OFFICE OF THE INSPECTOR GENERAL
ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

JANUARY 2007

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INSPECTOR GENERAL

Office Of The Inspector General
Department Of Children And Family Services

January 1, 2007

To Governor Blagojevich and Members of the General Assembly:

Families who come to the attention of DCFS live in our communities. They are our neighbors, and sometimes, they are our family members. Some face untreated psychiatric disorders or substance abuse or suffer because of the poor quality of the treatment offered. In many cases, state and private child welfare agencies cannot remedy child welfare problems without family-focused mental health and substance abuse interventions. The right diagnosis, matched with the right treatment and the supports of extended family, are critical components to the well-being of the DCFS involved family. The frequency of mothers suffering from post-partum depression, bi-polar and schizophrenia disorders, and the lack of substantive responses from our mental health systems reminds us that vulnerable moments for a parent may create vulnerable moments for children. With the right mental health interventions and the help of extended family, we as a community may be able to have better and safer outcomes for our parents and their children.

Children with challenging medical health problems also require community response. Prevention funding for public health visits to support families caring for medically challenged children is more appropriate than child protection investigations when the problem is often a lack of communication among treating sub specialists or lack of respite support for struggling parents.

Solutions to complex problems often span many systems. For example, research suggests that drug courts work for substance-affected families and the use of graduated sanctions for DCFS involved substance-abusing families may be an effective intervention. But to screen these neglect cases into Juvenile Court for orders of protection, when children are left in homes with substance abusing parents who refuse voluntary treatment, requires a joint commitment between state's attorneys and child welfare professionals.

A balanced and collaborative approach between child welfare, early intervention, public health, mental health, substance abuse treatment, and the legal system is likely to increase the safety and well-being of our families. When systems and families work together we create opportunities for safer families.

I submit the DCFS Office of the Inspector General's 2007 Annual Report for your review.

Respectfully,

Denise Kane, Ph.D.
Inspector General

OFFICE OF THE INSPECTOR GENERAL
REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

TABLE OF CONTENTS

INTRODUCTION 1

- Investigation Categories 1
- Investigative Process 3
- Reports 4
- Additional Responsibilities 5

INVESTIGATIONS 7

- Death and Serious Injury Investigations 7
- Child Death Report 39
  - Summary 40
  - Homicide 45
  - Undetermined 53
  - Accident 55
  - Natural 62
- General Investigations 79

OIG INITIATIVES 129

- Ethics 129
- Civility in the Workplace 131
- Home and Fire Safety Training 131
- Reunification of Substance Affected Families 147
- Cook County Pre-Adoptive Initiative for Older Caregivers 155
- Older Caregivers Housing Report 157

SYSTEMIC RECOMMENDATIONS 169

RECOMMENDATIONS FOR DISCIPLINE AND CONTRACT TERMINATION 179

LAW ENFORCEMENT CASES 183

DEPARTMENT UPDATE ON FY 05 RECOMMENDATIONS 185

DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS 201

APPENDICES: 215

Henry Foster Death Investigation (Fictitious Name)

Child Endangerment Risk Assessment Protocol (CERAP) Report

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 on 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 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 and the Office of the Executive Inspector General. 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 06:

TABLE 1
FY 06 CHILD DEATH CASES REVIEWED

Child Deaths in FY 06 Meeting the Criteria for Review	**86**
Preliminary Investigations Conducted	**7**
Investigatory Reviews of Records	**68**
Full Investigative Reports Submitted to DCFS	**3**
Full Investigations Pending	**8**

Summaries of death investigations, with a full investigative report submitted to the Director and the Executive Inspector General, are included in the Investigations section of this Report. See page 39 of this Report for a summary of all child deaths reviewed by the OIG in FY 06.

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 Child Welfare License permits centralized monitoring of all persons providing direct child welfare services, whether they are employed with the Department or a private agency. 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).

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 whether 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's 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 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 06, 11 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 23 cases, and monitored pending criminal or abuse/neglect charges in 17 cases. The following chart reports disposition of the 11 cases investigated in FY 06:

TABLE 2
FY 06 CWEL INVESTIGATION DISPOSITIONS

Disposition	Cases
License Relinquished	**2**
License Revoked	**3**
Charges Filed	**2**
No Licensure Action	**3**
Investigation Pending	**1**

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 06,

the OIG performed 1,744 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 whether to recommend administrative action.

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 an incident suggesting misconduct or a pending criminal charge (or child abuse investigation for referral to CWEL) against a child welfare employee. In FY 06, the OIG received 2,109 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 a 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 to the Governor with recommendations for discipline, systemic change, or sanctions against private agencies. The OIG monitors the implementation of accepted recommendations.

The OIG may work directly with a private agency and its board of directors to ensure implementation when recommendations pertain to a private agency. In rare circumstances, when the allegations are serious enough to present a risk to children, the Inspector General may request that an agency's intake for new cases be put on temporary hold or that an employee be placed on desk duty pending the outcome of the investigation.

The OIG is mandated by statute to be separate from the Department. OIG files are not accessible to the Department. The investigations and the Investigative Reports and Recommendations are prepared without editorial input from either the Department or any private agency. Once a 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 an 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

[1]This includes requests for investigation, notice of child deaths and serious injuries, notification of arrests or pending abuse investigations, and requests for technical assistance and information.

accused employee needs to have sufficient information to enable that employee 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 deleting confidential information 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 Office of the Executive Inspector General. 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 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 may recommend systemic reform or 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.

The Inspector General presents recommendations for discipline to the Director of the Department and, if applicable, 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 Director and the Board of Directors of that agency. The agency may submit a response to address any factual inaccuracies in the Report. In addition, the

Board and agency Director are given an opportunity to meet with the Inspector General to discuss the Report and recommendations.

In this Annual Report, 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. 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/or 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 06:

TABLE 3
CALLS TO THE OIG HOTLINE IN FY 06

Information and Referral	**1075**
Referred to SCR Hotline	**111**
Referred for OIG Investigation	**141**
Total Calls	**1327**

Ethics Officer

The Inspector General is the 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 Statements of Economic Interest.

For FY 06, 573 Statements of Economic Interest were submitted to the Ethics Officer. Of the 573 submitted, 79 indicated potential conflicts of interest. The 79 were further reviewed and 37 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. At the request of the state's external auditor, the OIG returned 44 Statements of Economic Interest where questions had been left unanswered by the employee. Letters were sent to the employees asking for properly completed forms. The external auditing firm had informed the OIG that forms with unanswered questions would no longer be acceptable, and that employees should indicate a question does not apply to them by answering "N/A" or "no". Of the 44 forms

returned to employees, 37 new forms have been submitted.

TABLE 4
OIG ACTION ON FY 06 STATEMENTS OF ECONOMIC INTEREST

Economic Interest Statements Filed	**573**
Statements Indicating Possible Conflicts	**79**
Advisory Letters Sent to Employees	**37**

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 3,200 employees were trained in FY 06.

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 127 of this Report for a full discussion of the current initiatives.

INVESTIGATIONS

This annual report covers the period of time from July 1, 2005 to June 30, 2006. The Investigations section has three parts. Part I includes summaries of child death and serious injury investigations reported to the Department Director and the Executive Inspector General. Part II contains aggregate data about and case summaries of child deaths in families who were involved with the Department in the preceding 12 months. 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 two-month-old girl died after being suffocated by her mother. The family had previously received intact family services through the Department and a child protection investigation of the mother was unfounded less than a month before the infant's death.

INVESTIGATION

The family became involved with the Department two years earlier after the mother called police to report she had struck her child in the face. Officers went to the home and transported the mother and her then two-year-old daughter to the hospital for an examination before taking the child into custody and placing the mother under arrest. During the ensuing child protection investigation, the mother stated she had been under stress as she was pregnant with her second child and had recently lost her job. The mother said she was on the telephone with her former employer when she struck her daughter who was crying and calling to her. She was convicted of domestic battery and sentenced to one year of court supervision. No Department representatives attended the hearing. Police also informed the Department the mother had been charged one year earlier with domestic battery against her own mother but the case was dismissed when the grandmother declined to pursue prosecution. The mother was indicated for cuts, welts and bruises and the case was referred for intact family services.

By the time the intact family caseworker met with the mother she had delivered her second child, a boy, and was living with the two children, her sister and the grandmother in the grandmother's home. The mother stated she had no friends and identified her sister and the grandmother as her only sources of support aside from the periodic assistance provided by members of their church. When asked by the caseworker to describe the chain of events that led her to strike her daughter, the mother stated the girl had jumped onto her stomach while she was lying down and she hit her reflexively. The caseworker did not note the difference between the mother's two accounts of how the incident occurred. The caseworker also learned that the mother derived her income from unemployment insurance and had been fired from her two previous jobs but did not inquire as to the reasons for her termination.

As part of her service plan, the mother was required to attend counseling and parenting classes, make herself and her children available to meet with the caseworker and keep the caseworker informed of developments related to her housing arrangements as well as the status of her probation. The mother was resistant to all

aspects of the service plan as she repeatedly refused or ceased participation in counseling, changed residences without notifying the worker and was absent from her home when the caseworker arrived for scheduled visits. The caseworker did not attend court proceedings related to the mother's domestic violence conviction and relied on the mother to provide information. The mother also discontinued her attendance at parenting classes, although the relevance of this portion of the service plan was questionable as they addressed general issues and were not particular to the issues faced by the family. Also, since the mother held an associate's degree in child development, it was unlikely her behavior stemmed from a lack of understanding of parenting standards. Despite the mother's non-compliance, the caseworker continually reported the mother's adherence to the service plan was satisfactory.

Five months after the case was closed, the hotline received a call from an adoption agency worker. During an informational meeting regarding making her children available for adoption, the mother, who was now pregnant with twins, stated she wished she had never had children and felt no connection to them. The mother described the children in derogatory terms, including calling them "bastards," before becoming agitated with the worker and terminating the meeting. A mandate worker was dispatched to check on the family within 24 hours and met with the mother at her home. The mother stated the adoption agency worker's report was a vindictive attack because the mother changed her mind about working with the agency. The mother denied speaking negatively about her children but acknowledged not wanting her unborn twins. In an interview with the OIG, the mandate worker stated she understood the mother's use of the term "bastard" to be literal, as the children had been born out of wedlock, and did not determine it to be inappropriate. The mandate worker completed a Child Endangerment Risk Assessment Protocol (CERAP) documenting all factors as "safe" and failing to check any risk factors, although prior convictions and indications for abuse and referring to offspring in derogatory terms are specific elements of the assessment. The mandate worker told the OIG she was aware of the mother's domestic abuse conviction and indicated finding against her daughter but did not feel the incident rose to a level that warranted an "unsafe" designation. The mandate worker also stated she did not speak to any of the mother's relatives because the mother asked that her family not be contacted.

Following the mandate worker's initial efforts, a child protection investigator assumed responsibility for the case. The mother had delivered her twins by the time she met with the investigator, however one of the babies was stillborn. The second investigator spoke with various people identified by the mother as friends who universally praised her parenting ability. None of the individuals interviewed by the investigator had been previously identified by the mother as sources of support. The investigator complied with the mother's request not to involve her family and did not speak to any of the mother's relatives. The investigator also did not contact the caseworker who had managed the intact family services case. In her interview with the OIG, the investigator stated she believed the mother's contentious meeting with the adoption agency worker was a "misunderstanding" and minimized the fact the mother had contacted the agency several times to make similar requests for information. The investigator determined the mother posed no risk to her children and unfounded the case.

Less than one month later, the mother's two-month old daughter was transported to a hospital emergency room where she died. The mother told authorities she had placed the infant in a closed dresser drawer with a pillow over her in order to stifle the baby's crying. The mother's two children were taken into protective custody and placed with the grandmother. The mother was charged with first-degree murder and is currently awaiting trial.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Whenever there is court involvement with a parent, whether through juvenile, criminal or domestic relations court intact family workers should attend court hearings if the offense is related to the care of the child. If the parent is assigned a social services monitor or probation officer

the worker should coordinate services and monitoring. If a parent is not participating in services the worker should seek a court order to mandate the parent's participation using a graduated sanctions model.

This item was covered in a "Practice and Procedural" memorandum issued to management staff on November 7, 2005.

2. This report should be shared with the intact family caseworker, her supervisor, the mandate worker and the child protection investigator.

The report was shared with all involved staff on November 21, 2005.

3. The intact family caseworker should be counseled for poor assessment of risk of the case and failing to address the mother's ambivalence about parenting.

Counseling for this staff person occurred November 21, 2005.

4. The child protection investigator should be disciplined for not contacting the intact family worker or supervisor when the case had been closed just four and a half months earlier and for not contacting the extended family who had relevant information on the mother.

An oral reprimand was issued to this staff person.

5. The mandate worker should be counseled for failing to contact extended family members who had previously cared for the children as part of an earlier safety plan.

Counseling occurred with this staff person.

6. The Department should evaluate the availability of parenting education that goes beyond classroom-based training. When a case involves physical abuse the worker should assure that the services offered to the parent address specific family problems. Either the worker or the parenting agency should assess the parenting skills by observing the children and the parents in the home offering feedback and documenting progress.

This item was covered in a Practice and Procedural memo issued to management staff on November 7, 2005.

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

The bodies of a 20-month-old boy and his mother were found in their home. A child protection investigation was pending and the family had an open intact services case at the time of the mother and baby's deaths.

INVESTIGATION

The mother was a diagnosed schizophrenic who suffered from paranoid delusions and hallucinations. Her frequent and open discussions about the people who sought to harm her and her baby and the forces of "black magic" at work against her were recognized by the child welfare workers, medical professionals and law enforcement personnel involved with her at various times. Concern for her son's safety shortly after his birth due to her obviously impaired mental state prompted Department involvement, however it was difficult for child welfare professionals to ascertain the degree to which the mother's mental illness affected her ability to care for her child.

Involved workers, while noting their concerns regarding the mother's behavior, noted her dedication to her child and her proclamations of love for him. In addition, the mother kept regular medical appointments and maintained an acceptable level of cleanliness and care. Simultaneously, she refused all attempts to engage her in services and often became agitated and combative in response to suggestions she was mentally ill and required counseling or medication. The baby's maternal grandmother and aunt reported to workers that while the mother would often become verbally abusive towards them and throw items around the room, she was always careful with her son and put him down or moved him out of the way before these episodes began.

The stark contrast between the mother's behavior towards the public at large and her conscientiousness in caring for her child posed a difficulty for workers attempting to gauge the possible risk posed to the baby by remaining in her care. Because she had never been witnessed acting in an inappropriate manner towards her baby or threatening to harm herself or her son, workers and the local State's Attorney determined there was insufficient cause to screen the case into court or take protective custody. Two child protection investigations were unfounded on the basis of a lack of substantiated evidence to show the mother posed a risk of physical harm. While the mother never gave voice to thoughts of harming her son he figured prominently in her delusions, as she insisted he was the product of asexual reproduction and was in danger of being abducted by "others" who sought to clone him. The mother's distorted perception of reality presented the possibility she might harm her son in the process of protecting him from outside threats, however this was deemed too speculative to support taking the baby into protective custody.

Department Rule allows for State intervention and the removal of a child from a parent's care in cases of abuse, neglect or dependency. While initiating proceedings based on dependency might provide an option for taking custody in such cases, the criteria is ill-defined and provides little guidance to workers in the field confronted with such situations. Furthermore, since dependency petitions are rarely utilized, most workers are unfamiliar with the process and many State's Attorneys, including those involved in this case, have not had frequent occasion to pursue them.

Two months after the second child protection investigation was opened, the baby's aunt found the mother's body on top of the baby's bed. The body of the baby was later located underneath. The mother's vehicle was found abandoned and inoperable in another location where neighbors said it had been for four days. The condition of the bodies prevented authorities from determining the manner of death for either, however the baby's cause of death was ruled to be dehydration. A police investigation into the deaths is ongoing.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's Clinical Division in the region should provide training and consultation for supervisors in the region on risk assessment and decision-making for screening cases of severe mental illness.

The DCFS Clinical Manager met with managers and supervisors in the region to do an in-service training regarding clinical consultations and the role of clinical staff in decision-making and screening with cases of severe mental illness.

2. Although the Juvenile Court Act has a provision for dependency cases it is rarely needed and requires specialized skills. The Department should explore the local State's Attorney's willingness to assist the Department in developing a taped training discussion on how the Department's legal and clinical divisions can prepare cases for protective orders or screening when the field confronts this issue.

This has been completed. The training described in Recommendation 1 of this case included information on how DCFS legal and clinical can help prepare cases for screening or protective orders.

3. The procedures for completing a Child Endangerment Risk Assessment Protocol (CERAP) should be amended so that the guidelines regarding a household member's developmental disability or mental illness direct a worker to consider pursuing a dependency petition.

The committee revising the safety assessment continues to work on the safety framework protocol. Targeted completion date is June 2007.

4. The procedures for completing a CERAP and the decision tree for mentally ill parents should be amended so that the guidelines note the need to assess risk to the child when a parent incorporates a child into their delusional system, even in the absence of overt negative statements.

The committee revising the safety assessment continues to work on the safety framework protocol. Targeted completion date is June 2007.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

A four-year-old girl died as the result of physical abuse inflicted by her maternal great uncle. During the year prior to the girl's death, the family had been the subject of four child protection investigations.

INVESTIGATION

The family unit consisted of a mother, her three children, ages three, four and seven, her uncle and his 14-year-old daughter, who had severe physical and developmental delays. On the night the four-year-old died, she had been brought to the hospital by paramedics who answered a call from the family home and arrived to find her face down on the floor. An examination found her body was covered with bruises and had an adult-sized handprint on her chest. After the girl was transported to the hospital, staff noted that both the mother and her uncle smelled of alcohol. The mother provided inconsistent explanations as to how the girl sustained her injuries, prompting hospital staff to contact law enforcement. The day after the girl's death, the mother told law enforcement the girl's injuries were the result of the uncle repeatedly tripping her and pushing her to the floor, causing her to hit her head. The mother stated the uncle's actions were a form of discipline because the girl was disobedient. The mother estimated the uncle tripped the girl and pushed her to the floor at least 20 times before the girl did not get up, at which point her eyes closed and she stopped breathing. The mother acknowledged she and the uncle had been drinking alcohol on the night the girl died. Both the uncle and mother were arrested and charged with murder and aggravated battery of a child. The mother faced an additional charge of obstruction of justice. The mother's two surviving children and the uncle's daughter were placed in traditional foster care.

An OIG review of the family's previous involvement with the Department found an extensive history of abuse and neglect allegations against both the mother and the uncle. The mother had been the subject of reports dating back seven years. The uncle, who was 20 years older, had been involved with the Department for 15 years and his three older children had previously been removed from his custody. He also had prior indicated findings of abuse, including throwing lit firecrackers at his own children. Records maintained by the Department did not contain information related to the previous abuse and neglect charges against the uncle because the findings had been entered more than five years earlier and had been expunged, in accordance with the law. The overall family history was convoluted by both the mother and uncle's relationships with various paramours throughout the years, some of whom had children of their own and separate issues related to involvement with the Department.

The family's involvement with the Department during the year prior to the girl's death began with a report the uncle's daughter had been examined at a hospital emergency room and diagnosed with pubic lice. Although the daughter was only 13 at the time, the State Central Register (SCR) operator did not accept the call for investigation but made a referral for child welfare services. In an interview with the OIG, an SCR administrator stated the report did not meet the criteria for investigation because the girl did not make an allegation of abuse and was old enough to engage in consensual sexual relations. The 14-year-old was not referred to the regional Children's Advocacy Center (CAC) for assessment. After securing an agreement from the uncle that he would seek appropriate treatment for his daughter, the follow-up worker consulted with her supervisor and closed the case.

During three subsequent child protection investigations, investigators from the local field office accepted repeated denials from the family related to allegations of physical abuse and inappropriate sexual contact between the four-year-old girl and her seven-year-old brother. Although an OIG review of the investigations shows that, taken individually, overwhelming evidence did not exist to support the allegations, investigators did not utilize information contained in the State Automated Child Welfare Information System (SACWIS) and the Child and Youth-Centered Information System (CYCIS) to construct an overall history and develop a greater understanding of family functioning.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Children with increased vulnerability, either because of age or developmental disabilities, who present with a medical condition that could be the result of sexual exploitation, should be referred to the local child advocacy center for a victim sensitive interview to assist in determining if the medical condition is the result of abuse.

The Department agrees. A memo will be distributed to staff regarding this issue.

2. The Department's Procedural Guideline for Investigation of Paramour Involved Families ("Paramour Policy") should be amended to include a determination of whether the paramour has any other children not living in the household and specifics about where and with whom they reside.

The Department agrees. The Department will revise its policy to reflect changes in Paramour Policy (Procedures 300, Appendix H) regarding paramours' children.

3. SACWIS training for child protection investigators should emphasize the use of SACWIS databases to search for historical family information. A redacted copy of this report should be used for training purposes.

Conducting background searches utilizing SACWIS databases information is in Procedure 300.50 and it is included in training for new hires. The Deputy Director of the Division of Child Protection issued a memorandum in August 2005 and the Director issued an Information Transmittal July 2006 reiterating the expectation of comprehensive database searches. Steps for conducting this type of comprehensive search will be made available on the D-Net as an ongoing reference to staff.

4. The Department Administrator responsible for this region should assign designees to convene a case conference to review and discuss this report with the involved child protection and child welfare staff. A redacted copy of this report should be distributed to involved staff for this purpose

The report was shared with involved staff.

5. A redacted copy of this report should be shared with the regional Children's Advocacy Center.

The report was shared with the CAC.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION

A three-year-old boy died from multiple injuries and blunt trauma suffered while in the home of his father's girlfriend, a licensed foster parent. Two months earlier, the boy's four-year-old brother suffered a broken leg while in the same home. The father and his sons were involved with intact family services through the Department at the time of the boy's death.

INVESTIGATION

The four-year-old was brought to a hospital emergency room by his father with a fractured tibia and fibula. The father told treating staff the boy had suffered the injury five days earlier during a party in the girlfriend's home but offered two accounts of how the boy was hurt. The severity of the injury and the amount of time that had lapsed before the father sought medical treatment led to a hotline report and the initiation of a child protection investigation. A mandate worker went to the girlfriend's home, which the father had identified as his residence, and conducted interviews. Both the father and the girlfriend denied knowing how or when the boy had been injured because of the activity of the numerous guests in the home during the party. The mandate worker completed a safety plan requiring the father's two children and two other children in the home, identified at the time as additional siblings, to be placed in the temporary custody of the girlfriend's cousin. Responsibility for the case was then assumed by a child protection investigator.

In conducting her investigation, the child protection investigator committed a number of errors and violations of Department Procedure that were exacerbated by her supervisor's failure to provide adequate oversight. The investigator conducted a Law Enforcement Agency Database System (LEADS) check of the father and learned he had been arrested one week earlier for battery. The investigator accepted the father's explanation that the incident was related to an episode of roughhousing with a co-worker that got out of hand and did not verify his account. An OIG examination of police documents found the father was alleged to have strangled a co-worker with a dog leash until the man lost consciousness. The investigator did not perform a LEADS check on the girlfriend. In separate interviews with the OIG, both the investigator and her supervisor stated that the girlfriend reported she had demanded the father move out of her home in order for the other two children to be returned to her. The investigator and her supervisor explained that they did not believe it was necessary to conduct a check on the girlfriend, even though her residence was where the boy was injured. The girlfriend refused to provide names of other individuals at the party who may have witnessed the injury, stating they did not want to get involved. The father said he could not remember who was present.

The investigator did conduct a LEADS check of a family relative who assumed care of the four children. The check showed the relative had previous convictions for battery, robbery, burglary and theft. Despite learning of the relative's criminal history, the investigator allowed the children to remain in the home and used the relative as a collateral source of information regarding the father's parenting abilities. The investigator and her supervisor failed to note that the other two children in the home were Department wards. The investigator told the OIG she was aware the two children, brothers ages six and four, had open cases with the Department and was told by the girlfriend the boys were relatives and that she had applied for a foster care license. Neither the investigator nor her supervisor alerted the private agency that held her license application of the pending child protection investigation regarding serious injury to a child in her home. A review of the investigator's case notes found several references to the girlfriend as being the boys' mother. The investigator requested and received waivers from her supervisor permitting her to bypass performing certain required tasks, however the OIG was unable to review the validity of these waivers because the State Automated Child Welfare System (SACWIS) does not currently retain historical data on waivers once cases have been closed.

The investigator referred the case to the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC), a medical team intended to provide additional analysis in cases of suspected child abuse and neglect. The MPEEC physician who reviewed the case file, but never examined the boy, told the investigator

that the boy's injury could have been the result of jumping while playing with other children, the explanation for the injury the father provided to police. The physician did not determine that such an event was the cause of the injury and expressed his concern with the numerous scars and bruises found on the boy, including a bite mark on his left thigh, as well as the father's delay in seeking treatment. The physician also noted the boy was non-verbal and possibly autistic which complicated the process of ascertaining how the marks on his body were caused. He recommended that the boy be evaluated by a doctor specializing in child abuse. No further physical examination of the boy was conducted nor was his younger brother checked for possible signs of abuse. Body charts were not completed for either of the brothers.

The report against the father was indicated for medical neglect for waiting five days before getting treatment for his son's fractured leg. The case was referred for intact family services through the Department, however the case remained open for only three weeks. During that time, the intact caseworker was informed by the father that his younger son was residing with the girlfriend while the boy who had broken his leg stayed with his biological mother. The father also stated he was looking for a new home but frequently stayed with his girlfriend. Although the presence of an adult with an indicated report for child neglect in the home of a foster parent was a violation of licensing standards, the intact worker did not inform the private agency that held the girlfriend's foster home license. In an interview with the OIG, the intact worker stated she had informed her supervisor of the living arrangement, however a review of the case file and an interview with the worker's supervisor did not corroborate the worker's claim.

While the child protection investigation against the father had been pending, the girlfriend had contacted a second private agency and inquired about serving as a foster placement for her three-year-old female cousin. An administrator from the second agency contacted the licensing agency and a decision was reached to pursue placing the girl in the home. Involved workers from both agencies agreed to conduct an in-person staffing to discuss the case, however no meeting was ever held. The licensing agency's procedures require such staffings to be conducted in cases where responsibility for case management is split between two agencies. The second agency had no written protocol for the handling of split cases. The absence of a meeting between child welfare professionals from the two agencies led to a lack of communication regarding the needs of the girl or how her history of sexual abuse could affect her placement in a home with the two brothers, who had been returned to the girlfriend's residence.

Two months after the four-year-old boy had broken his leg, his three-year-old brother was brought to a hospital emergency room by paramedics who had responded to an emergency call from the girlfriend's home. He was in full cardiac arrest by the time they had reached the house and he was pronounced dead on arrival. The cause of death was multiple injuries due to blunt trauma and child abuse. An autopsy identified numerous old scars on the boy's face and torso and a healing bite mark on his chest.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should receive non-disciplinary counseling for not following the Paramour and LEADS procedures, and not interviewing Other Persons With Information (OPWI) or possible witnesses to the incident; and disciplinary counseling for failing to pursue information on children with open cases, for not notifying the licensing agency of a pending abuse investigation and removal of foster children from the foster home, and placing children in the home of a convicted felon whose background suggested a propensity for violence.

The identified staff person is currently on medical leave. This item will be addressed upon her return.

2. The investigator's supervisor should receive non-disciplinary counseling for violating the paramour and LEADS procedures, and for approving an investigation that lacked completion of basic investigative tasks. The supervisor should receive disciplinary counseling for failing to notify the

licensing agency of a pending abuse investigation and removal of foster children from the foster home. The supervisor should be required to attend the Department's impending training for child protection investigation supervisors.

The supervisor resigned from the Department effective September 2, 2006.

3. The intact family services caseworker should receive non-disciplinary counseling for not immediately informing her supervisor of critical facts including that the parent's girlfriend was a licensed foster parent who was violating licensing standards by allowing an indicated adult to live in her home, and for not notifying the licensing agency that an indicated paramour was staying at the foster home.

A counseling session was conducted with the worker with a confirmation memo issued.

4. Referrals to the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) for second opinions on serious injuries should include body charts of non-verbal children in the child victim's household.

A Practice and Procedural memorandum distributed to DCP management staff dated October 20, 2006 addresses this issue and states: "In Cook County, when investigations are referred to MPEEC for second opinions on serious injuries, Investigation Specialists are to include body charts of non-verbal children in the child victim's household."

5. The MPEEC team should review the four-year-old boy's records that were reviewed by their physician and his MPEEC report to determine whether the report met MPEEC's standards for assessment and to address future consideration of second opinions in tenuous situations. The Inspector General will meet with a representative from the Department's Division of Child Protection and representative(s) of MPEEC to discuss findings and future considerations.

A meeting with MPEEC is scheduled for January 2007.

6. The Department should prohibit ongoing management of split cases among private agencies. When consolidating a split case, the agency that has the licensing responsibility should be considered for full case management responsibility. The agency that relinquishes foster children through case consolidation should not be penalized and should be moved up for case assignment. Under extenuating circumstances, such as a caseworker's long-term relationship with assigned foster children, a waiver could be issued by Agency and Institution Licensing managers based on a presentation of the circumstances at a staffing that must take place at the licensing agency. For each waiver granted, an Agency and Institution Licensing representative must attend a case staffing.

This recommendation will be discussed at a future meeting between the Director and the OIG.

7. A modification of the SACWIS system so that the system has the necessary data to be capable of (1) identifying foster parents when their name is entered into the 'Person Search' option and (2) notifying a foster care licensing agency when the State Central Register receives a report on a foster parent or foster home. Although this report does not involve identification of private agency employees, modification of the SACWIS system should include identification of private agency employees because of DuPuy*.

It has been determined that the recommendation requires implementation of the Licensing and Resource systems which was scheduled for Phase III of SACWIS. Phase III is currently on hold due to a lack of available resources.

8. The OIG reiterates its previous recommendation that the SACWIS program be adjusted to enable child protection managers to access investigators' rationales for requested waivers on a "read only" basis after investigations are closed. When there are unfortunate outcomes, management needs to be able to review the appropriateness of the entire investigation for learning purposes.

This recommendation is in process and anticipated implementation date is December 2006.

9. Staff from the licensing agency did not follow agency policy and procedures for receiving a child from an outside agency for placement in a foster home. The agency should provide in-service training to its foster care staff on its procedures for handling split cases with emphasis on communication and interagency staffings. When possible, interagency staffings should include other outside service providers servicing the child.

This recommendation will be discussed at a future meeting between the Director and the OIG.

10. The second private agency should put in writing, policy and procedures for placing a child in the foster home of another private agency and for receiving a child from another agency for placement in a foster home. The protocol should require a face-to-face interagency staffing prior to a placement decision for the purpose of achieving goodness of fit with the help of a thorough discussion of each foster child, the foster family, and the home. When possible, interagency staffings should include outside service providers servicing the child. In-service training should be provided to the foster care staff on the protocol for handling split cases with emphasis on communication and confidentiality rules and procedures.

This recommendation is on hold until the next OIG/Department meeting.

*DuPuy was a federal class action lawsuit in which the Department agreed to provide heightened due process protections for individuals accused of abuse or neglect, whose livelihoods could be affected by an indicated finding.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION

An 18-month-old girl died of acute respiratory distress syndrome and pneumonia. At the time of the girl's death, her family had an open intact family services case with the Department.

INVESTIGATION

The family's involvement with the Department began one month after the girl's birth following a hotline report of a missed medical appointment. The girl had been born with significant physical abnormalities and health complications. The child protection investigator assigned to the case met with the parents, the baby girl and the couple's then one year-old son in the home of the children's paternal grandmother, where they all resided. While the mother denied she had any substance abuse issues, the father stated he was on parole following a conviction for manufacturing methamphetamine and was required to participate in substance abuse treatment and submit to random drug tests. The investigator did not obtain the name of the father's parole officer in order to notify the officer of the child neglect allegations or to verify the father's participation in his substance abuse program. Despite the father's admission of drug use and production, the investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) listing no safety concerns. It was determined that the factors that led to the missed medical appointment had been resolved by the family's move into the grandmother's home and the report was unfounded. The case was referred to a private agency to provide short-term intact family services.

Six weeks later, a second child protection investigation was initiated based on allegations the mother had not been adhering to medical advice regarding the infant's care, particularly related to the baby's low weight. Testing conducted at a regional hospital led physicians to diagnose the baby with organic failure to thrive and a feeding tube was inserted to assist her growth. The report against the mother was unfounded and the family continued to receive services through the private agency, although the couple had separated in the interim between hotline reports. One month after the second report, while being arrested for criminal trespass, the father was seen swallowing a plastic bag of white powder. Officers transported the father to a hospital to have his stomach pumped and later learned he had ingested a bag of methamphetamine.

Over the course of the following year the family situation deteriorated. The father's behavior became increasingly erratic as the various unstable living arrangements the parents entered into added additional stress to their volatile relationship. During this time period, the father violated his probation by testing positive for methamphetamine and was arrested and jailed on charges of sexual assault, contributing to the delinquency of a minor and underage consumption of alcohol following an incident involving a 15-year-old girl. Multiple incidents of domestic violence resulted in the development of a safety plan prohibiting the father from having any contact with the couple's children. As part of services, the father was required to participate in substance abuse testing and counseling as well as parenting and anger management classes. The father was consistently non-compliant with services and at one point threatened to take his family and leave the state if workers attempted to screen the case into court. He cited his illiteracy as a contributing factor in his inability to effectively participate in services that required reading or writing and expressed frustration and confusion with how to engage in such programs despite court mandates that he do so.

The mother was more receptive to services but frequently missed her own parenting classes and was complicit in repeated violations of the safety plan by allowing the father access to the children. The first of these violations resulted in a third child protection investigation that was ultimately indicated against both parents for risk of harm. Although the mother did at one point file for an order of protection against the father, during the court hearing she minimized his behavior and stated she had only filed the petition to placate the family's private agency caseworker. The case was dismissed and shortly thereafter the mother and father were married.

The infant girl's myriad medical issues continued to pose a challenge to the family and the efforts of physicians to improve her condition were unsuccessful. At the age of 18 months, after 9 weeks of hospitalization for weight loss, dehydration, pneumonia and respiratory failure, the parents accepted their daughter's poor prognosis for survival and requested withdrawal of her ventilation support system.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. With growing concern of methamphetamine abuse, the public has a reasonable expectation that county and state agencies (parole, probation, Office of Alcohol and Substance Abuse, and the Department) collaborate to optimize service outcomes when providing services to shared clients. In the interest of improving interagency communication, collaboration, and cooperation the Department should require interagency case staffings.

The revised Substance-Affected Family Procedures, including the recommended changes, have been adopted and were posted on the D-Net September 8, 2006 (Policy Transmittal 2006.11, Procedures 302, Appendix A, Substance Affected Families.) Training on the new procedures is underway as part of the Department's reunification training.

2. The public also has a reasonable expectation that methamphetamine abusers have access to effective research-based treatment interventions. To that end, the Office of Alcohol and Substance Abuse/DCFS Initiative providers should adapt their treatment approaches to include interventions that have demonstrated statistically significant reductions in drug and alcohol use, improvements in retention and treatment completion, and improvements in psychological indicators and functioning. Empirical evidence has demonstrated that the Matrix Model treatment approach significantly improved treatment attendance and retention, increased methamphetamine-free urine samples during treatment, reduced drug use, and improved functioning. The Matrix Model is a highly structured outpatient treatment approach for cocaine and methamphetamine disorders that integrates treatment elements from a number of specific treatment strategies, including relapse prevention, motivational interviewing, psychoeducation, family therapy, 12-Step program involvement, and monitored for drug use by urine and breath-alcohol testing. At a minimum, Office of Alcohol and Substance Abuse /DCFS Initiative providers should adopt weekly random urine and breath-alcohol testing, and include family therapy and family education when working with methamphetamine abusers. Office of Alcohol and Substance Abuse and DCFS also need to develop funding mechanisms to adequately support the additional drug testing, monitoring, and transportation costs associated with treating methamphetamine abusers.

DCFS has received a 3-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement Matrix Model methamphetamine treatment in selected counties starting in January 2007. The Department's IV-E waiver project has been approved for a 5-year expansion starting in January 2007 into two other counties to implement its Recovery Coach in an area impacted by methamphetamine abuse. The DCFS legislative initiative in Champaign and Danville will incorporate the matrix treatment model into its program plan in FY 07, beginning in November 2006.

3. Literacy involves communication: reading, writing, speaking and listening. When literacy is a problem, caseworkers should make referrals to appropriate literacy intervention programs, preferably family literacy programs. Service and treatment providers should be informed when an individual's literacy problem poses an obstacle to effective interventions.

The Department will include this information in our training curriculum.

4. During the course of an abuse or neglect investigation the child protection investigators should be required to contact the Departments of Corrections and Probation when an investigator discovers the

alleged perpetrator, paramour or caregiver of the child is on probation or parole. The child protection investigators involved in this case should be counseled to contact the Departments of Corrections and Probation when the above circumstance exists.

Counseling (teaching) memos were issued to identified staff on June 16, 2006.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

A three-year-old boy suffered severe head trauma after being thrown to the floor of his home by his mother's boyfriend. Two months prior to the incident, two child protection investigations regarding abuse of the boy had been unfounded.

INVESTIGATION

The first child protection investigation was initiated after the boy arrived at school with a black eye. Four days earlier school personnel had observed a bruise on his cheek. Although the boy originally told the preschool director he did not know how he obtained the eye injury, he later informed his teacher that his mother's boyfriend had punched him on the face and back. The boy demonstrated how he had been struck on the back and the teacher saw old and new marks on his body in the area he identified. A child protection investigator was assigned and conducted an interview with the boy at his school the same day. The boy's responses to the investigator as to the cause of his injuries varied, at first telling her he didn't know how they occurred and later alleging he had been hit by the boyfriend. The investigator noted that when she asked the boy a third time about the nature of his injuries, he looked at her and laughed. The investigator spoke to the preschool director who stated the mother had explained to staff that the boy had punched himself in the eye. The investigator observed the boy's black eye and determined it to be approximately five days old by utilizing a color dating of bruising chart developed by the Department. The OIG recommended discontinuing the use of this chart in 2001, as its reliability is not supported by current literature.

The investigator later met with the mother in the family home. The mother stated that both the black eye and the earlier mark on his cheek had been caused by accidents involving the iron frame of his bed. The mother could not provide an explanation for the marks on the boy's back but hypothesized they may have been the result of his frequent wrestling with his seven-year-old brother. The mother informed the investigator her boyfriend had moved into the home a week earlier and that since his arrival the three-year-old had been having nightmares and wetting the bed. The investigator also interviewed the boyfriend who corroborated the mother's explanation and denied disciplining or being left alone with the boys. The investigator requested that the mother take the boy to be examined by his physician. The investigator then spoke to the physician who stated he had observed the injury to the boy's eye and that it was consistent with the mother's explanation. An OIG review of the doctor's notes found no indication he examined or considered the marks on the boy's back.

Six days after the initial hotline call, while the first investigation was still pending, a second report was made after the mother informed staff the boy had suffered a concussion after falling out of bed while sleeping. The same investigator assumed responsibility for the report. The mother told the investigator the boy suffered from nightmares and frequently woke up crying and screaming. She said she had heard him screaming during the night and entered his room to find him lying on the floor with a bump on his forehead. The investigator subsequently spoke to the boy's doctor who stated he had examined the boy and again found his injuries to be consistent with the mother's explanation. The doctor said he had diagnosed the boy as having "night terrors" and had ruled out abuse as a possible cause of his injuries. The investigator relied upon the doctor's conclusion although she did not share with him vital information she had obtained, such as the mother's alternate explanation for the black eye that she provided to the school, the boy's allegation against his mother's boyfriend or the fact the boyfriend had recently moved into the family home. The doctor's determination, which served as much of the basis for the investigator's ultimate decision to unfound both reports, was made without the benefit of all relevant information. Following the second report, the mother informed the school the boy would no longer be attending. Although the boy's teacher, to whom he originally reported the abuse, expressed concern over his removal from school and stated her desire to speak with the investigator, she was not interviewed during the course of either investigation.

Two months after the reports were unfounded, the boy was brought to a hospital emergency room by his mother. Upon his arrival he was unresponsive and presented severe head trauma and other injuries. The mother offered conflicting accounts of what had occurred to cause his condition. Law enforcement later determined the boyfriend had turned the boy over and dropped him on his head on the kitchen floor while the mother was out of the home. The boyfriend was arrested and charged with aggravated battery of a child. Following a child protection investigation of the incident the boyfriend was indicated for head injuries by abuse and the mother was indicated for head injuries by neglect. Both were indicated for substantial risk of physical harm. The mother relinquished custody of both children to their father, with whom they currently reside. The boys and their father are participating in intact family services. The mother continues to live with her boyfriend, whom she met over the internet only two months before he moved in, and continues to deny he abused her three-year-old son.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Deputy Director of Child Protection should develop with her staff a list of prompting questions that must be used in supervision of all investigations in which a physical injury is alleged. Use of this list should be required by Procedure 300 and be included in the investigative record. Questions should include, but not be limited to:
- Have there been a series of injuries to child(ren) in the home in the last 6 months?
- Have there been any changes in household composition or caretaking that correspond with the onset of injury?
- If parents are separated or divorced, have both parents been contacted for information and/or placement?
- Has there been a delay in seeking care for any of the injuries?
- Were there any witnesses to the injury, if so, what did the witnesses report?
- Is the explanation for the injury consistent with the injury? Whose opinion is it and what facts were shared?
- Were conflicting explanations given for the injury? What were they and by whom?
- Are the injuries occurring only in one setting (e.g., home v. school or daycare)?
- Are the injuries occurring only with one particular caretaker?
- Have the factors allegedly causing the injuries occurred across settings?
- Was there corroboration for the explanations given for the injuries? What was it?

The committee convened to review and revise the safety assessment instrument and process is still working on this project. The prompting questions will be included in the revisions. Target date: June 2007.

2. The Department Medical Director should consult with local experts on child abuse about the prompting questions developed in Recommendation 1 regarding what, when, and how the information should be shared when seeking an opinion from a doctor about physical injuries. Procedure 300 should be updated to include this.

The Department will develop the guidelines after completion of the prompting questions list. Target completion date: September 2007.

3. Once developed, all child protection investigators, supervisors, and managers should be trained on Recommendations 1 and 2.

The Department agrees. The Office of Training will incorporate the guidelines into the CORE Training when they are complete. Target completion date: September 2007.

4. This report should be shared with the appropriate Department Administrator. The Administrator

should review the report toward improving the Subsequent Oral Report (SOR) conference process in her area.

The Division of Child Protection is in the process of evaluating SOR conferences across the state in an effort to standardize expectations, processes, etc., for all participants required to attend. The report was shared with involved staff.

5. The body chart used in child protection investigations should be corrected to reflect current research on the dating of children's bruises. This information must be conveyed via training, including supervisor training.

The Department agrees. Procedure 300 is under revision and this information will be included in the revisions. Training will follow completion of Procedure 300.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

A 15-month-old boy brought to a hospital by his mother with numerous severe physical injuries and ailments was diagnosed with battered child syndrome, physical abuse, sexual abuse and medical neglect. At the time his condition was discovered, a child protection investigation for physical abuse against the mother was pending.

INVESTIGATION

The family came to the attention of the Department after the State Central Register (SCR) accepted a hotline call reporting the boy had multiple scratches and bruises on his head, hands and back. The mother had stated the boy was injured while attempting to learn how to walk. The call was accepted naming the mother as the possible perpetrator while the mother's boyfriend and another woman were both listed as Other Persons With Information (OPWI), though minimal additional contact information was provided. A mandate worker was immediately dispatched to visit the child and traveled to the home of a babysitter where the baby was believed to be. The babysitter's father told the worker the baby had been picked up by his mother 20 minutes earlier and denied any knowledge of their whereabouts. The babysitter's father stated he did not want his family to be involved in the investigation and expressed concern for his daughter's safety as a result of the report. The father stated that the babysitter would not speak with the mandate worker. The following day the case was assigned to a child protection investigator.

At the time she received the case, the child protection investigator was serving as the Temporarily Assigned (TA) supervisor in her field office, responsible for handling the regular supervisor's duties when she was away from the office. In an interview with the OIG, the investigator said that as TA she was often unable to leave the office, precluding her from attempting to visit the family on the day the case was assigned. As a result of the scant and inaccurate information available regarding the family's identity or residence, the investigator's repeated efforts to locate the family were unsuccessful for 10 days. In a separate interview, the investigator's supervisor acknowledged that an all-shift alert, requiring other workers to make continuing attempts to locate the family, was not implemented. The supervisor stated she was new to her position at the time and was unfamiliar with the practice. Ultimately the investigator was able to identify the mother's residence as a basement apartment in the home of the woman listed as an OPWI in the initial report.

