Sexually problematic behaviors should be treated separately from sexually aggressive behavior. Only when the aggressive behavior rises to the level of immediate danger to other children should a call to SCR be made, initiating an emergency protective plan developed in the absence of information obtained through the Integrated Assessment.

STATE CENTRAL REGISTER

SCR should revise the Notice of Indicated Finding sent to parents to comply with Rule 336.60. The current Notice does not inform parents of the identity of the indicated perpetrator.

TEEN PARENTS

TPSN workers should be trained to: use the psychosocial assessment tool; be proficient at identifying stable and changing risk and protective factors; develop a specific parenting plan that builds on teen parents' social support and positive parenting skills; and monitor the progress of mental health treatment to identify areas of weakness and deficiency.

In cooperation with the National Alliance for the Mentally Ill (NAMI), supportive psychoeducational and peer support programming should be developed for teen parents with Major Depression, Bipolar Disorder, and other psychotic disorders. A representative of NAMI has offered to work with the Teen Parent Initiative to set up and pilot a short-term psychoeducational mental health and peer support group for appropriate teen parents with mental health problems.

All teen-parent wards with children who have a chronic health problem should receive specialized training on their children's health problems, using DCFS *A Guide for Care Manual.* The caseworkers should baseline and plot parents' progress in applying the guidelines to the child's medical care.

The collaborative training by the Chicago Department of Health, the Teen Parenting Service Network, DCFS, and the Chicago Park District on teen violence prevention should be replicated to serve all of DCFS' Cook County teen parents. Similar programming should be developed for the rest of the State.

Family mediation sessions should be initiated for teen-parent families to delineate the voluntary terms of alternative or back-up caregiver arrangements.

DCFS should convene a panel of psychiatric, medical and child welfare practice clinicians to develop special criteria for assessing risk to children of wards where there are underlying conditions and a pattern of behavior by the parent that are problematic but have not yet resulted in abuse or neglect. The panel should consider recommending use of specialized counseling to determine the ward's desire to continue parenting or the use of the dependency provisions of the Juvenile Court Act to screen children of wards into court when the special criteria of risk specified by the panel are met.

The Department should ensure that, once the Teen Parent Services Network is notified by UIR of a pregnant or parenting ward who is 14 years of age or older, it must arrange for Title X counseling of that ward within 48 hours.

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.

- A private agency caseworker initiated two romantic relationships with two compromised clients.
- A child protection investigator falsified several case notes of interviews she did not conduct in a child protection investigation of alleged sexual molestation.
- A supervisor failed to note obvious discrepancies in a falsified child protection investigation.
- A Department employee diverted Department funds intended for families in need to relatives and friends.
- An intact family caseworker servicing a long term split-custody case failed to assess the safety of the child at home; failed to provide early intervention services to the child; failed to ensure that the mother was receiving needed mental health services; failed to communicate with child welfare and other professionals servicing the siblings in placement, failed to adequately document case activity and failed to ensure that the children's needs for permanency were addressed.
- An intact family supervisor in a split-custody case failed to assess the safety of the child at home; failed to ensure that early intervention services were provided to the child; failed to ensure that the mother was receiving needed mental health services; failed to ensure that the caseworker communicated with child welfare and other professionals servicing the siblings in placement; and failed to ensure that the children's needs for permanency were addressed.
- A child protection manager and child protection investigator failed to take protective custody of a five-year old child who was living in a home with a registered child sex offender. The child sex offender had exhibited behavior that demonstrated his lack of boundaries during the child protection interview, which the investigator had documented in her notes. A second man, who was an indicated sex abuser frequented the home and was found to have violated a safety plan in which he was not to be left alone with the child. Rather than taking custody, the manager and investigator devised a safety plan that depended on the promises of other caretakers to ensure that the child was never alone with either of the men. The only other caretakers in the home were the child's aunts, who had significant developmental disabilities and did not believe that the men presented any risk to the child; one of the aunts had previously been married to the man living in the home and the other was his current fiancé.
- A child protection investigator failed to review SACWIS information regarding the existence of a safety plan prohibiting an indicated sex abuser who frequented the home from being left alone with the child, and therefore did not realize that the circumstances in which she found the child, alone with an indicated sex abuser, was a violation of an existing safety plan.
- A child protection investigator allowed a child to return to the care of an indicated sex offender. The investigator had brought the offender and child to the DCFS office, but was told by her supervisor to permit the child and caretaker to leave.

- A Department employee violated Rule 437, Conflict of Interest, by accepting Department funds intended for families in need for her own use.

- An intact family supervisor (1) neglected to ensure that children were safe and properly monitored through intact family services; (2) failed to take protective custody of a medically fragile infant whose mother was non-compliant with drug treatment, who was involved in a domestic violence relationship, and who demonstrated impulsive and verbally aggressive behavior; (3) failed to explore placement options for the infant before placing him in a shelter; and (4) demonstrated poor judgment when he proposed an inexperienced 19-year-old become the children's guardian without full information or assessment of the young adult.

- An intact family caseworker (1) failed to take protective custody of a medically fragile infant whose mother was non-compliant with drug treatment, who was involved in a domestic violence relationship, and who demonstrated impulsive and verbally aggressive behavior; (2) failed to explore placement options for the infant before placing him in a shelter; (3) failed to inform shelter staff about the medical condition of the fragile infant; and (4) failed to contact the mother after leaving her and two children at a shelter.

- A child protection investigator and supervisor failed to identify and investigate the presence of domestic violence in a home; failed to complete a LEADS checks on the father with whom the children were having contact; and failed to attend a 'hand-off' meeting with intact services after discussing the possibility of screening the case with court indicating that there was moderate to high risk to the children.