Upon arriving at the residence the investigator found the mother's boyfriend alone with the baby. The boyfriend had left the baby unattended in a running bathtub to answer the door. When the investigator questioned him about this practice, the boyfriend became defensive. The investigator did not observe the marks reported in the hotline call, which had been made 10 days earlier. The investigator did not obtain information from the boyfriend necessary for conducting Child Abuse and Neglect Tracking System (CANTS) or Law Enforcement Agency Database System (LEADS) checks as required by Department procedure. The investigator assumed the boyfriend was merely watching the baby briefly and his surly demeanor discouraged her from asking more probing questions. After speaking to the mother by phone later that day and receiving assurances the baby would be seen by his doctor, the investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) noting no safety issues.

The day after the CERAP was finalized, the investigator learned the mother had not taken the baby to see his physician as agreed. The mother stated work commitments prevented her from keeping the appointment but promised to reschedule for early the following week. The investigator's supervisor instructed her to revisit the family and confirm that a doctor's visit occurred. Over the next month the investigator documented four unsuccessful attempts to contact the mother by telephone, culminating in her learning the phone had been disconnected. A certified letter mailed to the address elicited no response. The investigator did not speak to the baby's doctor to verify the mother's previous statement that the boy had been injured while learning how to walk. An OIG review of the boy's medical records obtained from the physician found no record he was

seen after the CERAP was completed and found no evidence of a conclusion the boy had been injured during an attempt to walk. Both the investigator and her supervisor told the OIG that at the time the case was assigned, the investigator not only had responsibility for serving as TA but was also involved with a particularly difficult case that required a great deal of her attention. The supervisor stated she had several other workers who required more direct instruction than the investigator, diverting her attention from the investigator's caseload.

One month after the investigator's last contact with the family, while the initial report was still pending, police were called to a hotel by the boyfriend who claimed he had been robbed. Officers observed that the baby's head was swollen and that he had several bruises, marks and scratches. The baby was transported to a hospital where an emergency room nurse identified a multitude of injuries. The mother stated the baby had fallen down the stairs, however the nurse determined the injuries were inconsistent with this explanation and called the hotline. Upon further examination doctors found the baby suffered from closed head trauma, a broken arm, human bite marks, gonorrhea and rectal tearing as well as other wounds at various stages of healing. The boyfriend later admitted to police that he had harmed the boy repeatedly, including burning his hand and inserting a toilet plunger handle into his rectum as a form of discipline. The boyfriend was charged with predatory criminal sexual assault and aggravated battery of a child. A second child protection investigation resulted in both the boyfriend and the mother being indicated for a number of allegations including head injuries, burns, bone fractures, torture and sexual penetration. The Department was granted temporary custody of the boy and a no contact order was entered against the mother and the boyfriend. The baby was placed in the care of his paternal grandmother.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be counseled for violating the paramour and LEADS procedures. In addition, given the host of unknown critical information, the OPWI and doctor should have been interviewed immediately. In the absence of information from the doctor and OPWI, the investigator and her supervisor should have recognized the possibility of abuse and implemented a safety plan once the family was found, given the vulnerability of the victim and poor judgment of the mother and paramour.

The child protection investigator received counseling.

2. The child protection supervisor should receive non-disciplinary counseling for violating the paramour and LEADS procedures. In addition, given the host of unknown critical information, the OPWI and doctor should have been interviewed immediately. In the absence of information from the doctor and OPWI, the investigator and her supervisor should have recognized the possibility of abuse and implemented a safety plan once the family was found, given the vulnerability of the victim and poor judgment of the mother and paramour.

The child protection supervisor received counseling.

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

This case is being included in the revision to Foundations Training, which all child welfare workers attend. This case will be used as a training tool on the OIG web page.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION

An 18-month-old boy drowned in his family's swimming pool. His adoptive parents were licensed foster care providers and had an open case with the Department for adoption assistance at the time of the boy's death.

INVESTIGATION

The parents' foster care license had been monitored by the Department for six years after their license was transferred from a private agency. At the time the license was transferred to the Department, the couple had three adopted children in their home. The parents were approved to accept three children into their home which allowed them the capacity to care for a total of six children, the maximum number permitted by Department Rule without obtaining a special waiver from the Director. Department Rule further states that the number of children permitted to be placed in a home will be reduced by one for every child in the home who presents special needs. One year after moving their license to the Department the couple adopted a fourth child. The Department licensing worker responsible for monitoring the family home did not reduce the capacity to two despite the addition of another child.

The following year, the couple had a fifth child placed with them through a private adoption agency. The child, a one month-old girl, required specialized care for physical problems and developmental delays. Although the licensing worker authorized the placement, she did not adjust the home's licensed capacity in light of the addition of a medically complex infant. At that time, the home's capacity should have been reduced to zero in accordance with Department Rule. The parents later adopted the baby's sister following her birth. The sister had been born substance exposed and was unable to breathe without the assistance of a ventilator. When the parents subsequently applied for renewal of their license they listed the presence of all six children in their home, the youngest two of whom had serious medical issues. The renewal request maintained the level of capacity at three. Neither the licensing worker who recommended renewal nor her supervisor who approved it recognized that, given the family's composition, the home already exceeded the Department placement limit by two children. Six months later the licensing worker requested an expansion of the home's capacity by three, bringing to nine the total number of children who could have resided in the home. The request was denied by the Director.

Despite the fact the licensing worker recognized no more children could be placed in the home, she was unaware the home was beyond its capacity. Furthermore, she continued to permit children to be placed in the home through private adoption agencies. In an interview with the OIG, the licensing worker stated she had been told by her former supervisor that the Department did not have the authority to regulate the number of children adopted by a licensed foster family. The worker's current supervisor also held the same belief. During a six-month period, three more infants were placed in the home. The couple's oldest child had since turned 18, however there were eight children living in the home, five of whom were 4 years-old or younger.

The second youngest child had been placed in the home through a private agency program intended to offer short-term foster care for at-risk children. The child entered the program after her mother told hospital staff that she needed an opportunity to solidify her living situation before caring for the child. However a child protection investigation was initiated after it was determined the mother's myriad health and social issues greatly decreased the possibility the child could be returned to her care. The child protection investigator assigned to the case did not notify the private agency of the mother's compromised position and the decision to continue including the baby in a short-term care program was not reconsidered.

Although the couple's home included a swimming pool, pond and creek, the licensing worker never addressed issues of water safety with the family during the initial transfer of the license to the department or the renewal assessment. One evening while the entire family was present in the home, the 18 month-old was out of sight of the parents for a short time and was later found unresponsive in the pool. A pool alarm was found to be

malfunctioning. Department Rules and Procedures do not include safety standards or requirements regarding homes with access to water. Drowning has been identified as a primary cause of accidental death among children under the age of four.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The parents' foster home license capacity should be amended to zero. Department licensing staff should sensitively explain the reduction with the couple, including acknowledging staff's failure to accurately interpret and properly implement the applicable Department Rule. Licensing staff should explain to the parents that even with a license at 0, if they chose to maintain their license, they must continue to complete training hours, and licensing staff must continue to conduct monitoring assessments of their home. Because of this, the option of close/surrendering their license should be explained and made available to them.

The foster parents have surrendered their license.

2. The Department should reevaluate whether the licensing worker's former supervisor should be disciplined for failure to recognize or correct the licensing worker's misinterpretation of Department Rule 402.15, and for signing approval of capacity levels that were out of compliance with foster home licensing requirements.

The Department believes that this occurred too long ago to discipline at this point. Also the fact that he is no longer a licensing supervisor in charge of making these type of judgments makes a difference as well.

3. The Department should amend Rule/Procedure 402 to require that licensing staff develop a water safety plan with the foster parents in any home that has a pool, hot tub, or whose property has or abuts a lake, stream or other body of water. The licensing worker should review the safety plan with the foster parents annually and assess the safety measures (i.e., test pool alarms, check locks, etc.). The safety plan should be maintained as part of the licensing file.

The Department agrees. We have addressed this issue in our day care home standards and it should also be included in our Foster Family Home standards since the population in terms of age and risk would not differ.

4. The Department should amend Procedure 402 to require that licensing workers document, as part of each monitoring visit, the ages of all children under 18 residing in a licensed foster home and their special needs, and their assessment of the foster family's capability to meet those needs. The licensing supervisor should sign-off approval of the determined appropriate capacity annually, ensuring it is in accordance with 402.12(d) and 402.15. The determined appropriate license capacity and the worker's assessment of the foster family should be placed in the licensing file.

A Department form was reworked to require that all children in the home are listed with their date of birth; the supervisor reviews the form and signs off before the annual visit can be entered.

5. Since the extent of the problem of licensing staff misinterpreting Rule 402.15 is unknown, the Department should immediately issue a policy clarification regarding the number and ages of children permitted in licensed foster homes. The clarification memo should emphasize that all children receiving full time care in the home - birth, adopted, foster and otherwise - are to be figured in to the total.

Draft policy that was submitted is being re-written by the Office of Child & Family Policy. It is expected to be finalized in December 2006.

6. A redacted version of the report should be used as a learning tool for licensing workers and supervisors in the region regarding assessing and understanding Rule 402.15.

The Office of Training has included this in training of Licensing staff.

7. This report should be shared with the private agency that administers the short-term foster care program for their consideration of the couple's participation in the program.

This report was shared with the private agency for their consideration of the foster parents' participation in the program.

8. This report should be shared for educational review with the child protection investigator, her supervisor and the child protection manager to reinforce the practice of reassessing needs and risk whenever additional information is learned about a case. Once the child protection investigator learned that the case entailed more significant issues and risk than was known at the time of the referral, she should have notified the private agency that the case needed to be returned to the Department.

As of the completion of the OIG investigation, the worker is on medical leave and the manager just returned from medical leave. The report will be shared with the manager by December 2006. The report will be shared with the worker when she returns from medical leave.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION

An eight-month-old boy drowned in the bathtub of his family's home. A child protection investigation of the boy's parents was unfounded two weeks prior to the baby's death.

INVESTIGATION

The child protection investigation was initiated after the parents arrived in a hospital emergency room in a neighboring state complaining that insects were crawling out of their rectums. The couple provided hospital staff with samples of their fecal matter and asked that it be tested for the presence of bugs. The attending physician observed the parents had open sores on their bodies and, coupled with what was believed to be paranoid behavior, identified them as possible methamphetamine users. The parents were accompanied by their three children, all under the age of five, whom hospital staff noted were filthy and inappropriately dressed. The physician requested that the hospital social worker contact local child welfare workers as well as the Illinois State Central Register (SCR). Since applicable laws in the neighboring state prevented hospital staff from stopping the family's departure from the premises, the parents took their children and left the hospital prior to the arrival of local child welfare workers. SCR in Illinois accepted the report for environmental neglect and a child protection investigator was assigned to the case.

The investigator went to the family home on the same day the report was taken and conducted an initial home visit. Upon her arrival, the father expressed his refusal to be "interrogated" and left the home. The mother disclosed that the father had a history of substance abuse and that he had been prescribed anti-depressant medication but was not currently taking it because the drugs were too expensive. The mother stated she and the father were divorced but were in the process of attempting reconciliation. The mother told the investigator she was preparing to have the home "bombed" in an effort to combat what she believed to be an insect infestation. In her notes, investigator recorded that she did not observe any bugs in the home as well as her conclusion that the mother's behavior may have been the result of "tweaking," a slang term used to refer to the delusional psychosis that often afflicts persistent meth users. Despite the mother's disclosure of the father's previous drug use, the investigator completed a Substance Abuse Screen that denied the existence of any drug-related issues with the family. Even though the investigator questioned the mother's sobriety and identified methamphetamine use as a possible explanation for her behavior, she did not refer the mother for a drug assessment. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) that found no concerns of environmental neglect based on the home's general appearance, the absence of any observable insects and the mother's intention to have the home fumigated later that week. Because no concerns were recorded in the CERAP regarding possible substance abuse by the parents, no safety plan was implemented. The completed CERAP determined the home to be safe and was approved by the investigator's supervisor the next day.

The assigned investigator had recently been hired by the Department and was not certified as a child protection specialist until two months after she began working on the case. She did not obtain a copy of the records from the family's visit to the emergency room. Although this was the third child protection investigation involving the parents, she did not review records to assess the family's history. An OIG check of the two previous investigations found substance abuse, specifically allegations and admissions of metahamphetamine use, to be factors in both. In an interview with the OIG, the investigator stated she did not consider adding a risk of harm allegation related to the father's drug use to the initial report because the mother told her he did not reside in the home. In a separate interview, the investigator's supervisor stated that children are rarely removed from their parents' custody as a result of methamphetamine use. Both the investigator and the supervisor were unaware of the differences between the laws of Illinois and the neighboring state regarding protective custody and assumed that since the hospital did not conduct tests on the parents or prevent them from leaving, the possibility of drug use as a safety issue was negligible.

Two weeks after the third child protection investigation was unfounded, the boy was transported to a hospital and pronounced dead after being found unresponsive in a bathtub by his mother. Two days after the baby's death, his maternal aunt informed Department personnel that she had received a phone call from the mother on the night of the incident informing her the boy had drowned. When she arrived at the family home, the aunt learned neither of the parents had called for an ambulance. The aunt called for emergency assistance but believed the baby had been dead for approximately an hour-and-a-half before she arrived. Both parents later admitted to the aunt they had been using methamphetamine the day their son drowned. A drug test administered to the mother by Illinois State Police when she arrived at the hospital with her son later returned positive for methamphetamine. Following these revelations, the other two children were taken into protective custody by the Department and placed with the maternal aunt.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The State Central Register manager should review with call takers that risk of harm allegations should be added to hotline calls alleging behaviors associated with substance misuse that compromise parent reasoning and judgment.

This issue was discussed in team meetings with the State Central Register. A memorandum regarding this subject was issued to State Central Register staff on July 7, 2006.

2. Training should include the caveat that different states have different laws governing who can take protective custody.

A Practice & Procedural memorandum distributed to Division of Child Protection management staff dated October 20, 2006 addresses these issues and states, "Criteria used by law enforcement and physicians in Illinois and other states in the decision to take protective custody may be different than criteria employed by DCFS. Thus, the decision to indicate or unfound an investigation must be based solely on the inculpatory and exculpatory evidence and should not be based on whether or not an outside professional took protective custody of the involved children. The emphasis must be on seeking out and then critically analyzing all evidence prior to rendering a final investigative finding."

3. Department Procedures should be amended to include a provision that the decision to indicate or unfound should not be based on whether an outside professional took protective custody.

A Practice & Procedural memorandum distributed to DCP management staff dated October 20, 2006 addresses these issue and states, "Criteria used by law enforcement and physicians in Illinois and other states in the decision to take protective custody may be different than criteria employed by DCFS. Thus, the decision to indicate or unfound an investigation must be based solely on the inculpatory and exculpatory evidence and should not be based on whether or not an outside professional took protective custody of the involved children. The emphasis must be on seeking out and then critically analyzing all evidence prior to rendering a final investigative finding." Additionally, this recommendation was included in revisions to Procedure 300, which is currently in Division of Child Protection administrative review.

4. The child protection supervisor should be counseled for failing to recommend that the investigator add an allegation of risk of harm during the third investigation after medical professionals reported that the parents' paranoid behavior was consistent with methamphetamine use.

An administrative meeting was held with the identified staff person. After the rebuttal process, counseling was imposed.

5. As previously recommended: With the growing concern of methamphetamine abuse in southern Illinois, the public has a reasonable expectation that county and state agencies and offices (parole, probation, Office of Alcohol and Substance Abuse, and the Department) collaborate to optimize service outcomes when providing services to shared clients. In the interest of improving interagency communication, collaboration, and cooperation, the Department should require interagency case staffings.

The revised Substance Affected Family Procedures include requirements for interagency staffings and require participation of parole and probation officers when applicable

6. As previously recommended: The public also has a reasonable expectation that methamphetamine abusers have access to effective research-based treatment interventions. To that end, the Office of Alcohol and Substance Abuse/Department Initiative providers should adapt their treatment approaches to include interventions that have demonstrated statistically significant reductions in drug and alcohol use, improvements in retention and treatment completion, and improvements in psychological indicators and functioning. Empirical evidence has demonstrated that the Matrix Model treatment approach, a highly structured outpatient treatment approach for cocaine and methamphetamine disorders, significantly improved treatment attendance and retention, increased methamphetamine-free urines samples during treatment, reduced drug use, and improved functioning.

DCFS has received a 3-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement matrix model methamphetamine treatment in selected counties starting in January 2007. The Department's Title IV-E waiver project has been approved for a 5-year expansion starting in January 2007 into Madison and St. Clair Counties to implement its Recovery Coach in an area impacted by methamphetamine abuse. The DCFS legislative initiative in Champaign and Danville will incorporate the matrix treatment model into its program plan in FY-07, beginning in November 2006.

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION

A two month-old boy died of undetermined causes while in the care of his parents. At the time of the boy's death, his mother's three other children were in Department custody and she was in a substance abuse program to address her issues with drugs and alcohol.

INVESTIGATION

The mother, a former ward, and her three children, then ages six, three and one, had first become involved with the Department two years earlier after the children's uncle was arrested and convicted of aggravated battery of a child for physical abuse of the three year old. No charges were leveled against the mother but the children were placed in foster care and the family was referred to a private child welfare agency for services. At the time the case was opened, the mother had no permanent address, was unemployed and had a history of substance abuse and depression. The mother acknowledged a dependence on drugs and alcohol and was selected to participate in the Illinois Substance Abuse Waiver Project through a second agency specializing in dependency issues. Following an assessment, the mother entered a 90-day inpatient treatment program. She left the placement after only three days but enrolled in another facility three weeks later and successfully completed treatment.

Over the ensuing two years the mother continued to struggle with her issues of dependency, moving in and out of treatment programs with varying degrees of success. During this same period, she continued to receive services through the child welfare agency. Although both the child welfare agency and the agency assisting in her substance abuse treatment remained active with her family case, neither agency established an effective long-term plan for ensuring the mother could effectively care for her children and there was little to no collaboration between professionals from the two organizations. The mother's child welfare agency caseworker noted that prior to the time the case was opened, the mother had not obtained necessary immunizations for her children and the six year old had not been enrolled in school, however, the child welfare agency made little effort to enhance the mother's parenting ability. Throughout her involvement with services, the mother suffered relapses in her efforts to overcome her substance abuse. Staff from the agency dealing with the mother's substance abuse focused almost exclusively upon that issue and did not identify family and child well being as an outcome of interest. Recognizing that the goal was for the family to remain intact, the development of a comprehensive approach to addressing the family's needs involving both agencies could have facilitated a greater likelihood of the mother achieving success.

Six months after the case was opened the mother experienced her first relapse. Over the next year and a half she failed to maintain reliable contact with the workers involved with her case and periodically returned positive substance abuse screens. Nine months after the case was opened the mother reengaged in services following a period of inactivity. She tested positive for marijuana and informed a worker she was pregnant. The mother refused a recommendation to enter residential treatment. After that time her involvement with services and her attendance at visits with her children, which had been consistent, became increasingly sporadic. After a five-month period during which she had no contact with her worker or her children, the permanency goal was changed to substitute care pending termination of parental rights. Following the death of her infant son, who had remained in her care, the mother withdrew from participation in services and had minimal contact with her children. Her parental rights were terminated and the children were subsequently adopted. The mother has since given birth to a fifth child, a girl. The mother and her daughter have no involvement in services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Illinois Substance Abuse Waiver Demonstration project staff should be trained on providing integrated services to clients that address the family's well being and emphasize parental involvement while children are in foster care. Parents should be supported in establishing relationships and taking an active role with their children's school and pediatrician. The OIG Project

Initiatives staff can convene this training using a redacted copy of this report, a status and outcome assessment developed for the Department and Indicators for Progress in the Substance Abuse Recovery Process.

The revised Substance Affected Family Procedures include requirements for workers to emphasize family involvement. A recovery matrix will be developed to encourage and document a parent's involvement with their children while in foster care. Use of the recovery matrix is included in the statewide reunification training now underway. Service Intervention staff are working with OIG staff to find a mutually agreeable time to deliver this training. Target completion date: June 2007

The Office of Training & Professional Development is working with the Erikson Institute to develop a web-based series of training modules on early childhood. These will be posted as separate resources on the Training website. Zero to three programming services will be included.

2. For child welfare cases involved with the Illinois Substance Abuse Waiver Demonstration project, the Department should require quarterly team meetings for the child welfare staff and recovery coaches or other substance abuse treatment staff. Additional meetings should be convened at critical points in a case, such as during periods of relapse, the birth of subsequent children or case progress setbacks.

The private contractor responsible for the project has revised its procedures for the Recovery Coach program to include quarterly team meetings and meetings at critical points in a case as recommended.

3. The Illinois Department of Human Services recognizes that for cases in which the permanency goal is return home, federal zero to three programming is available to assist biological parents. Emphasizing treatment in a natural setting, DHS services should be accessed to assist both biological parents and foster parents.

- The Substance Abuse Waiver Demonstration project staff should receive training specific to zero to three services available for children and their families.

- The Department's Office of Training and Development should post information about such services on its training web site.

Training target completion date: June 2007.

The revised Substance Affected Family procedures include requirements to include parents in Department of Human Services Zero -3 services.

Training posted this information on the D-Net on March 27, 2006.

4. Copies of *A Helpful Guide for Parents and Caregivers* should be provided to both the child welfare agency and the substance abuse treatment agency for review and distribution to their staff.

Recovery Coaches have received the Guides and are using them with the families they serve.

DEATH AND SERIOUS INJURY INVESTIGATION 11

ALLEGATION

A one month-old boy suffocated while sleeping on a couch in his family's home. At the time of the infant's death, the family had an open child protection investigation

INVESTIGATION

A hotline call was received shortly after the baby's birth alleging the mother suffered from post-partum depression and had been hospitalized after exhibiting combative behavior towards family and authorities called to her home. The assigned child protection investigator spoke with the mother who denied post-partum depression but acknowledged experiencing a great deal of personal turmoil at that time related to her father's serious illness and the potential dissolution of her marriage. The mother told the investigator she had asked her husband for a divorce because he was physically abusive towards her and had recently caused her to suffer a hairline fracture. The mother agreed to provide the investigator with doctor's reports related to her hospitalization following her son's birth. The next day the investigator interviewed the father who stated his wife was a good mother but he was concerned about her current mental state and possible excessive use of prescription painkillers given to her after her Caesarean-section delivery. The father said the mother had been diagnosed with post-partum depression and promised to give the investigator documentation verifying his claim.

As the investigation continued, the mother never provided the consent for the investigator to review her hospitalization records. Department Rule requires that when a child is considered at risk, child protection investigators must obtain pertinent medical records and speak with treating physicians. In separate interviews with the OIG, the investigator and her supervisor stated the mother consistently agreed to provide the necessary paperwork but did not follow through. Neither the investigator nor her supervisor were aware that consent is not required to obtain medical records when the individual is the subject of a child abuse or neglect report. The records may be subpoenaed in order to conduct the investigation.

The investigator performed a Law Enforcement Agency Database System (LEADS) check on both parents and found the father had recently been arrested for violating an order of protection. Although LEADS information usually lists the parties covered by an order of protection, that information was not included in the report. The mother told the investigator she did not have an order of protection against her husband. In a separate conversation, the father told the mother the order had been filed against him by a girlfriend and he asked that she not disclose the circumstances to his wife. The investigator accepted the father's explanation and did not verify his account. Given the mother's allegations of domestic violence, which she retracted in subsequent conversations with the investigator, the existence of an order of protection involving the father should have been examined. By obtaining underlying documentation of the arrest from police, the OIG learned the father had violated an order of protection covering his wife and the couple's two older children. Both the investigator and her supervisor stated they had never received any training on how to obtain underlying documents from law enforcement agencies.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should ensure that subpoena training and training on accessing confidential medical and other information is included in CORE child protection training. Until such training can be implemented, and for current child protection staff, Department regional attorneys should conduct trainings throughout the state to ensure an understanding of the Department's ability to access such information, as well as the mechanics of issuing subpoenas.

The Division of Child Protection worked with the Legal Division to revise and update the administrative subpoena (CANTS 7), which is on DCFS templates available for all staff.

The Division of Child Protection has incorporated a training module in the pending Comprehensive Investigation Training addressing mechanics of administrative subpoenas. A memo regarding expectations for subpoena usage was distributed to staff in May 2006.

Additionally, Procedure 300.60 has been revised to include updated requirements regarding subpoena issuance and language usage on the document. The Division of Child Protection continues the divisional review of Procedure 300 reformatted by the Office of Child and Family Policy (OCFP). These recommendations have been added, including the Joint Commission on Administrative Rules (JCAR) process. It is anticipated revised procedures will be implemented in 2007.

2. An information transmittal should be issued to ensure that whenever child protection supervisors are faced with an inability to access needed information, they notify their field service manager, who should intervene with hospital administrators or others to ensure needed information is accessed as the law permits.

A Practice & Procedural memo was distributed on May 10, 2006.

3. 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 committee continues work on revisions to Administrative Procedure 6 - LEADS Protocol. Issues leading to development of this workgroup have been incorporated into the current draft. The Illinois State Police reviewed a recent draft and their comments have been included. The Legal Division representative is reviewing the draft in light of the Adam Walsh Act to ensure appropriate provisions are included in the LEADS protocol. Anticipated completion of revisions should be by the beginning of 2007.

4. The subpoena procedures should be amended to provide for subpoenas whenever parents refuse "or fail to immediately provide" consents.

DCP worked with Legal Division to revise and update the administrative subpoena, CANTS 7, which is on DCFS templates available for all staff.

DCP has incorporated a training module in the pending Comprehensive Investigation Training addressing mechanics of administrative subpoenas. A memo regarding expectations for subpoena usage was distributed to staff in May 2006.

Additionally, Procedure 300.60 has been revised to include updated requirements regarding subpoena issuance and language usage on the document. The Division of Child Protection continues the divisional review of Procedure 300 reformatted by the Office of Child and Family Policy. These recommendations have been added. Including the JCAR process, it is anticipated revised procedures will be implemented 2007.

DEATH AND SERIOUS INJURY INVESTIGATION 12

ALLEGATION

A three week-old girl died of Sudden Infant Death Syndrome (SIDS). During the four months prior to the girl's death, her parents were the subjects of two child protection investigations and the family was involved with intact services through the Department. After the girl's death, another investigation was initiated after her older brother was present in the family's home during a knife fight.

INVESTIGATION

The first child protection investigation was initiated after the parents brought their one year-old son to a hospital emergency room with a scalp hematoma. The mother stated she did not know the cause of the injury and noticed it after she picked the child up from the home of a babysitter. The mother told the assigned child protection investigator she had previously resided in another state and the father acknowledged he had a child who lived in a third state. The investigator completed a Law Enforcement Agency Database System (LEADS) check on the mother that showed she had six recent arrests for solicitation, including one just three days earlier. The investigator did not conduct a LEADS check on the father or perform out-of-state checks on either parent. A LEADS check of the father conducted by the OIG found an extensive history of arrests and convictions in five states for assault and battery and possession of controlled substances.

The one year-old son was placed in the care of his paternal grandmother. In separate interviews with the OIG, the two supervisors responsible for monitoring the investigator's work during this time each stated they were unable to recall discussing LEADS information about any of the family members with the investigator. One supervisor, who had filled the role in a temporary position, incorrectly stated that even if the investigator had obtained the family's complete criminal histories, such information could not be shared with the State's Attorney in the event the case was screened into court. The investigator ultimately concluded there was insufficient evidence to support allegations of abuse against the parents but indicated the report against an unknown perpetrator. The investigator's case closing included no information regarding the child's living arrangement, whether he would be returned to his parents or remain with the grandmother. The investigator told the OIG the parents had entered into a private guardianship agreement with the grandmother, however there was no evidence in the case file indicating the establishment of such an arrangement. A child protection manager had granted approval for the investigator to close the case without performing tasks required by the Department. Neither the manager nor the OIG were able to review the reasons provided for allowing the tasks to be waived because the State Automated Child Welfare Information System (SACWIS) does not permit access to this information after a case has been closed.

Two months later a second investigation was opened after the mother gave birth to a baby girl and both tested positive for cocaine. The child protection investigator assigned to the second case performed LEADS checks on both parents but did not request out-of-state criminal histories. Although the second investigator was aware of the father's history of convictions for violent crime, she completed a Substance Abuse Screen showing he had no prior charges for crimes unrelated to drugs. The parents told the second investigator that the grandmother had custody of their son but steps were not taken to confirm his guardianship status.

During her initial visit with the family, the intact services worker completed a Child Endangerment Risk Assessment Protocol (CERAP) finding the baby girl to be safe in her parents' care. The worker noted the parents were low risk for involvement in drug activity or parenting concerns. Questions related to the mother's prenatal care and the father's relationship to the family were left unmarked.

Ten days after the intact case was opened the infant girl's mother found her lying unresponsive in her bed. Paramedics transported her to the hospital where she was pronounced dead. Subsequent to the girl's death, the family's intact services case was closed, as the one year-old boy had not been included in the family

composition. Two months after the girl's death the father was arrested after cutting a man with a knife while being presented with an eviction notice. The couple's son was present in the home at the time of the incident. A hotline call was made and the investigator who handled the first report involving the family was assigned, however she unfounded the case the next day after concluding the grandmother and the boy had only been visiting the parents' home at the time of the altercation.

The investigator referred the grandmother to Extended Family Support Services (EFSS), which provides short-term support and intervention for children who are not part of the formal child welfare system. Program staff identified a need to assist the grandmother to obtain private guardianship in probate court. Four months after the referral had been made, guardianship of the boy remained unresolved because a LEADS check of the grandmother remained pending. The OIG contacted the part-time Department employee responsible for forwarding LEADS requests from EFSS. The OIG learned the employee had received the grandmother's information and background clearance, along with LEADS checks required in order for the EFSS worker to proceed with private guardianship but had failed to relay it in a timely manner. The employee had failed to perform his duties on a number of other cases as well.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The inadequacy of the first child protection investigator's work on the initial abuse report set the stage for the mishandling of subsequent investigations and intact family services. The first child protection investigator should be disciplined for failing to: follow the Department's LEADS Protocol and Rule and Procedure 300 during an investigation of a head injury; adequately assess risk to a child in terms of the parents' LEADS histories, their relationship and difference in ages; and failing to ensure the safety of an eight-month-old child at the close of a DCP investigation that left the child without a legal relationship to a relative or an open intact family case.

The worker received a written reprimand.

2. The second child protection investigator should be counseled for failing to: follow the Department's LEADS protocol, which advises obtaining out-of-state LEADS checks when available information suggests the need for such checks, and assessing risk in association with the parents' involvement in drugs and alcohol abuse, criminal activity, and violent behavior, the lack of prenatal care, and the parents' age difference in relation to their LEADS histories. The second child protection investigator did not attempt to establish the one year-old boy's legal relationship to his grandmother. Although the second investigator opened an intact family case for a substance-exposed newborn, this was done at the exclusion of a one year-old sibling. Consequently, the older sibling's safety was not assessed through a CERAP during later child protection investigations or by the intact family worker.

Counseling was held with this worker.

3. The Department should counsel the intact family services caseworker for her inadequate initial assessment of the parents (rating them as low risk pertaining to drug use in the family) and failing to acknowledge the mother's lack of prenatal care. The caseworker failed to acknowledge the father's relationship to the family and his admission to drug use. She should have inquired about the parents' backgrounds when she was assigned the family or when she had contact with the child protection investigator. Although the caseworker was only involved with the family for a short time, there was no indication that she intended to verify the legal status of the one year-old boy nor did she assess the older sibling's safety through a CERAP.

Counseling was held with the worker.

4. The Department should share this report with all child protection investigators and intact family services supervisors and administrators involved with this case. The Department should also correct the misconception pertaining to sharing parents' LEADS information with the State's Attorney's Office when screening cases.

The report was shared with the staff and misconceptions were corrected.

5. The Department needs to ensure that the legal status of a child living with non-parents is resolved prior to closing the investigation.

A "Practice and Procedural" memorandum dated November 7, 2005 was issued to DCP management requiring resolution of a child's living arrangement prior to closing an investigation. The memo was to be shared with supervisors and investigators.

6. For failing to carry out his primary job function under his current contract, the Department should not renew the contract of the Department employee responsible for forwarding LEADS requests from EFSS workers. This report should be shared with the Department's liaison to law enforcement to develop an adequate system for timely exchange of LEADS information from the Department to the EFSS program and probate court. Such a system should include the ability to track requests and responses for timely follow up.

The contractor is no longer employed in this position.

7. The SACWIS program should be adjusted to enable child protection managers to access child protection investigators' rationales for requesting waivers on a "read only" basis after the close of investigations. When there are unfortunate outcomes, management needs to be able to go back and review the appropriateness of the entire investigation for learning purposes.

This was implemented October 22, 2006.

CHILD DEATH REPORT

The OIG receives notification from the Illinois State Central Register (SCR) of child deaths reported to SCR when 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 service case within the preceding twelve months.[1]

The notification of a child death generates a preliminary investigation in which the death report is reviewed, computer databases are searched and information reviewed, and if available, a chronology of the child's life is reviewed. The next level of investigation is an investigatory review of records in which records may be impounded, subpoenaed, or requested, and reviewed. When warranted, a full investigation, including interviews, is conducted. A full investigation generally results in a report to the Director of DCFS.

In Fiscal Year 2006, the OIG received notification from SCR of **86** child deaths meeting criteria for review. In **7** cases preliminary investigations were conducted. In **68** cases investigatory reviews of records were conducted. In **11** cases full investigations were opened: in 3 cases reports were sent to the Director; in 8 cases the investigations are pending. Summaries of death investigations that resulted in major recommendations are included in the Investigations section of this annual report. The OIG received notification of 53 fewer deaths in FY 06 than in FY 05 when it received notice of 139 deaths. Forty-three of the 53 fewer deaths (81%) were in the natural category, as there were 87 natural deaths in FY 05 and 44 natural deaths in FY 06.[2]

Over the last several years, the OIG has worked to reduce the number of sleep-related deaths in DCFS-involved families. In 2003 the OIG issued a report on child deaths involving infant sleep safety that recommended the Department attempt to reduce infant sleep-related deaths by requiring investigators and caseworkers to educate DCFS-involved families about safe sleep practices for infants. The OIG developed the Home Safety Checklist, a tool designed to increase children's safety in their homes (see Home and Fire Safety Training in the Section entitled OIG Initiatives). Since June 2004 investigators and caseworkers are required to complete Home Safety Checklists.

In FY 06, 9 of the 18 children whose deaths were classified as accidental died from asphyxia (suffocation) because of inappropriate sleeping arrangements; they were laid over by someone, were trapped between surfaces, or were smothered in bedding. Some of the deaths classified as Sudden Infant Death Syndrome, a natural cause of death also may have been related to inappropriate sleeping practices: several of these children were sleeping in adult beds or on their stomachs. The American Academy of Pediatrics (AAP) recommends that babies be put to sleep on their backs on a firm mattress in a crib, bassinet, or cradle (that

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[1] 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 deaths are not always reported. 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. It is not known whether this is regularly occurring; in addition, some death certificates are sent to the Child Death Review Team Coordinator well after the fiscal year in which the death occurred. 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 county coroners and Sharon O'Connor at the Cook County Medical Examiner's Office for responding to our requests for autopsy reports.

[2] While this difference is statistically significant, the trend does not seem to be continuing for FY 07. Mid-FY 07 numbers more closely track those in FY 05 than FY 06.

meets Consumer Product Safety Commission guidelines); soft objects and loose bedding should be kept out of the crib. The AAP recommends that infants not bed share during sleep (2005).

Summary

Following is a statistical summary of the 86 child deaths received by the OIG in FY 06 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 four manners: homicide, undetermined, accident, and natural. There were no suicides in FY 06 meeting OIG criteria for review.

Key for Case Status at the time of OIG investigation:

Ward . . . . Deceased was a ward

Unfounded DCP . . . . Family had an unfounded DCP investigation within a year of child's death

Pending DCP . . . . Family was involved in a pending DCP investigation at time of child's death

Indicated DCP . . . . Family had an indicated DCP investigation within a year of child's death

Child of Ward . . . . Deceased was a ward's child, but not a ward themselves

Open Intact . . . . Family had an open intact family case at time of child's death

Open Placement . . . . Deceased, who never went home from hospital, had sibling(s) in foster care

Split Custody . . . . Deceased, who was at home with family, had sibling(s) in foster care (or out of home pursuant to a DCFS safety plan)

Preventive Services . . . . Intact family case was opened to assist family, but not as a result of an indicated DCP investigation

Return Home . . . . Deceased or sibling(s) was returned home to parent(s) from foster care within a year of child's death

Extended Family Support . . . . . Service case was opened to assist extended family members caring for children because of a child welfare need or safety plan

Child Welfare Services Referral A request was made for DCFS to provide services, but no abuse or neglect was alleged

Interstate Compact . . . . A ward from another state was placed in a foster home in Illinois and an Illinois worker was monitoring the placement

Table 5: CHILD DEATHS BY AGE AND MANNER OF DEATH

Child Age		Homicide	Undetermined	Accident	Natural	TOTAL
MONTHS OF AGE	At birth	0	0	0	3	3
	0 to 3	1	1	8	11	21
	4 to 6	0	1	1	7	9
	7 to 11	2	0	0	5	7
	12 to 24	0	1	1	6	8
YEAR OF AGE	2	2	0	1	2	5
	3	1	0	2	2	5
	4	1	0	0	2	3
	5	0	0	2	0	2
	6	0	0	1	1	2
	7	0	0	0	0	0
	8	0	1	0	0	1
	9	0	0	0	0	0
	10	1	0	0	0	1
	11	2	0	0	1	3
	12	0	0	0	1	1
	13	1	1	0	0	2
	14	1	0	0	0	1
	15	0	0	0	1	1
	16	2	0	1	0	3
	17	3	0	0	0	3
	18 or older	2	0	1	2	5
	TOTAL	19	5	18	44	86

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

Reason for OIG investigation		Homicide	Undetermined	Accident*	Natural*	TOTAL
Ward		4	1	2	10	17
Former Ward		1	0	0	0	1
Open Placement		0	0	0	2	2
Open Intact		4	1	3	12	20
Closed Intact		0	0	1	0	1
Split custody		0	0	1	1	2
Child of Ward		0	0	0	1	1
Preventive Services		1	0	1	3	5
Child Welfare Services Referral		0	0	0	3	3
Interstate Compact		0	0	0	1	1
DCP	Indicated	0	1	0	0	1
	Unfounded	7	2	8	8	25
	Pending	2	0	2	3	7
TOTAL		19	5	18	44	86

* Two of the cases also had pending DCP investigations in addition to having a type of service case open at the time of death.

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

County**	Homicide	Undetermined	Accident	Natural	TOTAL
Adams				1	**1**
Cass				1	**1**
Champaign			2	1	**3**
Christian		1			**1**
Coles	1		2		**3**
Cook	14	2	8	21	**45**
Fulton	1			1	**2**
Grundy			1		**1**
Jefferson			1		**1**
Kane				1	**1**
Kankakee			1		**1**
Marion				1	**1**
McLean				1	**1**
Madison			1	1	**2**
Marshall			1		**1**
Peoria	1			2	**3**
Perry				1	**1**
Pike				1	**1**
Rock Island	1				**1**
St. Clair			1	3	**4**
Sangamon		2		2	**4**
Tazewell				1	**1**
Union				1	**1**
Williamson				1	**1**
Winnebago	1			3	**4**
TOTAL	**19**	**5**	**18**	**44**	**86**

** 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	Undetermined	Accident	Natural	TOTAL
Child exposed at birth	1	0	2	6	**9**
Mother has history of substance abuse	1	1	2	2	**6**

FY 2006 DEATH BREAKDOWN BY MANNER OF DEATH

Homicide:

Nineteen deaths were classified homicide in manner.

Cause of death	Number
Gunshot wounds	9
Blunt head trauma	4
Multiple injuries due to blunt trauma/assault	2
Abdominal injury due to blunt trauma	1
Disease Process following blunt trauma injury	1
Suffocation/Asphyxia	2
TOTAL	**19**

Perpetrator information:

Perpetrator	Number of deaths
Father	3
Mother	2
Mother and Mother's Boyfriend (alleged)	1
Father's Girlfriend*	1
Foster Mother's Boyfriend	1
Adoptive Brother	1
Great Uncle	1
Unrelated Peer	4
Unknown/unsolved	5

*The girlfriend was also a foster parent, but not to the victim.

Perpetrator sex	Perpetrator age range
Male: 11	14-47 years
Female: 4	20-36 years
Unknown: 5	

Nine of the 19 homicides involved gun shootings. Four were by unrelated individuals who are being/have been prosecuted. Five of these cases are unsolved. Ten of the 19 homicides involved children being killed by a caregiver or someone living in their home. Perpetrators are being prosecuted in 7 of these 10 homicides. One case is still being investigated, and charges may be filed.

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.

Five deaths were classified undetermined in manner.

- 3 children also had an undetermined cause of death.
- 1 child died of asphyxia, due to overlay.
- 1 child drowned in a swimming pool.

Accident:

Eighteen deaths were classified accident in manner.

Cause of death	Number
Asphyxia/sleep related deaths	9
Fire related deaths	2
Drowning	2
Motor vehicle related deaths	3
Hanging	1
Complications of remote closed head injury	1
TOTAL	**18**

Natural:

Forty-four deaths were classified natural in manner.

Cause of death	Number
Sudden Infant Death Syndrome (SIDS)	11
Complications from premature birth	3
Cardiac disease or complications from heart problems	9
Pneumonia or respiratory illness (including asthma)	5
Progressive illness	6
Cerebral abnormalities or neurological disease	4
Stillborn	1
Viral Illness	2
Sepsis	3
TOTAL	**44**

Homicide

Child No. 1	DOB April 1988	DOD July 2005	Homicide
Age at death:	17 years		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unrelated adult male		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Seventeen-year-old was shot at approximately 11 pm in his neighborhood. He was dead at the scene. A 27-year-old unrelated male was charged with first degree murder.

Prior History: The deceased was one of at least six siblings. The family has a history with the Department dating to 1992; although there had been no DCFS involvement from March 2001 to October 2004 when a school social worker contacted the hotline about a black and swollen eye of a teenaged autistic brother of the deceased. A DCP investigation revealed that a neighborhood boy had likely caused the injury and the investigation was unfounded for abuse by the mother. In May 2005 a school counselor contacted the hotline to report medical neglect because of chronic tooth pain and swelling of an 11-year-old sister of the deceased. A DCP investigation revealed that the girl was being taken for dental treatment by her father because her mother had recently had a baby, and the investigation was unfounded for neglect. Neither of the recent investigations involved the deceased.

Child No. 2	DOB July 1988	DOD July 2005	Homicide
Age at death:	17 years		
Substance exposed:	No		
Cause of death:	Gunshot wound of the abdomen		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Seventeen-year-old was visiting with friends on the street when two people walked up and one shot the teenager in the stomach. He was pronounced dead around 10 pm. No one has been charged with the shooting; a police investigation remains open.

Prior History: In February 2005 the Department received a hotline report alleging abuse to the teenager's 5-year-old sister by the father. Police and a child advocacy center investigated the allegation with the Department. The allegation was unfounded because of insufficient information. The child was referred to the advocacy center's extended assessment program, and the mother was provided with referrals for family counseling. There have been no further reports involving this family.

Child No. 3	DOB June 2003	DOD August 2005	Homicide
Age at death:	2 years		
Substance exposed:	No		
Cause of death:	Cerebral injuries due to blunt trauma		
Perpetrator:	Mother and boyfriend, alleged		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation, Report to Director 9/20/06		

Narrative: Two-year-old child was killed in his home while being cared for by his mother's 20-year-old boyfriend. The boyfriend called the mother at work and then called 911 reporting that he found the child unresponsive. The mother and boyfriend were the child's only caretakers in the time leading up to his fatal injuries. No one has been charged in the child's death, and a DCP investigation of the child's death is still pending.

Prior History: Three months prior to his death, the child's biological father and paternal grandmother

brought him to the hospital with injuries including bruising and swelling to his forehead, swelling to his eyelids, a burn on the top of his head, burns on his hand, and a bruise on his back. The hotline was called with a report of abuse, which police and DCFS investigated. The police investigation was closed without charges. The Department's investigation was unfounded. The mother and boyfriend denied the child was abused and described two incidents for the injuries that the child protection investigator found plausible.

Child No. 4	**DOB October 2004**	**DOD August 2005**	**Homicide**
Age at death:	9 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Multiple injuries due to assault		
Perpetrator:	Foster mother's boyfriend		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Forty-year-old foster mother left her 9-month-old foster son in the care of her 30-year-old boyfriend while she was working. When she returned home, the child was crying and appeared to be having seizures, so she called 911. The baby was taken to the hospital where doctors discovered a skull fracture and subdural hematoma. The baby died the following day. The foster mother was indicated for neglect in the child's death, and her foster care license was surrendered with cause. The boyfriend was indicated for causing the child's death. He was charged with first-degree murder and is in jail awaiting trial.

Prior History: The deceased was the youngest of his 30-year-old mother's ten children, and the third child born substance-exposed. The mother has a history with DCFS dating to 1986, and she has lost custody of all her children. The deceased entered foster care after his birth. He was the first foster child placed with his foster parent, who had no biological children. When the foster parent was first licensed, she was not working and childcare arrangements were not designated. Shortly before the baby's death, the child's caseworker called the foster home and spoke with the foster mother's brother who said she was working. The caseworker conducted a background check on the brother. After the baby's death, the agency learned that the foster mother's boyfriend was living in her home and had been providing care for the baby for about two weeks. The foster mother had kept this information from the agency. The boyfriend had a felony conviction for an offense that would have barred him from being an approved caregiver for the baby.

Child No. 5	**DOB May 1994**	**DOD August 2005**	**Homicide**
Age at death:	11 years		
Substance exposed:	No		
Cause of death:	Subdural hematomas due to assault		
Perpetrator:	Adoptive brother		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Eleven-year-old adopted child was found unresponsive in bed by his adoptive teenage brother. According to the teenager, he and his brother were play wrestling the night before, and the 11-year-old complained of a headache and went to bed. The children's mother was not home. Police investigated, but closed the case as an accidental death.

Prior History: The deceased entered foster care as an infant and was adopted in 2002 at age 8 by the mother, who was a licensed foster parent. The child had been in the home for 10 months prior to his adoption. Between November 2002 and August 2005 there were six investigations involving allegations of injuries to the child, including bruises, scratches, and bite marks. Four of the investigations were unfounded on the mother; one investigation was indicated for bite marks by an unknown perpetrator; and one investigation was indicated for cuts, welts, and bruises by the child's aunt after he was beaten by his

aunt, minor cousin and adoptive brother and required stitches for his injuries.

Child No. 6	**DOB August 2002**	**DOD August 2005**	**Homicide**
Age at death:	3 years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to blunt trauma due to child abuse		
Perpetrator:	Father's girlfriend		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Full investigation, Report to the Director 6/26/06		

Narrative: Thirty-two-year-old licensed foster parent was caring for her boyfriend's 3-year-old son while her boyfriend was at work. The girlfriend called 911 to report that the child fell and hit his head while running and did not get up. When police and paramedics responded, the child was found to have multiple bruises and bite marks. The child was taken to the hospital where he was pronounced dead. The girlfriend was indicated for abuse of the child and causing his death. The 34-year-old father was indicated for abuse of the child and neglect in the child's death. Both were indicated for substantial risk of physical injury to the surviving children in the home. The girlfriend's three foster children were removed from the home, as was the deceased's brother. The girlfriend was charged with murder and is in jail awaiting trial. Her foster care license is being revoked.

Prior History: Two months earlier, the Department received a hotline report alleging abuse and neglect of the deceased's 3-1/2 year-old brother who was suffering from an untreated spiral fracture of his right tibia and fibula (lower leg). The bone fracture occurred in the girlfriend's home. Investigators were unaware that the girlfriend was a licensed foster parent. The father was indicated for medical neglect of the brother because he was told by the child's primary care physician five days earlier to take the child to the emergency room. An intact family case was opened. The younger brother died 3 weeks later.

Child No. 7	**DOB August 1991**	**DOD August 2005**	**Homicide**
Age at death:	13 years (one day shy of 14th birthday)		
Substance exposed:	No		
Cause of death:	Gunshot wound to head		
Perpetrator:	Two unrelated peers		
Reason For Review:	Child was a ward		
Action Taken:	Preliminary investigation		

Narrative: Thirteen-year-old boy was shot at 2:00 in the morning, allegedly by gang members, the day before his 14th birthday. He was pronounced dead four hours later. The deceased was a ward of the Department who was on run from his foster home. Two teenagers have been charged with murder and are awaiting trial.

Prior History: The deceased was one of seven children. His family has a history with DCFS dating to 1994. The children entered foster care in August 2000. The deceased was placed in a foster home with his sister in June 2002. In June 2004 the two went on run together. The Juvenile Court issued juvenile arrest warrants in June 2004. The children's caseworker followed DCFS protocol in attempting to locate the children. She also filed missing person reports with the police.

Child No. 8	DOB January 1991	DOD August 2005	Homicide
Age at death:	14 years		
Substance exposed:	No		
Cause of death:	Gunshot wound to head		
Perpetrator:	Unknown		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Fourteen-year-old child was a passenger in a van, riding around with friends at around 2:00 am. The van turned onto a street where a group of guys approached the van and started shooting. The child was shot multiple times. The van driver drove the child to the hospital where he was treated and transferred to another hospital where he died. No one has been charged in the shooting; a police investigation remains open.

Prior History: In March 2005 the Department investigated an allegation of substantial risk of physical injury to the child and his 11-year-old brother because their mentally ill mother threatened to harm them. The children's father sought help from a community agency. The hotline report was unfounded because the boys and mother denied that she threatened to harm them (she only threatened to harm herself); the mother engaged in services, and a professional believed the mother was seeking attention; and the father was living in the home and was a protective influence.

Child No. 9	DOB February 1994	DOD October 2005	Homicide
Age at death:	11 years		
Substance exposed:	No, but mother has a history of substance abuse		
Cause of death:	Multiple injuries due to blunt trauma		
Perpetrator:	Father		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Full investigation pending		

Narrative: Eleven-year-old child was taken to the hospital by her 35-year-old father and 33-year-old stepmother. The father reported that the child looked as though she were going to pass out and then fell to the floor and hit her head. The child was pronounced dead at the hospital. She had multiple recent injuries indicating she had been beaten. The parents had been caring for nine children. The father and stepmother were indicated for abuse in the child's death and risk to their surviving children. Six of the children were placed in foster care; two teenagers were allowed to remain with their mother. The father was charged with first-degree murder and is in jail awaiting trial.

Prior History: Six days prior to the girl's death, her teenage brother's school called the hotline to report that the boy left home because his father had hit him on his leg with a bat, knocking him over a fence. That same day, a child protection investigator spoke with the school, the child, the father, the stepmother, the deceased's SASS (Screening Assessment Support Services) worker (who was present at the home), and the child's siblings. The siblings denied being abused and denied ever seeing their brother get hit with a bat. The investigator examined the child and observed swelling to his arm and leg that the boy said was from his father hitting him with a bat. The investigation was pending at the time of the girl's death.

Child No. 10	DOB September 1989	DOD November 2005	Homicide
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Gunshot wound		
Perpetrator:	Unknown		
Reason For Review:	Pending DCP investigation at time of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old boy was walking down the street with a female friend shortly after 10 pm when he was shot in what police believe was a gang-related shooting. No one has been arrested, and a police investigation is still open.

Prior History: The deceased and his younger brother came to the Department's attention in December 2004 when police called the hotline after the teenage boys were arrested with their 43-year-old father for home burglary. The boys reported that they did not want to participate in burglaries, but their father forced them to do so. The father had recently assumed custody of the boys after his release from prison; the mother had moved to another state and had not been heard from since. The father was indicated for substantial risk of physical injury to the children, and the Department opened an extended family support case to assist the grandfather in obtaining guardianship of the children. The case was open for support services through March 2005. In October 2005 the police called the hotline to report the children's mother did not respond to requests to come to the police station where her children were being held for disorderly conduct. Investigation revealed that the mother had reassumed custody of the boys when she returned from out-of-state, but she could not control them and wanted them to go to juvenile detention because of gang concerns. The mother requested that police release the boys to their grandfather. The boy was living with his grandfather at the time of his death.

Child No. 11	**DOB September 1995**	**DOD November 2005**	**Homicide**
Age at death:	10 years		
Substance exposed:	No		
Cause of death:	Bronchopneumonia as a result of hypoxic encephalopathy after cardiac arrest from peritonitis; a significant contributing factor was medical neglect in delaying treatment after sustaining inflicted blunt injuries to the body		
Perpetrator:	Father		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Ten-year-old medically complex ward, who was residing in a residential care facility since June 1999 because of abuse, contracted pneumonia and was hospitalized. He died in the hospital six days later. The father was indicated for death by abuse, and he was criminally charged with, but not prosecuted for, endangering the life of a child.

Prior History: The Department's first contact with the family was in April 1999 when the deceased was brought to the hospital by his 19-year-old stepmother after he stopped breathing. The 3-1/2-year-old had been beaten by his 23-year-old father five days earlier for not eating his food. The family delayed seeking medical care because they feared DCFS would be called when doctors saw the child's bruises. The child had appendicitis, which was not related to the beating, but because of the delay in seeking medical treatment, the child developed peritonitis. The peritonitis progressed into septic shock, causing the child to go into cardiac arrest and suffer brain injury. The father was indicated for the child's injuries, and the child and his four siblings entered foster care. The child was placed in a residential care facility where he lived until his death. The parents failed to participate in services and his siblings, including a child born after he was injured, have been adopted or placed in subsidized guardianship.

Child No. 12	**DOB March 2001**	**DOD January 2006**	**Homicide**
Age at death:	4-1/2 years		
Substance exposed:	No		
Cause of death:	Blunt force injuries of head		
Perpetrator:	Maternal great-uncle		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full Investigation, Report to Director 6/30/06		

Narrative: Four-and-a–half-year-old girl died after she was repeatedly tripped and pushed to the

ground by her 47-year-old maternal great-uncle who lived in her home. Her 27-year old mother sat on the couch and watched, and she did nothing to stop the abuse. Eventually, the mother called 911 and reported the child fell out of bed. When paramedics arrived, they found the child on the floor seizing. She was covered from head to toe in bruises, and the mother smelled of alcohol. Seven and 3-year-old siblings were injury-free as was the great-uncle's 14-year-old child. All of the children entered foster care. The great-uncle and mother were indicated for abuse in the child's death and substantial risk of physical injury to the surviving children. They have both been charged with murder and are awaiting trial.

Prior History: In the year prior to the child's death, there were three investigations involving the deceased (two also involved her siblings) that were unfounded. The maternal great-uncle was living in the home during these investigations, but the extent of his prior DCFS involvement, including the 1999 termination of his parental rights to a child, was not readily known from DCFS database searches.

Child No. 13	**DOB April 2005**	**DOD February 2006**	**Reckless Homicide**
Age at death:	10 months		
Substance exposed:	No		
Cause of death:	Asphyxia due to inhalation of products of combustion due to automobile fire		
Perpetrator:	Mother		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Thirty-six-year-old mother left her 10-month-old son with his 3 and 5-year-old siblings unsupervised in a car while she went into a store. A fire started, which is thought to have been caused by the 5-year-old playing with matches. The two older children escaped, but the infant was strapped in his car seat and died. The mother was indicated for death by neglect and substantial risk of physical injury to her eight surviving minor children. The children were placed in foster care where they remain. The mother was charged with felony child endangerment and is awaiting trial.

Prior History: The mother has a history of neglect dating to 1999. An intact family case was open from September 1999 until October 2000. In June 2004 a neighbor called the hotline stating the home was filthy, there was no food, and the children were not properly supervised. The mother was indicated for environmental neglect and inadequate supervision, and an intact family case was opened. While the case was open, housekeeping, supervision, and discipline were addressed with the mother, who was cooperative and met consistently with the worker. The intact family case was closed in March 2005.

Child No. 14	**DOB December 2005**	**DOD March 2006**	**Homicide**
Age at death:	3 months		
Substance exposed:	No		
Cause of death:	Asphyxia due to head forcibly held face down onto a bed for a prolonged time period		
Perpetrator:	Mother		
Reason For Review:	Open preventive services case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-four-year-old mother suffocated her 3-month-old son by repeatedly pushing his head face down onto a bed because he would not stop crying. The mother was indicated for abuse in the baby's death. She has been charged with first-degree murder.

Prior History: Two months prior to the infant's death, a nurse from the county health department called the hotline to report that the mother and the 29-year-old father were developmentally delayed and were not mixing the baby's powdered milk properly. The nurse also was concerned that the mother may be suffering from post-partum depression. The mother's doctor put the mother on antidepressant medication and encouraged her to obtain mental health treatment. Prior to the hotline report, the doctor

and nurse had spoken to the mother about engaging in DCFS services, and she agreed to a referral. The nurse called the local DCFS office to make a referral for services and was informed that if she called the hotline, services could be put into place more quickly. The nurse called the hotline and a child protection investigator investigated an allegation of risk of harm; the investigation was unfounded. Once the infant's formula was changed to ready made, he began to gain weight. In addition, the parents had support from both their families, and they wanted DCFS services. A preventive services case was opened nine days after the report was made. The case was open for only six weeks at the time of the infant's death. During that time, the mother was meeting weekly with her intact family worker, who gave her the phone number of the county mental health agency. After being unsuccessful in making an appointment, the mother and worker called the mental health agency together to set up an appointment for an assessment. Eleven days later, the worker received a message from a counselor at the agency who said that she had been unable to reach the mother. The worker called back and left a message asking to make the appointment for the mother as she would be bringing her to the appointment. The infant died three days later. In addition to meeting with her intact family worker, the mother also met regularly with the county health department nurse and her family support specialist. The three professionals all noted that the mother acted appropriately toward her baby and was attentive to his needs.

Child No. 15	**DOB July 1987**	**DOD April 2006**	**Homicide**
Age at death:	18 years		
Substance exposed:	No		
Cause of death:	Gunshot wound to back		
Perpetrator:	Unknown		
Reason For Review:	Teenager was a ward		
Action Taken:	Investigatory review of records		

Narrative: Eighteen-year-old ward was shot and killed around 2:00 am near his biological mother's home. No one has been arrested, and a police investigation remains open.

Prior History: The deceased was one of seven children. His family has been DCFS involved since 1991 when both parents were indicated for abuse. The children entered foster care, the mother participated in services, and the children were returned to the mother's custody in 1997 under an order of protection. The children reentered foster care 11 months later after the mother violated the order of protection. Four of the children aged out of foster care and the two youngest are in subsidized guardianship. The deceased had a history of mental health and behavioral problems. He was gang-involved and was on probation for criminal behavior including weapons offenses and drug use. He had been in numerous placements and had a history of running from them. At the time of his death, the teenager had been living in the same residential facility since September 2003, although he had left and returned to the placement numerous times. Two days prior to his death, staff filed a missing persons report on the teen because he had left two days earlier and had not returned or checked in. That evening he called asking to be picked up, and he was returned to the facility. He left again a few hours later.

Child No. 16	**DOB November 1989**	**DOD April 2006**	**Homicide**
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Gunshot wound to head		
Perpetrator:	Unrelated peer		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old boy was with a group of friends in a vacant lot. An argument ensued and the teenager was shot in the head. The teenager was taken by ambulance to the hospital where he was pronounced dead. An unrelated peer was arrested and charged with his murder.

Prior History: The deceased was one of eleven siblings. In May 2005 a police officer called the

hotline to report that two of the children, ages 10 and 12 years, were refusing to return to their mother's home after staying with their father. The children alleged that their mother physically abused them. Investigation revealed that the 42-year-old mother and the two children's father (age unknown) were in a custody battle over the children, and the children wished to live with their father. The investigation was unfounded; neither child had any injuries and all of the mother's children denied abuse. The father was pursuing custody of the children in domestic relations court. The deceased was not a subject of the investigation.

Child No. 17	**DOB September 1987**	**DOD April 2006**	**Homicide**
Age at death:	18 years		
Substance exposed:	Unknown		
Cause of death:	Gunshot wound to head		
Perpetrator:	Unrelated peer		
Reason For Review:	Teenager was a ward within a year of his death		
Action Taken:	Preliminary investigation		

Narrative: Eighteen-year-old was shot in the head at 2:00 in the afternoon and taken to the hospital for treatment, where he died. The police believe his shooting was gang-related. One youth was charged and pled guilty to second-degree murder. He was sentenced to eight years in prison.

Prior History: In March 1999 the hotline was called with a report that the deceased's 32-year-old mother was in a shelter and too intoxicated to care for her four children. An intact family case was opened, and in October 2000 the children entered foster care with a relative because of continued neglect. The deceased had a history of running from his placements. He also was involved in the juvenile justice system. In March 2006 the teenager requested emancipation, and the court released him from the Department's guardianship.

Child No. 18	**DOB December 1988**	**DOD May 2006**	**Homicide**
Age at death:	17 years		
Substance exposed:	Unknown		
Cause of death:	Gunshot wound to head		
Perpetrator:	Unknown		
Reason For Review:	Open intact family case at time of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Seventeen-year-old boy was shot and killed just after 10 pm in a drive-by shooting while standing outside a residence. It is unknown if he was the intended victim. No one has been charged in the shooting; a police investigation remains open.

Prior History: The deceased was the product of his mother's rape at age 11 by one of her mother's friends; the mother was placed in foster care with her maternal grandmother for 4 years, and she received DCFS services until she reached adulthood. The deceased was raised by his mother's grandmother like a sibling of his mother. In July 2005 the mother gave birth to her second child, a boy born substance-exposed. The mother was indicated for substance misuse, and an intact family case was opened. The mother was noncompliant with her service plan, and the maternal great-grandmother obtained private guardianship of the child. The deceased also was cared for by the great-grandmother, and he was not a subject of the intact family case.

Child No. 19	**DOB May 2004**	**DOD June 2006**	**Homicide**
Age at death:	2 years		
Substance exposed:	No		
Cause of death:	Hemoabdomen due to lacerations of the liver and spleen due to blunt trauma		
Perpetrator:	Father		

Reason For Review:	Open intact family case within a year of child's death
Action Taken:	Full investigation pending

Narrative: Twenty-three-year-old father called 911 stating he awoke to find his 2-year-old son unresponsive. When police and paramedics responded, they discovered the child had multiple bruises and abrasions. The child died from injuries to his liver and spleen; the father admitted to police that he hit the child in the stomach, but maintained the child's injuries were the result of a fall. The father was charged with first-degree murder.

Prior History: The deceased and his older sister came to the Department's attention in October 2005. The 26-year-old mother and her two children, all of whom suffered from a seizure disorder, went to the emergency room because the mother needed medication for herself and her children. The mother was disoriented and could not provide information about her children's health histories. DCP took protective custody of the children, but the State's Attorney's Office declined to take the case to court, and the children were released to their mother. DCFS opened an intact family services case to assist the mother. The case was closed in March 2006. Shortly after the case was closed, the mother reconnected with the child's father, and he began taking the child on weekends and holidays. After the child's death, the Department reopened the intact family case, and it remains open.

Undetermined

Child No. 20	DOB April 1992	DOD July 2005	Undetermined
Age at death:	13 years		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Thirteen-year-old child was found dead in his bed by his 49-year-old mother. He had vomited over the side of his bed. A cause of death could not be determined. According to the pathologist, "self-induced asphyxia without the aid of aerosols and certain medical conditions such as cardiac arrhythmias due to clinical conduction system abnormalities would not necessarily be detectable at autopsy." The autopsy report noted the child had a history of substance abuse, but a toxicology study revealed no evidence of lethal drug levels.

Prior History: Prior to the 13-year-old's death, a sibling alleged abuse by his brother. DCFS and the police investigated the allegation with assistance from a child advocacy center. The allegation was unfounded after the sibling recanted and said that he made the allegation to get his brother in trouble. The police and child advocacy center found the recantation credible. An intact family case was opened to help the family obtain services. At the time of the 13-year-old's death, both children had participated in services. The sibling continued in services and the intact family case was closed in January 2006. There has been no further involvement with DCFS.

Child No. 21	DOB October 1996	DOD August 2005	Undetermined
Age at death:	8-1/2 years		
Substance exposed:	No		
Cause of death:	Drowning in a swimming pool		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Eight-and-a-half-year-old went swimming in an apartment complex swimming pool with his older ½ siblings while he was staying with his non-custodial father. A sibling noticed the child appeared to be missing, and he was later found face down in the deep end of the pool. The child was taken to the hospital; his family removed him from life support four days later.

Prior History: The child's father has no prior history with DCFS. The child's 27-year-old mother was reported to the hotline previously for medical neglect of the child's younger sibling. The sibling failed his school hearing test, and the mother did not follow through on a recommendation to get his hearing evaluated. The investigation was unfounded because the mother had not been provided with referral information for the hearing evaluation. Once she was provided with the information, the mother followed through on the referral.

Child No. 22	**DOB December 2004**	**DOD January 2006**	**Undetermined**
Age at death:	12-1/2 months		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Eighteen-year-old father called 911 stating he found his son unresponsive. The father and 30-year-old stepmother reported that they gave the baby a bottle in his crib around 6:30 in the morning and went back to sleep. The father checked on the baby when he awoke and found him unresponsive and blue. He said he picked him up and dropped him on the floor. An autopsy was performed and a cause of death could not be determined. There was no medically significant trauma, no toxicological explanation of death, no evidence of medical disease, and the child was over the age of one, excluding SIDS as a cause of death. At the time of the child's death, the home was dirty and had no running water, and a report of environmental neglect was indicated.

Prior History: The child lived with his father part of the time and his mother part of the time. From February 2005 through December 2005 there were seven investigations involving the mother, father, and deceased. All were unfounded; five were expunged and, other than the hotline report narratives, were unavailable for review. The investigations involved the parents making allegations of abuse against each other. The father had one indicated report against him for cuts, welts, and bruises to his step-daughter. In September 2005 his stepdaughter went to visit her father. At the time she had stitches on her head that her older brother said were inflicted by their stepfather when he threw a book bag at her. The stepfather admitted to throwing the book bag, but denied intending to hit her; he was tossing the bag to her so she could do her homework. The stepdaughter agreed this was why he threw the book bag. There has been no further DCFS involvement.

Child No. 23	**DOB August 2005**	**DOD January 2006**	**Undetermined**
Age at death:	4-1/2 months		
Substance exposed:	No, but mother tested positive for opiates at child's birth		
Cause of death:	Asphyxia due to overlay		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Twenty-eight-year-old mother was sleeping in bed with her 4-1/2-month old baby. There was no crib in the home. The 38-year-old father returned home around 1:00 in the morning and found the baby lying on his stomach next to the mother. He turned the baby over, and he was unresponsive. The mother admitted to using heroin once a week, but denied using it in the week leading up to the baby's death. The mother was indicated for neglect in the baby's death. At autopsy the infant had a non-displaced linear fracture on the left side of his skull. It did not cause his death. The father reported that he had bumped the child's head on a narrow doorway; a child protection investigator confirmed the doorway was only 22 inches wide. The pathologist said the fracture could have occurred in the manner described by the father.

Prior History: In April 2004 the mother's 4-month-old son entered foster care and was placed with his maternal grandmother who had earlier obtained private guardianship of the mother's older child. A caseworker attempted to get the mother into services, but she was in and out of jail. In February 2005 the mother and father surrendered their parental rights to the child in foster care. The maternal grandmother adopted him in June 2006. In September 2005 the mother gave birth to the deceased, and the hotline was called. Shortly thereafter, the mother went to jail and the father assumed custody of the infant. The child protection investigator indicated the mother for substantial risk of physical injury to the child, assessed the child to be safe with his father, and referred the father to a community agency for services.

Child No. 24	**DOB January 2006**	**DOD April 2006**	**Undetermined**
Age at death:	2-1/2 months		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Nineteen-year-old mother found her 2-1/2-month-old daughter unresponsive. The mother had been sleeping with the infant on a couch. After autopsy and investigation there was no apparent cause for the infant's death. According to the autopsy, because the circumstances of death suggested that an accidental obstruction of the infant's breathing may have occurred during sleep, the cause of death could not be determined.

Prior History: The mother has been involved with DCFS since she was five years old. She was a DCFS ward from ages 11 to 18. When she was 15 she gave birth to her first child. A year later, in April 2003, she was indicated for inadequate supervision and substantial risk of physical injury to the child. In March 2004 a second report was made alleging substantial risk of physical injury, and the child entered foster care. The mother gave birth to a second child in January 2006. The infant entered foster care at birth because of the mother's history. The mother had only begun participating in services in December 2005 to address her problems. In February 2006 the Court gave DCFS the right to place the children with their mother because of her increasing stability and progress in services. The children were placed with their mother in March 2006. A Home Safety Checklist was completed prior to the children's placement; a crib was observed in the home and sleep safety was discussed with the mother.

Accident

Child No. 25	**DOB March 2005**	**DOD July 2005**	**Accident**
Age at death:	3 months		
Substance exposed:	No		
Cause of death:	Asphyxia due to probable overlay		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-five-year-old mother found her 3-month-old daughter unresponsive in the morning. The mother and her four children were staying in a camping trailer on the maternal grandmother's property. The mother, infant, and two siblings slept in the same bed. Another sibling slept elsewhere. The hotline was contacted at the time of the infant's death because the infant was extremely dirty when she arrived at the hospital. The surviving children were dirty as well. The trailer the family was staying in did not have a kitchen or bathroom. The mother was indicated for environmental neglect; she went to stay with the children's paternal grandparents, and an intact family case was opened.

Prior History: In April 2005 the hotline was called with an allegation of inadequate supervision of the mother's 5-year-old child. A woman called the Sheriff's Department stating a 5-year-old child had walked into her house and asked for a popsicle. Law enforcement responded and noticed a woman driving around

appearing to look for something. She was the child's mother. The investigation revealed that while the mother was still sleeping that morning, the child left the house. The family was living with the maternal grandmother and responded to the situation by placing locks at the tops of the front and back doors. The investigation was unfounded.

Child No. 26	DOB May 2005	DOD July 2005	Accident

Age at death:	6 weeks
Substance exposed:	No
Cause of death:	Positional asphyxia
Reason For Review:	Open intact family case and pending DCP investigation at time of child's death
Action Taken:	Investigatory review of records

Narrative: Six-week-old infant was found unresponsive in the morning by her mother. The infant had been sleeping with her mother, her mother's boyfriend, and her sibling in a small bed pushed up against a wall. At some point after feeding the infant, the mother went to sleep on a couch. When she awoke in the morning she went to check on the baby and found her unresponsive. There was a bassinet in the bedroom, but the mother reported the baby liked to be held so she did not put her to sleep in the bassinet.

Prior History: The 29-year-old mother has three other children. A preventive services case was open on the family for six months in 1999-2000 when the mother requested housing assistance. The next DCFS involvement was in January 2004 when a boyfriend of the mother's was indicated for sexual molestation of one of the young children. The mother did not allow him back in the home. Two-and-a-half weeks after the deceased's birth, an anonymous reporter called the hotline alleging escalating domestic violence between the mother and her current boyfriend, which put the children at risk. Two weeks into the investigation, an intact family case was opened to address domestic violence and other issues. At the time of the infant's death, the intact family worker had met with the mother once; the mother had canceled a second appointment, and the worker rescheduled it. The DCP investigation was ultimately indicated for substantial risk of physical injury/environment injurious to the children because of domestic violence, and the intact family case remained open. From April to July 2006, the three surviving children were placed with a relative in foster care because the mother was overwhelmed with grief and not able to parent her surviving children as a result. The family continues to receive DCFS services.

Child No. 27	DOB July 2005	DOD August 2005	Accident

Age at death:	3 weeks
Substance exposed:	Unknown, mother admitted to drinking and using crack cocaine while pregnant
Cause of death:	Asphyxia due to overlay
Reason For Review:	Open intact family case at time of child's death
Action Taken:	Investigatory review of records

Narrative: Three-week-old infant was found unresponsive in the morning by her mother. The infant had been sleeping in an adult bed with her 30-year-old mother and two of her siblings. The mother was indicated for death by neglect because she admitted the infant was in bed with her because she was exhausted from drinking and using cocaine two nights prior, and because she knew it was unsafe to sleep with the baby. The mother was also indicated for substance misuse because she was breastfeeding the baby and toxicology reports showed the infant had cocaine in her system. The three surviving siblings were placed in foster care.

Prior History: The family has a history with DCFS dating to 1998 when the mother was indicated for inadequate supervision of a 4-year-old child. Two years later she was indicated for inadequate supervision of a 3-year-old child. In 2002 the mother was indicated for inadequate supervision of both children, and an intact family case was opened to provide services to both parents, who separated often. The mother participated sporadically, and the father refused services. In 2003 DCFS requested court involvement and neglect petitions were filed. The court case was continued under a supervision order that required the parents to participate in services. In March 2004 because of increasing issues with the family, a petition to

revoke the supervision order was filed, and the children were placed in protective custody. A month later, the court returned the children to their mother and admonished the parents to cooperate with their service plan or the State would proceed on the petition to revoke supervision. The parents failed to comply and in April 2005 the case was set for adjudication which was pending at the time of the infant's death.

Child No. 28	DOB June 2005	DOD August 2005	Accident
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Asphyxia due to inappropriate sleeping arrangements		
Reason For Review:	Pending DCP investigation at time of child's death; open foster care case on sibling		
Action Taken:	Full investigation pending		

Narrative: Twenty-four-year-old-mother awoke to find her 2-month-old daughter unresponsive. The mother went to sleep in a bed with the infant sleeping in her arms. The mother had been educated about sleep safety for newborns before the infant was discharged from the hospital. The mother was indicated for neglect in the child's death.

Prior History: In November 2003 the hotline was contacted with a report of substantial risk of physical injury to the mother's 1-year-old child. The mother had pushed her way into someone's home and appeared disoriented. The police were called, and the mother and child were taken to the hospital. The child was released to her grandmother's care. Mother was hospitalized with a major mental health diagnosis and tested positive for marijuana. She was prescribed medication, but never filled the prescription. While the investigation was pending, the mother threatened to harm the maternal grandmother, and the child was taken into custody and formally placed with the maternal grandmother. The mother participated in a parenting program, underwent psychological and substance abuse assessments, and visited her child on a regular basis. Four weeks after the deceased's birth, the caseworker called the hotline with a report of substantial risk of physical injury to the deceased because the mother had mental health issues and had a child in foster care. When the child protection investigator contacted her, the caseworker reported that the mother was currently participating in services, but still had to complete counseling and outpatient substance abuse treatment. The investigation had been pending for 3 weeks at the time of the infant's death.

Child No. 29	DOB August 2002	DOD September 2005	Accident
Age at death:	3 years		
Substance exposed:	No		
Cause of death:	Drowned in family swimming pool		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Three-year-old boy and his 32-year-old mother laid down for an afternoon nap. The mother awoke when her daughter arrived home from school asking where was her brother. The boy had left the house, taken off his clothes, and gotten into the family's swimming pool, where he drowned. The family had moved into the home a month earlier. There was a gate to the pool, but it did not lock. The mother was indicated for inadequate supervision of the boy.

Prior History: Eight months prior to the boy's death, an anonymous reporter called the hotline alleging risk to the boy because the family dog bit him. The reporter said the dog had gone after the boy, unprovoked, on another occasion, and the family subsequently failed to keep the dog locked up. The investigation was unfounded because the boy's only injury was two scabs on his nose, both the size of a pinhead. The boy was nipped while he and the dog were playing. The mother told the investigator they were thinking of giving the dog away and had him on a waiting list to be taken in by a shelter. While the investigator did not confirm this, the dog was no longer in the home at the time of the child's death.

Child No. 30	DOB July 2005	DOD October 2005	Accident
Age at death:	2 months		
Substance exposed:	No, but mother has a history of substance abuse		
Cause of death:	Asphyxia due to smothering in a face down position into a mattress during sleep		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Mother was awakened by her daughter's crying and found her infant son face down under her boyfriend's arm. The infant, who was born seven weeks prematurely, was sleeping in a twin bed with his mother and her boyfriend. Neither recalled putting the baby in bed with them. Both were indicated for death by neglect and substantial risk to the mother's two surviving children because the boyfriend admitted he went to bed severely intoxicated, and the mother admitted to "chugging Nyquil" before going to sleep. The mother's two surviving children were placed in foster care after she violated for a second time a safety plan prohibiting her from unsupervised contact with the girls pending investigation of the infant's death. The girls are placed together in a home of a relative and have a goal of return home.

Prior History: In August 2005, a month after the infant's birth, an anonymous reporter called the hotline alleging the mother was neglecting her 9-month and 3-year-old daughters and beating them with belts and fly swatters. This report was being investigated at the time of the infant's death. It was ultimately unfounded; investigation revealed that one child was staying with an aunt out-of-state and the other was being cared for by her mother with help from the maternal grandmother with whom they lived. The child was observed to be clean, healthy, and injury-free. In March 2005 the mother and her husband were indicated for inadequate supervision of the girls when they argued and each left the home in anger, leaving the children alone. The Department offered the family services, but they declined them.

Child No. 31	DOB June 2005	DOD October 2005	Accident
Age at death:	4 months		
Substance exposed:	No		
Cause of death:	Asphyxia due to trapping in a chair		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-four-year-old mother found her 4-month-old infant son unresponsive in a chair when she awoke from a nap. The mother, 29-year-old father, and infant were staying in a motel. The deceased was an only child.

Prior History: In July 2005 police called the hotline to report they had responded to a domestic disturbance between the parents. They were staying in a (different) hotel and had been fighting. The mother was arrested on an outstanding warrant, and the baby was left in the care of the father. There was a drug pipe in the motel room. DCFS investigated and unfounded a report of substantial risk of physical injury. Both parents stated that they had an argument, but no physical altercation. The father admitted to having a marijuana pipe, but did not smoke around his son. Family members on both sides gave positive reports about the parents, and the mother was involved with a local social service agency to secure public aid, WIC, and housing.

Child No. 32	DOB September 2005	DOD November 2005	Accident
Age at death:	Seven weeks		
Substance exposed:	Yes, cocaine		
Cause of death:	Overlaying		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-nine-year-old mother fell asleep while lying on the couch watching television. She was lying on her side with her 7-week old daughter lying in the crook of her arm. The mother was awakened the next morning by her teenage brother who said something was wrong with the baby. The

mother often slept with the baby, despite the baby having a playpen to sleep in. A death by neglect investigation was unfounded against the mother.

Prior History: In October 2002 the mother was indicated for medical neglect of her 5-year-old daughter. The mother left her daughter, who had some medical problems, with a maternal aunt. The child needed medical care, but the mother's whereabouts were unknown. Because the aunt was not the child's legal guardian, she could not consent to medical treatment for the child. In February 2003 the aunt obtained guardianship of the child in probate court. In September 2005 the deceased was born substance-exposed. The mother was indicated for substance misuse, and an intact family case was opened. The mother and infant were staying with the infant's maternal grandmother and step-grandfather. The intact family case was closed when the baby died. There has been no further DCFS involvement.

Child No. 33	**DOB October 1985**	**DOD November 2005**	**Accident**
Age at death:	20 years		
Substance exposed:	No		
Cause of death:	Bronchopneumonia due to complications of remote closed head injury		
Reason For Review:	Deceased was a ward		
Action Taken:	Preliminary investigation		

Narrative: Twenty-year-old medically complex ward was admitted to the hospital three days before her death because of respiratory problems. She was diagnosed with pneumonia and her condition continued to deteriorate while hospitalized. The ward had a history of respiratory problems because of having only one functioning lung, and she had been hospitalized before for breathing issues. She was non-verbal, non-ambulatory and functioned at the level of a one month old. She resided at a residential care facility.

Prior History: The deceased had been a ward since June 1988 when, at age 2-1/2 years, she was severely beaten by her 20-year-old mother and her mother's boyfriend. The beating left the child in a near vegetative state, and she required 24-hour care. She lived in the same residential facility since January 1997, and a DCFS caseworker visited her regularly. The mother and boyfriend were indicated for abuse and criminally charged for the child's injuries. The mother served 8 years in prison; the boyfriend served 11 years.

Child No. 34	**DOB May 2000**	**DOD January 2006**	**Accident**
Age at death:	5-1/2 years		
Substance exposed:	No		
Cause of death:	Hanging		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Five-and-a-half-year-old girl accidentally hung herself with a bed sheet while playing on the top bunk of a bed with her twin brother. A 13-year-old sibling was caring for the twins and a younger brother while their 34-year-old mother was at work. The mother was indicated for inadequate supervision of the children because earlier a child protection investigator had cautioned the mother not to make her 13-year-old daughter care for her younger siblings, and because the teenager admitted she had never been instructed about what to do in case of an emergency, and she did not know what to do when her sister became unresponsive. The mother refused intact family services, stating the family would utilize school and community services to address their grief.

Prior History: In November 2005 the 13-year-old girl alleged that her mother hit her and made her stay home from school to watch her younger siblings. During the DCP investigation, the mother admitted to hitting her teenage daughter because the girl started a physical altercation with her, but the girl had no injuries. The investigator also learned that the teenager was expelled from school, and therefore, was being home-schooled, causing her to be at home during the day. The younger children were at school and daycare during the day. The investigation was unfounded.

Child No. 35	DOB January 2006	DOD March 2006	Accident
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Sudden Unexplained Death in Infancy, with bed sharing a significant condition contributing to death		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-four-year-old mother found her two-month-old daughter unresponsive. She last saw the infant alive when she put her in bed with her and the infant's older brother. The mother reported that she only slept with the baby a couple times. She laid the infant in bed with her that night because she was fussy. The infant was placed in the double bed between her mother and her brother. When the mother awoke, the infant's face was in her arm like she was snuggling up into it. She was not breathing. There was a bassinet right next to the bed. DCFS investigated and unfounded the mother for death by neglect.

Prior History: In January 2006 the hotline was called with an allegation of abuse to the deceased and her older brother by their maternal grandmother, who lived with them and helped care for them. An adult daughter of the grandmother, who lived with her father growing up, recalled being abused by her mother as a child. The investigation was pending at the time of the infant's death and was subsequently unfounded.

Child No. 36 37	DOB September 2000 July 2003	DOD March 2006 March 2006	Accident Accident
Age at death:	5-1/2 and 2-1/2 years		
Substance exposed:	No		
Cause of death:	Carbon monoxide intoxication due to inhalation of smoke and soot from a house fire		
Reason For Review:	Unfounded DCP investigation within a year of children's death		
Action Taken:	Investigatory review of records		

Narrative: Five-and-a-half and two-and-a-half-year-old siblings were spending the night at a maternal great-aunt's home with their 23-year-old mother. A 3-year-old cousin, who was supposed to be asleep, set fire to a mattress with a lighter found in a relative's purse under the bed. The younger sibling was pronounced dead on arrival at the hospital, and the older sibling died several hours later. A teenage cousin also died from the fire.

Prior History: In January 2006 the hotline was called with a report that the mother dropped off her four children with a relative and was supposed to return the next day, but did not pick them up until a week later. DCP investigated and unfounded an allegation of inadequate supervision by the mother. An uncle had agreed to care for the children for a week, but then took the children to another relative to care for them. When that relative had to go to work, she left the children with the reporter. Family members agreed there was a misunderstanding among relatives about who was to care for the children and for how long. A Home Safety Checklist was not completed on the mother's home during the investigation.

Child No. 38	DOB January 2000	DOD March 2006	Accident
Age at death:	6 years		
Substance exposed:	No		
Cause of death:	Multiple injuries due to motor vehicle striking pedestrian		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Six-year-old boy was crossing the street in the morning with his siblings when a car struck him. He was taken to the hospital by ambulance and then airlifted to a trauma center where he died.

Prior History: In October 2005 police called the hotline with an allegation of substantial risk of physical injury to eight children. A 15-year-old child called the police to report that his mother hit him with a baseball bat. Investigation by DCFS and the police revealed that the 39-year-old mother became frustrated when none of her children admitted to taking $50 from her purse. When questioning the children, her 15-year-old son grabbed a bat and attempted to hit the mother; she grabbed the bat and hit her son with it. The mother had recently had open heart surgery and could barely raise her arm. The teenager had some bruising, but he was not seriously injured. The child had become increasingly disrespectful toward his mother since she had become ill. The investigation was unfounded. There has been no further DCFS involvement.

Child No. 39	DOB January 2003	DOD April 2006	Accident
Age at death:	3 years		
Substance exposed:	No		
Cause of death:	Drowning in a pool		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Three-year-old child was found by his 32-year-old father at the bottom of the pool at his father's home. The father had been taking a shower and when he got out, he noticed the boy was missing. The boy and his older brothers were supposed to be getting ready to go out. The father was indicated for death by neglect and substantial risk of physical injury because the pool's cover had been taken off three days earlier to drain and clean the pool for the summer, but it had not been done and the cover had not been put back. There also was access to the pool from patio doors that were not secured by any locks. An intact family case was opened following the child's death.

Prior History: In April 2005 the police made a hotline report after they took protective custody of one of the boys in the family. The boy had an infection in his foot and required intravenous medication at home. The police found the father and two friends intoxicated, and the father was unable to administer the child's medication. The father was indicated for inadequate supervision of the child, and an intact family case was opened. In June 2005 another allegation of inadequate supervision involving the boy was unfounded. Shortly thereafter, the 30-year-old mother, who was separated from the father, took the children and moved to Wisconsin to be closer to her family. The intact family worker advised Wisconsin social services of the family's involvement with Illinois DCFS and that the family was relocating to Wisconsin. Illinois DCFS was unaware the family had returned to Illinois.

Child No. 40	DOB January 2005	DOD May 2006	Accident
Age at death:	16 months		
Substance exposed:	Yes, cocaine and alcohol		
Cause of death:	Multiple injuries sustained as a pedestrian struck by a sport utility vehicle		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-month-old child was accidentally run over by his half-sister, who was also his relative foster mother. The toddler was playing in the backyard with his foster mother's 17-year-old daughter. The foster mother went into the garage and got into her SUV to run errands for a graduation party the next day. The daughter approached the SUV to speak with her mother, and both thought the toddler was still in the backyard. When the foster mother backed out of the garage, she ran over the child. He was declared brain dead the following day, and his parents wished to donate his organs. The police and DCFS investigated and determined the incident was an accident.

Prior History: The child entered foster care following his substance-exposed birth. His 41-year-old mother admitted to doing cocaine and drinking alcohol weekly while she was pregnant. She did not receive prenatal care. The mother had previously given birth to five children, three of whom were born substance-exposed. She has a history with DCFS dating to 1990. She has no children in her custody. The

child's foster parent/half-sister was appropriately caring for him. She was cooperative with service providers, met his medical needs, took him for developmental screening, and was willing to become his guardian.

Child No. 41	DOB March 2006	DOD June 2006	Accident
Age at death:	3 months		
Substance exposed:	No		
Cause of death:	Asphyxia due to overlaying		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Twenty-eight-year-old mother of seven awoke to find her 3-month-old daughter unresponsive. The 3-month-old and her twin brother had been sleeping in an adult bed with their mother. The mother was indicated for neglect in the infant's death, and an intact family case was opened.

Prior History: A few days after the twins' birth the hotline was called with a report of environmental neglect. The investigation was unfounded and expunged and was not available for review.

Child No. 42	DOB November 1989	DOD June 2006	Accident
Age at death:	16 years		
Substance exposed:	No		
Cause of death:	Multiple traumatic injuries due to motor vehicle mishap with thoracic outlet syndrome with coagulant therapy a significant condition contributing to death		
Reason For Review:	Open preventive services case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old girl died after she lost control of her car when she hit loose gravel. The car rolled over, throwing the teenager out of the car. The girl was airlifted to the hospital where she was pronounced dead in the emergency room.

Prior History: A month earlier, child welfare services were requested for the teenager and her mother after they got into a physical altercation because the girl failed to call home. A DCFS caseworker met with the mother and daughter on two occasions and made phone calls in between. Within a week of opening the case, the daughter was diagnosed with thoracic outlet syndrome (compression of the brachial plexus and subclavian artery by attached muscles in the region of the first rib and the clavicle, characterized by pain in the arm, numbness in the fingers, and weakness in the hand muscles) resulting in her hospitalization in the intensive care unit. At that time, the family requested the DCFS case be closed as they were focusing their attention on the daughter's medical needs. After the daughter got sick, mother and daughter realized how insignificant their differences were. The case was closed the day before the teenager died. The caseworker was helpful to the family in the short time she was involved with them. She modeled problem solving for the mother and daughter and got them to agree to small changes in behavior to improve their relationship.