- A child protection investigator failed to identify substance abuse as an issue possibly compromising a mother's ability to care for her child despite the mother's admission that she smoked cocaine weekly prior to her pregnancy and had a history of heroin addiction. The investigator failed to revise the Child Endangerment Risk Assessment Protocol or implement a safety plan in response to revelations of domestic violence issues and further evidence of serious substance abuse. The investigator also failed to conduct a LEADS check or interview the father, who was living in the home, and failed to verify the mother's assertion that a neighbor provided childcare while the mother used cocaine.

- An intact family caseworker and supervisor inadequately assessed risk to a child and failed to provide a student intern adequate case oversight, counseling, or the supervision necessary to competently manage a complex substance affected family case.

- A private agency supervisor assisted a child's grandmother in obtaining custody of her grandson when the existing safety plan prohibited the child from being cared for by the grandmother because of alcohol abuse. The supervisor subsequently failed to take immediate action to ensure the child's safety when presented with imminent risk of harm to the child.

- A child protection investigator developed an unrealistic safety plan, failed to contact the paternal grandmother in relation to the safety plan, failed to obtain police reports as directed by her supervisor, and failed to request LEADS information in a timely manner.

- A supervisor approved an unrealistic safety plan in a home with extreme domestic violence and substance abuse issues and failed to ensure that the investigator completed directed tasks of obtaining police reports and conducting a LEADS check in a timely manner.

- A private agency supervisor, who supervised both the case manager and licensing worker, failed to ensure that critical information regarding the child's injuries and the foster mother's reports of the injuries was shared between case management and licensing staff. The supervisor also failed to act on the information provided by case management and licensing staff to ensure the safety of the child.

- A child protection manager (1) signed a Consent for emergency medical treatment for a non-ward without seeking parental consent; (2) directed protective custody be taken without evidence of the presence of imminent danger to the child; (3) failed to make reasonable efforts to prevent removal of a medically fragile child from her home; and (4) failed to ensure adequate care of the child after taking protective custody.

- A child protection investigator denied the parents of a medically complex child the right to visit their child while she was in the hospital without evidence of risk of harm. The investigator also failed to gather critical information during the child protection investigation.

- A caseworker conducted only *announced* home visits in monitoring a home in which a child lived with a registered child sex offender under a safety plan administered by two developmentally delayed adults.

- A Department manger failed to provide clear direction and assistance to the field in a difficult case and failed to disclose his own conflict of interest with the case. The manager had participated in discussions regarding handling of the case and was later asked to initiate investigatory interviews concerning the case.

- A manager failed to rectify problems repeatedly identified in numerous chronic and one critical ACR feedbacks.

- A private agency homemaker provided false information in her casenotes.

- A child protection investigator failed to recognize the risks to the children placed with a relative. During the child protection investigation, a doctor advised the investigator that the relative should not be caring for the children. The investigator also failed to consider the relatives' inability to ensure the children attended school, reports of inadequate clothing, and the squalid conditions of the home.

- A child protection investigator failed to interview the attending physician (or an expert physician) to inquire whether an infant's head injury was likely accidental or abusive, failed to obtain medical records from the treating hospital, and failed to further investigate conflicting information gathered in the course of a child protection investigation.

- A supervisor failed to substantively supervise a child protection investigator, ensuring that she fully investigated a case of a head injury to an infant. The supervisor's notes contained boilerplate language rather than specific investigative tasks related to the allegation of a head injury.

- A Department administrator failed to note on the OIG's *Statement of File Integrity and Security* changes that had been made to the record after the death of a child.

- A supervisor assigned an indicated follow-up case to an intact worker who was on vacation when another worker with more experience was available and had a similar caseload.

- A Department employee engaged in off-duty conduct involving access to child pornography.

- A child protection supervisor failed to ensure that investigatory protocol, including a LEADS check and interviewing the reporter, was followed and failed to add a risk of harm allegation to a medical neglect investigation in which the mother's drug lifestyle compromised her ability to care for her children.

- A child protection investigator failed to contact the child's physician, failed to conduct an investigation of the family's collateral contacts, and demonstrated poor risk assessment in assuming that alleged abuse by mother could be addressed by lecturing the family on the importance of protecting the child.

- A supervisor signed off on a child protection investigation that did not include the required physician contact but a faxed "contact," and she did not ensure that her own instructions were followed (i.e., to see the collateral contacts, to confirm diagnosis with pediatrician, etc.)

- A supervisor failed to document oral complaints against an investigator, failed to retain records of written complaints in supervisory files, and provided misinformation to the OIG when questioned about the existence of prior written complaints.

- A private agency caseworker was paid for working as a caseworker while he was working a second job as a substitute teacher.

- A Department employee 1) failed to fully disclose to the court that a potential caregiver had recently tested positive in a drug screen; 2) suggested to private agency staff that they withhold the information from the court and court personnel about the caretaker's positive urinalysis; 3) avoided a direct question by the judge about an assessment of the caretaker; and, 4) failed to tell the court about an existing safety plan to protect the child from the caretaker until the positive drug screen could be confirmed.

- A caseworker provided a letter to an attorney that stated that the client was fully compliant with services, when the client, who was required to participate in substance abuse services, had failed to appear for one drug screen and had tested positive on the most recent drug screen. The caseworker had been notified of the positive drug screen.

- A caseworker and supervisor failed to ensure that a drug abuse counselor received critical information for treatment. The caseworker had learned that the client was being criminally investigated for illegal sale of prescription drugs and had tested positive for abuse of prescription drugs.

- A licensing representative engaged in conflicts of interest by soliciting contributions to a not-for-profit cause and conducted outside business with staff from agencies that she regulates.

- A private agency manager failed to alert a new supervisor to the serious performance deficiencies of an existing worker.

DEPARTMENT UPDATE ON FY 04 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.

The DCFS field auditors' site visit to the private 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 must be established and implemented; establish and implement effective internal accounting controls; achieve resolution of the apparent conflict of interest involving the CPA firm; the agency should hire a new auditor; compliance with the Illinois Procurement Act and DCFS contracts (from OIG FY 04 Annual Report, General Investigation 9).

FY 04 Department response: The Contract Compliance unit went to the agency to get updated information. The Licensing Unit has prepared a corrective action plan for the agency. APT has submitted their report and is waiting for the overall report to come back from contract compliance. At that point the Department will proceed with follow-up action.

FY 05 Department update: The agency is on a corrective action plan for both programmatic and financial concerns and non-compliance to DCFS contractual provisions.

FY 05 Agency's update: The agency's deficit has been reduced by $36,000 during FY 04 and the agency has a Board-approved, DCFS-reviewed deficit reduction plan in place to continue this trend of reducing the deficit. The agency has hired a new auditor.

Rule 434, Audits, Reviews and Investigations of the Office of Field Audits procedures should be amended as follows:

- **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 simply 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 (from OIG FY 04 Annual Report, General Investigation 9).

FY 04 Department response: Rule 434 has been revised and is in the review process.

FY 05 Department update: Rules 356, 357 360 and 434 were amended simultaneously to transfer requirements in an existing rule to the more appropriate title. None of these recommendations were incorporated because they are already addressed. The Division of Budget and Contracts notes that it is a Government Accounting Office requirement that agencies have a comprehensive cost allocation system; non-allowable costs are excluded from payment; auditing procedures identify when a cost allocation is not clear and follow-up occurs; all excess revenue review letters, for substitute care including profits or losses are directed to the Deputy Director.

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 (from OIG FY 04 Annual Report, General Investigation 9).

FY 04 Department response: Seven staff have been added to address this issue.

FY 05 Department update: Additional field audits have been completed due to the addition of five staff members and streamlining of the process. The Field Audit procedures direct the Auditors to focus on 6 areas: Internal controls, board oversight, financial records, spending patterns, cost allocation, and payroll and tax liabilities.

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%; as, the document provides assurance that the agency is in compliance with Federal and State laws, the forms are a valuable source of salary data, and the forms provide a list of Directors of the Board, and their compensation, if any (from OIG FY 04 Annual Report, General Investigation 9).

FY 04 Department response: This recommendation is under review.

FY 05 Department update: During the Desk Review process a letter will be sent to all agencies that submitted an audit report for fiscal year 2004 requesting that the AG990 be submitted along with their independent audit reporting package for fiscal year 2005. This process has started and will continue through March 2006.

The OIG reiterates the following recommendations previously made in OIG report #020161:
a. 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.
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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 5).

FY 04 Department response: The Department agrees. The Office of Child and Family Policy and DCP 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 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 SAF 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.

FY 05 Department update: Revised procedures for Intact Families were distributed in October 2005. The revised procedures require weekly face to face contact with the family. Workers are to refer families with a second or more substance exposed infant to specialized treatment services for substance misuse/abuse.

Service Intervention is currently completing the re-write of substance affected family policy guide (99.13). Final policy will be disseminated by February 2006 and the training is scheduled to be rolled out and completed by June 2006.

OIG Note: The final revised Appendix O does not address specialized intact services or orders of protection. The OIG will enter into discussions with the Department to determine how the recommendations can be otherwise implemented.

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 (from OIG FY 04 Annual Report, General Investigation 2).

FY 04 Department response: The Department will review the current process and make any appropriate revisions. Implementation date: April 2005

FY 05 Department update: The Director's Office, Labor Management, and DCFS Legal are conducting meetings to prepare a comprehensive waiver plan.

At the time any family reaches an "M" sequence (13), 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 identified in this report. 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 Team should specifically evaluate the county

to determine if there are problems particular to that county (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 1).

FY 04 Department response: A management review team completed its review in September 2004. The team is working on the analysis to forward to DCP & DPO. Once received, implementation efforts will be focused on this field office. Completion date: February 2005

FY 05 Department update: Quality Assurance completed a review of the 12 families identified at Sequence M. All reports that reach the thirteenth sequence are subjected to weekly review by an upper level administrator with oversight by the Division of Child Protection. Additionally, all activities, information gathered and case plans are assessed. Administrative guidelines state that all subsequent oral reports will have the weekly scrutiny to monitor appropriate interventions and case directives. This is an on-going activity.

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 potentiality of violence when families present issues of physical violence combined with possession of weapons (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 1).

FY 04 Department response: OCFP developed Procedures 302, Appendix O, Intact Families to strengthen the services and interventions provided. DCP is further revising Procedures 302. ACR Critical & Chronic Feedback Reports were distributed for review in November 2004.

FY 05 Department update: Procedure 302.388 was released and distributed to the field in October 2005.

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 all previous and relevant psychological assessments for the service providers. Service providers should receive all prior assessments and requests for assessments (from OIG FY 04 Annual Report, General Investigation 21).

FY 04 Department response: A tracking system has been created and will be in place by January 2005.

FY 05 Department update: The tracking system log was tested on a statewide basis with Sexual Abuse Service Coordinators from January to March 2005. Full implementation went into effect in March 2005.

The Department must immediately implement the OIG's previous recommendations for the SACY program made in FY 2000 and accepted by the Department (from OIG FY 04 Annual Report, General Investigation 21).

FY 04 Department response: Revision 302, Sub-Part B will be finalized by January 2005.

FY 05 Department update: Distribution of the revised Procedure 302 is deferred pending a revision in statutes. OIG recommendations are incorporated. The new Legislative Liaison will be asked to address the change in statutes.

DCFS clinical should immediately refer this family to a Parenting Assessment Team. The father's bi-polar diagnosis and the mother's extensive substance abuse warrants the intensive assessment. Further, DCFS needs guidance for future service planning and placement of the children (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 23).