Natural

Child No. 43	DOB December 2001	DOD July 2005	Natural
Age at death:	3-1/2 years		
Substance exposed:	No		
Cause of death:	Respiratory failure due to intraventricular hemorrhage due to congenital hydrocephalus and seizures		
Reason for review:	Open intact family case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-three-year-old mother went to wake her 3-1/2-year-old medically complex son in the morning and found that he had died in his sleep.	
Prior History: The mother has a history with DCFS dating to 2001. In January 2003 the mother was indicated for medical neglect of the deceased and his 2-month-old sibling. The sibling was born with a heart condition, and the mother had missed medical appointments for both children. An intact family case was opened in February 2003 and closed in March 2006 because services were completed. There has been no further DCFS involvement.	

Child No. 44	**DOB September 2002**	**DOD July 2005**	**Natural**
Age at death:	2-1/2 years		
Substance exposed:	No		
Cause of death:	Bronchial asthma		
Reason for review:	Open intact family case within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-and-a-half-year-old boy had difficulty breathing all day and his mother administered nebulizer treatments. In the evening, the child's condition became worse, and family members took him to the hospital. The boy arrived at the hospital unresponsive. Resuscitation attempts failed, and the boy was pronounced dead.

Prior History: The boy was a twin who was born prematurely. At 7 months of age, the child was hospitalized and diagnosed with non-organic failure to thrive and malnutrition, for which the mother was indicated. During the child's hospitalization, the mother learned how to correctly feed the child, and he was released to her care. DCFS opened an intact family case and provided services. The case was closed in October 2004. A child protection investigation of the boy's death was unfounded, and there have been no further reports involving this family.

Child No. 45	**DOB July 2005**	**DOD July 2005**	**Natural**
Age at death:	0		
Substance exposed:	Yes, cocaine, alcohol		
Cause of death:	Respiratory distress due to prematurity with maternal cocaine use a significant condition contributing to death		
Reason for review:	Open intact family case within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirty-nine-year-old mother delivered her seventh child. The infant was delivered by emergency c-section at 27 weeks gestation because of premature rupture of membranes, placental abruption, and breech presentation. The infant was born substance-exposed, in respiratory distress, and with congenital defects. He died in the hospital five hours after birth. The mother had not received regular prenatal care. The mother was indicated by DCFS for substance misuse and death by neglect. An intact family case was opened and remains open.

Prior History: The family became involved with DCFS in December 2002 when the mother gave birth to a child who tested positive for cocaine. The child was her sixth. The mother was indicated for substance misuse, and an intact family case was opened. The mother participated in, but did not complete, substance abuse treatment. In the summer of 2003 the child was diagnosed with tumors, and the mother was traveling frequently with him to doctor appointments. The case was closed in October 2004 because the mother had family support, was employed, and was providing for the needs of her children.

Child No. 46	DOB July 2005	DOD August 2005	Natural
Age at death:	3 weeks		
Substance exposed:	No		
Cause of death:	Complications from prematurity		
Reason for review:	Open foster care case on siblings; pending DCP investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-week old twin died in the hospital from complications from his premature birth at 25 weeks gestation. His twin sister survived and entered foster care in November 2005.

Prior History: Prior to giving birth to the twins, the child's 19-year-old mother had given birth to three other children. These children entered foster care in November 2004 because of the mother's instability and limited support system. The mother has participated in some services, but it is unlikely she will be able to care for her children without on-going instruction and monitoring. The foster care case remains open.

Child No. 47	DOB February 2005	DOD August 2005	Natural
Age at death:	6 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Child welfare services referral within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Forty-year-old father awoke from a nap to find his 6-month-old daughter unresponsive. The father had laid the baby on her stomach on a pillow next to him in a full size adult bed.

Prior History: Following the infant's birth, the hotline was contacted with a request for child welfare services for the mother, her 10-year-old son, and the infant. According to the reporter, the mother was single and did not have good social skills, and the reporter was concerned the mother would not bond with the infant. A DCFS worker met with the mother who declined services. The mother said if she needed community services she knew how to access them. The worker gave her the names and phone numbers of several community agencies.

Child No. 48	DOB February 2005	DOD August 2005	Natural
Age at death:	6-1/2 months		
Substance exposed:	No		
Cause of death:	Complications from Osteogenesis imperfecta		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Thirty-four-year-old mother and 35-year-old father found their 6-1/2-month-old child unresponsive in her crib following a nap. The parents called 911 and began resuscitation efforts. The baby was taken to the hospital, but further lifesaving efforts were unsuccessful.

Prior History: Three months prior to her death, the infant was brought to the hospital with an injured leg. The parents reported that the baby fell off a bed. The baby was diagnosed with a leg fracture, skull fracture, and a healing rib fracture, and abuse was suspected. During the course of medical treatment, the baby was diagnosed with the brittle bone condition, Osteogenesis Imperfecta, which increased the baby's risk for multiple fractures. The treating physician recommended the investigation be unfounded. At autopsy, the pathologist noted that the baby had a variant of the disease, resulting in a portion of the skull bone being absent, which made her more likely to suffer from a skull fracture.

Child No. 49	DOB March 1985	DOD September 2005	Natural
Age at death:	20 years		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Cardiac arrhythmia due to Cardiomyopathy due to Cardiomegaly		
Reason for review:	Deceased was a ward		
Action taken:	Preliminary investigation		

Narrative: Twenty-year-old ward was playing basketball in a correctional center playground. He stopped to get a drink of water and passed out in front of the guards. CPR was administered. The ward was then taken by ambulance to the hospital where he was pronounced dead.

Prior History: The deceased was the oldest of seven children. His family has a history with DCFS dating to January 1990 because of neglect. Over time, all of the children entered foster care. The deceased had been placed with his maternal grandmother until he was incarcerated for robbery in May 2003.

Child No. 50	DOB February 2005	DOD September 2005	Natural
Age at death:	7 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-five-year-old mother found her 7-month-old son unresponsive in a double bed.

Prior History: The mother and 26-year-old father had three children. In April 2005 the hotline was called with a report that the mother had caused a swollen lip and other injuries to her 6-year-old child. DCP and the police investigated. The child had a mark on her lip, which the mother admitted to causing by slapping the child on the mouth when she bit the mother during a tantrum. The child was examined at the hospital where some redness to her buttocks was noted and attributed to a spanking for misbehavior. After thorough investigation, the mother was unfounded for abuse.

Child No. 51	DOB July 2005	DOD September 2005	Natural
Age at death:	2 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Bronchopneumonia		
Reason for review:	Child was a ward		
Action taken:	Investigatory review of records		

Narrative: Two-month-old baby was found unresponsive in the morning by her relative foster mother. The baby was taken to the hospital where she was pronounced dead. The infant was born prematurely and substance-exposed. She spent three weeks in the hospital before being released to her foster mother.

Prior History: The deceased was her 31-year-old mother's third substance-exposed infant. The mother has a history with DCFS dating to 1994. She has six living children. Five were adopted by foster parents, and the sixth is in the custody of a maternal uncle.

Child No. 52	DOB April 2005	DOD September 2005	Natural
Age at death:	5-1/2 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Open intact family case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-one-year-old mother found her 5-1/2-month-old baby unresponsive following a nap. The mother was visiting an uncle with her children and had placed the infant to sleep in a crib.	
Prior History: In January 2005 the mother's 4-year-old son was seen in the emergency room with a second degree glove-like burn to his hand. The hotline was called with an allegation of abuse. The mother's 22-year-old boyfriend confessed to police that he held the child's hand under hot water as punishment. The boyfriend was indicated for abuse to the child, and he was charged with domestic battery. The mother was at work at the time of the incident. The mother, who was pregnant with her third child (the boyfriend's second), separated from her boyfriend. An intact family case was opened to provide services to the family.	

Child No. 53	**DOB December 1993**	**DOD September 2005**	**Natural**
Age at death:	11 years		
Substance exposed:	No		
Cause of death:	Valvular heart disease		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Investigatory review of records		
Narrative: Eleven-year-old complained to her grandmother that she was experiencing chest pains. Her grandmother told her to stay home from school, but the girl said she felt well enough to attend. She walked across the street to school and collapsed on the ground. She was taken to the hospital by ambulance, where she was pronounced dead. According to her mother, the child had been diagnosed with a heart murmur a month after birth, but it had not been detected again.			
Prior History: The family's only involvement with DCFS was in August 2005 when the hotline was called with a report of inadequate supervision of a 12-year-old sibling of the deceased. The child was selling candy at a mall and was arrested for trespassing after refusing to leave. The boy said that his adult cousin and friends left him there. Investigation revealed that the cousin and friends left the mall after the boy did not show up at the designated time and place. The investigation was unfounded.			

Child No. 54	**DOB December 2000**	**DOD October 2005**	**Natural**
Age at death:	4-1/2 years		
Substance exposed:	No		
Cause of death:	Pneumonia due to Spinal Muscular Atrophy		
Reason for review:	Open preventive services case at time of child's death		
Action taken:	Investigatory review of records		
Narrative: Medically complex child, who had 24-hour nursing care, developed a low-grade fever for which his mother gave him Tylenol. His nurse monitored him and called 911 when he became lethargic and started turning blue. The child was taken to the hospital where he was pronounced dead.			
Prior History: In March 2005 an anonymous reporter contacted the hotline expressing concern that the child appeared malnourished and might not be receiving adequate medical care. The child protection investigator spoke with the mother and the child's doctor and saw the child's medical equipment in his home. The doctor reported that the child's weight was appropriate for his condition and the child received consistent medical care. The investigation was unfounded. In June 2005 the mother called the hotline asking for housing assistance. She and her son were staying with a friend, but had to find another place to live. The Department opened a case for housing assistance because of the child's medical condition.			

Child No. 55	DOB November 2000	DOD October 2005	Natural
Age at death:	4-1/2 years		
Substance exposed:	No		
Cause of death:	Aspiration due to pneumonia		
Reason for review:	Open preventive services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-and-a-half-year-old child, who was born with a neuro-degenerative genetic disease, was brought to the emergency room by his 23-year-old mother and admitted for pneumonia shortly before going into cardiac arrest. The child had been in a pediatric hospice program as his disease was terminal. He lived far beyond his life expectancy.

Prior History: The deceased was a twin. His twin brother had the same disease and died 3 years earlier. The deceased also had a younger half-sibling who is healthy. The family came to the Department's attention in September 2001 when the young mother was referred for child welfare services. The mother had little family or community support, and she needed help caring for her medically compromised, developmentally delayed twins. The worker assisted the mother in acquiring needed services such as nursing care, transportation, and financial assistance. The case remained open until September 2006.

Child No. 56	DOB August 2005	DOD October 2005	Natural
Age at death:	2 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome (SIDS)		
Reason for review:	Open foster care case on sibling		
Action taken:	Investigatory review of records		

Narrative: Twenty-two-year-old father fed his 2-month-old son in the early evening and put him to sleep on his stomach. When he checked on the baby five minutes later, the infant was not breathing.

Prior History: The deceased was the fifth child of his 25-year-old mother and the second of the father. The mother has DCFS involvement dating to 2000 because of neglect. Her first three children entered foster care and were subsequently adopted. In 2004 a fourth child was born and entered foster care because the parents had not consistently participated in or made progress in services, and they tried to hide the pregnancy and child. After this child entered foster care, the parents began to comply with their service plan and by Spring 2005 were fully compliant. At the time the deceased was born, the parents had moved in with the mother's father who was a stable influence; the mother had obtained employment, and the father had enrolled in school. Because of the progress the parents had made, they were allowed to keep the deceased in their custody, with the agency monitoring the child in the home. The fourth child remains in foster care and continues to have a goal of return home.

Child No. 57	DOB June 2005	DOD November 2005	Natural
Age at death:	4-1/2 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Open intact family case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-and-a-half-month-old infant was sleeping in an adult bed with her 40-year-old father. When the father awoke, the infant was not breathing. He called 911 immediately and attempted CPR. The infant coughed a few times, but by the time she reached the hospital she was dead. Two weeks after the baby died, her 3 and 6-year-old siblings were removed from their parents' care because the father was drinking, the mother's developmental delays prevented her from caring for the children without his assistance, and the house was dirty and roach-infested. The children remain in foster care.

Prior History: The deceased was the couple's sixth child. Their parental rights were terminated on their first two children, and they surrendered their rights on the third. In February 2003 when their fourth and fifth children were 3 years and 9 months, the parents called the hotline requesting help because the family had no housing. The parents located their own housing, but an intact family case was opened; this case was open at the time of the infant's death. Both parents are developmentally delayed and require ongoing community resources. DCFS monitored the family and linked them to services.

Child No. 58	**DOB August 2005**	**DOD November 2005**	**Natural**
Age at death:	2-1/2 months		
Substance exposed:	Unknown		
Cause of death:	Sudden Unexpected Death in infant with mild viral respiratory illness		
Reason for review:	Open preventive services case at time of child's death		
Action taken:	Preliminary investigation		

Narrative: Two-and-a-half-month-old infant was found unresponsive, lying on her back in an adult bed, by her 23-year-old mother. The mother and her two children were evacuees from Louisiana following Hurricane Katrina, and they were staying in a church in Illinois at the time of the baby's death.

Prior History: The deceased was born six weeks prematurely and had an extended stay in the hospital. She was transferred from a hospital in New Orleans to a hospital in Forth Worth, Texas before coming to Illinois. In October 2005 the mother contacted a social services agency requesting help in locating housing, employment, and services to benefit her children. A DCFS case was opened and a private agency had begun assisting the family.

Child No. 59	**DOB August 1999**	**DOD November 2005**	**Natural**
Age at death:	6 years		
Substance exposed:	No		
Cause of death:	Cardiac arrest due to cerebral palsy		
Reason for review:	Child was a ward		
Action taken:	Investigatory review of records		

Narrative: Six-year-old medically complex child was found unresponsive in his foster home by his nurse. The nurse performed CPR until emergency personnel arrived. The child was taken to the hospital where he was pronounced dead.

Prior History: The child's father was also his maternal grandfather. The child's parents had two other children who were also in foster care and later adopted. The deceased was adopted in 2004. The deceased's adoptive parents both became ill with cancer, and by May 2005 they were unable to care for the child any longer. The child entered foster care on a dependency petition, and in June 2005 he was placed in the home where he died.

Child No. 60	**DOB December 1992**	**DOD December 2005**	**Natural**
Age at death:	12-1/2 years		
Substance exposed:	No		
Cause of death:	Congenital heart disease		
Reason for review:	Open intact family case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-and-a-half-year-old child died four months after having heart surgery. In the days prior to his death, the child developed a fever and was taken to his doctor who advised the family to go to the hospital. The child was admitted to the hospital and died two days later from a staph infection related to his heart surgery.

Prior History: The child was being raised by his 45-year-old father and his father's 49-year-old girlfriend. The child had congenital heart disease and only one functioning kidney. He was developmentally delayed and had attention deficit hyperactivity disorder. There were two indicated allegations of cuts, welts, and bruises to the child by his father's girlfriend: the first was in January 2002 when she hit him in the face because he hit the dog, and the second was in May 2004 when she hit him with a paddle on the back because he did not make his bed. An intact family case was open from January 2002 to December 2002 and again from May 2004 until the child's death. After the second incident, the child protection investigator requested court involvement, and the family was placed under court supervision until October 2005. The investigator also referred the case for criminal prosecution of the girlfriend because of the child's fragile medical condition. No charges were filed.

Child No. 61	**DOB December 2005**	**DOD December 2005**	**Natural**
Age at death:	6 days		
Substance exposed:	No		
Cause of death:	Hyaline membrane disease (respiratory distress syndrome)		
Reason for review:	Pending DCP investigation at time of child's death		
Action taken:	Investigatory review of records		
Narrative: Six-day-old infant, born prematurely at 26 weeks gestation, died in the hospital.			
Prior History: A month prior to the infant's death, a hotline report was made alleging bruising by neglect and inadequate supervision to a 2-year-old child by her 23-year-old mother's live-in boyfriend (the deceased's father). The 32-year-old boyfriend, who was home alone with the 2-year-old and her 3-year-old sibling, reported that he had fallen asleep and was awakened by a loud thud. He ran into the bedroom where he found the 2-year-old child lying on the floor screaming and crying. The boyfriend surmised that the child fell while trying to climb up the ladder to the top bunk bed. The only injury to the child was bruising on her left cheek. The investigation was pending at the time of the infant's death. It was ultimately unfounded because the boyfriend gave a consistent explanation for the injury across settings; a scene investigation was conducted and the explanation was consistent with the scene; the couple sought immediate medical care; the boyfriend's ex-wife and mother of his son had no concerns about physical abuse; law enforcement officials were contacted and had no concerns; and the couple had been together for a year. There has been no further involvement with DCFS.			

Child No. 62	**DOB September 2005**	**DOD January 2006**	**Natural**
Age at death:	3 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Investigatory review of records		
Narrative: Twenty-eight-year-old mother was sleeping in a queen size bed with the baby and one of the baby's 3 siblings. The mother awoke in the morning to discover the baby unresponsive. The baby was taken to the hospital where she was pronounced dead. The baby was the second of the mother's children to die; an 8-day-old infant died in 1996 from congenital heart problems.			
Prior History: Four months prior to the baby's birth, the mother was investigated for abuse of two of her children. The mother admitted to hitting the children because they had stolen $20 out of her purse. The mother had recently lost her job, the $20 was her last, and she planned to use the money to buy food. After thorough investigation, the investigation was unfounded: the children's injuries were not serious; they reported their mother did not usually hit them; relatives, who lived in the same apartment building and helped care for the children, reported the mother did not usually hit the children; and the school had no concerns.			

Child No. 63	DOB December 1990	DOD January 2006	Natural
Age at death:	15 years		
Substance exposed:	No		
Cause of death:	Commotio Cordis		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Full investigation pending		

Narrative: Fifteen-year-old boy was reported to have not been feeling well, began choking, and passed out at his girlfriend's home. His friends called 911 and started CPR. The teenager was taken to the hospital where he was pronounced dead. The teenager died from Commotio Cordis, a sudden disturbance of heart rhythm occurring as the result of a blunt impact to the chest wall. It was reported that the teenager had been punched in the chest while playing a game with his friends at his girlfriend's home.

Prior History: In April 1999 the deceased and his three younger siblings were adopted by their maternal grandparents who were 63 and 65 years old at that time. The children had lived with their grandparents since their mother's death in 1996. In early 2004 an intact family case was opened, and the family was referred to the Older Caregiver Program for services because the adoptive parents were in poor health and had trouble managing and supervising their teenaged children. Services were provided to the family, and extended family members were involved in planning possible alternative living arrangements for the children. The adoptive father passed away in June 2005, and the adoptive mother's health declined. Shortly after the fifteen-year-old died, his siblings entered foster care.

Child No. 64	DOB December 2005	DOD January 2006	Natural
Age at death:	3 weeks		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Open interstate compact case		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old mother found one of her 3-week-old twin sons unresponsive in the morning. The twins, who were born at 37-1/2 weeks gestation, were sleeping in a bassinet together, propped on their sides.

Prior History: In 2005 a neighboring state requested that the mother and her 1-year-old daughter be monitored in the maternal grandparents' home. The teenager had entered foster care after her mother moved out of state, and an interstate compact was conducted to place the mother and daughter in the maternal grandparents' home in Illinois. Illinois provided monthly monitoring of the family until May 2006.

Child No. 65	DOB September 2005	DOD January 2006	Natural
Age at death:	4-1/2 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Recurrent pneumonia due to anoxic brain injury at birth		
Reason for review:	Child was a ward		
Action taken:	Investigatory review of records		

Narrative: Four-and-a-half-month-old medically complex ward was taken to the hospital from his nursing home because he was having trouble breathing. He was found to have pneumonia in both his lungs, and he died later that day.

Prior History: The deceased was the eighth child born to his 38-year-old mother. He was delivered at 31 weeks gestation by emergency c-section because of severe fetal bradycardia (slowing of the heart beat) secondary to placental abruption. He was born brain damaged because of a lack of oxygen to his brain. He also was born substance-exposed. The mother has a history with DCFS dating to 1998. All of the children have been in foster care, some remain, some have aged out, and some have been adopted.

Child No. 66	**DOB September 2004**	**DOD February 2006**	**Natural**
Age at death:	17 months		
Substance exposed:	No		
Cause of death:	Sepsis due to necrotizing fasciitis		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirty-one-year-old mother took her 17-month-old son to the emergency room at 5 pm because the child had an ear ache and his right leg was cold to the touch and he was limping on it. The hospital took an x-ray of the child's leg, prescribed antibiotics for his ear, and sent the child home with his mother. At 11 pm the mother called an ambulance because of her son's declining condition. Emergency room staff worked on the child for several hours, but were unable to save him. He died from what is commonly known as a flesh eating disease.

Prior History: The deceased was one of six children. The family's only prior DCFS involvement was an unfounded investigation in November 2005 when a mandated reporter called the hotline to report that he had been told that the mother's boyfriend hit the deceased's 9-year-old sibling in the face with his fist, causing a cut lip and bleeding. The child did not have any injuries and denied being hit. The mother and boyfriend both denied the child was hit. Staff at a shelter where the mother and children stayed reported the child never had injuries and that the child spoke highly of his mother's boyfriend.

Child No. 67	**DOB March 2005**	**DOD February 2006**	**Natural**
Age at death:	11 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Eleven-month old baby was found unresponsive in his crib by the mother's boyfriend who checked on the baby around midnight.

Prior History: Nine days prior to the baby's death, an ambulance was called to the home for an adult suffering an asthma attack. Ambulance personnel noted a smell of ether in the home and suspected possible methamphetamine use. The hotline was called with an allegation of substantial risk of physical injury to the baby and his two siblings. Police also responded and searched the home. Police did not find any methamphetamine or methamphetamine making materials, but did discover that a pilot light was out in the laundry room. The landlord was immediately notified of the problem, and the following day he relit the pilot light and installed smoke and carbon monoxide detectors. The investigation was unfounded following the baby's death.

Child No. 68	**DOB August 2004**	**DOD February 2006**	**Natural**
Age at death:	18 months		
Substance exposed:	Yes, amphetamines		
Cause of death:	Seizure disorder due to central brain failure due to anencephaly		
Reason for review:	Child was a ward		
Action taken:	Investigatory review of records		

Narrative: Eighteen-month-old medically complex ward died in her nursing care facility. The child, who was born prematurely with multiple deformities, far outlived her doctors' expectations.

Prior History: The Department became involved with this family in August 2004 when the deceased was born prematurely with numerous medical problems and tested positive for amphetamines. The 28-year-old mother admitted to using methamphetamines and was indicated for substance misuse and substantial risk of physical injury to her children. The newborn and her two siblings entered foster care. The siblings were placed with their paternal grandmother and have a goal of return home to their father. The deceased was the second child in her family to die; a brother died earlier from a genetic disorder.

Child No. 69	**DOB March 2005**	**DOD February 2006**	**Natural**
Age at death:	11 months		
Substance exposed:	No		
Cause of death:	Lissencephaly		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-two-year-old mother found her 11-month-old medically complex son unresponsive in his baby swing. The infant had Lissencephaly, which is a congenital malformation or absence of the convolutions of the cerebral cortex. He also suffered from seizure disorder and reflux.

Prior History: In June 2005 the mother called an ambulance to take her son to the emergency room for breathing problems. After waiting to see a doctor for two hours, the mother left with the child against medical advice. The hotline was contacted with an allegation of medical neglect. The investigation was unfounded; the mother followed the investigator's instruction to return to the emergency room, where the child was found to be fine, and the mother notified her child's doctor of the incident.

Child No. 70	**DOB January 2005**	**DOD March 2006**	**Natural**
Age at death:	13 months		
Substance exposed:	No		
Cause of death:	Brain edema and hematoma due to cardiopulmonary arrest due to S/P small bowel transplant with Rotavirus and Parainfluenza infection		
Reason for review:	Child was a ward within a year of his death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-month-old child died in the hospital where he had been recovering from an intestinal transplant in November 2005. The child had been born with only 15 cm of small intestine, far below the average length.

Prior History: In June 2005 the 18-year-old mother took her medically complex son from his 21-year-old father's home without some of the infant's medical equipment on which he was dependent. The mother was indicated for substantial risk of physical injury to the infant. The child was taken into custody and placed with the father, who lived with the paternal grandmother. The Department provided services to the family until October 2005 when the court returned guardianship of the child to his father.

Child No. 71	**DOB December 2005**	**DOD March 2006**	**Natural**
Age at death:	2-1/2 months		
Substance exposed:	No		
Cause of death:	Sepsis due to pneumonia due to congenital heart disease		
Reason for review:	Pending DCP investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-and-a-half-month-old infant died after three days in the hospital where she had been admitted for respiratory distress. Four days earlier, the infant was discharged from the hospital after a five-day stay for rotavirus. The infant was born prematurely and had heart surgery at fifteen days of age. She was being followed by a cardiologist.
Prior History: The family, who recently moved to the United States from Mexico, came to the Department's attention in December 2005 when a 2-year-old child was brought to the hospital with second degree burns to her chest. The burns occurred two days prior to her being brought to the hospital when she reached for a cup and spilled hot water down on herself. The hotline was called with allegations of burns by neglect and medical neglect. Teenage cousins, who were caring for the child at the time of the accident, confirmed that she pulled a cup of hot water down on herself. The parents had treated the burn with cream over the weekend and took the child to the doctor on Monday. The doctor sent the family to the hospital. While the investigation was pending, a second report was made alleging head injuries by neglect and medical neglect to the 2-month-old infant. The infant was brought to the hospital with vomiting and diarrhea. While the infant was being treated, her parents reported that she had fallen off a toddler bed onto a carpeted floor two weeks earlier. A CAT scan revealed a subdural bleed. The parents' explanation was consistent with the injury. The parents were indicated for medical neglect on both of the reports. An intact family case was opened, and it remains open.

Child No. 72	**DOB November 2003**	**DOD March 2006**	**Natural**
Age at death:	2 years		
Substance exposed:	No		
Cause of death:	Respiratory distress due to myotubular myopathy		
Reason for review:	Open intact family case and pending DCP investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old child was born with myotubular myopathy, a congenital birth defect characterized by slowly progressing generalized muscle weakness and atrophy. The child required a tracheotomy tube for breathing and a gastrotomy tube for feeding. The child's twenty-year-old father reported that his son's oximeter (device for measuring the oxygen saturation of arterial blood) alarm went off and he began checking the child's equipment as trained, but could not get the monitor to go off and called 911. The child was taken to the hospital where he was pronounced dead. The readout from the child's monitor showed that it had been going off for two hours prior to 911 being called. The father admitted to police that he left his new girlfriend alone to care for the child; she had not been trained on how to operate the child's medical equipment, and she did not know what to do when the alarm went off. The father was indicated for neglect in the child's death.

Prior History: In November 2005 the Department indicated a report of environmental neglect against the 20-year-old father and 19-year-old mother. Home health nurses said that the dirty condition of the home was hazardous to the child's health. An intact family case was opened two days after the hotline report. In February, the mother, who was the child's primary caretaker, died unexpectedly, and the father continued to care for the child with the help of home health nurses and relatives. Nine days prior to the child's death, an anonymous reporter called the hotline stating the father was on drugs and unable to care for the child. The report was actively being investigated at the time of the child's death.

Child No. 73	**DOB March 1987**	**DOD March 2006**	**Natural**
Age at death:	19 years		
Substance exposed:	No		
Cause of death:	Nonischemic cardiomyopathy		
Reason for review:	Teenager was a ward		
Action taken:	Preliminary investigation		

Narrative: Nineteen-year-old ward died in the hospital from heart failure. He left behind a 2-year-old daughter. The daughter's mother knows she should have the child monitored periodically for potential heart problems.	
Prior History: The teenager's mother died in 1991 from heart failure. His father was also deceased. The teen's maternal grandmother assumed custody of the deceased and his siblings after their mother's death. The children entered foster care a few years later after one of the siblings was abused by the grandmother. At the time of his death, the deceased was living with family and receiving services from the Teen Parent Services Network (TPSN). He left behind a young daughter who is being monitored for potential heart problems.	

Child No. 74	**DOB September 2005**	**DOD April 2006**	**Natural**
Age at death:	6-1/2 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Child was a ward		
Action taken:	Investigatory review of records		
Narrative: Sixty-year-old maternal grandmother/foster parent found her granddaughter unresponsive when she checked on her during a nap. The infant had not been well and had vomiting and diarrhea.			
Prior History: The infant's 42-year-old mother has a history with DCFS dating to 2000 when her 11-year-old son entered foster care. The maternal grandmother became foster parent to that child as well as the mother's second child, whom she adopted in 2006. The deceased was placed with the grandmother following her substance-exposed birth.			

Child No. 75	**DOB March 2006**	**DOD April 2006**	**Natural**
Age at death:	1 month		
Substance exposed:	No		
Cause of death:	Langerhans cell histiocytosis		
Reason for review:	Open intact family case within a year of child's death		
Action taken:	Investigatory review of records		
Narrative: Twenty-one-year-old mother checked on her 1-month-old son while at a friend's home and found him unresponsive, laying face up on a bed. The child died from Langerhans cell histiocytosis. Also known as histiocytosis X, it is a rare and poorly understood spectrum of disorders that has a wide range of clinical manifestations per child and can affect any body site (ranging from a single asymptomatic skin lesion to widely disseminated disease).			
Prior History: An intact family case was opened in June 2003 on the mother and her two young children following an indicated report of neglect. In June 2004 the mother gave birth to a third child who went to live with his father a year later. The intact family case was closed a few weeks prior to the deceased's birth after the children were assessed to be safe in the mother's care. She had a supportive extended family who helped her with the children. There has been no further DCFS involvement.			

Child No. 76	**DOB September 2005**	**DOD May 2006**	**Natural**
Age at death:	8 months		
Substance exposed:	No		
Cause of death:	Pulmonary hemorrhage due to sepsis		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		
Narrative: Eight-month-old medically complex ward, born prematurely at 29 weeks gestation, died in the hospital. The baby had not left a hospital setting since birth.			

Prior History: In March 2006 the hotline received a report that the forty-year-old mother had missed several appointments to learn how to care for the baby and appeared ambivalent about taking the baby home. The infant suffered from neurological, pulmonary, cardiac and muscular problems. The baby required a feeding tube and a ventilator. The mother was indicated for substantial risk of physical injury, and the baby was taken into custody. The mother has no other children.

Child No. 77	**DOB December 2005**	**DOD May 2006**	**Natural**
Age at death:	5 months		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Five-month-old infant was found unresponsive on the couch by her father.

Prior History: In May 2005 the 20-year-old mother was indicated for substantial risk of physical injury to her 1-1/2 and 3-year-old children because of involvement in a domestic dispute. The Department opened an intact family case. The mother completed services, and the children were involved in Early Intervention Services. The case was closed in March 2006. A month later, the police called the hotline to report that the children were found on the street alone. The mother reported that the children had gone to the park with a neighbor's older children, the oldest of whom was 15 years old. When the other children came back without her children, the mother went to the park to find them. She called the police who told her they had already been found and had been taken to the hospital. The children were released to their mother, and the report was unfounded.

Child No. 78	**DOB September 2005**	**DOD May 2006**	**Natural**
Age at death:	8 months		
Substance exposed:	No		
Cause of death:	Congenital heart abnormalities, Down's Syndrome		
Reason for review:	Pending DCP investigation; open child welfare services referral		
Action taken:	Investigatory review of records		

Narrative: Eight-month-old baby girl died while hospitalized for her medical condition.

Prior History: In January 2006 a request was made for child welfare services for the family because the 43-year-old mother of ten children did not think she could care for a medically complex child. In March 2006 the Department investigated medical neglect of the mother's 17-year-old daughter who had missed appointments for monitoring a rare medical condition that put her at high risk for developing cancer. The investigation remained open for several months to ensure the teenager received medical treatment; it was ultimately unfounded because the teenager was attending her medical appointments, her condition was stable, and she had turned 18, making her responsible for her medical care.

Child No. 79	**DOB May 2006**	**DOD May 2006**	**Natural**
Age at death:	0		
Substance exposed:	No		
Cause of death:	Stillborn		
Reason for review:	Open intact family case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirty-year-old mother gave birth to her ninth child who was stillborn. The baby's umbilical cord was wrapped around her neck.

Prior History: The mother and father had an intact family case open with court supervision from 1999 to 2000 for neglect. A second intact family case was opened in April 2005 following an indicated report of environmental neglect. Appropriate housing has consistently been an issue for the family. The intact family case remains open.

Child No. 80	**DOB April 2005**	**DOD June 2006**	**Natural**
Age at death:	14 months		
Substance exposed:	Yes, cocaine		
Cause of death:	Sepsis		
Reason for review:	Child was a ward		
Action taken:	Investigatory review of records		

Narrative: Fourteen-month-old ward was found unresponsive in the afternoon by her daycare provider while she was taking a nap. The child was not feeling well and had thrown up the night before. The child had been placed with her foster mother since birth, and the foster mother had planned to adopt her.

Prior History: The deceased was the eighth child born to her 37-year-old mother. She was born substance-exposed, as were her seven siblings. The mother has a history with DCFS dating to 1994; all of her children have been removed from her custody and placed in foster care. Three children are in subsidized guardianship; one has been adopted; two have goals of guardianship; and one has a goal of adoption.

Child No. 81	**DOB March 2006**	**DOD June 2006**	**Natural**
Age at death:	2 months		
Substance exposed:	Unknown		
Cause of death:	Sudden Infant Death Syndrome		
Reason for review:	Father of infant was a ward		
Action taken:	Preliminary investigation		

Narrative: Two-month-old infant was found unresponsive by his mother (age unknown) and his 20-year-old father, who is a ward. The infant and his mother lived in Mississippi and were visiting the father in Illinois at the time of the infant's death.

Prior History: The father has been a ward since 1994. He has been stable in his placement in an independent living program since December 2004. Following his son's death, he was referred for grief counseling.

Child No. 82	**DOB June 2006**	**DOD June 2006**	**Natural**
Age at death:	7 days		
Substance exposed:	No, but mother has a history of substance abuse		
Cause of death:	Congenital cardiac anomalies		
Reason For Review:	Open foster care case on sibling		
Action Taken:	Investigatory review of records		

Narrative: Medically complex infant died seven days after birth. He never left the hospital.

Prior History: The infant was the 33-year-old mother's third child. The mother's oldest child is in private guardianship with the paternal grandmother. The mother's second child was born substance-exposed in 1997. The mother was indicated for substance misuse, and an intact family case was opened. Subsequently, the mother was indicated for burns by abuse to the second child; he had burns on both arms up to his elbows. The mother was criminally charged and incarcerated for the abuse. The child was placed in foster care with a relative until July 1999 when he was placed with his father under court supervision. In January 2002 the case was closed. The child reentered foster care in October 2004 when the mother was released from prison and the father allowed her to live with him and the child despite a no-contact court order. The child was placed with an aunt. He was returned to his father in July 2006.

Child No. 83	**DOB November 2004**	**DOD June 2006**	**Natural**
Age at death:	19 months		
Substance exposed:	No		
Cause of death:	Multiple system organ failure due to intestinal perforation due to sickle cell disease with chromosome 8 deletion a significant condition contributing to death		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Child, who had been hospitalized for several months, was taken off life support and died the same day. In addition to sickle cell disease, the child suffered from cardiac problems and a rare chromosomal disorder characterized by deletion of a portion of the eighth chromosome.

Prior History: In October 2005 the child was hospitalized for failure to thrive, and the 19-year-old mother was indicated for medical neglect and failure to thrive because she had not been giving the child her medication or feeding her properly. The mother reported that caring for the child was overwhelming. Relatives agreed to assist the mother, and an intact family case was opened. In December 2005 a second investigation was initiated when relatives told the intact family worker that the mother was not following the doctor's instructions. The report was unfounded because the doctor said the mother brought the child in regularly and the child was gaining weight. The child had extensive medical needs and the intact family worker assisted the mother in attending all the child's appointments and monitored the mother's care of the child. The intact family case was closed after the child's death because the mother had no other children.

Child No. 84	**DOB June 2002**	**DOD June 2006**	**Natural**
Age at death:	3-1/2 years		
Substance exposed:	No		
Cause of death:	Asthma		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Child, five days shy of his fourth birthday, was being cared for at home by the mother's twenty-year-old boyfriend. The child and his younger sibling were playing in a park when he began having an asthma attack. The boyfriend brought the children home to calm down. The children went into the bedroom to take off their shoes, but the deceased did not come out. The boyfriend found the child on the floor unresponsive. The twenty-one-year-old mother was indicated for medical neglect in the child's death because she had not been giving him his prescribed medication as directed, and she had missed two follow-up appointments for him.

Prior History: The family was first involved with DCFS in January 2003 when the child was seven months old and hospitalized for pneumonia. A hotline report was made that the seventeen-year-old mother and twenty-two-year-old father ignored care instructions for the infant. The parents were indicated for substantial risk of physical injury, and an intact family case was opened until July 2003. In April and July 2005 the parents were reported to the hotline because of their escalating domestic violence. The parents were indicated for substantial risk of physical injury, and the mother was indicated for inadequate supervision because she left the two children in the car while she was in the father's house engaging in a physical altercation. An intact family case was opened in July 2005, and the Juvenile Court issued an order of supervision. The case remains open.

Child No. 85	**DOB September 2004**	**DOD June 2006**	**Natural**
Age at death:	21 months		
Substance exposed:	No		
Cause of death:	Viral pneumonia		
Reason for review:	Child welfare services referral within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-one-month-old child died in the hospital while being treated for viral pneumonia. The child had been in the hospital almost two months.

Prior History: In August 2005, the 21-year-old mother of the deceased and a 2-year-old child contacted the Department seeking housing for herself and her children. A worker contacted the mother the same day and informed her that providing housing was not a primary function of DCFS. The worker suggested the mother check with local shelters to see if there were any openings. The mother was not interested in any DCFS services, and the referral was closed.

Child No. 86	**DOB June 2006**	**DOD June 2006**	**Natural**
Age at death:	0		
Substance exposed:	No		
Cause of death:	Extreme prematurity		
Reason for review:	Unfounded DCP investigation within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Baby, born in the hospital at 22 weeks gestation, died an hour after birth.

Prior History: The baby was the only infant born to her 32-year-old mother and 28-year-old father. Both the mother and father have children from prior marriages, and all the children live with the mother and father. The father's children visit their mother every other weekend. In the months prior to the deceased's birth and death, an anonymous reporter called the hotline with allegations of abuse and neglect to the father's children while in their mother's care. The reports were unfounded; all family members, including the children's father, denied the allegations, and the father had no concerns about his ex-wife's care of the children. The mother requested that the reports be retained as evidence of false reports and harassment.

General Investigations

GENERAL INVESTIGATION 1

ALLEGATION

A private agency executive director misappropriated Department funds and failed to perform services for incarcerated wards he had been contracted to provide.

INVESTIGATION

The private agency was a new enterprise that consisted solely of the executive director at the time the initial contract was signed. The private agency had been contracted by the Department to provide counseling and support services to incarcerated wards. The contract called for the executive director to provide these services during the time the wards were incarcerated. The executive director had no professional background in child welfare or experience in working with incarcerated populations. The executive director had previously received small-scale contracts from the Department as an independent service provider. However a decision was reached to discontinue this arrangement based on his inability to manage financial matters and his unwillingness to comply with Department Rules and Procedures. At the same time the prior contract was being terminated, the Department approved a new contract with the executive director in the amount of $275,000 based on his projections of need to create the new agency. The Department administrator who approved the contract and was assigned to monitor the agency failed to recognize the executive director's poor history as a service provider and neglected to verify his credentials. The OIG learned the executive director misrepresented his academic and professional background while seeking approval of the contract and did not meet Department requirements to hold his position.

An OIG review of records maintained by the agency found almost no useable information pertaining to wards or proof of services provided. In interviews with the OIG, agency personnel stated they had few work related tasks to perform and stayed in their jobs only because they were able to receive inordinate compensation for their limited efforts. A review of agency financial records found scant documentation of legitimate expenses and showed the executive director had appropriated funds for his personal use. Of the more than $331,000 in Department funds the executive director received over the course of two fiscal years he was contracted to provide these services, less than $63,000 was deposited into agency accounts.

Throughout the course of the OIG investigation, the executive director practiced a pattern of deception and obstruction in order to conceal the agency's gaping deficits. He denied the existence of a second agency office he had rented unbeknownst to the Department. The executive director's mishandling of Department funds, failure to distinguish between personal and agency financial obligations and questionable business practices prevented any meaningful services from being provided to incarcerated wards.

The Department administrator responsible for monitoring the contract failed to require documentation of services provided and approved payments to the agency without the documentation required by law to ensure that Department funds were expended for children's services. Although a required review following the agency's first year should have identified egregious financial incongruities and a dearth of tangible work product, the administrator approved the agency to receive another one-year contract. The administrator never considered other agencies already involved in similar programs as alternative service providers.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department should immediately terminate its contract with the private agency.**

A termination letter was sent.

2. The Department should discipline the administrator for her failure to monitor the contract and for authorizing payments to the private agency without documentation that services had been provided.

The Department counseled the administrator.

GENERAL INVESTIGATION 2

ALLEGATION

A Department manager arranged for a private agency to receive a contract for services from the Department. After the funds were delivered, the private agency made a payment of more than half the amount of the contract to a company controlled by the Department manager.

INVESTIGATION

During the course of conducting an investigation into potential misappropriation of state resources by the Department manager, the OIG identified a questionable contract in the amount of $62,500 initiated by the manager that the Department entered into with a private agency owned by a married couple. The services to be provided through the contract were described as "community outreach". In addition, another company owned by the couple had a much larger contract to provide services related to family visitations, such as transportation, supervision and access to and maintenance of a center for gatherings. The Department contracts at various rates for visitation services depending on the degree of agency involvement and related costs incurred. Since the contract did not differentiate between which services were being provided at a given time, all hours accumulated during the corresponding time period were billed at the highest rate.

The OIG was unable to substantiate more than $8,000 of services provided through the $62,500 contract. A check for $35,000 was issued by the private agency to a company controlled by the Department manager. The balance of the amount was unaccounted for. The Department manager had resigned his position.

The OIG also learned that soon after a Department contract monitor was assigned to oversee the private agency's compliance with Department regulations, his wife accepted a position with the organization. Although she was identified in the agency's program plan submitted to the Department as the program director and contact person, she was listed by her maiden name. The contract monitor did not disclose his wife's position with the agency to his supervisor or in his Statement of Economic Interest.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should conduct a full audit of the private agency's finances and seek civil recovery of all Department funds received by the agency 1) for services not delivered; 2) for advance payments never reconciled and 3) for disallowable costs.

The private agency's phones have been disconnected and are no longer in their offices so no audit can be completed.

2. The Department should cease contracting with any entity that the couple operate or control.

All contracts with this provider have been terminated.

3. The contract monitor should be disciplined for failing to disclose the conflict of interest created when his wife accepted a position with the private agency.

The worker's supervisor is currently working with Labor Relations in this matter.

4. The contract monitor should be referred to the State's Attorney's Office for possible prosecution for failing to disclose his wife's employment at a contractor of the Department on his Economic Statement of Interest.

The OIG referred the contract monitor to the State's Attorney's Office.

5. The Department should review all visitation center contracts and differentiate rates for visitation supervision, visitation supervision at the visitation center and transportation.

New Transportation Contracts with new guidelines have been issued in Cook County effective June 1, 2006. We will continue to review visitation contracts.

6. The Department's Deputy Director of Budget and Finance should send a reminder to all contract liaisons that it is a conflict of interest when a family member is employed by a contractor that the liaison has ever worked with or will work with in the future. All such conflicts must be disclosed to the contract liaison's supervisor and on Statements of Economic Interest.

This topic will be included in the annual training of Contract Administration staff, which is currently scheduled to take place in February 2007.

GENERAL INVESTIGATION 3

ALLEGATION

A private agency caseworker ignored risks to two brothers, ages 13 and 6, in a non-relative foster home in another state and failed to inform court officials of concerns regarding the placement.