FY 04 Department response: The DCFS PAT Administrator has referred this family to a Parenting Assessment Team. The mother refused to sign consents. The father has signed consents for assessment scheduled for January 2005. A committee is updating 302, Appendix O, Services to Intact Families and will strengthen the sections for servicing families with substance misuse. Completion date: February 2005

FY 05 Department update: Throughout the life of the open case, the family has refused services. The court closed the case in August 2005.

Procedure 302.388, Intact Family Services was released for comment by OCFP from 07/28/05 through 08/19/05. Based upon comments and any needed revisions, an implementation date will be established. Policy Guide 99.13 (Substance Exposed Infants/Substance Affected Families) is still being revised with a targeted completion date for Spring 2006.

DCFS management should assure that the case is closely monitored as the parents have a history of deceiving DCFS 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-reports should be corroborated. The corroboration should be documented. DCFS should establish strict guidelines the mother must adhere to before she is allowed unsupervised contact. The Department's Liaison to OASA should be contacted to help develop these guidelines (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 23).

FY 04 Department response: The assigned worker is making weekly contact with the family and has access to experts in the field of substance abuse for consultation.

FY 05 Department update: Throughout the life of the open case the family has refused services. The court closed the case in August 2005.

The OIG reiterates a previous recommendation that 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 (See OIG# 03-0505 January 26, 2004). (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 23).

FY 04 Department response: The Department agrees. OCFP and DCP 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 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 SAF 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.

FY 05 Department update: Procedure 302.388 (Intact Family Services) was distributed to staff (after incorporation of pertinent comments) via the d-net on October 19, 2005. The Division of Service Intervention (SI) is the responsible lead division and is completing its tasks of updating and revising Policy Guide 99.13 (Substance Exposed Infants/Substance Affected Families), revising the Adult Substance Abuse Screen, developing a screening tool for adolescents, developing training, etc. DCP is represented on the workgroup with SI. It is believed SI will be completed by the beginning of 2006. Training is targeted for Spring 2006.

In an April 1, 2004 interim report the OIG recommended that DCFS clinical should immediately refer this family to a Parenting Assessment Team. According to the 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 23).

FY 04 Department response: The court has been advised of the mother's lack of cooperation - she has refused to sign the consents based on her attorney's advice. The father has signed consents and has PAT appointments in January 2005.

FY 05 Department update: Throughout the life of the open case the family has refused services. The court closed the case in August 2005.

When case and licensing transfers between agencies occur, the POS Division should track child and foster home files by establishing records inventory and sign-over procedures (from OIG FY 04 Annual Report, General Investigation 1).

FY 04 Department response: Sign-off procedures will be established. Implementation Date: January 2005.

FY 05 Department update: The transferring agency has the responsibility to identify in SACWIS that the case has been transferred to another agency and the date of the transfer.

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 (from OIG FY 04 Annual Report, General Investigation 1).

FY 04 Department response: 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 to develop a process. Implementation date: March 2005

FY 05 Department update: Procedure revisions are in process.

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 (from OIG FY 04 Annual Report, General Investigation 1).

FY 04 Department response: Foster home licensing staff will convene meetings with caseworkers with children currently placed in a foster home prior to their annual and monitoring home visit by the licensing worker. Implementation date: April 2005.

FY 05 Department update: The process has been implemented.

DCFS licensing enforcement procedures must provide for immediate licensing revocation proceedings with findings of egregious licensing violations (from OIG FY 04 Annual Report, General Investigation 1).

FY 04 Department response: Enforcement Rule 383 is currently under review and the definition for egregious will be included.

FY 05 Department update: Rule 383 is currently under revision. Target date: March 2006

A ward involved in a serious physical altercation should meet with the Medical Examiner to ensure his awareness and acceptance of responsibility for the other ward's injuries (from OIG FY 04 Annual Report, General Investigation 13).

FY 04 Department response: An update will be provided February 2005.

FY 05 Department update: The ward refused to speak to the Medical Examiner. The ward is now over 18 years old and has an Independence Goal.

The Department must work aggressively with a ward's father as a potential resource for return home (from OIG FY 04 Annual Report, General Investigation 13).

FY 04 Department response: An update will be provided February 2005.

FY 05 Department update: The ward has an Independence Goal and his biological father has admitted not being able to care for him.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: Procedure 383, Licensing Enforcement revisions will be completed by March 2005.

FY 05 Department update: The Office of Child and Family Policy (OCFP) has received a request for an extension of the review period for Rule 383. Comments that have already been submitted are being reviewed by Licensing and OCFP.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: R 401.25 is being amended to incorporate OIG recommendation requiring DCFS & POS to conduct monitoring visits at the same intervals. Completion date: March 2005.

FY 05 Department update: Procedure 402 has been revised to include these recommendations.

As previously recommended in OIG # 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: A utilization review is being done 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.

FY 05 Department update: Procedure 402 has been revised to include these recommendations and distribution is pending approval of the primary division.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: Quality Assurance will convene a workgroup comprised of QA and Licensing Staff to develop the procedures for reliability checks for the purpose of identifying foster homes with a CANTS report. Implementation date: April 2005.

FY 05 Department update: QA will begin conducting semi-annual reviews beginning January 2006 of a random sampling of CANTS reports to Licensing for reliability purposes.

Licensing currently has field notifications of indicated CANTS perpetrators applying for clearances to work in a licensed childcare facility stored on the G drive of the Departments computer network. QA may be granted access to review a sampling of these reports for reliability checks. IMSA screens may also be reviewed to determine if a correct identification has been made. Hard copies of these files are located in Central office of Licensing for further verification.

Finally, the Background Check Unit (BCU) performs all CANTS checks on individuals requesting clearance to be licensed or employed by a childcare facility. Authorizations for this check (CFS 718 (E)) are completed and submitted by each individual seeking employment or licensing. BCU uses SACWIS to soundex each 718 to determine if a match is found. If additional information is needed, the supervising agency or individual requesting clearance is contacted to determine if the individual is the actual perpetrator.

A supervisor should be counseled for failing to adequately supervise a worker. He neglected to act when made aware of potential problems in the foster home and did not instruct the 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 DCP staff and the multi-worker assessment staffing, or to facilitate a meeting when the APT monitor did not. The failings noted in this report should be reflected in his next performance evaluation (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: Employee will be counseled. Completion date: January 2005

FY 05 Department update: Because of exceeding the acceptable timeline in Merit Comp discipline, the Department is proposing unofficial discussions with the supervisor.

OIG Response: Provided that the failures are noted in the appropriate evaluation, as recommended, the OIG agrees.

The Department should consider not renewing the contract this 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: The FPSS currently has a reduced contract. The Department will evaluate renewal for FY06.

FY 05 Department update: The FPSS continues to work as a foster parent support specialist. The Department renewed her contract as she had advocated well for the foster home she currently supports. This FPSS is one of the few foster parent support specialists that have continued to work under the FPSS contract. Her contract will be re-evaluated again prior to the FY07 contract year.

A redacted version of this report (#031079) should be used as a training tool with Child Protection Investigators, licensing workers and supervisors (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: CPSW training is currently under revision and applicable sections of this report will be incorporated in training modules. Completion date: May 2005.

FY 05 Department update: The CPSW training curriculum for new DCP hires has been completed and approved by the DCP Deputy Director. A representative from the OIG participated on the workgroup and reviewed the curriculum for inclusion of and compliance with OIG recommendations.

The therapist for a ward who was severely abused by his foster parents should develop a therapeutic intervention to address the Department's failure to protect him. The therapist should also address visitation with his siblings (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 04 Department response: This has been completed. The ward's siblings have been adopted and the Department will explore visitation.

FY 05 Department update: Operations Staff and the APT Liaison are coordinating sibling visits.

The Department and the State's Attorney's Office should convene a working 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 8).

FY 04 Department response: A workgroup to address this has been convened. Completion date: May 2005.

FY 05 Department update: A meeting was held between DCFS Legal and the State's Attorney's Office. Orders of Protection will be considered as an option in all cases.

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) (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 8).

FY 04 Department response: An Intact Family Services workgroup was convened and is currently revising/updating Procedures 302-Appendix O. The procedures should be completed by January 2005.

FY 05 Department update: Procedures 302.388 were released for agency-wide comments during the month of August 2005. Comments from the OIG and other entities were incorporated and the Procedure distributed to staff on October 19, 2005.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 6).

FY 04 Department response: Completion date: May 2005.

FY 05 Department update: Procedure 302 was distributed October 20, 2005.

The Department should revise Department Procedure Part 302 – Services Delivered by DCFS to include Procedures for Assisting Fathers to File for Custody When the Parents Are Not Legally Married (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 23).

FY 04 Department response: An Intact Family Services workgroup was convened and is currently revising/updating Procedures 302-Appendix O.

FY 05 Department update: Procedures 302.388 were released for agency-wide comments during the month of August 2005. The Procedures for Assisting Fathers to File for Custody When Parents Are Not Legally Married were incorporated into 302.388. Comments from the OIG and other entities were incorporated and the Procedure distributed to staff on October 19, 2005.

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 criminal investigation for a crime, which, if true, would jeopardize the health, safety or welfare of children to be placed in the home, the Director may place an involuntary hold on the placement for up to 60 days without notice to the foster parent (from OIG FY 04 Annual Report, General Investigation 4).

FY 04 Department response: The Department agrees that the Director may place an involuntary hold on a foster home and the Department will notify the agency in confidence.

Procedure 301 is currently being revised and language authorizing the Director to place a hold without notification to the foster parent will be included.

FY 05 Department update: This revision is currently being reviewed in OCFP. The revision includes language allowing the Director to place an emergency hold on a home without notice for up to 60 days.

To address deficiencies noted in this report, the Department should institute investigative training targeted specifically to this geographic area. The training should be two tiered. Management and supervisor investigative training should address: The need for individual 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 2).

FY 04 Department response: The CPSW curriculum revision will include processes for completing scene investigations, creating timelines, verifying mechanics of injuries and the critical analysis of operating assumptions and biases. Completion date: May 2005.

FY 05 Department update: The Curriculum was completed March 2, 2005.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 2).

FY 04 Department response: The Department will clarify nurse roles and responsibilities including the reporting structure by June 2005.

FY 05 Department update: The Nurses reporting structure has been moved from the regions to the Clinical Division effective February 2005. The nurses' job description has been clarified to make it consistent with their roles.

The Regional Administrators for this 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, 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 teams that can be convened on an as need basis (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 2).

FY 04 Department response: The Department is developing a protocol for DCFS to have representation on all hospital CP teams. The Department is beginning this effort in Cook County and will initiate the process in Downstate regions. Statewide completion date: March 2005.

FY 05 Department update: The Cook County portion of this recommendation is complete. Many Downstate hospitals do not have child protection teams and this, combined with the number of possible hospital participants, has caused delay. Also, with the planned statewide re-alignment/re-organization of worker and management staff, it appears best not to assign Department staff until after this has occurred to avoid possible reassignments. This task is targeted for completion by the second quarter of 2006.

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 (from OIG FY 04 Annual Report, General Investigation 12).

FY 04 Department response: Wards with Juvenile Diabetes can receive their routine medical treatment through their primary care physician. Their specialty care will be overseen by a pediatric endocrinologist, who would make the necessary subspecialty referrals. The child's primary care physician will make the specialty care referral to the pediatric endocinologist. Regional nurses can also 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 OCFP by January 2005.