INVESTIGATION

The brothers were placed in the out-of-state foster home two years earlier, along with their then 13-year-old sister, following the death of their grandmother who had been caring for them in Illinois. The family had previously provided a home for the children's oldest sister, who had since turned 18 and moved into her own apartment. The children were placed through an Interstate Compact Agreement in which Illinois pays for the placement but the other state provides monitoring and other services. One month after the children were placed, the 13-year-old was psychiatrically hospitalized after threatening to kill the foster parents' 16-year-old son. After her release, the girl returned to Illinois to live with a relative. The girl made statements to child welfare and mental health professionals that the son had been physically abusive to her and attempted to engage her in sexual acts. The Illinois private agency did not forward the girl's report to the monitoring worker in the foster family's home state. Soon afterwards child welfare staff in the other state noted in a home study that the foster parents' 16-year-old son had been detained in the state's youth rehabilitation and treatment center. In an interview with the OIG, the Illinois caseworker for the two boys stated she was unaware the son had ever been incarcerated and acknowledged she might never have reviewed the girl's case file since she was not her assigned worker.

One year after the boys were placed in the home, the older brother told the monitoring worker that the situation in the foster home was "not good." Staff from the boys' school also expressed concerns to the monitoring worker that the parents were not engaged in the children's education and did not provide adequate support. In an interview with the OIG, the monitoring worker stated that following these disclosures she attempted to contact the boys' caseworker in Illinois but her call was not returned. Two months later the older brother arrived at school without books he needed for class. In the presence of school staff he called the home to ask if someone could bring the books to school. Staff later reported to the monitoring worker they could hear the person on the other end of the phone yelling at the boy, who began to cry. After the boy hung up he told staff he had been speaking with the 16-year-old son who threatened to beat him when he returned home. The boy said the son was responsible for watching the boys after school until the foster parents arrived home and that he had beaten them in the past. The boy also stated that the son had outstanding warrants for his arrest and expressed fear at returning to the home. After school personnel notified law enforcement of the son's presence in the foster home, police went to the residence and located him despite a relative's claim he was not there. Following his arrest, the son was placed in the state's youth incarceration center.

In the wake of this incident, the monitoring worker contacted the Illinois caseworker's supervisor to convey her concerns with the brothers' safety in the foster home. The Illinois caseworker minimized the risks in the foster home, stating that the foster parents could not have been expected to turn in their own child to authorities. Throughout her involvement with the case, the Illinois caseworker relied solely upon information provided to her by the foster parents that the brothers, particularly the older boy, displayed problematic behavior and made allegations against them in response to routine attempts to discipline them. The caseworker consistently discounted the observations of the monitoring worker, who made regular visits to the family home, and school personnel who saw the boys every day. The caseworker made a single trip to the foster home during the time she serviced the case and repeatedly returned to the opinion she formed during that visit that the home was appropriate. She minimized the older boy's increasingly frequent complaints of mistreatment as attempts to manipulate the foster parents. As the monitoring worker became more adamant in voicing her concerns regarding the placement, the caseworker became increasingly combative, accusing the monitoring worker of racism against the foster parents and questioning her ability to perform her job.

The caseworker's intractability was exacerbated by her supervisor's complete reliance upon her conclusions and failure to critically assess the information provided by all sources. He accepted the caseworker's beliefs in their entirety and internalized her assumptions about the case as his own. While the caseworker and her supervisor did meet with a senior administrator of the private agency, the administrator engaged in the same unquestioning acceptance of the reports provided by his subordinates. The administrator supported the caseworker and supervisor's decision to attempt to maintain the placement without making any effort to ascertain any information about the case independently.

The monitoring worker made a written request the day after the son's arrest to have the boys removed from the home and returned to Illinois, however her letter was ignored. Department Rule 328.5 states that a child from Illinois placed in another state must be removed from a placement if a written request is made by the accepting state. In interviews with the OIG, the two Department administrators responsible for overseeing interstate placements acknowledged they were unfamiliar with the Rule.

Three days after the son was arrested, the foster parents requested that the older boy be removed from their home. The caseworker facilitated the boy's return to Illinois but did not inform the monitoring worker and did not respond to her inquiries as to his whereabouts. The caseworker notified the brother's Guardian ad Litem (GAL) that the older boy had returned to Illinois but did not share with her the circumstances that precipitated his removal or the safety concerns regarding the foster home where the six year-old brother remained. The GAL did not learn of any of the issues involving the home until her representative traveled to the other state and, after being unable to visit the home, spoke with staff from the boy's school. The GAL filed an emergency motion requesting the younger boy's removal from the home, which was granted. The boys are both currently in Illinois and reside in separate foster placements.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Upon placement of an Illinois child in an out-of-state placement, the Interstate Compact Office should notify the Illinois worker and supervisor of the availability of the Illinois Interstate Compact Office for consultation. The notification should include a contact number and refer the worker and supervisor to Rule and Procedure 328 Interstate Placement of Children.

Recommendations have been incorporated into the Interstate Compact Office procedures.

2. The agency's caseworker's supervisor should be disciplined in accordance with the private agency's personnel procedures for failing to adequately supervise the caseworker. Specifically, for 1) failing to critically assess his worker's conclusions; 2) failing to seek and corroborate additional information; 3) inadequate response to safety concerns in foster home; 4) failure to assess or consider the younger brother's well-being after the older boy was removed from the home.

The agency stated that appropriate discipline action with staff has been completed.

3. The Illinois caseworker should be disciplined in accordance with the private agency's personnel procedures for 1) insufficient response to safety concerns in foster home; 3) failing to inform court personnel of reported safety concerns to the boys and inform of written/verbal recommendation from out of state child welfare professional that the boys be immediately removed; 3) failing to maintain case notes.

The agency stated that appropriate discipline action with staff has been completed.

4. This report should be shared with the private agency senior administrator as a learning tool on the need to critically assess information his staff presents to ensure their recommendations/decisions are

sound, and are in line with Rule and Procedure.

The agency stated that appropriate discipline action with staff has been completed.

5. The Department should pursue disciplinary action against the Department administrators responsible for overseeing interstate placements for failing to follow Rule 328.5.

The identified staff were counseled.

GENERAL INVESTIGATION 4

ALLEGATION

A private agency caseworker transported a 10-year-old boy to a Department Emergency Reception Center (ERC) on a winter evening. The worker left the boy at the front door of the facility with his paperwork and his belongings, which included an unmarked bottle of medication.

INVESTIGATION

One week before the boy was taken to the ERC, he had been removed from the unlicensed home of his aunt and placed in a traditional foster home. The aunt requested the removal because she felt she could not control him. The boy had a history of psychiatric and behavioral problems and was prescribed multiple psychotropic drugs to manage his condition. Once placed in the new foster home, the caseworker's supervisor did not ensure the boy had filled prescriptions or his medical card and did not review the boy's medicine schedule with the new foster parent.

After one week, the foster parent brought the boy to the private agency office and asked for the boy to be removed from her home. The foster parent stated the boy had been expelled from school that day for fighting with fellow students and insubordinate behavior towards the principal. The new caseworker had not met the boy or reviewed his case prior to his arrival at the office. The caseworker contacted the ERC but did not have all the information the intake staff requested. An OIG review of the Department's ERC manual found that the publication failed to delineate how many attempts to identify an alternative placement constitute the "reasonable effort" required for ERC Intake. The caseworker secured an agreement from the foster mother to keep the boy for one more night and returned him to the foster home.

The following evening, the caseworker returned to the foster home and picked the boy up to transport him to the ERC. Upon arriving at the center, the caseworker gave the boy some of his paperwork along with his belongings and instructed him to enter the facility. In an interview with the OIG, the caseworker stated she was running late for her second job. Upon arriving at the front desk, the boy spoke with ERC staff and told them he only had one of his three prescribed medications, which was in an unmarked bottle. The caseworker resigned her position before the completion of the OIG investigation.

An OIG review of the boy's case file found a history of inconsistent administration of the multiple psychotropic drugs he was prescribed and a lack of education regarding his medicinal needs provided to his caretakers. The OIG has previously recommended that wards be educated on how to monitor their own behaviors through the use of daily "mood journals" to track their progress with particular medications.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency should consider discipline for the caseworker's supervisor for jeopardizing the safety and well being of a minor when she failed 1) to ensure the child was supplied with prescribed psychotropic medication at the time of a placement change, and 2) to document critical information in the child's case record.

The report has been shared with the private agency's director and Board of Directors.

2. The private agency should consider enhancing their current procedure for placement disruption after hours to require that the on-call worker obtain key child information from the foster parent, obtain a clinical consult to determine whether the child can safely remain in his/her current placement for 24 hours with services, attempt to locate and secure a new foster home for the child, and arrange for the move with the child's assigned caseworker to assist the child with the transition to a new placement.

The Inspector General will meet with the agency to discuss the findings and recommendations.

3. The Department should review and update the Emergency Reception Center Manual to include expectations of follow-up workers bringing children to the ERC.

The ERC redesign committee continues revisions to the ERC Protocol. The recommendation has been forwarded to the Child Protection ERC administrator to ensure incorporation of requirements/expectations for workers who must bring children to the Emergency Reception Center and use of ERC field staff in the placement process. It is anticipated the updated protocol will be completed in 2007. An informational transmittal will be distributed detailing expectations and training of all direct-service staff.

4. The Department Guardianship Administrator should address a lack of resources, i.e., software license to enable the Division of Guardianship and Advocacy and its contractual employees to sort, track and monitor data collected on wards, especially young children, ages 10 and under, who are taking psychotropic medication. The Guardian should proactively track and monitor wards with significant issues, i.e., medically complex conditions.

Data was available at the contractual employees' main office at the time the information was needed. Data management software has since been installed on appropriate contractual staff computers.

5. The guardianship administrator should ensure that wards on psychotropic medication be taught how to use mood diaries to develop self-monitoring skills. The OIG has made this recommendation in prior reports.

The best criteria to determine appropriate treatment for a child/youth is to consider data from many sources e.g. foster parent observation, clinician, residential staff, and child. While on the surface mood diaries accomplish the stated objective--to capture what the child/youth is feeling internally--what the diaries miss are the externalizing behaviors—aggression, anti-social behavior, opposition, inattention, which research indicates is better reported by external reporters. A goal of mood diaries is to teach a child/youth how to self monitor one's mood in order to learn appropriate self-regulating techniques. However, before a child/youth can develop the self-monitoring skills to learn basic self-regulation, appropriate insight as to what is causing the action/reactions must be developed. Research indicates that external reporters better identify behaviors not reported by youth, which may be the triggers of the actions/reactions. The central issue really is why do these children become aggressive, agitated, and extremely active. Even a child/youth knowing the primary trigger ahead of time, through use of mood diaries will not change the behavior. What are required are the foster parents, clinical, and other individuals' observations so that a basic self-regulation method is developed in order that the child/youth gains appropriate insight into his/her behavior.

The Department response does not address whether wards on psychotropic medication will be taught to use mood diaries to develop self-monitoring skills. Since depression is a covertly experienced disorder, only the child is aware of the subjective symptoms. Any treatment needs tailoring. Thus, asking a child or adolescent to evaluate their symptoms of depression and asking other responsible key informants to evaluate signs of the disorder is not only useful, but contributes to efficacious treatment. The mood diary would also capture side effects of medication, the child's daily exercise routine and diet.

6. The Department should review wards in traditional foster homes who are receiving two or more psychotropic medications to determine whether they should be given a specialized foster care designation that would offer specialized services to foster parents and enhance the child's well being.

The Department agrees to use the Child and Adolescent Needs and Strengths (CANS) assessment to review wards in traditional foster homes that are receiving two or more psychotropic medications.

GENERAL INVESTIGATION 5

ALLEGATION

An 11-year-old male ward was transported from his school to a hospital emergency room after expressing thoughts of violence and self-injury. After being informed of the boy's hospitalization, an administrator from the residential facility where he lived failed to respond appropriately or take necessary steps to ensure the boy's welfare.

INVESTIGATION

The boy, who had been living at the residential facility for three months, participated in special education classes and had previously been diagnosed with behavioral problems. Prior to his hospitalization, school personnel had observed a deterioration of his conduct and noted his increased level of anxiety. Over the course of two days, the boy set off a fire alarm, threatened to bring a gun to school and kill fellow students, faculty and staff, and told his teacher, "One way or another I am going to hurt myself." The boy's erratic and potentially dangerous behavior prompted school personnel to call 911 and request that the boy be transported to a hospital for psychiatric evaluation. After the boy was taken from the building, school staff contacted the residential facility to provide notification of his hospitalization.

The residential facility administrator who received the call responded to the situation by stating that the boy was the school's responsibility until the end of the school day and that she would not send anyone from the facility to the hospital until after classes had been dismissed. School district personnel were alerted to the administrator's inaction and contacted the OIG for assistance. An OIG investigator contacted the administrator who verified school staff's account of her response to learning of the boy's hospitalization. The administrator stated that ongoing conflict between the school and the residential facility had resulted in strained relations between the two institutions. The administrator acknowledged the residential facility was responsible for the boy's round-the-clock care and agreed to send a representative to the hospital immediately. In an interview with the OIG, the Executive Director of the residential facility expressed her disappointment with the handling of the situation and stated the administrator had reported the incident and was told her actions were inappropriate.

Standard tests conducted on the boy during his hospitalization produced abnormal results regarding his blood count and thyroid levels. It is imperative that residential facilities and other caregivers properly monitor and address any health issues involving wards in their care in a timely manner.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The residential administrator's personnel record should reflect counseling by her supervisor and the reasons for discipline.

The OIG will meet with the agency.

2. The residential facility should follow through with a pediatrician on the abnormal laboratory results from the boy's hospitalization.

The OIG will meet with the agency.

GENERAL INVESTIGATION 6

ALLEGATION

A private agency caseworker allowed a mother to sign a form giving consent for her two year-old son to be adopted by his foster mother. The form was completed outside the presence of the court and without the knowledge of the mother's attorney.

INVESTIGATION

The caseworker had been assigned the family's case four months earlier, shortly after being hired by the agency. The caseworker's brief tenure at the agency was characterized by a lack of diligence in providing services and conflicts with other staff. The caseworker did not document a single visit to the two year-old's foster home during the time she was responsible for the case. When questioned by her supervisor why she had not been conducting visits, the caseworker stated that health concerns had prompted her to ask another worker who monitored other children in the home to observe the boy. In an interview with the OIG, the other worker stated that she was never asked to serve as a substitute and said that when she asked the caseworker why she didn't conduct the visits, she was told the supervisor and the agency program director had given her permission to waive them. Both the supervisor and the program director denied the caseworker's claim. The second worker also stated when the caseworker was called to testify at a permanency hearing as to the boy's welfare, she first attempted to convince the second worker to report on his progress before taking the stand herself despite never having been to the home. The caseworker testified another worker had assumed responsibility for her visits and assured her that the child was safe.

During the hearing, the caseworker expressed her belief the boy's goal should be changed from reunification with his mother to permanent placement in the foster home. She testified that the mother agreed with the plan and that the program director had approved it that morning. In his interview with the OIG, the program director stated he had no recollection of such a decision being made or even discussing the matter with the caseworker. The court explained to the caseworker that the mother had completed all required tasks and that additional supports should be put in place to help her prepare for her son's eventual return home. Two days after the hearing, the caseworker contacted the Department's adoption supervisor and initiated the process of obtaining specific consents from the mother to allow for the boy to permanently reside with the foster mother. The caseworker prepared a service plan and social addendum stating the mother wanted her son to be adopted. The mother's attorney had no knowledge of the move towards adoption until she found reference to it in the service plan. By the time the attorney contacted Department administrators and secured an agreement to delay the process until the mother could be contacted directly, the mother had already signed the adoption consent forms. The attorney contacted the private agency program manager and requested the caseworker be removed from the case. The program director complied and the caseworker resigned her position. She is not believed to be working in child welfare. The presiding judge invalidated the specific consents, however the mother, who is diagnosed with borderline intellectual functioning, has not visited her son since signing the consents.

An OIG review of the caseworker's personnel file found she had been hired for a position that required a valid driver's license and insurance in order to transport children, however the transportation statement she provided to the agency confirmed she did not possess a license. The OIG learned the caseworker's license had been suspended for six years as a result of her failure to appear for a hearing and an arrest for driving on a suspended license in another state. In the intervening years she had been cited for numerous moving violations. In interviews with the OIG, both the agency's office manager and program director stated the caseworker frequently transported children to sibling and parent/child visits. Both said they were unaware the caseworker did not hold a driver's license. The program director also stated he had not reviewed the caseworker's lone reference, a report from another private agency which noted she had been terminated from her position. The office manager told the OIG that since the caseworker had already been hired when the

document arrived, she filed it without showing it to anyone. The OIG contacted the second agency and learned the caseworker had been fired for stealing $900 from the organization.

The OIG also determined the agency had begun assigning cases to the caseworker within days after she took the child welfare licensure exam. The agency's quality assurance manager told the OIG that the caseworker began receiving cases after the agency learned she had passed her exam based on the assumption she would be licensed. However, the OIG found that notification of the caseworker's passing score was not received by the agency until after cases had been assigned to her. In fact, the caseworker was never granted a child welfare license. Department personnel learned the caseworker had not achieved a bachelor's degree, a requisite for obtaining a license, from the university listed on her application. Although both Department personnel and the agency's quality assurance manager informed the program manager of the caseworker's unsuitability for licensure, he contended he was unaware the caseworker did not receive a license. In a separate interview with the OIG, the caseworker's supervisor said she did not know the caseworker was unlicensed until she was informed by a co-worker sometime after the caseworker had begun providing services to families. The supervisor stated that when she addressed the issue with the program director he told her he was working with the caseworker to resolve the issue.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency program director should be disciplined in accordance with the agency's personnel procedures for assigning a caseload to a worker who had not obtained a child welfare license; for allowing a worker who did not meet criteria to obtain a child welfare license to continue carrying a caseload and to remain employed; for failing to respond to allegations that the caseworker perjured herself and tried to get another worker to do the same; and for an inadequate response to learning the worker had not been visiting the foster home.

The OIG has shared the report with the private agency. The Inspector General will meet with the Director and Chair of the Board of Directors of the agency to discuss the findings and recommendations.

2. The private agency should review the program director's system of management and institute a corrective action plan.

The OIG has shared the report with the private agency. The Inspector General will meet with the Director and Chair of the Board of Directors of the agency to discuss the findings and recommendations.

3. The private agency's Board of Directors should review the agency's personnel practices to determine whether the problems identified in this report are a result of problematic structural/systemic design or a result of individual personnel performance (i.e., office manager, quality assurance manager, program director). The board should direct the agency to take appropriate action based on the findings of their review.

The OIG has shared the report with the private agency. The Inspector General will meet with the Director and Chair of the Board of Directors of the agency to discuss the findings and recommendations.

4. The private agency's Agency Performance Team (APT) liaison should conduct a random review of the agency's case records to determine whether failure to conduct home visits as required was isolated to the caseworker or whether it is problematic throughout the agency. The APT liaison should also verify that all case-carrying workers have Child Welfare Licenses.

Agency Performance Team currently conducts random reviews that would determine whether required home visits occurred. Agency and Institution Licensing biannual review would ensure that case-carrying workers

have Child Welfare Licenses.

5. The Department's Specific Consent Unit needs to have a verification of notice check box with a date that the parent's attorney has been contacted prior to taking specific consent.

The Specific Consent referral form has been revised to reflect that the parent's attorney will be notified prior to scheduling a consent.

GENERAL INVESTIGATION 7

ALLEGATION

An 18-year-old ward alleged she was sexually molested by a Department caseworker.

INVESTIGATION

The allegation of sexual molestation arose after a picture fell from the 18-year-old's purse during a visit with her four-year-old daughter in the girl's foster home. The daughter pointed to a man in the picture and told her foster mother she didn't like him because, "he kisses [the mother] and takes off her clothes." The foster mother identified the man in the picture as the 18-year-old's former caseworker. The mother later stated to her therapist that the caseworker had molested her while transporting her and her daughter in his car. The hotline accepted the call for information only because the ward was 18 years old. The mother's cognitive limitations prevented her from providing specific information, such as when or where the alleged incident occurred or what time of year it took place.

The Department caseworker denied ever touching the mother inappropriately. Other involved professionals were skeptical of the mother's assertion she was molested. Her caseworker noted the mother had previously made an accusation against another individual, which had been unfounded and had a history of indiscriminately engaging in sexual acts, sometimes for money. The Department caseworker and the 18-year-old's mother both stated there had never been an occasion when he the 18-year-old and the 4-year-old had been in his car at the same time. This assertion was confirmed following a review of the case record. The 18-year-old's foster mother identified the picture as one taken the day the mother was placed in her home and denied knowledge of anything other than a professional relationship between the mother and the Department caseworker. The OIG also interviewed a former volunteer who had a positive influence on the 18-year-old and wished to stay involved in her life.

Five months after the mother made her claim of sexual abuse by the Department caseworker, she made a similar allegation against a security guard at her therapeutic school. The security guard denied the accusation and school staff asserted the incident could not have occurred as the mother contended given the institution's policies and practices regarding supervision of students.

Although a professional assessment concluded the mother's account was credible, the mother's inability to provide even general details of the time and place of the alleged incident and the absence of any other evidence to support the claim precluded taking any further action. Subsequent to the investigation, the private agency received approval for the mother to be placed in a residential facility. She has twice been removed and hospitalized for behavioral problems. The private agency assigned a new caseworker, a man who speaks little of the mother's native language, although his supervisor is fluent. The mother, an undocumented resident, first became a ward as a result of neglect by her natural mother as a youth. Although the United States Department of Immigration and Naturalization (INS) allows for wards to achieve legal status, the INS determined that since the 18-year-old originally entered state custody based on an adjudication of no fault dependency she did not meet the program's criteria. Since another provision of the rule allows for legal status to be granted to wards who were the victims of violent crime, the OIG and the private agency are attempting to compile records documenting a sexual assault perpetrated against the mother when she was 13. Establishing legal resident status would allow the mother to obtain a social security number, become eligible for Supplemental Social Income (SSI) and permit her to be enrolled in the Community Integrated Living Arrangement (CILA) program.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency responsible for monitoring the mother should assign a bilingual female worker to her case.

The mother now has a female bilingual worker.

2. The Department should arrange for a private agency volunteer who previously cultivated a positive relationship with the mother to be assigned in a capacity to serve as a friendly visitor for her. The volunteer is a person the mother knows and with whom she is comfortable.

The Department agrees to request that the agency facilitate such contacts, subject to Department Rules and Procedures.

GENERAL INVESTIGATION 8

ALLEGATION

A Department administrator's ability to perform his professional responsibilities was limited by his second job as a high school athletics coach. The administrator also failed to notify his superior that two members of his team were wards of the state.

INVESTIGATION

The administrator had been a coach at the high school for one season prior to being hired by the Department. The administrator never informed his supervisor of his job as a coach or that he came into contact with Department wards in that role. The administrator misled his superior in order to arrive at practices and games by falsely claiming that he needed a flexible work schedule in order to leave early to pick his son up from a tutoring class.

One of the wards on the team was identified as a promising prospect because of his athletic ability. The administrator told the OIG he was unaware how the boy came to be enrolled at the school where he coached and denied having any knowledge of the boy's academic performance. Through a review of the boy's case file and interviews with involved Department and private agency child welfare professionals, the OIG learned of multiple occasions when the administrator used his position to influence decisions related to the boy's care to ensure he continued to attend the school where he coached.

After the private agency operating the group home where the boy lived determined he should be transferred to another school, the administrator contacted a high-ranking Department official and appealed to him that the boy be returned to the school where the administrator was a coach. The administrator falsely claimed that the boy's grades and progress with his behavioral problems had improved. The administrator did not disclose to the official either his or the boy's participation with the team. The boy's progress report showed that of his seven classes, he was receiving a grade of D in two and was failing the other five. In addition, he had recently been arrested for committing a robbery in the school. The boy was re-enrolled in the school where the administrator coached. Staff from the group home deferred the boy's participation in services in order to accommodate his athletics schedule.

The summer after the boy's first year at the school, his case was referred for a Child and Youth Investment Team (CAYIT) review to assess his placement and service needs in light of his continuing difficulties, which included running away on multiple occasions and a delinquency adjudication. During the CAYIT meetings, which the administrator attended, other involved child welfare professionals identified the need for the boy to participate in psychiatric, psychological and substance abuse evaluations. The other workers expressed frustration at the lack of academic supervision the boy received at school and the school staff's unwillingness to work with personnel from his group home. It was also determined that the boy's participation in sports could not take precedence over his educational and emotional needs and that he needed to participate in summer school. A review of the boy's case file showed that his caseworker made several notations regarding the administrator's efforts to recruit the boy for his summer league team.

The other ward on the team stated the administrator had approached him and his foster mother's grandson while they played sports in a local park and encouraged them to attend the school where he coached. The two boys later enrolled at the school. The following season, after the coach announced he was moving to another school, he attempted to convince the boys to follow him to the new school. IHSA rules and the handbook of the amateur athletic association prohibit coaches from recruiting or influencing youths into attending a particular institution.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discipline the Department administrator, up to and including discharge, for failing to disclose secondary employment to his supervisor, failing to

disclose his contact with wards of the state through his second job, and for placing his self-interest as a coach before the concerns of a ward. In the event that the administrator retains employment with the Department, he should be barred from secondary employment in which he would have contact with wards of the state.

The employee has been terminated.

2. The Department should implement the recommendations of the Child and Youth Investment Team pertaining to the 16 year-old. The Department should also clarify in its policy, Mandatory Regional Intervention Review Events that CAYIT staffings of wards should occur for both youth adjudicated delinquent and youth who have been criminally charged.

CAYIT policy was published and distributed on June 2, 2006.

3. A redacted copy of this report should be shared with the private agency that operates the group home for the counseling of involved staff.

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

4. A redacted copy of this report should be shared with the local Board of Education's Inspector General's Office for consideration of investigation of the coaching staff of the school the boys attended.

The Department agrees. The OIG shared the report.

GENERAL INVESTIGATION 9

ALLEGATION

The Department failed to notify the administrators of an educational institution that a clergyman on staff was the subject of a child protection investigation.

INVESTIGATION

After a 10-year-old boy alleged he had been sexually molested by a clergyman on the premises on two separate occasions, a child protection investigation was opened. A parallel investigation was initiated because the boy lived in a neighboring town and a second investigator was assigned to handle the investigation locally. Throughout his work on the case, the second investigator made minimal efforts to establish the facts related to the alleged abuse and demonstrated an unwillingness to perform necessary tasks. The second investigator neglected to thoroughly review the Victim Sensitive Interview (VSI) conducted with the boy and did not conduct a scene investigation. The second investigator also failed to determine whether the employee continued to have contact with children at the institution in order to assess potential safety risks to the boy and other students. The OIG learned that the clergyman served as both a teacher and athletics coach. The investigator's supervisor failed to adequately monitor the investigator's work on the case and ensure that he followed her directives. The supervisor approved the investigator's decision to close the parallel investigation without having conducted any collateral interviews or completing a safety plan to ensure the clergyman had no access to children while the investigation was ongoing.

The supervisor for the primary child protection investigator also neglected to adequately perform his duties. The primary supervisor failed to obtain verification of the school employee's contact with students. He did not notify the clergyman's employers at the institution of the child protection investigation as required. In an interview with the OIG, the supervisor stated he did not take steps to ensure officials of the institution were notified of the investigation because he assumed an attorney hired by the clergyman had been retained by the institution and concluded the attorney would have told the employers of the investigation. The supervisor did not document his communications with the attorney because he believed their conversations were "off the record." The primary child protection investigator ultimately substantiated the allegations and determined the report should be indicated. Both the primary supervisor and a Department administrator approved of the decision to close the case without providing notification to the employee or officials from the facility.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should impose disciplinary counseling of the second child protection investigator's supervisor for failure to enforce her own supervisory directives and approving the closing of a parallel investigation without a safety assessment.

The redacted report was received and forwarded to the Deputy Director of the Division of Child Protection. Disciplinary action is in process.

2. The Department should discipline the second child protection investigator for failing to assess children's safety in a facility investigation involving a DuPuy* class member. He should be required to submit weekly itineraries to his supervisor, and his supervisor should review his contact notes for accuracy over the next quarter. The child protection manager should monitor the supervisory review.

The redacted report was received and forwarded to the Deputy Director of the Division of Child Protection. Disciplinary action is in process.

3. The second investigator is handling two subsequent investigations of the institution employee. The second investigator's supervisor and manager should carefully review both investigations for accuracy

and completeness before closing.

An Investigation Manager, prior to entering the final approval, reviewed both investigations.

4. The Department should discipline the primary child protection supervisor for making critical decisions based on "off the record" and undocumented conversations with a collateral source. He also gave final approval to close a facility investigation of sexual molestation without a completed safety assessment of children who were at risk of harm by the alleged perpetrator.

The redacted report was received and forwarded to the Deputy Director of the Division of Child Protection. Disciplinary action is in process.

5. The Department administrator should be disciplined for approving the closing of a facility investigation of sexual molestation without a completed safety assessment of children who were at risk of harm by the alleged perpetrator.

The redacted report was received and forwarded to the Deputy Director of the Division of Child Protection. Disciplinary action is in process.

6. While developing its protocol for investigations of abuse and neglect in religious facilities the Department should develop a general protocol for ascertaining superiors and administrators for official notification. An appointed designee of the Department's Legal Division or the State Central Register should facilitate notification to the proper religious superiors.

The Department has developed a draft protocol for investigations concerning religious facilities that include notification to appropriate facility administrators/officials.

*DuPuy was a federal class action lawsuit in which the Department agreed to provide heightened due process protections for individuals accused of abuse or neglect whose livelihoods could be affected by an indicated finding.

GENERAL INVESTIGATION 10

ALLEGATION

A private agency supported the adoption of a seven-year-old girl by her foster mother despite serious unresolved issues regarding the family's housing and finances.

INVESTIGATION

The private agency had placed the girl in the home more than five years earlier after she was removed from her mother's custody. The foster mother, a senior relative, had already adopted the girl's four older siblings and had been deemed a responsible caretaker, although she had been the subject of a previous indicated report for corporal punishment. Because of the indicated report, the foster mother was required to attend parenting classes. Since she had not yet participated in classes at the time the girl was placed, her adoption of the girl was initially denied and she was referred to a program managed by a second private agency designed to provide support to older caregivers.

A consultant from the second private agency assessed the home and found significant structural problems and unsanitary conditions that compromised the safety of the children. In addition it was learned the foster mother was delinquent on her utility bills and had no ability to resolve her debts. It was recommended that she be provided with assistance to access municipal programs that allocate funds for home improvements and bill repayment for qualified recipients. One year later these same observations and recommendations were reiterated by a second program consultant. Despite repeated identification of the substandard condition of the home and the tenuousness of the family's financial situation, neither agency was able to resolve the issues and did not communicate knowledge of these facts to one another, the girl's Guardian *ad litem* or the court.

Throughout her involvement with the family, the private agency caseworker assigned to monitor the girl's placement asserted to the court that the foster mother's home was suitable and minimized the persistent environmental and financial problems, even though the girl's adoption by the foster mother had been denied a second time. While the agency provided substantial services to the foster mother, many hazards remained unresolved. Information regarding the status of the home and the foster mother's finances was not conveyed to the girl's Guardian ad Litem or the court in order to allow for decisions regarding her care to be made with the benefit of a complete picture of her living situation.

In multiple reports and appearances, the caseworker stated the issues had either been addressed or were on the verge of resolution. The adoption study that was eventually provided to the court, which had been prepared by the caseworker and supported the girl's permanent placement with the foster mother, had been completed 18 months earlier and did not accurately reflect conditions in the home at the time the adoption was being considered. Four months after the adoption was finalized, the Department's Public Guardian filed a petition to vacate the adoption after learning of the long-standing unresolved issues in the home. In separate interviews with the OIG, both the foster mother's attorney and the girl's adoption GAL stated they were unaware of the environmental and financial concerns until the petition was filed. The GAL said she was appalled at the condition of the home after visiting and stated that the poor condition of the building was obvious.

The Public Guardian's petition to vacate the adoption prompted a concerted, collaborative effort among the involved child welfare professionals, overseen by the court, to rectify the problems in the home. The necessary repairs were made through the utilization of municipal assistance funds and the petition to vacate the adoption was voluntarily withdrawn.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Child Welfare Division of the private agency handling the girl's case should immediately participate in the older caregiver training.

The OIG has shared the report with the private agency. The OIG will meet with the Director and chair of the Board of Directors of the private agency to discuss the findings and recommendations.

2. The private agency and the Department's private agency performance team monitor should review the agency's supervisory practices to ensure that its caseworkers are receiving appropriate clinical direction and training in record documentation, and its general agency practices to ensure that it is not directly or indirectly promoting adoptions at any cost.

The OIG has shared the report with the private agency. The OIG will meet with the Director and chair of the Board of Directors of the private agency to discuss the findings and recommendations.

3. The private agency caseworker should be counseled for irresponsibly communicating inaccurate and misleading information to the courts.

The OIG has shared the report with the private agency. The OIG will meet with the Director and chair of the Board of Directors of the private agency to discuss the findings and recommendations.

4. The private agency caseworker requires direct and intensive training and supervision, which should include reviewing her case records for appropriate documentation; clinical assessments of service needs, and follow up on service referrals; and courtroom testimony.

The OIG has shared the report with the private agency. The OIG will meet with the Director and chair of the Board of Directors of the private agency to discuss the findings and recommendations.

5. The supervisor of the second private agency overseeing the older caregiver program should be counseled on the need to be more proactive in assuring that the GAL and the court receive critical information on a timely basis.

The supervisor was counseled.

6. The second agency should revise its practices to include:
a) Sending a written "Memorandum of Understanding" to a referring source agency (i.e., case management agency or GAL) confirming the referring source's expectations of the older caregiver program and outlining the second agency's expectations of the case management agency and GAL (e.g., participation in staffings, informing the second agency about upcoming court dates and court outcomes, etc.). If the need for additional or expanded services develops, a revised memorandum should be written and sent.
b) Issuing timely reports (interim and final) that provide a clear statement of recommendations to the case management agency, the GAL, and if applicable, to the Department's adoption liaison.
c) Ensuring that case conferences occur prior to any significant court event, but at least every six months to discuss the global well being of the family.
d) Promptly providing the child's GAL with written information about any known safety or risk of harm concerns.

The private agency and the OIG agreed that it is critical to arrive at a common understanding regarding the services the referring entity is requesting from the second agency involved with senior caretakers and the issue requiring assessment. A meeting should be conducted at the outset of the case with all parties to ensure common understanding of these issues. The outcome of such a meeting should be documented in a letter to the GAL and case management agency. The agency agreed to revise its practices accordingly.

7. The Department should revise its practices to require that a case conference be conducted on any case that has been reviewed by an adoption liaison and not approved twice.

The Department disagrees because this is already being addressed through the Adoption program that has been reorganized. DCFS Adoption Specialists are now non-case carrying specialists assigned to specific teams. They follow a case on an ongoing basis with regular case conferences with the CWS, Triad and supervisor. There is also a Statewide Adoption Coordinator that monitors/tracks all cases moving toward adoption or guardianship. Under this new structure the lack of coordination between multiple providers would not have occurred.

The Department will use a redacted copy of the report as a teaching tool for adoption specialists.

8. The Department should refer the girl's case to the Demonstration Project for Backup Care Plans, which should include exploring a standby adoption arrangement with the caregiver for the girl's younger sibling.

The Department has been given an appropriation for a special pilot program to develop a better system for stand-by adoption arrangements. The Pilot program administrator will report their findings to the General Assembly in the Spring session. The General Assembly will then make a decision whether to continue appropriations for the pilot program.

9. This report should be shared with the Office of the Public Guardian and the girl's Guardian *ad litem* in the adoption proceedings.

The Department agrees. The report has been shared.

GENERAL INVESTIGATION 11

ALLEGATION

A private agency caseworker allowed a 12 year-old girl to live in the same home as her stepfather, who had been indicated for sexually abusing her 6 years earlier.

INVESTIGATION

The family's initial involvement with the Department began after the girl alleged her 13 year-old sister had been sexually abused by the stepfather's 16 year-old son. During the course of that investigation it was learned the stepfather had engaged in inappropriate contact with the then six year-old girl. Both allegations were established and indicated reports were entered against the stepfather and his son. While the investigation was ongoing, the sisters traveled to another state to stay with their maternal grandmother. The sisters remained in the grandmother's care for almost one year, however no formal guardianship arrangement was ever made. The Department never opened cases for either girl and did not create a comprehensive safety plan to account for potential disruption of their placement with the grandmother or their possible return to Illinois. Neither of the girls' fathers were contacted or considered as prospective caregivers. After the girls' mother convinced the grandmother she had ended her relationship with the stepfather, the sisters returned to her and moved back into the family's home.

Shortly after the sisters' return it was learned the stepfather was also residing in the home. A second child protection investigation was initiated and the younger sister was taken into protective custody and placed with her maternal grandfather. The older sister had since moved in with her father. The child protection investigation resulted in indicated reports against both the mother and stepfather for risk of sexual injury. The mother was additionally indicated for inadequate supervision. Over the next four years, the mother and stepfather successfully completed services while the girl remained with her grandfather. The mother had three more children by the stepfather during this time. It was ultimately determined by the private agency responsible for handling the family case that the mother and stepfather had established themselves as suitable caretakers and the girl was returned to her mother's custody. One year later another child protection investigation was opened after it was learned the girl was in the sole care of the stepfather following the mother's entry into a substance abuse treatment program. The stepfather was alone with the girl when he drove her to school, a violation of the safety plan. All of the children were removed from the home and the girl was returned to the custody of her grandfather.

The OIG determined the actions of child welfare professionals involved in this case did not rise to the level of misconduct. Private agency personnel provided appropriate assessments and monitoring to family during services and thoroughly deliberated whether the girl could be returned to her mother's care.

OIG RECOMMENDATIONS / DEPARMENT RESPONSES

1. **The Department should ensure that available fathers be explored as potential placements. If a safety plan is likely to last longer than six months, the Department should facilitate a legal relationship between the child and the caretaker.**

A committee has been formed to revise the safety assessment process. The Committee continues to work on the safety assessment framework protocol. Targeted completion date is June 2007.

GENERAL INVESTIGATION 12

ALLEGATION

During a routine review of Statements of Economic Interest, 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 Statement of Economic Interest, 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 with the Department 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 provided checks 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.)

The full investigation found that nearly $250,000 of Department funds were deposited into an account over which the Department manger had sole control. The Department manager resigned his position during the investigation. The OIG referred the case for criminal prosecution.

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 is developing a workgroup that will consist of Contract Administration staff, Budget and Finance staff, and a representative(s) of the Conflict of Interest Committee to analyze the current processes and make recommendations to the Director for changes/enhancements.

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 is developing a workgroup that will consist of Contract Administration staff, Budget and

Finance staff, and a representative(s) of the Conflict of Interest Committee to analyze the current processes and make recommendations to the Director for changes/enhancements.

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 is developing a workgroup that will consist of Contract Administration staff, Budget and Finance staff, and a representative(s) of the Conflict of Interest Committee to analyze the current processes and make recommendations to the Director for changes/enhancements.

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 is developing a workgroup that will consist of Contract Administration staff, Budget and Finance staff, and a representative(s) of the Conflict of Interest Committee to analyze the current processes and make recommendations to the Director for changes/enhancements.

GENERAL INVESTIGATION 13

ALLEGATION

The OIG received an allegation an individual received a $50,000 Department contract based solely on political connections.

INVESTIGATION

The Department contracted with a newly formed private agency to monitor services related to family visitations. The money for the contract was diverted from an existing contract with an established agency that had a history of reliability and successful partnership with the Department. At the time the contract was initiated, the new agency was effectively non-existent and consisted of nothing more than the director who had yet to secure a location for the organization or hire any employees. In accordance with the contract, the director was required to monitor the visitation services provided by other agencies and ensure that they complied with Department regulations. The contractor rarely worked more than 20 hours per week but was not required to document her time. No employees were ever hired.

An OIG review of the agency's financial records found the director had received a payment for $12,000 from one of the private agencies she was assigned to monitor. In an interview, the director initially denied receiving any money from an agency she was responsible for overseeing and recognized such action would constitute a conflict of interest. After being presented with a copy of the canceled check, the director stated she had been informed by a Department manager that she would not be provided with the financial support necessary to fund her own new agency but would be subcontracted through one of the agencies she monitored. The director said she refused the arrangement but accepted the payment in the belief it was the first quarterly installment of her contract. Financial records showed the director received all four quarterly payments from the Department. In addition, the agency received an advance payment to enable her to establish the new agency. Contrary to Department Rule, the agency was never required to repay the advance.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. If the Department determines to renew the transportation monitoring contract, it should be based on an hourly fee for service rate and should include requirements for submission of time records and for computerized tracking of data. The Department should ensure that the contractor has all necessary skills to perform the work.

In future transportation monitoring contracts, payment for service will be based on the hourly rate to be determined by the Department. The contract will contain language requiring submission of time records (possibly in voucher form) to be data entered. The voucher method of payment will permit the computerized tracking mechanism relative to payments. Future transportation monitoring contracts will contain language describing what skills, education, licenses, experience, etc. is required to obtain the contract (suggested skills include: Social Work degree supplemented by five years of experience in child welfare that includes two years of supervisory experience. A licensed child welfare specialist and valid drivers license and insurance.)

2. The Department should deduct the $12,000 payment the new agency received from the private agency providing visitation services from the remainder in its current contract.

The Department agrees that it will not pay the remaining $12,000 balance in the contract.

3. The Department must immediately ensure that no further advance payments are issued without procurement of a surety bond and without signed verification that the expected billings and proposed budget will support timely repayment of the advance. Contract monitors must ensure that contractors are not incurring needless expenditures, such as the rental payments that the new agency incurred.

The Division of Budget and Finance will work with the Office of Legal Services to develop an appropriate protocol for implementing a surety bond process as it relates to advance payments for non-board contracts.

4. The Department must separately track all advance payments and ensure they are repaid in a timely manner.

The Department's Office of Contract Administration and Office of Financial Management will work together to develop a separate tracking mechanism for advances made with non-board contracts. Estimated date of completion is February 28, 2007.

GENERAL INVESTIGATION 14

ALLEGATION

A private agency with an unstable leadership structure and a history of financial mismanagement and ineffective board oversight was unable to deliver quality services to wards.

INVESTIGATION

The agency, which contracted with the Department to provide transitional and supervised independent living services, had been in operation for 13 years. Almost 100% of the agency's funding was provided by the Department. Since its inception, the agency had been plagued with mismanaging its resources, including two instances of criminal conduct by staff, which resulted in misappropriation of over $210,000 of Department funds. Six years prior to this investigation, the agency was placed in receivership after a Department audit concluded that an agency co-founder had kept over $200,000 in agency cash and property. As part of the receivership agreement, a second private agency was installed to oversee the agency and provide staff who temporarily assumed the role of executive director to monitor the agency's activities.

A Department licensing investigation found numerous areas of noncompliance including: the absence of a fiscal officer to manage financial operations, inadequate records related to agency staff and operations, and a failure to inform the Department of personnel changes among administrative positions. After the president was disqualified from remaining CEO because her academic credentials did not meet licensing requirements, several individuals cycled through the position creating further instability within the organization. The title of executive director was eventually bestowed upon a friend of the president who filled the role in title only and resided in another state where she continued to pursue her own full-time business ventures.

The agency's tenuous financial situation was exacerbated by the hiring of an unqualified individual as fiscal officer. The agency neglected to verify the fiscal officer's credentials, which would have shown she was ineligible to hold the position. The agency then allowed an unqualified program aide to assist in financial operations and assume control of financial matters in the absence of the fiscal officer. Although it was learned the program aide had a previous conviction for weapons possession, he was provided access to the company safe and was entrusted to handle agency funds on a regular basis. It was later discovered the program aide had stolen checks from the agency and used them to steal agency funds

Throughout their dealings with the Department, the agency president and her daughter, who was employed by the agency, exhibited an unwillingness to comply with Department rules and exhibited a pattern of deceptive behavior intended to conceal the agency's inappropriate practices. The absence of any meaningful oversight from the Board of Director's has prevented the agency from recovering from years of mismanagement as systematic deficiencies and constant staff turnover have become institutionalized. After the OIG investigation was initiated, it was alleged the president had taken retaliatory measures against an employee who she believed had cooperated with the OIG. The agency's deficient infrastructure and organizational dysfunction have made it impossible for it to fulfill the purpose of its contract with the Department, to provide meaningful effective services to wards.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discontinue contracting with the private agency.

The provider has been notified that it will not have a contract in FY 07.

2. An auditor from the Department's Office of Field Audits should review the agency's personnel payroll to confirm if the salary of the employee who cooperated with the investigation was reduced and to determine if the salaries of any other employees were reduced as well. The Department should share

its finding with the OIG if it appears the employee's salary was the only one reduced.