FY 05 Department update: Reference to regional nurses assisting with finding specialty medical providers (e.g. pediatric endocrinologists) was included in the draft nurse referral policy guide sent to OCFP in April 2005. DSI-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by DCP. Several meetings were held throughout the summer and fall. A final draft has been circulated to committee members for their review and comment. Once this draft is finalized and ready for submission to OCFS, DSI-Health Services staff will meet with OCFP staff, DCFS Medical Director, Clinical and others to determine what changes are required to the draft nurse referral policy guide.

The Department should require Agency Performance staff to ensure that prior to approving a case transfer between POS 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 (from OIG FY 04 Annual Report, General Investigation 22).

FY 04 Department response: The Case transfer approval form will be revised to indicate that there is no known or obvious conflict of interest. Completion date: January 2005

FY 05 Department update: Procedure will be sent to POS agencies in January 2006.

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 (from OIG FY 04 Annual Report, General Investigation 24).

FY 04 Department response: A CPSW curriculum workgroup has been convened and will incorporate recommendations into the appropriate training modules. A Procedures 300 workgroup has been convened for updates and revisions to the burn allegation. Recommendations will be incorporated into the revision. Completion date: May 2005

FY 05 Department update: The correct burn index has been incorporated into the CPSW curriculum. Appropriate revisions have been incorporated into Procedure 300.

When DCP investigators contact a local police department for a copy of a report on a specific incident they should ask about the availability of other reports, especially cases with domestic violence (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 11).

FY 04 Department response: 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.

FY 05 Department update: This provision has been incorporated into the recently revised P 300. A practice and procedural memo was distributed to management staff on June 17, 2005, in which this item was discussed. It is also included in comprehensive investigative training.

In a previous OIG report, #020704, June 24, 2002, the OIG reaffirmed an even earlier recommendation made on June 17, 1998, that in all 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 OIG #970700; from OIG FY 04 Annual Report, Death and Serious Injury Investigation 7).

FY 04 Department response: The Department agrees. The Policy and Procedure will be issued by January 2005. Training curriculum will be completed by January 2005. Training will begin March 2005.

FY 05 Department update: Policy Transmittal 2005.07 was released September 30, 2005. On-line training is available.

The Department should secure the assistance of the regional 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 local residential programs (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 15).

FY 04 Department response: The Department will consider this recommendation.

FY 05 Department update: There is no longer a residential facility in this area as it has been closed. Thus, this item is no longer applicable.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 15).

FY 04 Department response: The Department will pursue pending available funding.

FY 05 Department update: The Department's Clinical and Training Divisions will be researching effective aggression replacement treatment incorporating social skill, anger management and moral reasoning interventions and promising programming identified in the Surgeon General's Report on Youth Violence and the Office of Juvenile Justice Demonstration Project's Blueprints for the Violence Prevention Project.

All of the Residential Performance Monitors have been trained to assess how well residential providers are developing appropriate transition plans, including having the residents spend supervised time in the community doing goal-directed and therapeutic activities. Facilities will receive feedback on a quarterly basis as their performance in these categories.

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 ward's case record (See Recommendation #8 in SACY report dated June 13, 2000). The Department should audit the Sexual Abuse Program to ensure that the OIG recommendations implemented and that children with developmental disabilities who have been sexually abused are receiving services that emphasize development of pro-social skills (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 15).

FY 04 Department response: Revised program standards & DCFS policies are being reviewed by the CWAC committee. Completion date: March 2005

FY 05 Department update: Proc 302.388 includes screening tools to identify DD and strategies to help wards develop pro-social behaviors. Supervision plans must list developmentally appropriate activities approved for the child. Issued 10/20/05.

The Department and the State's Attorney's Office should discuss the development of a restorative justice model for DCFS wards (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 15).

FY 04 Department response: No response was provided by the Department.

FY 05 Department update: The Department has concluded, upon further consideration, that it is not the Department's responsibility to replicate the model of restorative justice currently in place in Cook County. However, discussions have taken place with the Probation Department and others to assure that wards are eligible for as many programs within the restorative justice system as possible.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 04 Department response: When the Department does not have legal on these children, we can only participate if the parent agrees. The Workgroup is addressing this issue. The Department has requested copies of the IEP Workbook for staff to use as a training/working tool.

FY 05 Department update: A memo was sent to staff regarding Intact Families and IEPs in June 2005.

The 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 04 Department response: Reference to these issues will be included in the draft nurse referral policy guide which will be finalized for submission of OCFP by January 2005.

FY 05 Department update: DSI-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by DCP. Several meetings were held throughout the summer and fall. A final draft has been circulated to committee members for their review and comment. Once this draft is finalized and ready for submission to OCFP, DSI-Health Services staff will meet with OCFP staff, DCFS Medical Director, Clinical and others as necessary to determine what changes are required to the draft nurse referral policy guide.

The Department should require intact family caseworkers to meet with medical personnel when a child in the family has a chronic medical condition (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 04 Department response: When the Department does not have legal on these children; we can only participate if the parent agrees. The Workgroup is addressing this issue. The Department has requested copies of the IEP Workbook for staff to use as a training/working tool. We expect a response from CPS in late January.

FY 05 Department update: The Medically Complex Protocol will address the OIG's concerns and is in its final review with workgroup members. It is anticipated that DCP will discuss the protocol with the OIG either late November or early December 2005 for final comments and subsequent revision, if required. With the approval process, it is expected the protocol will be distributed to staff within the first quarter of 2006.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 04 Department response: DCFS Policy Guide 99.02 is in the process of being updated and will be finalized for submission to OCFP by January 2005.

FY 05 Department update: DSI-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by DCP. Several meetings were held throughout the summer and fall. A final draft has been circulated to committee members for their review and comment. Once this draft is finalized and ready for submission to OCFP, DSI-Health Services staff will meet with OCFP staff, DCFS Medical Director, Clinical and others as necessary to determine what changes are required to the draft nurse referral policy guide.

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 #020161) (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 16).

FY 04 Department response: When policy is revised, in-service training in IFR and SAF is being planned for the private agencies involved. Completion date: February 2005.

FY 05 Department update: The work group to revise the substance affected family policy has been meeting and revised procedures will be submitted to the OCFP in November. The revised procedures address previous recommendations from the OIG and the case review completed by Quality Assurance. The work group will continue meeting to develop the training plan for DCFS and POS staff. The revised procedures are scheduled to be disseminated by OCFP by February 2006 and the training developed and rolled out by June 2006.

The Department should issue a Policy Transmittal to its Agency and Institution Licensing Division to ensure that in checking compliance with Licensing Standards 401.210, the Licensing Representative should document compliance with the procedures outlined in the Informational Transmittal (from OIG FY 04 Annual Report, General Investigation 10).

FY 04 Department response: DCFS Legal is working with the Contract Office on this issue. CMS has revised the contract boilerplate to be sure the language is appropriate.

FY 05 Department update: Language was incorporated into the FY06 contract via an addendum for all contracts except multi-year. The multi-year contracts will have this language when renewed in FY07 (FY06 is the third year of the three-year contracts.)

The Procedure for the allegation of Poisoning (#6/56) should include information from medical literature, including: 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 24).

FY 04 Department response: A workgroup was convened to revise/update Procedures 300. A draft protocol for conducting investigations when Factitious Disorder by Proxy is suspected. Reference to allegations 5/56, 15/65 and 10/60 will be included. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

FY 05 Department update: The draft policy is complete. It was reviewed with the OIG for final comments and subsequent revisions. Distribution to staff is expected within the first quarter of 2006.

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. Department Procedures should also acquaint workers with the following critical information necessary to investigate Factitious Disorder by Proxy (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 24).

FY 04 Department response: A workgroup was convened to revise/update Procedures 300. A draft protocol for conducting investigations when Factitious Disorder by Proxy is suspected. Reference to allegations 5/56, 15/65 and 10/60 will be included. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

FY 05 Department update: The drafted policy is complete. It was reviewed with the OIG for final comments and subsequent revisions. Distribution to staff is expected within the first quarter of 2006.

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 sibling's records contain evidence of false pediatric reporting?**
- **Interview the treating doctor to determine whether appropriate laboratory tests have been ordered to detect the presence of poisons or emetics (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 24).**

FY 04 Department response: A workgroup was convened to revise/update Procedures 300. A draft protocol for conducting investigations when Factitious Disorder by Proxy is suspected. Reference to allegations 5/56, 15/65 and 10/60 will be included. The workgroup decided not to limit FD by P to the poison allegation. Completion date: April 2005.

FY 05 Department update: The drafted policy is complete. It was reviewed with the OIG for final comments and subsequent revisions. Distribution to staff is expected within the first quarter of 2006.

Whenever investigators suspect intentional poisoning or Factitious Disorder by Proxy, an immediate referral must be made to law enforcement and the State's Attorney (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 24).

FY 04 Department response: A workgroup was convened to revise/update Procedures 300. A draft protocol for conducting investigations when Factitious Disorder by Proxy is suspected. Reference to allegations 5/56, 15/65 and 10/60 will be included. The workgroup decided not to limit FD by P to the poison allegation. Completion date: April 2005.

FY 05 Department update: The drafted policy is complete. It was reviewed with the OIG for final comments and subsequent revisions. Distribution to staff is expected within the first quarter of 2006.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 24).

FY 04 Department response: A workgroup was convened to revise/update Procedures 300. A draft protocol for conducting investigations when Factitious Disorder by Proxy is suspected. Reference to allegations 5/56, 15/65 and 10/60 will be included. The workgroup decided not to limit Factitious Disorder by Proxy to the poison allegation. Completion date: April 2005.

FY 05 Department update: The drafted policy is complete. It needs to be reviewed with the OIG for final comments and subsequent revisions. The meeting with the OIG is targeted from late November to early December 2005. With the approval process, distribution to staff is expected within the first quarter of 2006.

The Department must initiate Multidisciplinary Review Committees in all regions (from OIG FY 04 Annual Report, General Investigation 11).

FY 04 Department response: The Department is in the process of identifying members for Multidisciplinary Review Committees. Completion date: January 2005.

FY 05 Department update: The Springfield CDRT convene multidisciplinary staffings for Downstate as needed. The Cook County Multidisciplinary Review Committee has been staffed.

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 very 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 4).

FY 04 Department response: The Department will clarify nurse roles and responsibilities including the reporting structure by June 2005.

FY 05 Department update: The Nurses reporting structure has been moved from the regions to the Clinical Division effective February 2005. The nurses' job description has been clarified to make it consistent with their roles.

The indicated report on the maternal grandmother should be expunged (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 4).

FY 04 Department response: A decision will be made by January 2005 as to whether this report can be expunged.

FY 05 Department update: The indicated finding was unfounded as of March 21, 2005.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 21).

FY 04 Department response: A committee is updating 302, Appendix O, Services to intact Families and will strengthen the sections for servicing families with substance misuse. Completion date: February 2005.

FY 05 Department update: Policy Transmittal 2005.09 was issued October 20, 2005. It is Procedures 302, Section 302.388, Intact Family Services. Requirements related to AODA-related issues are addressed in a number of areas in the policy issuance.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 21).

FY 04 Department response: 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.

FY 05 Department update: The workgroup to revise the substance affected family policy has been meeting and revised procedures will be submitted to the OCFP in November. The revised procedures address previous recommendations from the OIG and the case review completed by

Quality Assurance. The work group will continue meeting to develop the training plan for DCFS and POS staff. The revised procedures are scheduled to disseminated by OCFP by February 2006 and the training developed and rolled out by June 06.