The agency is closed. Payroll information has been requested from both the Executive Director and the accountant, but the Department has not received a response.

GENERAL INVESTIGATION 15

ALLEGATION

An individual hired by a private agency as clinical director was a former Department employee who had been terminated from her position with another state agency for rules violations.

INVESTIGATION

The clinical director was hired by the private agency while ostensibly taking a leave of absence from the other state government agency. The clinical director had resigned from the Department two years earlier without rehire rights. The clinical director's personnel file from the private agency showed she did not provide required documentation of her educational qualifications or necessary character references. The file, which falsely reports the inclusion of these documents, was signed by an agency administrator who approved the hiring.

The private agency that hired the clinical director had a long history of poor management practices and fiscal irresponsibility. The agency's culture of mismanagement had severely undermined its ability to provide services to wards. The hiring of an unqualified individual without verification of qualifications, references or history to fill the critical position of clinical director is representative of the agency's shortcomings and inability to prioritize the needs of the children they are contracted to serve.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should terminate its contract with the private agency.

The provider has been notified that they will not have a contract in FY07.

2. The Department's Division of Clinical Services should immediately manage the transition of wards from the agency.

The transition has been completed.

3. The Department's Division of Legal Services should review the Office of Employee Records and Payroll's current practices of responding to employee reference checks.

DCFS Legal reviewed current practice and found the following:
Payroll
The procedure used in DCFS Payroll appears to be appropriate.
Recommendation: Change the wording of the response to questions requesting confidential information that is used by the DCFS Payroll from "Unable to say" to "Payroll not authorized to respond to this question".
Employee Services
The procedure used in DCFS Employee services to respond to employment verification requests appears to be appropriate. Recommendation 1: Make no changes to the written response used by Employee Services, but make sure that the same response is used consistently in Springfield and Chicago.
Recommendation 2: Develop guidelines for disclosure of information when a personal reference is requested. (The supervisor at the request of the supervisee may most often give personal references.) These guidelines could be used agency-wide. Currently, there are no guidelines for DCFS personnel and Supervisors to follow when responding to personal reference checks on employees or former employees. However, it may be possible to offer a checklist or guide of the subjects that may or may not be discussed. The Office of Employee Services will draft a checklist. Legal will review/ approve. Implementation date: February 1, 2007.

GENERAL INVESTIGATION 16

ALLEGATION

At the request of the DCFS Director, the Office of the Inspector General (OIG) completed a comprehensive analysis of the Child Endangerment Risk Assessment Protocol (CERAP) in order to determine the problems in its implementation.

INVESTIGATION

The basis used for the analysis was OIG investigations and recommendations that directly involved risk assessment. The OIG investigations used were those that involved serious injury or death to a child. The analysis of the OIG recommendations related to the CERAP utilized a coding system based on logic and root cause analysis. Coding reviewed 85 recommendations representing 50 cases from OIG investigations conducted between 1993 and 2004, though most of the cases were after 2001.

A more in-depth analysis was made of 11 cases. The analysis uncovered hidden disincentives for assessing risk. Ten of the cases analyzed involved incorrect decisions to permit a child to remain and one involved an incorrect decision to remove a child. The cases selected provided a broad number of scenarios with the intent to aggregate the causes of CERAP failures. Problems within the CERAP assessment tool were identified. Three cases were randomly selected from the 11 for further review to show the most relevant factors in CERAP investigations. This additional review concentrated on the facts known to the child protection investigator when the CERAP was completed. The time frame looked at in the three cases was the period from the call to the hotline until completion of the initial CERAP.

The issues identified were the failure to develop or monitor a realistic safety plan, with monitoring being the most critical, and failure to recognize cumulative risk. The procedures for the CERAP did not contain any guidelines for how to develop a workable and realistic safety plan. The investigators gave little credence to information from extended family members and did not include them in safety plans, especially when violence was present. The importance of LEADS information was not appreciated when evaluating the trustworthiness of self-reports and development of the safety plan. Further the analysis process showed a failure to consider other adults with access to the child.

In eight of the cases studied there was sufficient information for a supervisor to have intervened as a check to investigator error, but in the eight cases, the supervisor failed to do so. The CERAP needs to show the sources of information relied upon for the safety assessment.

The CERAP instrument requires an investigator to make determinations beyond the worker's competence. In seven of the fifteen CERAP factors the investigator is required to predict future harm and three of those require an assessment of whether the harm is immediate or imminent. There are no guidelines to assist workers in making such determinations resulting in a lack of consistency and reliability. There is nothing in the instrument that allows for the investigator to express a need to obtain more information. The emphasis is on completing the CERAP within 24 hours. In all the cases reviewed, some vital information was unknown at the time of completing the CERAP.

The CERAP has several multiple-part questions, which assumes that the investigator has considered all parts. The instrument also overuses modifiers. The form has an inherent bias in that if the situation is ultimately considered to be unsafe, a safety plan has to be arranged, which yields more work. Staff shortages also impede risk assessment.

The complete CERAP INVESTIGATION is included as Appendix B.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Provide training and written guidelines for mitigation and development of safety plans, including specific components that should be in place for specific safety concerns, such as violence and physical abuse. The training and guidelines should address the need to consider inclusion of extended family or protective daycare as partners in implementing the safety plan.

The committee convened to review and revise the safety assessment instrument and process is still working on this project. Target date: June 2007.

OIG Response: At the request of the Director, OIG staff met with the committee and submitted draft comments.

2. Once a risk is identified, workers need more guidance on how to determine whether the risk is "urgent" or "immediate."

The committee convened to review and revise the safety assessment instrument and process is still working on this project. Target date: June 2007.

OIG Response: At the request of the Director, OIG staff met with the committee and submitted draft comments.

3. Add a third box to each safety factor, acknowledging that information for that factor may be "unknown" or "uncertain" and add a section at the conclusion of the factors list for identifying information that needs to be gathered in the future to further assess safety.

The committee convened to review and revise the safety assessment instrument and process is still working on this project. Target date: June 2007.

OIG Response: At the request of the Director, OIG staff met with the committee and submitted draft comments.

4. Devise a supervisory form to accompany the safety assessment that would allow a supervisor to determine the source of information that formed the basis of the particular safety factor decision and provide a check that basic available objective sources (such as the hotline report, prior child protection investigations, police reports and interviews with police, and criminal history information as required by Administrative Procedure 6).

The committee convened to review and revise the safety assessment instrument and process is still working on this project. Target date: June 2007.

OIG Response: At the request of the Director, OIG staff met with the committee and submitted draft comments.

GENERAL INVESTIGATION 17

ALLEGATION

The OIG conducted a review of the Older Caregiver Program and issues related to senior citizens caring for children.

INVESTIGATION

Housing problems have become increasingly challenging for many of DCFS' older caregivers. The housing issues that affect children and families are primarily the result of poverty. The majority of Chicago's DCFS older caregivers are clustered in 33 of the city's most poverty-stricken neighborhoods. These neighborhoods have the oldest and most poorly maintained housing in Chicago. In low-income areas with older housing stock, the inability of homeowners, or the unwillingness of landlords to pay for housing repairs, even basic maintenance, led to building deterioration and unhealthy conditions for children. For example, plumbing, roofing, and foundation leaks that went untreated for years caused the growth of mold and fed insect and rodent infestations. These conditions contributed to increased asthma attacks, rodent and insect bites, and exposure to pesticides.

The Older Caregiver Program provided housing services to seven licensed families, when combined the families cared for 26 children. Unlicensed homes of relatives represented 60% of the project's families with housing problems who cared for a combined 23 children in foster care. In addition to DCFS licensed and unlicensed families, the project provided housing assistance to three families with a combined 11 children referred by Extended Family Support Services, a DCFS-funded deflection program. The average age of the caregivers referred through Extended Family Services was 75.

Typically, the unlicensed relatives lived on fixed retirement incomes, limiting the monetary resources needed to maintain a safe home or deal with emergency housing expenses. Many of the older relatives struggled to provide for the immediate needs of the children, while utility bills went unpaid, home repairs were deferred, and the caregiver at times deprived himself or herself of necessary medication. Further, the relatives had little access to respite care for the children.

The majority of the homes had heating problems and crowded living conditions. Other problems the families faced included structural damage to the home, plumbing problems, rodent and insect infestations and physical disabilities of the older caregiver.

Older caregivers share a number of characteristics that put them at higher risk than the general population of homeowners and renters. They often live in extreme poverty, are particularly susceptible to scams and exploitation, have little knowledge or ability to do home maintenance, have difficulty with health and mobility, can be resistant to change, and may be living in isolation. The variety of housing problems experienced by these caregivers was complicated by their over extended financial obligations for basic necessities. In some cases subsidies were stretched to cover the needs of non-departmental children, or they were used to cover the continuing expenses of children who aged out of the system and no longer received subsidies.

The shrinking federal, state, and local social welfare budgets have impacted the low-income housing repair programs in Chicago. The Chicago Department of Housing funds two major repair programs Emergency Housing Assistance Program (EHAP) and Home Repairs for Accessible and Independent Living (H-RAIL). The Chicago Department on Aging and The Chicago Department of Public Health also provide funding to two private agencies that administer a minor repairs program for seniors including a lead paint mitigation program through Neighborhood Housing Association, and a home repair loan program for low-income families.

Regardless of whether older caregivers were homeowners or renters, housing conditions critically impacted these families. Solutions to older caregiver poverty issues require specialized knowledge of governmental and private programs external to DCFS, and the ability to collaborate with such programs. Caseworkers must never lose track of the primary question of child safety; if housing issues threaten child safety, the hotline must be called. Workers also need to develop a long-term assessment of the future capability of the caregiver to sustain the improved living conditions, independent of assistance.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should increase the $3,000 FY 2000 contract amount for client assistance for the 40 cases in the Older Caregivers Program to $15,000 to $20,000 to meet the expanded program needs (75 cases) and housing crises resulting from exponentially increasing energy costs and deteriorating housing.

The FY07 contract was increased.

2. The program plan for the Older Caregiver Program should be amended to allow for flexibility in service provision. Presently, the Older Caregiver Program model provides an initial assessment, provision of specialized elder support services, and family mediation. In addition to this full array of services for the 75 families, this program should be expanded to provide limited services to additional families on a fee-for-service basis. For example, court personnel may request a gerontology exam or housing consultations. Or, a caseworker may have determined that assistance is required for physical repairs on a home but is unaware of how to access these resources. In such cases where the Older Caregiver team discovers the need for comprehensive assessment and services, the case can be moved over to the grant-based project for full assessment and services.

The Department does not agree. There are resources within the state system to assist low-income families with energy assistance, housing repair issues and housing in general. We will begin to strategize within the state to provide families with appropriate resources.

3. Problematic cases with elderly caretakers should be referred for a Child And Youth Investment Teams (CAYIT) staffing to determine if the case should be referred to the Older Caregivers Program for either a full assessment or provision of limited services tailored to the family's needs. In conjunction with Department Training and Development staff, the OIG will deliver the Kids and Older Caregivers training for CAYIT, Administrative Case Review (ACR) and HELP Unit personnel.

The OIG has delivered several Older Caregiver trainings in Cook County. The Office of Training continues to provide co-trainers or logistics to support these trainings.

4. The OIG will provide training to Cook County court personnel, ACR and HELP Unit staff about the Older Caregivers Program and its availability.

The Department agreed.

5. The Department's Division of Service Intervention is convening a work group to address concerns related to older caregivers. The OIG will assist in these efforts.

The Division of Service Intervention staff compiled an Elder Caregiver Directory. The Directory was shared with Post Adoption staff and includes pertinent information regarding housing repair, health issues, Medicare, food pantry, counseling, etc. to assist the elderly.

6. The OIG, in collaboration with DCFS Division of Training and Development, will review current and developing training curriculums to ensure the incorporation of specific issues related to older caregivers, such as appropriate housing, finances, and back-up care plans.

The OIG has reviewed the Adoption Core curriculum, which includes older caregiver information. The OIG is going to provide Training with the older caregiver curriculum for inclusion into revisions to Licensing Core Training and Foundations Training.

GENERAL INVESTIGATION 18

ALLEGATION

Two Department employees held second jobs within the therapeutic field and provided services to Department clients in violation of Department Rule.

INVESTIGATION

The first Department employee, a clinical social worker, had also been employed on a part-time basis as an on-call worker at a psychiatric hospital for two years. The hospital contracts with the Department to provide mental health and substance abuse services to Department clients. In an interview with the OIG, the worker stated his job at the hospital included intake and conducting Screening And Supportive Services (SASS) assessments. The OIG found two instances when the worker assessed Department wards. The worker stated that although he performed the assessments of the wards, he had not engaged in any discussions with Department personnel regarding their cases. In his position with the Department, the worker participated in a review of proposals for SASS providers. The hospital was not part of the review and the worker stated he would not take part in a review of an organization he worked for. Although the worker stated his supervisor was aware of his other job, the supervisor stated to the OIG that she was unfamiliar with the hospital and could not recall whether or not the matter had ever been discussed. There was no record in the worker's personnel file indicating his employment at the hospital.

The second Department employee, a child protection specialist, led group discussions on domestic violence issues at a counseling center. The specialist had worked for the center in this capacity for four years. In his interview, the specialist acknowledged that in his role as a counselor he had worked with several individuals who had been somehow involved with the Department and that "on rare occasions" Department caseworkers had referred clients to his group. The specialist said the domestic violence sessions he presided over were the only ones offered in the area. In addition, the specialist provides individual counseling to one or two clients. The OIG obtained copies of emails and annual performance reviews in which the specialist disclosed his second job to his supervisor. In performance reviews, the supervisor wrote that he viewed the specialist's work as a positive influence as he believed it broadened his knowledge and involved him in the community.

In both instances, the Department employees and their supervisors failed to analyze how working with Department clients in different capacities constituted conflicts of interest. Ensuring the integrity of the Department is reliant upon the diligence of employees and supervisors to identify and address conflicts of interest in order to guarantee the trust of the public.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The clinical social worker must inform the psychiatric hospital that his position there constitutes a conflict of interest and formally end his employment.

The social worker notified the hospital that he terminated his contract.

2. The child protection specialist must inform the counseling center that he can no longer admit men who are involved with the Department into his domestic violence counseling group and that he can only provide one-on-one counseling to non-Department clients.

The Child Protection Specialist was directed to inform the center of the conflict in writing.

3. Both the worker's and the specialist's supervisors should have an ethics consultation with the Conflicts of Interest Committee on how to determine if their supervisee's secondary employment constitutes a conflict of interest.

Staff consulted with the Conflicts of Interest Committee of the Department.

GENERAL INVESTIGATION 19

ALLEGATION

Two separate instances in which young children were subjected to multiple medical procedures to determine if they had been victims of sexual abuse prompted the OIG to review their cases.

INVESTIGATION

In these two cases, involving girls four and five years of age, each child was examined on three occasions to reach conclusions regarding possible sexual abuse. The OIG found that in both cases, each procedure was preceded by a distinct allegation that required examination to determine the validity of the claim. In four of the examinations, physicians utilized a culposcope, a non-invasive magnifier that also allows images to be recorded and stored for future reference. While the OIG found that more efficient use of the culposcope's image-retention capabilities may have reduced the extent of one examination for each girl, each procedure was necessary in light of the allegations being made.

Investigations of sexual abuse against children must be conducted with the utmost sensitivity and regard for the minors involved. The intrusive nature of the physical examinations required to determine whether a child has been sexually abused can be difficult experiences in and of themselves for children. The need to substantiate or discount abuse must be weighed against the potential trauma that could result from unnecessary or redundant procedures.

One means of minimizing the frequency of examinations is through the maintenance of thorough records of any procedures performed. If physicians can rely on complete, detailed accounts of past examinations, they may be able to draw upon that information rather than being forced to begin anew. A great number of child sexual abuse examinations are conducted at Children's Advocacy Centers (CAC) located around the state. An OIG review of CAC intake forms from several regions found the forms used by each recorded different information and varied in the amount of data requested. The development of a singular, comprehensive intake form would provide consistency for physicians utilizing the forms and allow for a greater degree of familiarity with a particular case before determining whether to proceed with examinations.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should request that the Children's Advocacy Centers in Illinois employ an intake process that allows for more detail of relevant information. Comprehensive intake forms would enable investigators to contact referral sources and persons completing the intake form for clarification of information as needed. Detailed forms also provide physicians with important data about past physical examinations, improving their ability to determine the necessity of further evaluations. CACs with more comprehensive intake forms may be better equipped to eliminate stress to the child, minimize repeated examinations, and facilitate follow-up. CACs' intake form should include but not be limited to:

- **Known history of victim sensitive interviews and medical evaluations with results**
- **DCFS and law enforcement involvement**
- **Court involvement:**
- **Juvenile Court (delinquency; abuse and neglect)**
- **Domestic Court (divorce; child custody)**
- **Probate Court (third party custody of child)**
- **Name of referral source**
- **Basis for referral**
- **Description of allegation**
- **Name of the person completing the intake**

The Department submitted a request to the Children's Advocacy Centers of Illinois, which represents all 36 CACs, in November 2005. The request was for a comprehensive intake form that would provide more data and information with regards to the child's previous contact with the child welfare, law enforcement, courts and the medical systems. The CACs of Illinois surveyed their members and put together a composite intake form, which included the best features of many individual forms. As of August 2006, the CACI began distributing its sample Intake Form. The CACI has recommended that all Children's Advocacy Centers in the state begin a process of phasing in the use of this intake form at their locations

GENERAL INVESTIGATION 20

ALLEGATION

A child protection investigator made inappropriate, sexually-suggestive comments to women and a female minor while conducting two separate investigations.

INVESTIGATION

The investigator was assigned to investigate allegations of harm to a 15 year-old girl who had been injured intervening in an attack by her father against her mother. The investigator asked the girl what had precipitated the fight in the home. When the girl stated she did not know the cause, the investigator offered the theory that the argument arose over a dispute related to the parents' sex life. The investigator told the girl he had divorced his ex-wife because of her infidelity and unwillingness to participate in sex and supposed the father's anger stemmed from the same root cause. The investigator also said, "I would have desires but I would never get any. When a man has desires, he can do many things." The girl also stated that the investigator made comments about the mother's physical appearance and asked her if she had any attractive aunts.

In an unrelated investigation involving possible physical abuse of a two year-old girl, the same investigator interviewed the girl's babysitter in the woman's home. The babysitter's roommate was also present while the interview took place. When shown a picture of the alleged perpetrator, the investigator responded, "Oh wow, does she still look like that? Because if she does I'll be happy to find her." The babysitter said that throughout his time in her home, the investigator continued to make comments about his attraction to a famous actress and his desire to engage in sexual relations with her. When, during the interview, the babysitter mentioned to her roommate that she might have to secure other housing since the babysitter might assume responsibility for the child, the investigator offered to allow the roommate to move into his home. In an interview with the OIG, the roommate stated the investigator was persistent in his invitations and that it eventually became clear the arrangement would consist of a room in his home rather than a separate apartment. The roommate said the investigator returned to the home on several occasions and reiterated his offer. When she inquired about rent, he responded by stating they could "work it out" but provided no further information. The roommate stated she was present for part of an interview the investigator conducted with the mother and said the investigator repeatedly told the mother how pretty she was while questioning whether she was capable of abusing her daughter.

In his interview with the OIG, the investigator stated he did not recall making any comments of a sexual nature while conducting interviews. He was unable to account for why three women involved in two separate investigations who had no prior relationship with him or each other would claim he made inappropriate comments.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be terminated from his position.

The employee's resignation was effective August 23, 2006.

GENERAL INVESTIGATION 21

ALLEGATION

The mother and stepfather of three boys who had been removed from their custody lodged numerous complaints alleging misconduct by the Department.

INVESTIGATION

The boys, ages 12, 9 and 8, were removed from the mother and stepfather's custody three years earlier as a result of both caretakers being indicated for cuts, welts and bruises after the oldest boy returned to school following a one-day absence with marks on his arm, wrist, groin and buttocks. Prior to the boys' removal, the mother and stepfather pulled the children out of school and refused to cooperate with services offered by the Department. Since that time, the couple has leveled numerous accusations against the Department, the foster mother the boys were temporarily placed with, and their father, with whom they currently reside. Allegations of physical abuse, medical neglect and failure to provide adequate financial support were investigated and unsubstantiated. Claims made by the couple that the father had a criminal history had no basis in fact, making their further allegation that the Department ignored such a history groundless.

Charges of misconduct against the boys' caseworker were also found to be without merit. An inadvertent phone call the caseworker placed to the couple's home and her acceptance of a nominal gift from the children, delivered by the stepfather, prompted complaints of harassment and accusations the caseworker sought to entrap the stepfather in an unethical act. An additional allegation that the caseworker perjured herself in court was refuted by transcripts reviewed by the OIG. The couple had also made several requests to the Department asking for changes in the legal status of the case, although such decisions are the province of the court and beyond any reach of Department jurisdiction.

One valid complaint made by the couple involved the Department's reliance upon a therapist whose license had previously been placed on probation for three years for unethical conduct and unprofessional behavior. Although the therapist's probation expired 10 years ago, his past actions raise questions regarding his suitability as a contractor with the Department.

The OIG determined the couple's persistent accusations and complaints were the result of a misguided campaign to regain custody of the children. The OIG found no evidence to support their claims.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should seek the services of another therapist in the region.

All contractual relationships with the therapist were severed April 17, 2006.

GENERAL INVESTIGATION 22

ALLEGATION

The foster mother of an 11-year-old boy requested more than $200,000 in reimbursement from the Department as compensation for losses incurred in a fire she believed was started by the boy. The OIG was asked to review the validity of her claim.

INVESTIGATION

An OIG review of local fire department records confirmed the foster mother's home had been seriously damaged and many of her possessions lost during the fire. A mattress in the rear bedroom of the home was identified as the source of the blaze. Fire Department personnel theorized the cause was accidental related to smoking or the careless use of matches but did not conduct a complete investigation. The foster mother told authorities she had caught the boy starting fires in the home on two previous occasions but had not reported the incidents to his caseworker. Two months after the home was destroyed, the foster mother reported to the caseworker that she found the boy smoking cigarettes in a vacant apartment upstairs from the one where they had recently relocated. Upon being confronted by the caseworker, the boy initially denied the claim but later admitted he had been smoking in the empty apartment. The caseworker referred the boy for an evaluation of possible firesetting tendencies and he was subsequently admitted to a hospital. At the OIG's request, the Illinois Fire Safety Alliance Youthful Firesetters Intervention Association reviewed the boy's case records. It was recommended that the boy undergo further assessment specific to fire safety. The boy's caseworker agreed to arrange for his assessment by the Illinois Fire Safety Alliance.

The foster mother possessed homeowners insurance and received slightly more than $100,000 from the insurer for the loss of her home. The foster mother's initial claim submitted to the Department for reimbursement was in excess of $200,000. The Department raised questions regarding a number of the items included in the claim and narrowed the amount to just over $66,000, which was approved for payment. Some items were contested based on doubts regarding the legitimacy of receipts of purchase provided by the foster mother or, as in the case of a fur coat, whether she was the legal owner of the destroyed property. Another central issue for the Department was obtaining verification that the foster mother had not already been compensated for the loss of certain items through her homeowners' policy.

The OIG verified the documents submitted by the foster mother showing she had purchased valuable jewelry. However, some of the jewelry claimed contained diamonds that would not likely have been consumed in the flames. The OIG was unable to substantiate allegations the foster mother had falsified documents or acted fraudulently in order to inflate her reimbursement claim with the Department, however further documentation and verification should be required prior to the finalization of any transaction.

An OIG review of Department procedure regarding third-party coverage for foster parents found reimbursement was limited to a maximum of $5,000. A Department administrator told the OIG that the Department provides reimbursement beyond that amount when appropriate, however no such provision is formally included in Department Procedure.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Administrative Procedure 13 should be expanded to include circumstances for permitting discretionary reimbursement over $5000.

Procedure 13 is under review by the administrator of the Foster Parent Reimbursement Program. Estimated completion date: March 1, 2007.

2. The foster mother should provide an explanation for requesting reimbursement for diamonds, since the fire alone would not destroy diamonds. The foster mother should also provide ownership

information concerning the fur, since the appraisal submitted was insufficient.

Agreed. A negotiated payment to the foster parent was made on February 23, 2006.

3. Consistent with Administrative Procedure 13, the foster mother should sign a release and affidavit that she has received no other reimbursement covering the items that are the subject of the reimbursement from the Department.

The Release and the affidavit were received January 26, 2006.

4. The Department should follow through on any recommendations made by the Illinois Fire Safety Alliance Youthful Firesetters Intervention Association.

The Department will consider any recommendation given by the Illinois Fire Safety Alliance Youthful Firesetters Intervention Association.

5. The OIG will provide a follow-up memorandum concerning any questions raised about the boy's placement with the foster mother in light of licensing investigations.

No further concerns were noted that required sharing with Foster Care Licensing.

GENERAL INVESTIGATION 23

ALLEGATION

During the course of conducting another investigation, the OIG became concerned with the lack of general knowledge among Department and private agency child welfare professionals regarding the administration of psychotropic drugs to wards. The OIG requested statistics from the Department's Guardianship Administrator regarding the number of wards under the age of 10 who are currently prescribed two or more psychotropic medications.

INVESTIGATION

Wards Receiving Psychotropic Medications (As of May 2006)

	Number of Wards by Age Group				
Number of Psychotropic Medications	**Age Group 0-6**	**Age Group 7-12**	**Age Group 13-18**	**Age Group 18+**	**Grand Total**
1	249	745	920	7	1921
2	110	470	650	4	1234
3	35	287	440	5	767
4	12	138	276	4	430
5	4	53	133	1	191
>6	3	58	123	0	184
Grand Total	**413**	**1751**	**2542**	**21**	**4727**

The Department Guardian's consulting physician explained that the psychotropic medication detailed in this chart includes anti-convulsant medication that may not be administered for psychotropic purposes, i.e., seizure disorder.

It is vital that all Department and private agency employees involved with wards who are prescribed psychotropic medications are cognizant of the need to ensure that medication schedules are followed and that caregivers are provided with explicit instructions as to how and when these drugs should be administered. In addition, the potential interaction between psychotropic drugs a child is currently taking and any new medications they might be prescribed must be thoroughly examined by a physician.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Given the current data, the Guardianship Administrator should conduct a review of the above wards, ages 12 and under, to determine which minors are receiving additional non-psychotropic medications to assess the safety of drug interactions, i.e., beta-blockers are contraindicated for patients taking asthma medication.

The Department has contracted with the University of Illinois at Chicago Department of Psychiatry to provide an independent review of all psychotropic medication requests for its wards.

2. The Guardianship Administrator should oversee an evaluation of wards, ages 6 and under, receiving four or more psychotropic medications to ensure treatment is appropriate and safe.

Rule 325 is currently in revision and contains a provision for Oversight Treatment Teams that will review all

youth on 4 or more psychotropic medications and all children under 4 years of age on psychotropic medications other than stimulants. The Department does have safeguards in place for wards on psychotropic medications in the form of Administrative Case Reviews (ACRs). ACRs are held on all wards every six months. Medication regimens are reviewed in the ACRs and a member of the Centralized Consent Unit for Psychotropic Medications is charged with clarifying all issues related to psychotropic medications that arise in the context of the ACR. Regardless, a review of the 19 cases of all youth under age 6 on four or more psychotropic medications (4.6% of all children under age 6 on psychotropic medications) would be highly instructive. The Department will review these cases to determine factors related to the apparently high use of psychotropic medications in this population.

GENERAL INVESTIGATION 24

ALLEGATION

The mother of a six year-old girl alleged that her daughter's foster mother was employed as a caseworker by the same private agency that issued her foster care license. The mother contended the foster mother exerted her influence with the agency to prevent the girl's return home and had interfered in a child protection investigation of possible sexual abuse of the girl by the foster father.

INVESTIGATION

The foster mother's employment with the private agency had ceased five months before she was granted a foster license. The OIG also reviewed the unfounded Child Protection investigation and found no evidence of misconduct or any suggestion of an attempt by the foster mother to influence the outcome. Although no evidence of bias on the part of the agency was found in this case, it is important that agencies implement policies to ensure equal treatment whenever former employees are the subjects of monitoring.

During the course of the record review the OIG learned the foster father, a licensed in-home day care provider, had provided inaccurate information when completing his day care home license renewal application. At the time he was initially licensed, the foster father was unmarried and resided in a home with his mother where day care services were provided. By the time of the license renewal, the foster father, identified as the primary day care provider, had moved from the home. He did not notify licensing workers of his departure from the home or his marriage to the foster mother, who would have been required to undergo a criminal background check. A subsequent licensing investigation substantiated four licensing violations against the foster father, who acknowledged intentionally deceiving licensing workers. The foster father voluntarily surrendered his day care home license and the home was closed.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency should conduct a supervisory review with the foster care licensing representative who monitors the foster home to recognize and guard against biases that may occur in monitoring the home of a former employee.

The supervisory review was conducted by the private agency.

GENERAL INVESTIGATION 25

ALLEGATION

The OIG received a complaint that foster parents felt pressured to participate in a rally to support a legislative agenda.

INVESTIGATION

Department staff were instructed to contact private agencies and have the private agencies arrange for buses of foster parents to travel to a rally to promote state subsidized health care for Illinois children. The program would not benefit foster parents, as a group. The OIG referred the complaint to the Executive Inspector General, who declined investigation. The facts of the complaint were investigated by the OIG and submitted to the Ethics Board for comment. The Ethics Board determined that foster parents could easily feel that the Department might retaliate against them for refusing to participate. The Ethics Board also questioned the propriety of Department staff spending time to coordinate participation for a rally that was not directly related to Department work. The Ethics Board recommended that the Department develop guidelines that would delineate circumstances for soliciting clients for legislative activity, while minimizing clients' fear of potential retaliation from non-participation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should develop a policy concerning soliciting clients for legislative activity.

A draft policy was submitted to the Deputy Director of Legislative Affairs for review and final approval October 26, 2006.

GENERAL INVESTIGATION 26

ISSUE

The OIG prepared suggestions for a number of revisions to the Child Welfare Employee Licensure Rule [89 Ill. Adm. Code 412]. The suggestions were based on the OIG's six years of experience in investigating and prosecuting Child Welfare Employee License violations.

OIG RECOMMENDATIONS/ DEPARTMENT RESPONSES

The OIG recommended that the Rule be revised:

- To permit the Department to refuse to issue a license with knowledge that the applicant had committed a violation that would warrant revocation or if the applicant had engaged in behavior that would pose a risk to children or state resources;
so that the list of criminal pending charges or convictions that would warrant a refusal to issue be expanded to include any crime of which dishonesty is a essential element;
- To permit the Department to refuse to issue a license if the applicant provides false information during the licensing process;
- To provide guidelines for assessing criminal convictions and abuse or neglect findings that are not bars to licensure;
- To permit the Division of Child Welfare Employee Licensure to refer applications for investigation to verify facts presented.

The recommendations were accepted. The Department will pursue amending Rule 412.

GENERAL INVESTIGATION 27

ALLEGATION

The OIG reviewed Department guidelines regarding *ex parte* communications.

INVESTIGATION

After noting potential discrepancies in interpreting portions of the Ethics Law and the Department Employee Manual, the OIG sought guidance from the Executive Ethics Council concerning guidelines for determining whether a communication from someone outside of the Department constituted an *ex parte* communications for purposes of reporting the communication. The OIG also noted that the Department's policy on telephone use for employees contained a *reasonable use* exception while the policy on fax use did not.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should incorporate into its training and Employee Manual the qualification that in order to trigger the *ex parte* communication reporting requirements for pending rulemaking, the employee should reasonably believe that the contactor is intending to influence the rulemaking process.

Revisions have been approved for inclusion in the next revision of the Employee Handbook. Anticipated timeframe: December 2006.

2. The Department should consider a reasonable use exception for private (non-political) use of the fax machine to conform to the reasonable use exception for telephone use.

Labor Relations has provided the Director's Office with a draft and it is currently being reviewed. Implementation date: December 2006.

GENERAL INVESTIGATION 28

ISSUE	Several OIG investigations raised questions of conflict of interest or appearance of conflict of interest by decision-makers within the Department who had previously worked for private agencies.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's Conflict of Interest Committee should establish procedures for building walls between private agencies and DCFS Administrators who have decision-making power over agencies that they previously worked for.

The procedures have been drafted by the Conflicts of Interest Committee.

GENERAL INVESTIGATION 29

ISSUE

The OIG relies on the Office of Information Technology Services (ITS) staff to route current and archived computer files for OIG review. In response to a recent request for records, the ITS unit informed the OIG that the investigative request could not be filled for at least three months.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should review available resources to deploy needed personnel and equipment to ITS to address the additional workload responsibilities and hardware needs occasioned by compliance with the Grand Jury subpoenas.

This situation is believed to be a one-time issue arising from the necessity of complying with Grand Jury requests. All federal Grand Jury requests have been complied with at this time.

OIG INITIATIVES

ETHICS

Child Welfare Ethics Advisory Board

The Child Welfare Ethics Advisory Board was formed in March 1996 as an advisory body to the DCFS Inspector General. Its members are an interdisciplinary group appointed by the Inspector General.[1] During 2006 the Board welcomed two new members: James C. Jones, President and Chief Executive Officer of ChildServ, and David N. Schwartz, M.D., Division of Infectious Diseases at John H. Stroger Jr. Hospital of Cook County.[2] The Child Welfare Ethics Advisory Board met three times in 2006 to consider child welfare ethics issues presented by the Inspector General and other child welfare professionals.

The Office of the Inspector General (OIG) referred to the Board an inquiry it received regarding DCFS and private agency foster parents who were solicited to attend a rally to support a program to provide universal health care to Illinois children regardless of income. The Board considered what foster parents would gain from their attendance at the rally and whether the rally further served the interests of DCFS clients. The Board was concerned that even with a disclaimer assuring foster parents that participation or non-participation would not be held against them, they may retain the perception that it would. The Board recommended that staff be prohibited from soliciting foster parents for legislative activity in order to avoid the potential appearance of impropriety.

The OIG asked the Board to consider ethical issues raised when DCFS investigates abuse or neglect of children with complex medical needs. The Board recognized the need to investigate allegations of abuse and neglect appropriately and in a timely manner, while also recognizing the difficulties inherent in investigations involving children with complex medical needs. In these situations the best treatment is not always medically clear and viable options may not be available. It is sometimes difficult to determine what constitutes neglect because, unlike abuse, it is often based on lack of positive findings. The situation is further complicated by the need to act promptly; i.e., a child's medical condition might preclude anything other than prompt notification of the hotline. Finally, while recognizing the necessity of receiving full information before acting on allegations involving a child with medically complex needs, the Board acknowledged impediments within the medical system that inhibit receiving full information, such as lack of communication between primary and sub-specialty physicians, HIPAA (Health Insurance Portability and Accountability Act) regulations, and legal liability concerns. The Board recommended that DCFS develop a way of evaluating and handling cases in which abuse or neglect is alleged for

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[1] During this fiscal year, the members of the Child Welfare Ethics Advisory Board were:
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 Gonzales, M. D., pediatrician
James C. Jones, President and CEO, ChildServ
Jimmy Lago, M.S.W., M.B.A., Chancellor, Archdiocese of Chicago
David Ozar, Ph.D., Director, Center for Ethics and Social Justice, Loyola University Chicago
David Schwartz, M.D., John H. Stroger Jr. Hospital of Cook County
Ada Skyles, Ph.D., J.D., Fellow, Chapin Hall Center for Children, University of Chicago (Chair)
[2] James C. Jones replaced Eugene Svebakken, MSW, Executive Director and Chief Executive Office, Lutheran Child and Family Services, on the Child Welfare Ethics Advisory Board.

children with complex medical needs, including developing prompting questions that might be used to triage hotline calls, and training hotline personnel on handling calls made by medical providers that involve medically complex children.

The Board reviewed the AIDS Project in which DCFS wards participated in clinical trials. The Board considered the Project Director's potential for a conflict of interest. The Board was concerned whether a Project Director, who was charged with oversight of children participating in agency approved research projects, could be an independent party advocating on behalf of the children in the study if the Project Director also had an interest in the outcome of the study. The Board recommended that DCFS develop a protocol for a Project Director that would ensure against a conflict of interest.

The Board continued its discussion about wards' use of psychotropic medications. The Board was concerned about the number of wards, especially young children, who were reported to be receiving two or more psychotropic medications and whether the risk of medication interactions was sufficiently explored. Following a joint presentation made by the Division of Guardianship and Advocacy and the Department of Psychiatry at the University of Illinois at Chicago, the Board has tabled additional discussion for the next fiscal year.

OIG Ethics Staff Initiatives

In February 2006, the Inspector General and the OIG ethics staff attended a meeting of the Hispanic Advisory Council. The conversation focused on the Council's ethical responsibilities as an advisory body to the Director, and on conflicts of interest. The ethics staff provided educational materials on ethics and conflicts of interest, and discussed how the Council could disclose and resolve possible conflicts.

DCFS Ethics Officer

As Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General reviews the Statements of Economic Interest that senior DCFS employees are required to file with the Secretary of State by May 1 of each year. The Inspector General and the ethics staff noted entries that could constitute conflicts of interest. Potential conflicts were handled through educational efforts and through investigation, when appropriate.

In March 2006, the Inspector General, the OIG ethics staff and the OIG Legal Counsel attended the 2006 Ethics Officer Conference, which was held at the University of Illinois at Springfield by the State of Illinois Executive Ethics Commission. The one-day conference covered the State Ethics Act and the role of the Ethics Officer.

Annual Ethics Training

As required by the State Officials and Employees Ethics Act of 2003, state officials and DCFS staff continued ethics training for all new, contractual, seasonal, and temporary employees. The OIG coordinated and monitored the ethics training for the Department. The online ethics training for state employees consisted of lessons on various ethical dilemmas including accepting gifts, revolving door restrictions, whistleblower protection, conflicts of interest and prohibited political activities. There were three one-month training periods for which the OIG ethics staff notified employees registered to complete the training and kept track of their completion status. Upon conclusion of each period, the OIG submitted a report to the Executive Office of the Inspector General. Approximately 3,200 DCFS employees completed the ethics training in 2006. In addition to all DCFS employees, boards and commissions associated with DCFS were asked to have their members complete similar ethics training.

CIVILITY IN THE WORKPLACE

At the request of former Director Samuels, the Inspector General's Ethics staff developed and conducted training on workplace violence. Seventy-nine DCFS regional administrators, assistant regional administrators, managers and supervisors attended the Civility in the Workplace training that was held at the University of Chicago School of Social Service Administration. The training was dedicated to the memory of Senator Paul Simon. His words on humane service served as a backdrop of this training effort:

> *When we nurture hatred rather than understanding, when we tell unfunny jokes that ridicule another race or religion or ethnic group or sexual type, when we needlessly divide people for our own political or personal gain, we do a great disservice to our nation and humanity. The very word, humanity, suggests that to qualify for membership we should be humane.*
>
> *Paul Simon*

The keynote presenter was Eileen Gambrill, Ph.D., professor of Social Welfare at the University of California, Berkeley. Dr. Gambrill led participants through a morning workshop entitled: *Culture of Thoughtfulness vs. Culture of Excuses.* Ada Skyles, Ph.D., J.D., Associate Director and Research Fellow at Chapin Hall Center for Children and Chair of the Child Welfare Ethics Advisory Board, moderated a panel discussion on workplace civility and conflicts of interest. Panel members included Thomas Felder of the DCFS Conflict of Interest Committee and conflict mediator and author Andra Media. Trained ethicists facilitated small group discussions on scenarios that presented themes of tensions in the workplace, supervisor-supervisee conflicts, cultural divides, manager, supervisor, and client conflicts and situational violence. The purpose of the discussion groups was to develop practical solutions to problems that the participants could implement in their field offices. Follow-up consultations were arranged and follow-up educational materials were distributed.[3]

HOME AND FIRE SAFETY TRAINING

The Office of Inspector General's Project Initiatives staff assisted the Department in delivering field training for child protection investigators and intact family workers on home safety assessments and the promotion of child safety through educational tools. In FY 2006, Project Initiatives staff trained 290 DCFS child protection service workers, supervisors, and administrators on home safety checklists and tools that had been piloted and revised with input from front line workers (*The Home Safety Checklist for Intact and Permanency Workers,* CFS 2025, follows this section).

The Lombard Fire Department Public Education Coordinator and an investigator from the Chicago Medical Examiner's Office staff traveled throughout the state assisting the Department in trainings with

[3] According to a survey completed by participants, 90% of participants felt the training was applicable to their actual work. Ninety percent found Dr. Gambrill's workshop, *A Culture of Thoughtfulness vs. A Culture of Excuses,* easy to understand and applicable to their actual work environment. Eighty percent felt the small group discussions on conflicts in the workplace and conflicts of interest were useful. Participants commented that the best aspect of the training for them included, "The opportunity to interact with other supervisors and managers in order to network and share perspectives" and the helpfulness of, "Hearing our comments being presented by the panelists and hearing their responses."

the goal of lowering child fatalities.[4] The Chicago Fire Department contributed to the prevention efforts and donated over 500 smoke detectors for DCFS child protection and intact family workers to distribute to families without smoke detectors. Smoke detectors were also made available throughout the State for any child protection or intact family unit.

To prevent infant rollover deaths, local field offices have a system for DCFS workers to loan portable pack and play cribs to DCFS involved families who do not have cribs for their infants. Over 140 of these cribs have been distributed as a part of this educational effort for vulnerable families. The revised Home and Safety Assessment is completed on every family and families receive educational material with information on the specific safety issues germane to the family's situation.

As a supplement to the trainings, the Project Initiatives staff revised the family educational booklet, *A Helpful Guide for Parents and Caregivers,* to include the American Academy of Pediatrics and Chicago Children's Memorial Hospital Child Health Data Lab information on violence prevention.[5] This booklet as well as other supplemental educational material is available in English and Spanish.

[4] This is the fourth year that Mr. Plunkett, Lombard Fire Department Public Education Coordinator, has assisted the Office of Inspector General and DCFS training in serving the children and families of Illinois by educating child welfare workers on fire prevention He also coordinates the distribution of smoke detectors throughout the state for families served by DCFS. Mr. Plunkett is the President of the Illinois Youthful Firesetters Intervention Association.
[5] The guides can be ordered from the DCFS Central Store. An English and Spanish audio version of the guide for read-along by parents and caregivers will be piloted in FY 07.

State of Illinois
Department of Children and Family Services

HOME SAFETY CHECKLIST FOR INTACT AND PERMANENCY WORKERS

INSTRUCTIONS FOR COMPLETING THE HOME SAFETY CHECKLIST

Every year, 120,000 children 14 years of age and younger suffer some form of permanent damage due to unintentional/accidental injures. Infants and toddlers are at high risk of unintentional injury or death due to their inability to recognize and react to protect themselves from the danger. According to data from the National SAFE KIDS Campaign:

- Accidental, or unintentional, injury is the leading cause of death among children, teens and young adults.
- The five leading causes of accidental injury are burns, motor vehicle accidents, falls, poisonings and drowning.
- Burns and fires are the fourth most common causes of accidental death in children.
- Nearly 75 percent of all burns in children are preventable.
- Nearly 2,900 adults and children die each year in fires or from other burn injuries.
- The majority of children ages 4 and under, who are hospitalized for burn-related injures, suffer from scald burns (65 percent) or contact burns (20 percent).
- Hot tap water burns cause more deaths and hospitalizations than burns from any other hot liquids.

Fire/burns, motor vehicle traffic accidents, suffocation and accidental falls are the leading causes of unintentional deaths of children under the age of five in Illinois. Numerous Illinois children also die each year as a result of domestic violence.

While it may be impossible to eliminate all the dangers children encounter in their homes, one of the most important factors in reducing those dangers is parent education. The **Home Safety Checklist**, when properly used with parents and caregivers, provides an effective home safety assessment and educational tool that will assist in promoting the safety of children.

WHEN TO COMPLETE THE CHECKLIST

Intact Family Cases
Permanency workers shall complete the Home Safety Checklist:

- Within 30 days of the case opening regardless of whether a **CFS 2027** was completed by a Child Protective Service Worker (CPSW);
- Prior to a major change of life circumstance (e.g., move to a new home, child birth).
- Every six months during the life of the case.
- When a family with an open service case is the subject of a subsequent child abuse or neglect investigation.

Subsequent CA/N Investigations of Families with Open Cases
The child protective service worker or the CPSW supervisor shall notify the family's assigned intact or permanency worker or the worker's supervisor of the subsequent oral report (SOR) of alleged abuse or neglect within 48 hours after assignment of the investigation. The notification shall include the reminder that

the worker must complete a new checklist or re-certify the family's previous checklist within **14 days** of the SOR date. The intact or permanency worker must also complete a **SACWIS Case Note** that documents the worker's current assessment of home safety issues and forward the documentation to the CPSW. The CPSW cannot complete the investigation without receipt of documentation that a checklist has been completed.

A **Home Safety Checklist waiver** may be granted by the intact or permanency supervisor if the allegation or allegations of the SOR do not involve inadequate shelter, inadequate supervision, substance misuse, environmental neglect, inadequate food or inadequate clothing. The supervisor must complete a SACWIS supervisory case note documenting the waiver and rationale for the approval.

A **Home Safety Checklist re-certification** may be granted by the intact or permanency supervisor if the checklist was completed within six months of the SOR; and the SOR does not involve an allegation of inadequate supervision, inadequate food, inadequate clothing, inadequate shelter, environmental neglect or substance misuse; and the intact or permanency worker has completed a walk through of the family's home to confirm that the conditions of the home have not changed. The supervisor must complete a SACWIS supervisory case note documenting the approval and the rationale for the approval.

Placement Cases
Permanency workers shall complete the Home Safety Checklist:

- When a child is placed with an unlicensed relative (The assessment is completed on the home of the relative.).
- When there is a child abuse or neglect investigation of an unlicensed home with whom a child is placed.
- Prior to a scheduled unsupervised visit in the home of the parent.
- When there is a child abuse or neglect investigation involving an alleged incident that occurs during an unsupervised home visit.
- Prior to the placement of a pregnant or parenting teen in an independent living arrangement.
- When a parenting teen is identified as the alleged perpetrator of abuse or neglect involving his or her child or any child residing in the household.
- Prior to implementation of child care arrangements involving a child for whom the Department is legally responsible when a parent or caregiver plans to use an unlicensed day care home (The assessment is completed on the day care home).
- Prior to a major change of life circumstance (e.g., move to a new home, child birth).

HOW TO COMPLETE THE CHECKLIST

The home safety assessment is a service provided to the children and families served by the Department. In order for the **Home Safety Checklist** to be effective, the responsibility for its completion must be shared with the parent/caregiver. Use the information provided at the beginning of this section to explain the purpose of the assessment, provide the parent/caregiver a copy of the **CFS 2026** or **CFS 2026-S** (Spanish adaptation)**, Home Safety Checklist for Parents and Caregivers,** to use during the assessment, take notes on and retain for future reference. The formats of the **CFS 2025** and **CFS 2026/2026-S** differ; use the prompts provided on the **CFS 2025** to locate the corresponding **CFS 2026/2026-S** sections. Sign, date and have the parent/caregiver sign the completed assessment. If the parent/caregiver declines the opportunity to complete the checklist, check the declined box and request that the parent/caregiver verify his or her decision by signing the form. If the parent/caregiver refuses to sign the form, document the negative response on the parent's signature line. Place the completed **CFS 2025** in section I (B) of the client's case record.

Note: The CFS 2025 does not supersede any of the requirements for the completion of the CFS 1441 or CFS 454, HMR Placement Safety Checklist.

The **Home Safety Checklist** addresses 15 categories of home safety. Each category is supported by standards and straightforward supporting factual information that should be shared with the parent/caregiver to establish an instructive dialogue. There are three activities/tasks listed with each standard: "O" (Observed by

the worker.); “L” (Literature given to the parent/caregiver); and “I/S” (Worker instructed or showed). **Complete only those activities/tasks that are shaded for each standard.** For example, required activities/tasks for standard number one include O, L and I/S. If you observed that the family has a smoke detector located near their sleeping areas and the smoke detector works, place a yes (Y) in the O column. If the family does not have a smoke detector or has a smoke detector that does not work, place a no (N) in the O column. A no response requires a brief explanation of the finding in the Notes section. Also use the Notes section to document any observations made or instruction provided the family. Place a yes (Y) in the L and I/S columns after providing the family with the required fire prevention literature and instruction on the safety issues for the standard. The smoke detector standard applies to all families regardless of the ages of the children in the home. Other fire and burn standards may not apply due to the children’s ages. When your assessment indicates that a standard is not applicable (NA) to the family, place an NA in the appropriate column and explain the reason for the NA in the Notes section.

OBSERVED
When a standard requires the observation of a specific item or items (e.g., smoke detectors, small electrical appliances), you are required to complete the task if the item is readily observable. Do not open cabinets, drawers, move furniture or handle dangerous items.

LITERATURE
There are five pieces of literature (*PARENTS’ GUIDE to Fire Safety for Babies and Toddlers*, *Back to Sleep, Shaking A Baby Can Be Deadly, Violence Prevention* and *A Helpful Guide for Parents and Caregivers)* that you are required to provide the family. The literature can be ordered from Central Stores through normal channels. Suggest that the family visit the following resources if they have Internet access.

American College of Emergency Physicians, www.acep.org
American Association of Poison Control Centers, http://www.aapcc.org
American Red Cross Health and Safety Services, http://www.redcross.org
National Safe Kids Campaign, http://www.safekids.org

INSTRUCTED/SHOWED
Use literature and factual information provided for each standard to educate the family on the safety issues for that standard. For example, instruction concerning smoke detectors would include battery replacement information and, if the family does not have a smoke detector, information on how to obtain a smoke detector from their local fire department. Instruction can also be provided to the family through modeling behavior such moving matches or lighters out of the reach of younger children. Document any recommendations and instruction provided to the family in the Notes section.

State of Illinois
Department of Children and Family Services

HOME SAFETY CHECKLIST FOR INTACT AND PERMANENCY WORKERS

FIRE and BURNS	O	L	I/S	NA
Not Applicable				**NA**
Instructed/Showed			**I/S**	
Literature Given		**L**		
Observed	**O**			

Literature Relevant to the Following Standards: ***PARENTS' GUIDE to Fire Safety for Babies and Toddlers***				
1. The home has a working smoke detector located near the family's sleeping areas.				
2. The family has a fire escape plan that they practice so that they can react quickly in case of fire.				

Young children in Illinois are more than three times as likely to die in a residential fire than the rest of the state's population. Working smoke detectors save lives! Instruct the family to change smoke detector batteries when they reset their clocks, spring ahead and fall back. And that their local fire department can advise them on a fire escape plan. (These standards correspond to numbers 1 through 5 on the **CFS 2026/2026S**.)

3. Preschoolers and younger children do not have access to matches or lighters.				
4. The stove oven or burners are never used to heat the home.				

Forty percent of residential fire-related deaths among children are caused by child fire-play. Up to two-thirds of child fire-play victims are not the children playing with the fire. Instruct the family to place space heaters at least three feet from combustible materials such as furniture, walls and curtains. Other items such as blankets, clothing and paper should be kept a safe distance for the heater. Supervision of children will prevent fire play as well as other accidents. (These standards correspond to numbers 6 and 7 on the **CFS 2026/2026S**.)

5. The family's hot water does not come out of the faucet at scalding temperatures.				

Measure the hot water temperature by placing a thermometer in the stream of water from a kitchen or bathroom faucet. Keep the thermometer in the stream of water until the recorded temperature stops rising. The water temperature may be measured with outdoor, candy or digital thermometers. Digital thermometers are available from child protection. Encourage the family to set the hot water heater no higher than 120° Fahrenheit to prevent scald burns to children. Inform the family that children's skin is thinner than an adult's skin and that infants and young children will suffer partial and full-thickness (second and third degree) burns after ten seconds in 130° F water, four seconds in 135° F water, one second in 140° F water and one half second in 149° F water. The correct temperature for an infant's bath water is between 96.8° and 102.2° F. Instruct the family to never place a child in a bath without first checking the temperature of the water. (This standard corresponds to number 8 on the **CFS 2026/2026S**.)

6. Hot items, such as those listed below, are not kept within the reach of an infant, toddler or younger child.				
7. The handles of pots are always turned towards the back of the stove when they are on the stove.				

The majority of scald burns to children, especially among those ages six months to two years, are from hot foods and liquids spilled in the kitchen. Kitchens can be especially dangerous for children during meal preparation. Hot items such as coffee, tea, water, food, pots and pans, and lit cigarettes should never be left on table, countertops or stove tops within the reach of a child. Parents/caregivers should not hold children while they are cooking. (These standards correspond to numbers 9 and 10 on the **CFS 2026/2026S**.)

FIRE and BURNS (Continued)	O	L	I/S	NA
8. Electrical appliances (e.g., hair dryers, curling and clothes irons) are kept out of the reach of younger children.				
9. Electrical outlets are not overloaded.				

Children have been burned by appliances they have pulled down onto themselves. Children have also electrocuted themselves by dropping appliances into water. (These standards correspond to numbers 11 and 12 on the **CFS 2026/2026S**.)

10. Extension cords are not under rugs or furniture.				

Extension cords can wear out and spark. They will quickly cause a fire if they spark under a rug or furniture. (This standard corresponds to numbers 13 on the **CFS 2026/2026S**.)

11. Electrical outlets are covered when not in use.				

Children can be electrocuted if they place small objects in electrical sockets. (This standard corresponds to numbers 14 on the **CFS 2026/2026S**.)

Notes:

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SLEEPING	O	L	I/S	NA
Literature Relevant to the Following Standards: *Back to Sleep*				
12. The infant sleeps alone in a crib or bassinette.				
13. The infant does not sleep with toys, stuffed animals or pillows.				
14. The infant is always placed on his or her back to sleep.				

If there is a child under the age of one in the home, the following information must be shared with the parent/caregiver.

Infants should sleep alone in a crib or bassinette. Infants sleeping in adult beds are 20 times more likely to suffocate than infants who sleep in alone in cribs. The majority of infants suffocate when another person lays over them or when they smother in soft bedding or furniture when their face becomes trapped in the bedding or wedged in a small space such as between a mattress and a wall or between couch cushions.

If the parent/caregiver is without a crib, talk to your supervisor about loaning the family a crib until they can obtain one of their own.

When the infant is in the crib, the sides of the crib must be up; the mattress must be in the low position; the crib must not be placed near a window; window blind and electrical cords must be out of the reach of the child; pillows, stuffed animals and toys must never be left in the crib with the child. A child must never wear a pacifier on a ribbon or string placed around his or her neck. (These standards correspond to numbers 16 and 17 on the **CFS 2026/2026S**.)

SLEEPING (Continued)

Notes:

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CHOKING	O	L	I/S	NA

Literature Relevant to the Following Standard: *A Helpful Guide for Parents and Their Children*	

15. The children have child safe toys and choking hazards are kept out of their reach.				

Food such as hot dogs, hard candy, grapes, popcorn and nuts are common culprits in choking deaths. Small toys, tiny rubber balls, too small pacifiers, and bits of balloons are common non-food choking hazards. Children are also at risk for becoming entangled in the ties on a hood, cords that control window blinds, toys strung across cribs and strings used to attach pacifiers to clothing. As a general rule, any toy that can fit in a toilet paper roll is a choking hazard. (This standard corresponds to numbers 18 and 19 on the **CFS 2026/2026S**.)

Notes:

DROWNING	O	L	I/S	NA

Literature Relevant to the Following Standard: *A Helpful Guide for Parents and Caregivers*	

16. Baby pools are drained when not in use.				
17. Children are always supervised when they are near water.				

A young child can drown in as little as one inch of water. More than half of the drowning victims under the age of one drown in the bathtub during a brief lapse of supervision by the child's parent or caregiver. A child will lose consciousness within two minutes following submersion. Children must always be supervised when they are near water. (These standards correspond to numbers 20 through 23 on the **CFS 2026/2026S**.)

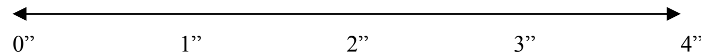
Notes:

FALLS	O	L	I/S	NA

Literature Relevant to the Following Standards: ***A Helpful Guide for Parents and Caregivers***	

18. Infants and toddlers are never left alone while they are on changing tables, tables, countertops, etc.				
19. Furniture that toddlers and younger children can climb on is not placed near windows.				
20. Baby walkers are not used.				

Children are more likely to die or be severely injured from window-related falls than adults. A screen is not strong enough to hold a child who is leaning against it. Screens are designed to keep insects out of the home, not to keep children from falling out the window. Children have fallen from windows that were open al little as four inches. Any window open more than four inches is potentially dangerous for children. Children crawling or jumping on beds are at risk of falling from open windows. Supervision is the key to keeping children safe from injury. (This standard corresponds to number 24, 25 and 26 on the **CFS 2026/2026S**.)



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Notes:

POISON	O	L	I/S	NA

Literature Relevant to the Following Standards: ***A Helpful Guide for Parents and Caregivers***	

21. Cleaning products, pesticides, medicine and liquor are kept out of the reach of children.				
22. The above products are not kept in food containers or soft drink bottles.				
23. Paint is not chipping or peeling off the walls or woodwork of the home.				
24. If rodent poisons and traps are used, they are of the reach of infants, toddlers and younger children.				
25. Toddlers and younger children do not have access to rotten food/trash.				

Poisoning in childhood is frequently due to household cleaning products, medicines, vitamin supplements, plants and cosmetics. Toddlers and preschoolers may be attracted to medicines and vitamins because they resemble candy; cleaning products may look like sweet beverages; cosmetics may smell like fruit or candy. Because young children explore the world by putting things in their mouths, poisoning is a serious risk. Lead can cause brain damage in a child. The most common way that a child comes into contact with lead is through peeling or chipping paint. If the paint in the home is suspected of containing lead, the family should be referred to the Illinois Department of Public Health's Childhood Lead Poisoning Prevention Program, 1-800-545-2200. The National Poison Control hotline number is 1-800-222-1222. (These standards correspond to numbers 27 through 32 on the **CFS 2026/2026S**.)

POISON (Continued)

Notes:

VIOLENCE	O	L	I/S	NA
Literature Relevant to the Following Standards: ***Never Shake a Baby! and Violence Prevention***				
26. The parent/caregiver knows how to calm a crying infant.				
27. The parent/caregiver knows never to shake a baby.				

The number one reason given by a perpetrator for killing an infant is that the infant would not stop crying. Other reasons perpetrators have given for injuring a child is that the child wet or soiled him or herself or the child was perceived as misbehaving. Instruct the family that they should NEVER, NEVER SHAKE A BABY and that they should remind their children's caretakers that they should never shake a baby. (This standard corresponds to number 32 on the **CFS 2026/2026S**.)

Recommend that the parent/caregiver do the following when their baby is crying.

- Make sure that the baby is not hungry, wet, hot or cold, sick or in pain.
- Offer the baby a pacifier.
- Rock or walk with the baby.
- Sing or talk to the baby.
- Take the baby for ride in his or her stroller or walk the baby in a snuggly body carrier.
- Play soothing music to the baby.
- Turn on a fan. Babies often like rhythmic noises.
- If the baby is overtired, lower the lights and turn off the television or radio.
- Talk with a family member, friend or neighbor about your frustration or have the person baby-sit so that you can have a well-deserved break.
- As a last resort, gently place the child in his or her crib, close the door and walk away. The parent/caregiver should check on the baby every five or ten minutes until the child stops crying or until the parent/caregiver is calm enough to resume comforting the child.

28. Firearms and ammunition stored in home are kept in separate locked locations.				

The safest home for children is one without weapons. Parents that keep firearms in the home should always store ammunition and unloaded weapons in separate, securely locked containers. The containers, if possible, should be stored in locations that are unknown and inaccessible to the children. The keys to the containers should always remain under the control of the parents. Fifty percent of all childhood unintentional shooting deaths occur in the home of the victim and nearly forty percent occur in the home of a relative or friend. It is difficult for children under the age of eight to distinguish between real and toy guns. Three-year-old children have the coordination and strength to pull the trigger of many handguns. In Illinois, it is illegal to allow a 14 year old to have access to firearms if that youth does not have a Firearm Owners Identification Card. (This standard corresponds to number 33 on the **CFS 2026/2026S**.)

VIOLENCE (Continued)

Notes:

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SUPERVISION	O	L	I/S	NA
Literature Relevant to the Following Standard: ***A Helpful Guide for Parents and Caregivers***				
29. Children are left with an appropriate caregiver when the parent/caregiver is not in home.				

Supervision by a parent/caregiver is the most important factor in keeping children safe from injury. Review the following questions with the parent/caregiver.
(This standard corresponds to number 34 on the **CFS 2026**/**2026S**.)

When choosing someone to watch your children consider the following questions.

The answers to these questions should be YES.

- Does this person want to watch your children?
- Will you have an opportunity to watch this person with your children before you leave?
- Is this person good with children the child's age?
- Has this person done a good job caring for other children that you know?
- Will your children be cared for in a place that is safe?
- Does this person know that a baby should never be shaken?

The answers to these questions should be NO.

- Will this person become angry if your children bother him or her?
- If this person is angry with you for leaving, will he or she treat your children roughly?
- Does this person have a history of violence that makes him or her a danger to your children?
- Has this person had children removed from his or her custody because he or she was unable to care for them?

Notes:

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AUTOMOBILES	O	L	I/S	NA

Literature Relevant to the Following Standards: *A Helpful Guide for Parents and Caregivers*	

30. Illinois law requires children under the age of eight to be in car or booster seats when riding in a car.				

Illinois state law requires any child under the age of eight to be secured in a car seat or booster seat when riding in an automobile. Children eight years of age and older must be secured with a seat belt while riding in an automobile. (This standard corresponds to number 35 on the **CFS 2026/2026S**.)

31. Young children are never left unattended in an automobile.				

The temperature in an automobile can rise extremely fast and lead to death by heat exposure. (This standard corresponds to number 36 on the **CFS 2026/2026S**.)

Notes:

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EMERGENCY TELEPHONE NUMBERS	O	L	I/S	NA

Literature Relevant to the Following Standard: *A Helpful Guide for Parents and Caregivers*	

32. Emergency telephone numbers are posted near a telephone or easily accessible location.				

Help the family prepare a list of telephone numbers that include their doctor or clinic, nearest emergency medical services, poison control (1-800-222-1222). *Post the list by the telephone or another easily accessible location if the family does not have a telephone.* (This standard corresponds to number 37 on the **CFS 2026/2026S**.)

Notes:

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FIRST AID KIT	O	L	I/S	NA

33. There is a first aid kit in the home.				

A home first aid kit should contain a thermometer, children's pain reliever (e.g., Tylenol), bandages, antiseptic solution (e.g., Bactine) and an antibiotic ointment (e.g., Neosporin). (This standard corresponds to number 38 on the **CFS 2026/2026S**.)

FIRST AID KIT (Continued)

Notes:

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ILLNESS	O	L	I/S	NA
34. The parent/caregiver can recognize signs of illness.				

Children that are ill, or becoming ill, will show one or more of the following signs of illness:

- Irregular crying that cannot be consoled
- Rashes
- Irregular breathing or wheezing
- Pain in the abdomen
- Diarrhea
- Irregular sleep patterns
- Fever
- Vomiting
- Ear pain
- Pain during urination
- Runny nose, unusual discharge
- Coughing or sneezing
- Poor appetite
- Unusual smell/color of bowel movement

(This standard corresponds to number 39 on the **CFS 2026**/**2026S**.)

Notes:

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IMMUNIZATIONS	O	L	I/S	NA
Literature Relevant to the Following Standard: ***A Helpful Guide for Parents and Caregivers***				
35. The children are up-to-date on their immunizations				

The following schedule of immunizations is recommended by the American Academy of Pediatrics, Centers for Disease Control and the American Academy of Family Practitioners.

- Hepatitis B (HepB): given at birth, between 1 – 4 months and between 6 – 18 months
- Diphtheria, Tetanus and Pertussis (DTaP): given at 2,4 & 6 months, between 15 – 18 months, and between 4 – 6 years (and Tetanus and Diphtheria (Td) should be administered between 11 – 12 years)
- Haemophilus influenza type b (Hib); given at 2,4 & 6 months and between 12 – 15 months
- Inactivated Polio (IPV); given at 2 & 4 months, between 6 – 18 months and between 4 – 6 years

IMMUNIZATIONS (Continued)

- Measles, Mumps and Rubella (MMR): given between 12 – 15 months and between 4 – 6 years
- Varicella (chicken pox): given between 12 – 18 months
- Pneumococcal (PCV): given at 2, 4 & 6 months and between 12 – 15 months

(This standard corresponds to number 40 on the **CFS 2026**/**2026S**.)

Notes:

MEDICAL CARE	O	L	I/S	NA
Literature Relevant to the Following Standard: ***A Helpful Guide for Parents and Caregivers***				
36. The children have physical examinations according to their doctor's schedule or the schedule listed below.				

Children usually have medical checkups performed by a physician at two weeks; two, four, six, nine, 12, 15 and 18 months; two years and annually thereafter.
(This standard corresponds to number 41 on the **CFS 2026**/**2026S**.)

Notes:

DENTAL CARE	O	L	I/S	NA
37. The children brush their teeth twice per day.				
38. The children receive preventative dental care.				

(These standards correspond to numbers 42 and 43 on the **CFS 2026** and **CFS 2026S**.)

Notes:

OTHER OBSERVED HAZARDS

Notes: ____

____

SIGNATURES

Parent's/Caregiver's Name: ____________________ ID Number (If Applicable): ____________________

Parent's/Caregiver's Signature: ____________________ ☐ Parent/caregiver declined the opportunity to complete the checklist

Workers Signature: ____________________ Date: ____________________

WAIVER REQUEST

CPSW Name: ____________________ Supervisor's Name: ____________________

Reason for the request: ____

____

____

Waiver Approved: Yes ☐ No ☐
If no, please explain:

____

____

____

CPSW Signature: ____________________ Supervisor's Signature: ____________________

Date: ____________________ Date: ____________________

RE-CERTIFICATION

Date of most current Home Safety Checklist: ____________________ Date of supervisory approval for the re-certification: ____________________

Date of home review for the re-certification: ____________________

CPSW Signature: ____________________ Supervisor's Signature: ____________________

Date: ____________________ Date: ____________________

REUNIFICATION OF SUBSTANCE AFFECTED FAMILIES

The OIG Project Initiatives staff and the Department's Clinical Division developed recovery matrices with clear behavioral indicators. The matrices will assist caseworkers and the court with assessing the parent(s)'s progress in substance abuse recovery and parenting over time. The Substance Abuse Recovery matrices provide a consistent measure of observable change and progress over 12 month periods. The matrices also help parents by outlining progress in a holistic manner, focusing the parents and caseworkers on behaviors that are consistent with everyday parental responsibilities and progress in substance abuse treatment. The matrices provide consistent documentation across settings over time and support a common language among caseworkers, attorneys and the court. The following are the directions and form, *Recovery Matrix For Placement Cases* (CFS 440-9):

RECOVERY MATRIX FOR PLACEMENT CASES (CFS 440-9)
Indicators for Progress in the Substance Abuse Recovery Process
and Parenting Responsibilities

INTRODUCTION

Recovery from substance abuse involves not only attaining and maintaining abstinence but also changing one's thinking and behavior and sustaining those changes over time. When measuring progress in recovery, it is important to keep in mind a child's sense of time, the parent's progress in treatment and the behaviors parents demonstrate that are consistent with good parenting. These behaviors include participation in health, educational, and developmental activities. Moreover, in order to increase visitation and eventual family reunification, the caseworker must document activities and observations that indicate a parent's progress in substance abuse recovery and the resumption of positive parenting responsibilities. The recovery matrix worksheets provide caseworkers, parents, and the court with criteria, guidelines and a visual representation for assessing and discussing a parent's progress in recovery and movement toward reunification over a 12-month period. The Recovery matrix uses clear behavioral indicators whenever possible in order to provide a consistent measure of change. By using these indicators, parents, caseworkers and the court have consistent tools to measure progress.

This Recovery Matrix is used in all placement cases where substance abuse has been determined by allegation or when indicated on the substance abuse screen (CFS 440-5). Each time the matrix is administered, the caseworker and the parent discuss the parent's progress towards recovery and parenting, unless the parent is unwilling or missing.

DIRECTIONS

- Following case opening, the caseworker meets with the parent to introduce the concept of the recovery matrix and to explain its use. There are five separate recovery matrix forms: Baseline 0-45 days, 45-90 days, 3-6 months, 6-9 months, and 9-12 months. These forms are used together sequentially to monitor and assess a parent's progress through the first 12 months following case opening. The caseworker completes these forms with the parent at the designated time frames.

  In some instances, substance abuse issues are identified later in the case. Once identified, caseworkers are to complete the matrix worksheet that coincides with the timeline following the

Temporary Custody date. For example, at eight months into the case, the caseworker identifies a substance abuse issue. The caseworker completes the six to nine month worksheet and indicates the date and circumstances surrounding how the substance abuse issue was identified in the Lack of Progress column. Any additional comments are to be made on the notes page.

- After introducing the recovery matrix at the caseworker's initial contact with the parent (e.g., 48 hour meeting), the caseworker meets with the parent to complete the appropriate Recovery Matrix worksheet (CFS 440-9) at the following times:
  - Prior to the 45 day Service Plan in order to establish a baseline, using the 0 – 45 day Baseline matrix
  - At the end of 90 days, using the45 –90 day matrix
  - Prior to the first ACR (6 months), using the 3 – 6 month matrix
  - At nine months from Temporary Custody, using the 6 – 9 month matrix
  - Prior to the next ACR and Permanency Hearing (twelve Months from temporary custody), using the 9 to 12 month matrix NOTE: When the case remains open beyond 12 months, the caseworker continues to use this matrix at three-month intervals as long as the goal remains return home.

- In addition to the parent's self report, the caseworker must examine additional sources of information to support completion of the recovery matrix: monthly treatment progress reports completed by the substance abuse treatment agency, urinalysis reports, and interviews with other professional collaterals, and family members.

- The caseworker should place check marks at the appropriate level of progress in both the Substance Abuse Treatment and Parenting Responsibilities columns. **Check all that apply.**

  Although the parent may be showing a lack of progress in one area, there may be partial progress in another. For example, a parent may be showing a lack of progress in parenting responsibilities and partial progress in substance abuse treatment. This process provides the caseworker an opportunity to acknowledge the parent's strengths and progress as well as areas of needed improvement. Because recovery is not always a linear process, a parent may experience periods of ambivalence and relapse. The ideal situation would be for a parent to complete substantial progress at the end of each interval in order to obtain unsupervised visitation and eventual reunification.

- The completed Recovery Matrix is signed by the caseworker and parent and then reviewed and signed by the supervisor. Each participant receives a copy before it is filed. Caseworkers submit the completed Recovery Matrix with other required documentation to Administrative Case Review (ACR) staff and court personnel.

•

Baseline Matrix: Zero to 45 days from TC (Complete prior to 45 day Service Plan)

Please use Notes Section (final page) to document significant events/concerns.

Substance Abuse Treatment - Baseline		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Continued to use and/or remains in denial of substance abuse/ addiction ❑ Had less than 50% clean urinalysis results ❑ Substance Exposed Infant born subsequent to case opening Date:____________ Other_______________________ ____________________________ ____________________________	Parent: ❑ Failed to consistently meet with caseworker ❑ Completed substance abuse assessment but has not yet followed recommendations or entered treatment. ❑ Had more than 50% clean urinalysis results. ❑ Self-reported abstinence for______ consecutive days Other___________________________ ______________________________ ______________________________	Parent: ❑ Entered residential treatment- movement has not been restricted ❑ Entered recommended outpatient treatment ❑ Attending at least 80% of sessions. ❑ Self-reported abstinence for the past 30 days ❑ Had all clean urinalysis for past 30 days Other___________________________ ______________________________ ______________________________
Visiting and Parenting Responsibilities - Baseline		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent was notified and did not attend/participate in: ❑ T/C hearing ❑ Was not notified about TC hearing ❑ Court Family Conference ❑ Integrated assessment ❑ Parent was not notified about TC hearing Parent: ❑ Unable to be contacted/located ❑ Failed to attend initial visit after T/C was taken ❑ Did not visit child(ren) ❑ Did not request visits ❑ Had not made self-available for services ❑ Failed to attend/cancelled visits	Parent has participated in **two** of the following meetings: ❑ T/C hearing ❑ Court Family Conference ❑ Integrated assessment Parent: ❑ Established a visiting plan with worker. ❑ Had begun to visit child attendance is sporadic ❑ Did not contact worker to reschedule missed visits. ❑ Failed to attend visits beyond parent's control (i.e. transportation)	Parent has participated in the following meetings: ❑ T/C hearing ❑ Court Family Conference ❑ Integrated assessment ❑ Initial 40 day Family Meeting Parent: ❑ Actively contribute to the development of the Comprehensive Service Plan. ❑ Consistently visited child/ren and actively engaged in critical educational, developmental and health appointments for child/ren ❑ Attend Comprehensive Health Evaluation with Healthworks Primary Care Physician ❑ Attended routine scheduled medical appointments ❑ Attended Pre-school or HeadStart

Case Worker Tasks to be completed for up to 12 months: Remove barriers that would prevent parent's entry into treatment and/or hinder visitation and reunification, such as arrange transportation, location for visits. Facilitate parent's participation in significant court hearings, assessments appointments, home visitation and engagement activities. Promote longer and more frequent visits to help assess parent's readiness for unsupervised visits. ***Reminder: One week prior to ACR, evaluate with Parent and Supervisor to review expectations & include the completed Recovery Matrix in required documentation for ACR reviewer***.

Remember: The time clock begins at case opening, therefore it is imperative to impress upon the parent that they are legally required to show substantial progress within 12 months from the date of the child's placement for successful reunification.

Progress is measured on the matrix from time of case opening, **NOT** from time the parent became available or agreed to enter treatment. I.e. if a parent does not enter treatment until nine months following custody, caseworkers would indicate " client continues to use and/or "unable to locate" on the matrix worksheets for months 0-3, 3-6 and 6-9 and check lack of progress in TX.

45 – 90 Days from TC (Complete at the end of 90 days- 3 months)

Please use Notes Section (final page) to document significant events/concerns.

Substance Abuse Treatment		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Failed to meet with caseworker ❑ Continued to use and/or remains in denial of substance abuse/ addiction ❑ Had less than 50% clean urinalysis results ❑ Substance Exposed Infant born subsequent to case opening Date:____________ Other________________________ ____________________________ ____________________________ ____________________________ ____________________________	Parent: ❑ Failed to consistently meet with caseworker ❑ Completed substance abuse assessment but has not yet followed recommendations or entered treatment. ❑ Had more than 50% clean urinalysis results. ❑ Self-reported abstinence for______ consecutive days Other___________________________ ______________________________ ______________________________ ______________________________ ______________________________	Parent: ❑ Entered residential treatment-movement has not been restricted ❑ Entered recommended outpatient treatment ❑ Attending at least 80% of sessions. ❑ Self-reported abstinence for the past 30 days ❑ Had all clean urinalysis for past 30 days Other___________________________ ______________________________ ______________________________ ______________________________ ______________________________

Visiting and Parenting Responsibilities		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent was notified and did not attend/participate in: ❑ T/C hearing ❑ Was not notified about TC hearing ❑ Court Family Conference ❑ Integrated assessment ❑ Parent was not notified about TC hearing Parent: ❑ Unable to be contacted/located ❑ Failed to attend initial visit after T/C was taken ❑ Did not visit child(ren) ❑ Did not request visits ❑ Had not made self-available for services ❑ Failed to attend /cancelled visits	Parent has participated in **two** of the following meetings: ❑ T/C hearing ❑ Court Family Conference ❑ Integrated assessment Parent: ❑ Established a visiting plan with worker. ❑ Had begun to visit child – attendance is sporadic ❑ Did not contact worker to reschedule missed visits. ❑ Failed to attend visits beyond parent's control (i.e. transportation)	Parent has participated in the following meetings: ❑ T/C hearing ❑ Court Family Conference ❑ Integrated assessment ❑ Initial 40 day Family Meeting Parent: ❑ Actively contributed to the development of the Comprehensive Service Plan. ❑ Consistently visited child/ren and actively engaged in critical educational, developmental and health appointments for child/ren ❑ Attended Comprehensive Health Evaluation with Healthworks Primary Care Physician ❑ Attended routine scheduled medical appointments ❑ Attended Pre-school or HeadStart

Case Worker Tasks to be completed for up to 12 months: Remove barriers that would prevent parent's entry into treatment and/or hinder visitation and reunification, such as arrange transportation, location for visits. Facilitate parent's participation in significant court hearings, assessments appointments, home visitation and engagement activities. Promote longer and more frequent visits to help assess parent's readiness for unsupervised visits. ***Reminder: One week prior to ACR, evaluate with Parent and Supervisor to review expectations & include the completed Recovery Matrix in required documentation for ACR reviewer.***

Remember: The time clock begins at case opening, therefore it is imperative to impress upon the parent that they are legally required to show substantial progress within 12 months from the date of the child's placement for successful reunification. Progress is measured on the matrix from time of case opening, **NOT** from time the parent became available or agreed to enter treatment. I.e. if a parent does not enter treatment until nine months following custody, caseworkers would indicate " client continues to use and/or "unable to locate" on the matrix worksheets for months 0-3, 3-6 and 6-9 and check lack of progress in TX.

This page of the form is to be:
- ✓ Introduced during the first contact with the parent
- ✓ **Completed at the end of 3 months (90 days)**
- ✓ Signed by parent, caseworker, and supervisor before being filed.

Three to 6 Months from TC (Complete prior to the first ACR and/or at end of 6 months)

Please use Notes Section (final page) to document significant events/concerns.

Substantance Abuse Treatment		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Failed to meet with caseworker ❑ Continued to use and/or remains in denial of substance abuse/ addiction ❑ Failed to obtain substance abuse assessment ❑ Failed to follow recommendations of substance abuse assessment ❑ Had less than 50% clean urinalysis results ❑ Initially engaged in treatment but left against staff advice (ASA) ❑ Discharged from treatment program for antisocial behavior and/or numerous unexcused absences ❑ Failed to attended 12-Step or other community support groups ❑ Substance abuse issues were not identified until the following Date: _____________ ❑ Substance Exposed Infant born subsequent to case opening Date:_____________	Parent: ❑ Entered residential treatment & movement not restricted ❑ Entered outpatient treatment, attended 50% of outpatient treatment sessions with few unexcused absences ❑ Developed relapse prevention plan, including relapse triggers and discussed them with worker and/or family members ❑ Identified and/or started attending 12-Step meetings or other community support groups ❑ Identified 12-Step sponsor or community support person(s) ❑ Able to self report relapse ❑ Self-reported abstinence for 30 days ❑ Had clean urinalysis for the past 30 days ❑ Began building a drug-free support network *Program and/or family members have reported that parent:* ❑ Acknowledged the impact substance abuse had on child's well being and the quality of family relations ❑ Improved insight into effects of substance abuse	Parent: ❑ Successfully completed treatment or stepped down to a lower level of treatment ❑ If still in treatment, attendance exceeds 80 %. ❑ Informed worker and or family of aftercare & relapse plans ❑ Regularly attended 12-Step or other community support groups ❑ Has 12-Step sponsor or other community support person(s) ❑ Self-reported abstinence for the past 60 days ❑ Had all clean urinalysis for past 60 days ❑ Involved in drug-free/sober relationships and/or activities as evidenced by…. ❑ Established a drug-free support network (Include: job training, employment readiness, employment, school, YMCA, church, etc) as evidenced by…. ❑ Reciprocated positive support received from non-drug using family and friends have offered ❑ Continued improved insight into effects of substance abuse

Visiting and Parenting Responsibilities		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Unable to be contacted/located ❑ Did not and/or inconsistently visits child (ren) ❑ Did not request visits ❑ Did not reschedule missed visits ❑ Did not attend 0 - 3 Screening ❑ Worker made arrangements to transport parent to visit but parent failed to attend/cancelled ❑ Did not attend well-child appointments or attend parent-teacher conferences ❑ Demonstrated no interest in establishing or resuming parental responsibility	Parent: ❑ Attended the majority of visits with child (ren) ❑ Demonstrated increased parenting responsibility during visits as evidenced by… ❑ Attended some well-child appointments ❑ Attended at least one parent-teacher meeting and/ or school conference ❑ Inconsistently attended visits but has attended coaching/ teaching visits	Parent: ❑ Consistently visited child/ren ❑ Attended initial 0 - 3 Screening ❑ Visited regularly and incorporates opportunities to encourage continued involvement and participation in educational, health and developmental activities for the child (ren) ❑ Requested and actively involved in developing a plan for unsupervised visits. ❑ Able to identify parenting deficits and strengths as evidenced by… ❑ Developed parenting goals that are child specific and measurable.

This page of the form is to be:
- ✓ **Completed prior to the first ACR (6Months)**
- ✓ Included in required *ACR* documentation for review
- ✓ Signed by parent, caseworker, and supervisor before being filed

Six to 9 Months from TC (Complete at end of 9 months)

Please use Notes Section (final page) to document significant events.

Substance Abuse Treatment		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Failed to meet with caseworker Unable to be contacted/located ❑ Continued to use and/or remains in denial of substance abuse/ addiction. ❑ Failed to obtain substance abuse assessment ❑ Participated in substance abuse treatment, but currently not in TX, or left against staff advice (ASA) ❑ Discharged from treatment for non-compliance, aggressive behavior, antisocial behavior and/or numerous unexcused absences ❑ Had less than 50% clean urinalysis results ❑ Substance abuse issues were not identified until the following date: _____________ ❑ Substance Exposed Infant born subsequent to case opening Date:____________	Parent: ❑ Consistently attended substance abuse treatment with few unexcused absences ❑ Self-reported abstinence for the past 60 days ❑ Identified 12-Step sponsor or community support person ❑ Inconsistently attended 12-Step meetings or other community support group ❑ Developed relapse prevention plan, including relapse triggers and discussed them with worker and/or family members ❑ If relapse occurred, parent able to self disclose and reengaged in treatment within one week ❑ Developed and shared relapse prevention plan with 12-Step sponsor and/or other informal support networks ❑ Support system confirmed drug free time ❑ Had all clean urinalysis for past 30 days Program and/or family members have reported that parent: ❑ Engaged in recommended after care services/activities	Parent: ❑ Successfully completed treatment ❑ Self-reported abstinence for the past 90 days ❑ Consistently worked self help program ❑ Attended self-help meetings and maintained regular contact with sponsor or mentor ❑ Accepted into a recovery home, transitional living program or is residing with non-drug using relative or friends. ❑ Involved in drug-free/sober relationships and/or activities ❑ Established a drug-free support network (job readiness training, employment, school, church, etc) ❑ Support network confirmed drug free time as evidenced by…. ❑ Had all clean urinalysis for past 90 days ❑ Reciprocated positive support from non drug using family and friends Program and/or family members have reported that parent: ❑ Demonstrated and understands new coping skills learned in treatment or in 12 step groups
Visiting and Parenting Responsibilities		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Unable to be contacted/located ❑ Unwilling to participate in services ❑ Did not request visits ❑ Unpredictable attendance at visits ❑ Did not reschedule missed visits ❑ Did not attend 0-3 Screening ❑ Worker made arrangements to transport parent to visit but parent failed to attend/cancelled ❑ Did not attend well-child appointments or attend parent-teacher conferences ❑ Demonstrated no interest in establishing or resuming parental responsibility	Parent: ❑ Consistently attended the majority of visits with child/ren and reschedules missed visits ❑ Participated in educational, health and developmental activities for child during visits, evidenced by ❑ Attended the majority of child's scheduled appointments such as: 0-3 screening, pres-school/school activities, medical appointments. ❑ Demonstrated increased parenting responsibility during visits as evidenced by…. ❑ Began to identify parenting deficits and strengths to program staff, worker, and or family	Parent: ❑ Consistently visited child/ren ❑ Used visits to take appropriate actions to enhance care giving skills and promote child's development ❑ Participated in child's educational or developmental program such as: 0-3 screening. school activities, medical appointments. ❑ Regularly attended child's school activities, such as: class plays, sports, teacher conferences. ❑ Actively involved in developing a plan for unsupervised visits ❑ Ready for unsupervised visits as evidenced by….

This page of the form is to be:

✓ **Completed at 9 months from Temporary Custody**

✓ Signed by parent, caseworker, and supervisor before being filed.

Nine to 12 Months from TC

(Complete prior to 2nd ACR, permanency hearing and as long as goal remains return home)

Please use Notes Section (final page) to document significant events/concerns.

Substance Abuse Treatment		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Failed to contact/meet with caseworker ❑ Continued to use and/or remains in denial of substance abuse/ addiction. ❑ Failed to obtain substance abuse assessment ❑ Initially engaged in treatment but prematurely left against staff advice (ASA) ❑ Discharged from treatment for non-compliance, aggressive behavior, and/or numerous unexcused absences ❑ Had less than 50% clean urinalysis results ❑ Substance abuse issues were not identified until the following date: _____________ ❑ Substance Exposed Infant born subsequent to case opening Date:____________	Parent: ❑ Consistently attended substance abuse treatment with few unexcused absences ❑ Self-reported abstinence for the past 90 days ❑ Identified 12-Step sponsor or community support person (s) ❑ Inconsistently attended12-Step or other community support group(s) ❑ Identified relapse triggers and discussed them with worker and/or family members ❑ If relapse occurred, parent able to self disclose and reengaged in treatment within one week of relapse. ❑ Developed/shared a relapse prevention plan with 12-Steps sponsor other informal support networks ❑ Support network confirmed drug free time ❑ Clean urinalysis for past 60 days Program and/or family reports: ❑ Engaged in recommended after care services/activities	Parent: ❑ Successfully completed treatment. ❑ Self-reported abstinence for the past 120 days ❑ Consistently worked 12-Step and community support programs, attended self-help meetings and maintained contact with sponsor ❑ Accepted into a recovery home, transitional living program or is residing with non-drug users ❑ Involved in drug-free/sober relationships and/or activities ❑ Support network confirmed drug free time ❑ Had all clean urinalysis for past 120 days ❑ Established a drug-free support network (Incl. job or employment readiness training, employment, school, YMCA, etc) ❑ Reciprocated positive support received from non drug using family and friends Program and/or family reports: ❑ Demonstrated and understands new coping skills learned in treatment or in 12 step or other self-help groups
Visiting and Parenting Responsibilities		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ❑ Unable to be contacted/located ❑ Unwilling to participate in services ❑ Did not request visits ❑ Unpredictable attendance at visits ❑ Did not reschedule missed visits ❑ Did not attend 0-3 Screening ❑ Did not attend well-child appointments or attend parent-teacher conferences ❑ Demonstrated no interest in establishing or resuming parental responsibility	Parent: ❑ Consistently attends the majority of visits with child (ren) and reschedules missed visits. ❑ Participated in educational, health and developmental activities for the child during visits as evidenced by… ❑ Attended at least 70% of child's scheduled appointments such as: 0-3 screening, pres-school/school activities, medical appointments. ❑ Demonstrated increased parenting responsibility during visits as evidenced by…	Parent: ❑ Consistently visited child/ren ❑ Used visits to take appropriate actions to enhance care giving skills and promote child's development ❑ Regularly attended child's health, educational/developmental activities ❑ Understood the importance of appropriate caregivers ❑ Developed an understanding of safety hazards as evidenced by… ❑ Reads to child/homework ❑ Reinstated roles, rules, & rituals ❑ Actively involved in developing a plan for children return home. ❑ Parent ready for reunification

This page of the form is to be:

- ✓ **Completed prior to 2nd ACR (12 months from Temporary Custody)**
- ✓ **Completed as long as return permanency goal is return home & every 3 months thereafter**

COOK COUNTY PRE-ADOPTIVE INITIATIVE FOR OLDER CAREGIVERS

An officer of the court requested an investigation of a 72-year-old foster parent of a four-year-old pre-schooler. The officer of the court was concerned that the family had not been assessed even after educational reports and school personnel expressed concern regarding the child's behavior and development and the pre-adoptive parent's capability to meet the child's needs.

A review of the family showed that the child was initially placed in care when she was 13-months-old as an emergency placement. The foster parent was 68 years old at the time. Shortly after the child was placed with the foster parent the private child welfare agency decided to seek a pre-adoptive home for the child. Review of the case file showed that the child welfare agency made no efforts to identify a pre-adoptive home for the child. There was no indication that the agency assessed the long-term viability or the support system of the foster parent. In addition, agency staff failed to consider the impact of the caregiver's re-occurring acute health problems, or how these problems compromised the foster parent's ability to care for a young child. On one occasion these health problems extended for over one month's time.