Service Intervention staff are working to implement breathalyzers in the Recovery Coach project on a pilot basis. A budget has been developed to equip the Recovery Coach teams with breathalyzers and necessary testing supplies. Implementation can begin as soon as funding is secured.

A redacted version of this report as well as literature on bruising should be discussed at a weekly Division of Child Protection meeting (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 3).

FY 04 Department response: The CPSW workgroup is currently revising the training curriculum and will incorporate information on bruising. Completion date: May 2005.

FY 05 Department update: The training curriculum revisions were completed in August 2005 and will be used for new hires and employee transfers.

This Report should be shared with DCP and SCR administrators to ensure that allegations of prior injuries are added when appropriate (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 3).

FY 04 Department response: In-service 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.

FY 05 Department update: These items were referred to the Legal Division for an opinion regarding possible legal ramifications. Legal is still assessing these matters.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 3).

FY 04 Department response: 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.

FY 05 Department update: These items were referred to the Legal Division for an opinion regarding possible legal ramifications. Legal is still assessing these matters.

Procedures for investigations of Cuts, Welts and Bruises should be amended to provide that when suspicious bruising is reported (indicative of fingerprints, implements or is otherwise suspect based

on developmental age of child or location of bruise), and investigator does not see bruise, reporter must be contacted prior to an initial safety CERAP determination (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 3).

FY 04 Department response: A workgroup convened to revise/update Procedures 300 and will incorporate recommendations in allegation #11 if deemed appropriate. Completion date: February 2005.

FY 05 Department update: This recommendation was incorporated into the current revised draft of P 300, Appendix B. The Department's Legal Division is currently reviewing these procedures.

The OIG report (#032076), along with OIG #02-1136 and 01-0558, January 30, 2003, and OIG #97-2870, November 11, 2000, 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, and 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 20).

FY 04 Department response: Report has been shared with the DCFS Justice Steering Group. The guidebook is still in development.

FY 05 Department update:
Since the original recommendation was made, the Department has instituted Children And Youth Investment Teams (CAYIT). Because of this recommendation, the Department is planning to require the convening of a CAYIT for all wards incarcerated in DOC in preparation for their hearings before the Prisoner Review board. The Department believes that the best place to address the OIG's concerns is through the CAYIT process.

OIG Note: The OIG still believes caseworkers need a practical guidebook to address issues specific to delinquent/ corrections involved youth

The Department needs to examine the current job description (must be gender neutral) and relevancy of the role of the DCFS Liaison to the Department of Corrections. 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 20).

FY 04 Department response: 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.

FY 05 Department update: We hope to be working with the new Juvenile System and will meet with the new Director of Juvenile Corrections when that person is named.

This agency'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 (from OIG FY 04 Annual Report, General Investigation 23).

FY 04 Department response: The ILO/TLP specialty contracts, which include P/PT and the mentally ill, are being revised and amended for FY06. Completion date: July 2005.

FY 05 Department update: The ILO/TLP redesign was postponed and will be implemented July 2006 for FY07 contracts.

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 reunification 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 (from OIG FY 04 Annual Report, General Investigation 23).

FY 04 Department response: The Mental Health/Behavior Development system is currently in development under the PIP. This is expected to be completed in FY 2005-2006.

FY 05 Department update: Beginning January 2006 there will be six pilot programs implementing this recommendation.

The Department needs to develop realistic funding mechanisms for services to wards with chronic runaway behavior (from OIG FY 04 Annual Report, General Investigation 23).

FY 04 Department response: Intensive Stabilization Services are being developed to address this issue.

FY 05 Department update: There are now four stabilization centers in Cook County in operation.

The ACR administrator should sample ACR reviews of missing and runaway wards to ascertain the relevancy and sufficiency of the assigned tasks (from OIG FY 04 Annual Report, General Investigation 23).

FY 04 Department response: This sample review will be completed by June 2005.

FY 05 Department update: The OIG instructed ACR to ensure that the workers follow the Department's protocol for missing children when these cases are presented at ACR. Managers have been instructed to make sure all of the reviewers are aware of the policy and that the workers adhere to the tenants of the policy. If the reviewers find the protocol is not followed,

then a feedback is generated which goes to the worker, supervisor, and other stakeholders involved in the case for a response and action plan to respond.

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. TPSN Policies and Procedures should be likewise amended (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 19).

FY 04 Department response: Revisions to Procedure 315 will be completed by March 2005.

FY 05 Department update: The CERAP Committee is reviewing procedure.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 19).

FY 04 Department response: The CERAP Advisory Council is currently reviewing the CERAP Protocol. The OIG recommendations will be shared with the group at their next meeting. January 2005

FY 05 Department update: Procedure 300.80 has been revised and the draft includes this consideration. Legal is currently reviewing Procedures 300 and it is projected all related tasks will be complete by the Spring of 2006.

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 TPSN and DCFS need to develop and make available specialized crisis foster placement 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 19).

FY 04 Department response: A workgroup convened to revise/update Procedures 300 will incorporate this recommendation if deemed appropriate. Completion date: February 2005.

In addition, DCFS is modifying and updating ILO/TLP contracts to reflect level of need for special populations that includes P/PT clients. DCFS is developing specialized contract providers for specialized populations.

FY 05 Department update: These recommendations and redacted copies of this report were sent to the committee reviewing CERAP. Target date for their review and recommendations to be complete: June 2006.

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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 13).

FY 04 Department response: Revisions were drafted and shared with the OIG and should be finalized by March 2005.

FY 05 Department update: The plan and budgetary issues are still in process. This could be implemented if the extra background check is limited in scope.

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 an 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 (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 13).

FY 04 Department response: Once the revisions are finalized, training will be provided to all legal staff regarding procedures on interstate compact placements.

FY 05 Department update: The training was provided.