Two years after the child was originally placed with the 68 year-old foster parent, the court terminated parental rights and adoption proceedings with the foster parent began. Although the caregiver identified a back-up caregiver for the child, the person identified changed three or four times over a six-month period. The child's teachers expressed concerns about the caregiver's abilities to meet the child's needs and provide the necessary structure. It was at this point that the officer of the court insisted that a referral be made for a comprehensive assessment of the family that included an assessment of the senior's long-term viability to care for a child.

In spite of all of these outstanding issues, referrals were never made for an assessment of the senior caregiver or for services to support the placement.

As a result of this investigation, the Department of Children and Family Services committed to a more formalized review of pre-adoptive parents and their identified back-up caregivers. In February of 2006, DCFS' Division of Monitoring and Quality Assurance, the Child Protection Division of the Circuit Court of Cook County, and staff of the OIG's Project Initiatives developed and implemented the 60+ Initiative for Cook County. Adoption Liaisons meet with pre-adoptive parents, ages 60 and older, and their back-up caregivers to review the viability of the back-up plan, and clarify the back-up's role to support the children in case the adoptive parent becomes incapacitated or unable to parent. If the Adoption Liaison identifies concerns regarding the living arrangement or the back-up plan the family is referred to the Child Protection Division Mediation Program of the Circuit Court of Cook County or other locally available mediation providers. Mediation provides an alternative forum where family members and other persons involved in the family can convene to resolve issues under the guidance of trained mediators. Mediation creates an opportunity for those individuals to collaborate and consider what course of action is in the best interests of the child and what can be done to expedite true permanency for children in the care of older adults.

OLDER CAREGIVERS HOUSING REPORT

INTRODUCTION

This report examines critical factors that, left unaddressed, threaten the permanency of DCFS involved children in the care of older caregivers.[1] A review of 26 older caregiver families with critical housing issues showed that a shortage of low income housing, the inherent vulnerability of older adults and a significant shortage of services and providers caused older caregivers problems with providing such basic necessities as heat and electricity.

Housing problems have become increasingly challenging for many of DCFS' older caregivers,[2] with the most severe housing problems occurring in the unlicensed home of an older relative who has adopted or become a subsidized guardian. Thirteen percent of DCFS homes in the metropolitan Chicago area cannot meet licensing standards because of problems with the home's physical plant, such as lack of space or too few bedrooms.[3] Sixty percent of older caregivers referred to The Older Caregivers Program received substantially fewer funds than licensed caregivers because their homes did not meet DCFS licensing standards.

The housing issues that affect children and families are primarily the result of poverty. The majority of Chicago's DCFS older caregivers are clustered in 33 of the city's most poverty-stricken neighborhoods.[4] These neighborhoods have the oldest and most poorly maintained housing in Chicago. Inadequate plumbing and faulty electrical services; rotted porches, doors, windows and roofs; and the dilapidated condition of homes often lead to unacceptable safety risks to both the children and the older caregivers.[5] Solutions to older caregivers' poverty issues require specialized knowledge of governmental and private programs external to DCFS, and the ability to collaborate with such programs.

Regardless of whether older caregivers were homeowners or renters, housing conditions impacted these families. Older caregiver renters, who needed larger units to house the children, often had trouble saving for the security deposit and first month's rent, even when the new rent was comparable to what they already paid. Many wanted to move out because of safety issues, bad neighborhoods, and/or lack of upkeep by their landlords. However, they were reluctant to move unless they knew they would be moving into a better school district.

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[1] Older caregivers are age 60 and over who provide care for children in foster care, home of relative care, subsidized adoption and guardianships.

[2] When discussing relative caregivers and caregivers over the age of 60, there are four distinct groups that sometimes overlap: 1) grandparents and other relatives caring for children by independent arrangement; 2) licensed grandparents and other relatives caring for children in the child welfare system; 3) unlicensed grandparents and other relatives caring for children involved in the child welfare system; and 4) licensed non-related caregivers of children in the child welfare system.

[3] In November 2005, OIG staff surveyed agencies for reasons caregivers were not licensed; agency staff cited physical plant problems in 99 of 697 families as the issue for denying the license, 11% of these homes are headed by caregivers age 60 or older, raising 209 wards.

[4] Based on Chicago Department of Planning and Development and Chicago Community Health Profile, Department of Public Health, November 2004 data of the 17 zip codes with the highest concentration of DCFS' older caregivers.

[5] DCFS Procedures 300 Allegation #77 Inadequate Shelter defines lack of shelter as: Lack of shelter which is safe and which protects the child(ren) from the elements. Examples of Inadequate shelter include, but are not limited to: Exposed, frayed wiring; Housing with structural defects which endanger the health or safety of the child; Housing with indoor temperatures consistently below 50 degrees F; Housing with broken windows in sub-zero weather; Housing which is a fire hazard obvious to the reasonable person; and Housing with an unsafe heat source that poses a fire hazard or threat of asphyxiation.

According to the 2000 U.S. Census, 103,717 Illinois grandparents are raising 213,465 grandchildren under the age of 18. The average age of these grandparents was 46, with 39% (41,480) age 60 or older. As of August 2005, 5,097 older relatives or foster parents were raising 10,386 of DCFS' children in foster homes or with subsidized adoption or guardianship funds. The average age of DCFS' older caregivers is 66, 20 years older than the general population of Illinois grandparents raising grandchildren. According to DCFS' data, children placed in homes of older caregivers had more stable placements and averaged the longest number of days in the same placement.

TABLE ONE: CAREGIVER AGE AS FACTOR IN LENGTH OF PLACEMENT

Type of Placement	Average Number of Days in Placement	
	Caregiver Under 60	Caregiver 60 and Over
All Children in Foster and Relative Care	471 Days	687 Days
Children in Foster Care	454 Days	569 Days
Home of Relative	463 Days	832 Days

Background on the Older Caregivers' Program and Housing Assistance

In July 2000, the Older Caregivers Program (OCP) began as a Chicago pilot project to support older caregivers and DCFS children placed in their homes. The pilot included families referred by DCFS extended family agencies. Initially, the program had a capacity for 40 families and covered designated Chicago south side communities. At the completion of the pilot evaluation in 2003, the program increased to a capacity of 70 families.[6] Since 2000, the project has served 159 families. The majority of the caregivers referred owned homes, similar to the 75% of Illinois households with the heads of household 65 years or older.[7] Close to 25% (40 families) of the referred families received housing assistance because of rundown housing, escalating utility bills, and an inability to make necessary home repairs.

The Department contracts with a private child welfare agency to administer the Older Caregiver Program. The private agency provides staff with expertise in geriatrics, child welfare, and housing to assist the public and private child welfare agencies that refer the families.[8] Services provided include: home-based assessments of caregivers and children, linkages with resources, family conference mediation, assistance to child welfare workers and families to develop reliable back-up plans, financial guidance and housing consultation. The overall goal of the program is to establish a strong internal (extended family) and external (state and community) support system for resources that will help the caregiver continue to care for the children. In situations where it is not possible for the children to remain in the home, the program assists the extended family to make new and more appropriate arrangements that ensure the safety, well-being and permanency of the children.

The Older Caregivers Program identified that older caregiver families are increasingly challenged by housing problems ranging from repair needs or utility payment debts to substandard environmental conditions that put children at risk. This report includes data collected from FY 2002 through FY 2005 on 26 older caregiver families who had critical housing issues that threatened removal of the children.[9]

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[6] 45 families capacity in FY 2003; 60 families capacity in FY 2004. In FY 2006 the Older Caregivers Program expanded to cover the entire city of Chicago.

[7] US Census data 2000.

[8] The Chicago Department on Aging tightly collaborates with the private agency that contracts with the Department to oversee the Older Caregivers Program.

[9] Some families received referrals because of housing problems. In many cases, however, the Older Caregiver Program staff discovered housing problems during their assessments. In 2005 only one case was referred for housing issues, and yet nine families were assessed to have housing problems and subsequently received services.

The average age of the licensed caregiver needing housing services was 69 while the average age of the unlicensed caregiver requiring assistance was 75. Most of the families required long-term supportive services. Fifteen of the 26 families' cases were closed, with an average of 17 months of services.[10] Eleven of the 26 families continue to receive services.

Licensed Foster and Adoptive Caregivers with Housing Problems

The Older Caregivers Program provided seven licensed families, caring for 26 children, with housing assistance. The average age of the licensed caregiver was 69. One home with six children had severe housing issues including: plumbing problems, structurally unsound roof over the front porch, exposed ceiling slats, and a broken door lock. In addition, the older caregiver had multiple bankruptcies, the home was in foreclosure, and a gas bill of $7,122 was overdue. Another home had no heat, with a past due gas bill of $1,519, while another home had no working refrigerator for six months. A 69-year-old licensed adoptive parent, caring for five children under the age of nine, could not receive subsidized services because she had previously received assistance from the city-funded program.

Unlicensed Home of Relatives with Housing Problems

Unlicensed homes of relatives represented 60% of the project's families with housing problems. Seven families were unlicensed foster parents who cared for 23 children in foster care, of whom 11 were adopted or under subsidized guardianship. The average age of the unlicensed relative was 75. The unlicensed families received a lower subsidy than licensed families. Typically, the unlicensed relatives lived on fixed incomes, limiting the monetary resources needed to maintain a safe home or deal with emergency housing expenses. Many of the older relatives struggled to provide for the immediate needs of the children. Utility bills went unpaid, home repairs were deferred, and at times the caregiver deprived himself or herself of necessary medication. The relatives had little access to respite care for the children.

While the majority of the homes had heating problems and crowded living conditions, one home posed severe health and safety risks. Three of the seven homes had no heat, a fourth home needed a new furnace. Similar to the licensed families who had heating problems, the unlicensed families' heating debts exceeded the suggested Norman funds limit. One family owed $4,800 for gas and utilities.

Most distressing of the unlicensed foster families served, were the housing situations of 11 older unlicensed caregivers (10 families) that were receiving adoption or guardianship subsidies for 41 children. Three of these families had no heat or electricity because they could not pay for their utilities. One adoptive family had expenses beyond their means while trying to care for two children with special needs. Other problems for the families included structural damage to the home, plumbing problems, rodent and insect infestations and physical disabilities of the older caregiver.

Case Study – An Unlicensed Relative Older Caregiver Homeowner

A seventy-one year old African American grandmother bought her 115-year-old home seven years prior to her referral to the OCP. Before purchasing her home, she lived in CHA housing. At the time of the referral, her two related foster children, ages 11 and 13, her adult daughter, and her daughter's four children, ages 4 through 12, lived with her in the home. Board payments for the two foster children combined with the grandmother's social security benefits provided a total monthly household income of $1,374. The adult daughter had a criminal record for drug possession that hindered her attempts to find employment. After a monthly mortgage payment of $571, the grandmother had $805 to cover all other expenses.

The private agency caseworker expressed concerns with the condition of the house. A home visit by private agency staff revealed a gas burner on the kitchen stove that the family had been unable to turn off

[10] This data is as of September 2005.

for several weeks, peeling lead paint on the front porch and exterior window trim, evidence of electrical wiring problems in the basement, roof leaks over a bedroom and a bathroom, a plumbing fixture leak, a clogged drain accompanied by an overflowing sink, basement stairs in hazardous condition, and locks in need of replacement. The adult daughter swept up piles of garbage in the attic, which served as a bedroom for she and her children. Staff observed a build up of grease on the stove that posed a potential fire hazard and a draw for insects. Cockroaches were visible on the walls in the dining room and the countertops in the kitchen. Rats invaded the home, leaving mounds of dirt in the basement where they tunneled. During the course of involvement with this family, private agency staff discovered that the client's gas had been turned off for 18 months and the family relied on space heaters.

The private agency replaced the faulty stove and paid for extermination services, while the program's senior and child specialists educated the family about the importance of good housekeeping. After several months, the private agency's housing specialist obtained services from Housing Opportunities and Maintenance for the Elderly (H.O.M.E.) to seal up the rat holes in the basement with concrete.[11] The housing specialist referred the family to Home Repairs for Accessible and Independent Living (H-RAIL), which replaced three windows and an exterior door. The client's daughter attended a free three-hour class at the Department of Public Health on how to safely remove peeling lead paint. Although the Older Caregivers Program alleviated some of the housing problems, because of the paucity of community resources and/or long waiting lists more repairs and safety improvements could not be offered.

Extended Family Support Service Referrals with Housing Problems

In addition to DCFS licensed and unlicensed families, the project provided housing assistance to three families with 11 children referred by Extended Family Support Services, a DCFS-funded deflection program. One of the homes was a private adoption home. Another was the home of an 85-year-old unlicensed relative of a teen mother, who had private guardianship of five other children. The average age of the caregivers referred through Extended Family Services was 75.

One case required services for 48 months because of persistent housing problems that proved to be not resolvable. In this case, the 70-year-old unlicensed relative completed adoption of a seven-year-old girl in 2005,[12] despite the extremely poor condition of the home.

The Housing Shortage in Chicago

Chicago low-income homeowners[13] and renters face a myriad of challenges. There is currently a housing shortage for low-income families, which is magnified for elderly persons with children. According to the 2000 U.S. Census, 46,000 rental units in Chicago were lost, while the population increased by over half a million. Of 52,042 new housing units built in the same period, over half were in eight of the city's 77 community areas, seven of which were described as either "booming" or "converting" by the Chicago Rehab Network.

Further straining the affordable rental housing market in Chicago is the Chicago Housing Authority's (CHA) efforts to transform its 40,000 public housing units.[14] In 2005, CHA planned to demolish 7,738 housing units. Tenants in effected buildings would be temporarily relocated either to other public housing projects, or to the private market with Section 8 rent subsidy vouchers. When the CHA initiative concludes in 2009, 25,000 units will either have been newly built or rehabbed. Sixty one hundred of

[11] H.O.M.E., a city-funded program administered by a separate private agency, typically performed minor repairs such as sealing and unclogging plumbing, repairing stairs, and replacing locks. Because of the high demand for their services among seniors, they only provide one or two services to each client.
[12] The relative adopted the child's four older siblings in 1997.
[13] In the 1990s, the number of foreclosures rose by 74%.
[14] Chicago Housing Authority FY 2005 Annual Plan for Transformation, Year 6.

these units will be in new mixed-income developments; 9,500 will be reserved for senior citizens without children; and 9,400 will remain as CHA units for low-income families. This 10-year plan essentially froze non-CHA low-income families out of the Section 8 program, since CHA used the housing vouchers for relocation of existing tenants.[15] The insufficient number of reasonably priced, large, three-or-more-bedroom units continued to be a problem, as the public housing system relied heavily on the Section 8 voucher program. The waiting list for a Section 8 voucher in Chicago is 14 years.[16] For many older caregivers, moving to a distant community out of the city, where Section 8 housing may be available, is not a solution.

For those who had Section 8 vouchers in Chicago, the process of registering, finding an apartment or a house, and keeping the agency informed of changes in income or household composition proved to be an arduous process, burdened with paperwork, numerous trips to CHA headquarters, and long waits. Getting questions answered or problems resolved took months.[17]

Chicago's future housing plans will not remedy the housing gap for the low-income older caregiver families. According to the Chicago Rehab Network's analysis of the Chicago Department of Housing's 2004-2008 Affordable Housing Plan, the city shifted its goals, dropping the number of multi-family units it intends to produce while increasing the number of new single-family homes. It is anticipated that more new homeowner units will be targeted to families with incomes over 80% of the area's median income (AMI), while fewer apartment units will be constructed for the poorest renters, who earn less than 30% of the AMI.

Age and Condition of Chicago Housing

Fifty-nine percent of Chicago's housing was built before 1950, almost three times higher than the national average.[18] In low-income areas with older housing stock, the inability of homeowners, or the unwillingness of landlords to pay for housing repairs, even basic maintenance, led to building deterioration and unhealthy conditions for children. For example, plumbing, roofing, and foundation leaks that went untreated for years caused the growth of mold and fed insect and rodent infestations. These conditions contributed to increased asthma attacks, rodent and insect bites, and exposure to pesticides. Two key risk factors linked to lead poisoning in children are living in older housing and living in a low-income household.[19] Chicago led the nation with 12,000 lead-poisoned children.[20] The costs of eliminating lead poisoning hazards are substantial. The Chicago Department of Public Health estimated the cost of mitigation and abatement of lead paint per housing unit to range from $3,000 - $10,000.

Other home repairs are much less costly, but equally important. Generally, re-roofing a house costs between $8,000 and 12,000; plumbers charge from $60 to $75 per hour; fixing a leaking toilet cost $100 to several hundred dollars and replacing leaking pipes cost $500 or higher. Often with plumbing jobs, carpenters need to do preparatory or finish work. Many older caregivers deferred plumbing repairs because they could not afford them. A 70-year-old unlicensed adoptive parent cared for eight children

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[15] Chicago Housing Authority FY 2005 Annual Plan for Transformation, Year 6.

[16] According to a recent Associated Press article ("Lack of affordable housing in Chicago scatters residents to neighboring cities, state" August 13, 2005), many low-income residents are leaving Chicago and moving to central Illinois or Indiana where they can still obtain Section 8 voucher.

[17] These barriers compound the already time-consuming and expensive process of finding and securing a rental unit in Chicago (See "Searching for Rental Housing with Section 8 in the Chicago Region, Popkin and Cunningham, The Urban Institute, February 2000).

[18] Nationally, 23% of housing stock was built prior to 1950.

[19] Briefing Paper, Lead Safe Chicago, Chicago Dept. of Public Health and Loyola University Chicago Child Law Center, March 2003.

[20] Lead Safe Chicago: A Plan to Eliminate Childhood Lead Poisoning in Chicago by 2010, Chicago Department of Public Health & Loyola University Chicago Civitas Child Law Center.

from four to 17. A toilet in an upstairs bathroom had a loose seal for many years. The slow leak from the base of the toilet seeped under the linoleum floor for so long that the floor joists rotted below the toilet. The plumber refused to replace the toilet until a carpenter repaired the floor structure. In another case a 73-year-old unlicensed relative caregiver of two foster children, had a host of housing issues related to years of deferred maintenance that included non-functional outlets, deteriorated wooden porches, peeling paint, cockroach and rat infestation, dampness in the basement, leaking plumbing fixtures, missing gutters, and water-damaged walls.

Vulnerability of Older Caregivers

Older caregivers share a number of characteristics that put them at higher risk than the general population of homeowners and renters. They often live in extreme poverty, are particularly susceptible to scams and exploitation, have little knowledge or ability to do home maintenance, have difficulty with health and mobility, can be resistant to change, and may be living in isolation. The variety of housing problems experienced by these caregivers was complicated by their over extended financial obligations for basic necessities. In some cases subsidies were stretched to cover the needs of non-departmental children, or they were used to cover the continuing expenses of children who aged out of the system and no longer received subsidies. In one case, an older caregiver financially supported an adult mother along with her children.

Poverty

According to the 2000 US Census, 17.4% of grandparent caregivers spent 50% or more of their income on rent. Families who received the unlicensed home of relative board payments had a greater financial disadvantage because their payments were lower than those of licensed foster parents. Thirty-three percent of the project's caregivers owed substantial amounts on utility bills. The projected utility and heating costs for the 2005-2006 winter increased 50-70% based on an increase in energy costs.[21]

Scams and Exploitation

Exploitation of Illinois seniors has become a growing problem and increased by 84% since 1993, when elder abuse reporting began. Of all forms of abuse, financial exploitation occurred the most, and accounted for 34% of all reported abuse.[22] In addition, the abuse of seniors and custodial grandparents by their minor children and grandchildren was a growing phenomenon, both in Illinois and throughout the U.S.[23]

Many older caregiver homeowners purchased their homes after years spent living in apartments, and did not have experience tending to a house. Some of the caregivers' lacked knowledge or their physical condition prevented them from performing necessary routine maintenance such as cleaning out gutters and repainting deteriorating porches. Further, these caregivers could not afford to pay for these services. Others, on fixed incomes, were reluctant to make routine home repairs, which set the stage for small problems becoming larger problems that required expensive repairs. Those who could not afford home insurance would be in a precarious position, should a fire or other major accident occur.

Elderly clients may overpay for a repair that was poorly executed, or pay in full for a repair the professional never completed. Seniors may be unable to check on repairs upon completion when they had little knowledge as to how much was completed and if the bill properly reflected the amount of work done. Physical ailments prevented seniors from going down stairs into a basement or up to a roof to monitor the work. Seniors trusted workers to fix problems at the proper cost. Elderly clients may overlook having critical repairs done before purchasing a home or moving into a rental unit. One

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[21] Associated Press Chicago Tribune, October 12, 2005.

[22] Belleville News-Democrat, September 12, 2005

[23] The Elder Abuse of Custodial Grandparents: A Hidden Phenomenon; Kosberg &MacNeil, Haworth Press, 2003

caregiver had a concrete front porch with one step in the middle twice as high as the others. The homeowner reported that she bought the house in this condition and did not request that it be repaired before signing a contract. Subsequently, the older caregiver has had difficulty obtaining homeowner's insurance.

Health and Mobility
Limiting health factors that are normative processes of older age, increasingly challenge older adults. Problems such as depression, diabetes, hypertension, heart disease, and cognitive impairments were common among older caregivers. Older caregivers may be unable to attend to their own healthcare needs because of a lack of childcare, respite care, or adequate health insurance.[24] One caregiver wanted to move because her obesity made it difficult for her to navigate the stairs to her second floor apartment. Two other seniors, one with asthma and the other with arthritis, lived in third floor apartments and needed assistance going up and down stairs. Workers and agencies should be educated about medical and cognitive conditions in the aging population and how they may impact long-term caregiving ability.

Isolation
Many caregivers lost contact with friends, neighborhood businesses, churches, or other sources of information and support, because of their physical limitations, lack of transportation, or lack of time and energy. As caregivers of children, they may be further distanced from their established support network, as their responsibilities and attentions do not match or align with those of other seniors who are no longer providing daily care for children. The tendency of older caregivers to isolate themselves can be moderated in ways that assure the safety and stability of otherwise loving and close-knit families.

Resistance to change/Lack of assertiveness
Older adults may be less flexible in undertaking changes in their living environments or communities. Sometimes, seniors live in risky situations from which they may wish to move because of gangs, neighborhood violence, frequent burglaries, and drug activity. Seniors may be living in crowded conditions, as they did not plan to still be raising children. Older caregivers may adapt to overcrowding by giving up their bedroom for the children to sleep there, sleeping with their children, or having children sleep on living room sofas, futons, or floors. Despite these negative factors, older caregivers were reluctant to relocate because of long-term ties to their neighborhood. Many older caregivers ultimately chose to stay where they were despite less then ideal conditions.

Older caregivers may be more hesitant to confront or report an uncooperative caseworker or a service provider who did not keep an appointment or did not return their calls than a younger person. Additionally, they may be less likely to pursue scarce services and resources to alleviate housing problems.

Emotional/Behavioral costs
A growing body of research indicates that poor housing had an emotional and behavioral effect on children. A recent study conducted on 95 public school children aged 9 -12 in Victoria and Québec City found that the general interior condition of a child's residence and the general physical condition of their neighborhood impacted the number of behavioral problems reported by the child's teacher and parent.[25] The author assessed over 300 physical features of the residence (including exposed wiring, clutter, damaged walls or floors, and the frequency with which the sink drains clogged or furnace problems

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[24] Grandparents and Other Relatives Raising Children: The Second Intergenerational Action Agenda. Generations United January 2005.
[25] Housing Quality and Children's Socio-emotional Health, February 2003, Robert Gifford, Canadian Mortgage and Housing Corporation

occurred) and the neighborhood. The more physical problems noted in these residences and neighborhoods, the more behavioral problems reported by the children who lived in them.

A similar study in the U.S. found that third through fifth-grade children residing in poorer quality housing had more psychological symptoms and less task persistence than their counterparts who lived in better quality housing.[26]

Shortage of Repair Programs and Lack of Responsiveness of Providers

The shrinking federal, state, and local social welfare budgets have impacted the low-income housing repair programs in Chicago. The Chicago Department of Housing funds two major repair programs.

Emergency Housing Assistance Program (EHAP)
EHAP provides emergency repairs for low-income households including roof, porch, and furnace repairs or replacements. As heat is an absolute necessity, any family who has a failed furnace during the heating season will receive service from EHAP. Roof and porch repairs are limited to approximately 700 per year on a first come first served basis. The list opens January 1 of each year and is generally full by January 10.

Home Repairs for Accessible and Independent Living (H-RAIL)
H-RAIL makes home improvements for low-income individuals 60 years and older to help seniors stay in their own homes. Such improvements are generally limited to the interior of the house and consist of window, door, and lock replacement, installation of grab bars in bathrooms, and minor repairs to ceilings, floors and walls. The city assigns H-RAIL funds to 24 delegate agencies throughout Chicago, some of which also provide handicapped ramps for seniors. The senior is responsible for contacting agencies and getting onto waiting lists, a task which may be difficult for seniors.

The Chicago Department on Aging and The Chicago Department of Public Health also provide funding to two private agencies that administer a minor repairs program for seniors including a lead paint mitigation program through Neighborhood Housing Association, and a home repair loan program (Home Repair Referral Service) for low-income families. Seniors in the Older Caregivers Program have had consistent difficulty obtaining services from these privatized programs, even with assistance from the OCP housing or financial specialists.

Lack of funding for electrical and plumbing work
The OCP could not locate any low-income programs for electrical or plumbing work, beyond minor repairs. Most of the older homes had electrical problems because the original wiring became brittle and the level of power/amperage proved to be inadequate. Flickering lights, fuses that often blew and use of extension cords posed potential safety and fire hazards. To upgrade the electrical service to 200 amps, rewire and replace faulty outlets had an estimated cost of $2,500 - $3,000 per house.

Case Examples
An older caregiver owned a 110-year-old home that had deteriorated electrical wiring, and many of the outlets in the house did not work causing the family to rely on extension cords. Exposed wiring in the basement posed a shock hazard and eventually caused sparking at the panel board. All the outlets in the living room failed. The older caregiver could not obtain a loan for repairs because of her poor financial history. The local electrical union donated $1,750 and found an excellent local electrical company to do the work. Contributions from a private agency and the Chicago Department on Aging (CDoA) covered the $2,500 electrical bill.

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[26] Housing Quality and Children's Socio-emotional Health, Evans, Saltzman, Cooperman, Environment and Behavior, Vol. 33, No.3, 389-399, 2001

A 63-year-old unlicensed foster parent of five children aged two to nine, had a house fire because of a wire overheating inside a wall in her bedroom. She was the only one home at the time of the fire and escaped without injury. Her insurance policy (activated only 11 months prior, through the aid of the OCP financial consultant) paid for repairs to the entire house.

ANALYSIS

Caseworkers must never lose track of the primary question of child safety; if housing issues threaten child safety, the hotline must be called. Workers also need to develop a long-term assessment of the future capability of the caregiver to sustain improved living conditions, independent of child welfare assistance.

Families who have received housing assistance through the Older Caregivers Program were often initially referred for assistance with other needs. Patterns evident in the 26 cases reviewed included serious housekeeping problems, which caused insect and rodent infestations, electrical and plumbing problems, and consistent heating problems. Several families had no heat, outstanding heating bills, and significant damage to the infrastructure of the home, leading to poor insulation. Older caregiver families with housing concerns tended to have complex problems that required intensive case management and internal and external supports. Some families did not have adequate food because of insufficient financial resources to purchase food or to refrigerate food. Clearly, heat and food are basic necessities in appropriately caring for a family, particularly small children. Problems of this magnitude, developed over a considerable period of time proved challenging to the Older Caregivers Program.

In general, it appeared that the homes of unlicensed older caregivers who had adopted or received guardianship of relative children were the most poverty stricken and overwhelmed. They were older, cared for more children, and (some) took on more responsibility than they could bear. This added responsibility led to significant financial strains, which ultimately had a severe impact on all levels of living conditions, and eventually had a detrimental impact on the health and safety of the children and the older caregivers. Because of the vulnerability of the highest risk families in this population, optimism for the continuing abilities to provide for themselves without continued intervention should be guarded.

RECOMMENDATIONS

1. The current contract amount of $3,000 allocated in 2000 for client assistance (40 cases) should be increased exponentially to meet the current program needs (75 cases).

2. The Program Plan for the Older Caregivers Program should be amended to allow for flexibility in service provision. Presently, the Older Caregivers Program model provides an initial assessment, provision of specialized elder support services, and family mediation. In addition to this full array of services for the 75 families, this program should be expanded to provide limited services to additional families on a fee-for-service basis. For example, court personnel may request gerontology exams or housing consultations. Or, a caseworker may have determined that assistance is required for physical repairs on a home but is unaware of how to access these resources. In such cases where the Older Caregiver team discovers the need for comprehensive assessment and services the case can be moved over to the grant based project for full assessment and services.

3. Problematic cases with elderly caretakers should be referred for a Child and Youth Investment Team (CAYIT) staffing to determine if the case should be referred to the Older Caregivers Program for either a full assessment or provision of limited services tailored to the family's needs. In conjunction with the Department's Training and Development staff, the OIG will deliver the *Kids and Older Caregivers* training for CAYIT personnel.

4. The OIG will provide training to Cook County court personnel and HELP Unit staff about the Older Caregivers Program.

APPENDIX 1

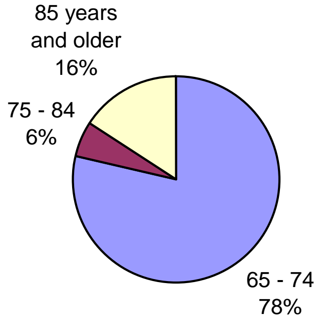
Poverty Rates for Corresponding Neighborhoods with Older Caregivers Age 60 and Older August 2005

Number of Caregivers 60+	Area by Zip Code	Area by Neighborhoods	% of Persons Below Poverty
50-99	60609	New City	34.5%
		Fuller Park	34.3%
	60612	Near West Side	34.8%
	60621	Englewood	43.1%
	60623	North Lawndale	44.3%
		South Lawndale	23.1%
	60629	West Lawn	7.3%
		Chicago Lawn	19.8%
	60637	Greater Grand Crossing	28.5%
		Woodlawn	38.1%
		Washington Park	51.6%
	60639	Belmont Cragin	11%
		Hermosa	16.6%
	60649	South Shore	26.7%
100-199	60617	South Deering	19.5%
		Avalon Park	8.4%
		East Side	12.4%
		South Chicago	29.5%
		Calumet Heights	11.9%
	60619	Chatham	17.6%
		Burnside	28.8%
	60624	East Garfield Park	34.4%
		West Garfield Park	35.5%
	60636	West Englewood	6.1%
	60643	Washington Heights	12.6%
		Morgan Park	11.2%
	60644	Austin	23.7%
	60651	Humboldt Park	30.9%
200 or more	60620	Auburn Gresham	20.6%
	60628	Roseland	17.3%
		Pullman	22.3%
		West Pullman	22.0%
		Riverdale	56.3%
		AVERAGE POVERTY RATE IN 33 COMMUNITY AREAS:	**24.1%**
		AVERAGE POVERTY RATE IN THE CITY OF CHICAGO:	**19.6%**

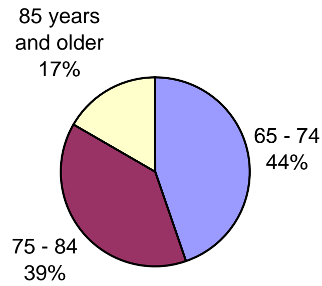
DCFS data on number of caregivers by zip code as of August 2005.
Poverty statistics are from Chicago Community Health Profile, Chicago Dept. of Public Health, November 2004, and Department of Planning and Development Community Area Map and Demographic data, and are based on 2000 Census results.

APPENDIX 2
2000 US Census Statistics for Illinois residents ages 65 and older

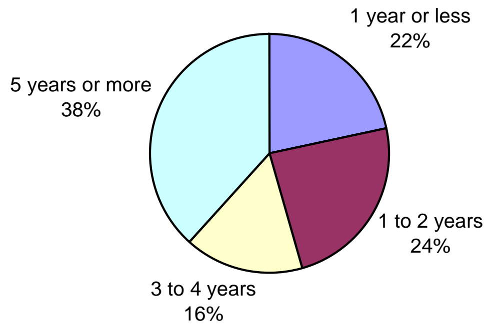
Owner-Occupied Housing for Illinois residents ages 65 and older-
24.2% (745,993) of total owner-occupied homes in Illinois



Renter-Occupied Housing for Illinois residents ages 65 and older-
14.1% (212,062) of total renter-occupied homes in Illinois



A total of 103,717 grandparents are responsible for raising 213,465 grandchildren.
Percentages of Grandparents Raising Grandchildren by Number of Years in Care



SYSTEMIC RECOMMENDATIONS

OIG investigative reports include both systemic and case specific recommendations. The systemic reform recommendations for Fiscal Year 2006 have been categorized below to allow for analysis of the recommendations according to the function that the recommendation is designed to strengthen within the child welfare system. 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
- CHILD PROTECTION INVESTIGATIONS
- CONTRACTS
- DEPENDENCY
- ETHICS
- LICENSING
- PERSONNEL PRACTICES
- SERVICES

ADOPTION

The Specific Consent Unit should have a system for verification of notice that includes a date that the parent's attorney has been contacted prior to taking specific consent.

An OIG investigation revealed that an adoption subsidy was approved on the third attempt without adequate investigation or resolution of the concerns that had caused the case to have been turned down on two previous occasions. The OIG recommended that DCFS revise its practices to require that a case conference be conducted when a case has been reviewed by an Adoption Liaison and not approved twice.

CHILD PROTECTION INVESTIGATIONS

Access to Information

Subpoena Use

The Department should ensure that subpoena training, as well as training on accessing confidential medical and other information, is included in CORE Child Protection training. Until such training can be implemented, Regional Attorneys should conduct trainings throughout the state to increase understanding of the Department's ability to access such information, as well as the mechanics of issuing subpoenas.

The subpoena procedures should be amended to provide for obtaining subpoenas whenever parents refuse "or fail to immediately provide" consents.

Medical Information

An Information Transmittal should be issued so that whenever Child Protection Supervisors are faced with an inability to access needed information, they notify their Field Service Manager. The Field Service Manager would contact hospital administrators or others to obtain the information as the law permits.

Criminal History

The Department should implement procedures for accessing underlying arrest reports to comply with its Administrative Procedure. The Department should utilize the Law Enforcement Liaison in the Office of the Director when implementing these procedures.

During the course of an abuse or neglect investigation, the Division of Child Protection Service Workers should be required to contact the Department of Corrections and the Department of Probation when anyone within the Division of Child Protection discovers the alleged perpetrator, paramour or caregiver of the child is on probation or parole.

Children's Advocacy Centers

The Department should request that the Children's Advocacy Centers (CAC) in Illinois employ an intake process that allows for more detail of relevant information. Comprehensive intake forms would: enable investigators to contact referral sources and persons completing the intake form for clarification of information as needed; provide physicians with important data about past physical examinations and improve their ability to determine the necessity for further evaluations; eliminate stress to the child, minimize repeated examinations, and facilitate follow-up. Children's Advocacy Centers' intake should include but not be limited to:

- Known history of victim sensitive interviews and results from medical evaluations, DCFS and law enforcement involvement
- Court involvement:
  - Juvenile Court (delinquency; abuse and neglect)
  - Domestic Court (divorce; child custody)
  - Probate Court (third party custody of child)
- Name of referral source
- Basis for referral
- Description of allegation
- Name of the person completing the intake

Children with increased vulnerability, either because of age or developmental disabilities, who present with a medical condition that could be the result of sexual exploitation, should be referred to the local CAC for a victim sensitive interview to assist in determining if the medical condition is the result of abuse.

Fathers

When the Department implements its review of safety plans, the Department should insure that identified fathers be explored as potential placements. If the safety plan is likely to last longer than six months, the Department should facilitate a legal relationship between the child(ren) and extended family/caretakers.

General

The Deputy Director of Child Protection should develop with staff a list of prompting questions that must be used when supervising all investigations in which a physical injury is alleged. Department Procedure 300 should require use of this list and documentation of its use should be included in the investigative record. Questions should include, but not be limited to:

- Have there been a series of injuries to child(ren) in the home in the last 6 months?
- Have there been any changes in household composition or caretaking that correspond with the onset of injury?
- If parents are separated or divorced, have both parents been contacted for information and/or placement?
- Has there been a delay in seeking care for any of the injuries?
- Were there any witnesses to the injury, if so, what did the witnesses report?

- Is the explanation for the injury consistent with the injury? Whose opinion is it and what facts were shared?
- Were conflicting explanations given for the injury? What were they and by whom?
- Are the injuries occurring only in one setting (e.g., home v. school or daycare)?
- Are the injuries occurring only with one particular caretaker?
- Have the factors allegedly causing the injuries occurred across settings?
- Was there corroboration for the explanations given for the injuries? What was it?

Department Procedures should be amended to include a provision that the decision to indicate or unfound an investigation should not be based on whether an outside professional took protective custody.

Medical Opinions
The DCFS Medical Director should consult with local experts on child abuse about the prompting questions developed for what, when, and how information is shared when seeking an opinion from a doctor about physical injuries. Procedure 300 should be updated to include this.

Referrals to the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) for second opinions on serious injuries should include body charts for non-verbal siblings of the victim.

Paramours
The Department's Procedural Guideline for Investigation of Paramour Involved Families ("Paramour Policy") should be amended to include a determination of whether the paramour has any children who are not living in the household and specifics about where and with whom they reside.

Religious Establishments
When developing its protocol for abuse and neglect investigations in religious facilities the Department should develop a general protocol for ascertaining superiors and administrators for official notification. An appointed designee of DCFS Legal or the State Central Register should facilitate notification to the proper religious administrative superiors.

Risk Assessment
Provide training and written guidelines for mitigation and development of safety plans, including specific components that should be in place for specific safety concerns, such as violence and physical abuse; the training and guidelines should address the need to consider inclusion of extended family or protective daycare as partners in implementing the safety plan.

Workers should receive more guidance on how to determine whether the risk is "urgent" or "immediate" once a risk is identified.

A third box should be added to each safety factor listed on the risk assessment form acknowledging that information for any factor may be "unknown" or "uncertain," and add a section at the conclusion of the factors list for identifying information that needs to be gathered in the future to further assess safety.

Develop a form that would allow a supervisor to determine the source of information in a safety assessment that formed the basis of the decision, thereby providing a check that available objective sources (such as the Hotline Report, prior child protection investigations, police reports and interviews with police, and criminal history information) were reviewed as required by Administrative Procedure 6.

The procedures for completing the Child Endangerment Risk Assessment Protocol (CERAP) and the decision tree assessment form used by Department staff to assess mentally ill parents should be amended.

Written guidelines should include the need to assess risk to the child when a parent incorporates the child into their delusional system, even in the absence of overt negative statements.

State Central Register
The State Central Register (SCR) manager should provide training to SCR call takers that risk of harm allegations should be added to the initial hotline allegations when behaviors associated with substance misuse compromise parent reasoning and judgment.

Statewide Automated Child Welfare Information System (SACWIS)
The Inspector General previously recommended that the SACWIS program be adjusted to enable child protection managers and administrators to access investigators' rationales for requested waivers on a "read only" basis after investigations are closed.

A modification of the SACWIS system should be made so that the system has the necessary data to be capable of (1) identifying foster parents when their name is entered into the 'Person Search' option and (2) notifying a foster care licensing agency when the State Central Register receives a report on a foster parent or foster home. Modification of the SACWIS system should also include identification of private agency employees.

Training
The body chart used in DCP investigations should be corrected to reflect current research on the dating of children's bruises. This information must be conveyed via training, including supervisor training.

All child protection investigators, supervisors, and managers should be trained on (1) incorporating physical injury prompting questions developed from OIG investigations; and (2) presenting physical injury cases to medical professionals for opinions.

SACWIS training for DCP investigators should emphasize the use of SACWIS databases to search for historical family information.

Division of Child Protection training should include the caveat that different states have different laws governing who may take protective custody.

CONTRACTS
An OIG investigation revealed that the Department had paid $50,000 per year for the services of a single part-time, unskilled worker who kept scant records and no time sheets. The Department paid the contractor several thousand dollars for "start-up" costs, without ensuring that the individual could or would repay the advanced funds. The OIG recommended that the Department immediately ensure that no further advance payments were issued without procurement of a surety bond and without signed verification that the expected billings and proposed budget would support timely repayment of the advance.

The Department must separately track all advance payments to contractors and ensure they are repaid in a timely manner.

The Department should review all Visitation Center Contracts and differentiate rates for Visitation Supervision, Visitation Supervision at the Visitation Center, and transportation.

The Deputy Director of Budget and Finance should send a reminder to all Contract Liaisons that it is a conflict of interest for a family member to be employed by a contractor that the liaison has worked with

or will work with in the future. All such conflicts must be disclosed to the Contract Liaison's supervisor and on Statements of Economic Interest.

DEPENDENCY

DCFS Clinical in the Southern Region should provide training and consultation for supervisors in the Southern Region about risk assessment and decision-making when screening cases of severe mental illness.

Although the Juvenile Court Act allows for a petition to be filed for a dependent minor, such filings are rare. The Department should explore the State's Attorney's willingness to assist the Department in developing a taped training discussion on how the Department can prepare cases for protective orders or screening in circumstances of dependency.

The procedures for completing the CERAP should be amended so that the guidelines for the factors regarding a household member's developmental disability or mental illness direct a worker to consider pursuing a dependency petition.

ETHICS

The OIG recommends that the Department establish procedures for building walls between private agencies and DCFS Administrators who have decision-making power over agencies for which they previously worked. The OIG also recommends that the Conflict of Interest Committee establish these procedures.

The Department should develop a policy concerning soliciting clients for legislative activity.

LICENSING

The Department should amend Rule and Procedure 402 to require that licensing staff develop a water safety plan with the foster parents in any home in which there is a pool, hot tub, or whose property has or abuts a lake, stream or other body of water. The licensing worker should be required to annually review the safety plan with the foster parent(s) and assess the safety measures (i.e., test pool alarms, check locks, etc.) in place. The safety plan should be maintained as part of the licensing file.

The Department should amend Procedure 402 to require that licensing workers document, as part of each monitoring visit, the ages of all children under 18 years old residing in a licensed foster home, their special needs, and an assessment of the foster family's capability to meet those needs. The licensing supervisor should annually sign-off approval of the determined appropriate capacity, ensuring it is in accordance with 402.12(d) and 402.15. The determined appropriate license capacity and the worker's assessment of the foster family should be placed in the licensing file.

The Department should immediately issue a policy clarification regarding Rule 402.15, the number and ages of children permitted to reside in licensed foster homes. The clarification memo should emphasize that all children receiving full time care in the home - birth, adopted, foster and otherwise - are to be included in the total.

PERSONNEL PRACTICES

In 2004, a DCFS employee was allowed to resign, with an agreement not to be rehired by DCFS, after she was charged with Conduct Unbecoming a State Employee, Falsification and Misuse of State Equipment. In 2006, a private agency, seeking to hire the former employee contacted DCFS, and, in answer to the

question, “Would you rehire?” the Department representative noted, “Unable to say.” The Department’s Office of Employee Records and Payroll’s current practices of responding to Employee Reference Checks should be revised to ensure needed disclosures are made to the private agencies to which we entrust our children.

The Department should consider a reasonable use exception for private (non-political) use of the fax machine to conform to the reasonable use exception for telephone use.

The OIG requested that the Department review available resources to deploy needed personnel and equipment to ITS to address the additional workload responsibilities and hardware needs occasioned by compliance with the Grand Jury Subpoenas.

The Department should incorporate into its training and Employee Manual the qualification that to trigger the ex parte communications reporting requirements for pending rulemaking, the employee should reasonably believe that the contractor is intending to influence the rulemaking process.

SERVICES

Court Involvement

The Department should ensure that the legal status of a child living with non-parents is resolved prior to closing an investigation.

Whenever there is court involvement with a parent (through juvenile, criminal or domestic relations court), intact family workers should attend court hearings if the involvement is related to the care of the child. If the parent is assigned either a social services monitor, or probation officer, the worker should coordinate services and monitoring. If a parent is not participating in required services, the worker should seek a court order to mandate parents’ participation using a graduated sanctions model.

Developmental Programming

The Department of Human Services recognizes that for cases in which the permanency goal is return home, federal zero to three programming is available to assist the biological parents. Emphasizing treatment in a natural setting, DHS services should be accessed to assist both biological parents and foster parent and when obtained:

(a) The Substance Abuse Waiver Demonstration project staff should receive training specific to zero to three services available for children and their families.
(b) The Department’s Office of Training and Development should post information about such services on its training Web site.

Emergency Reception Center (ERC)

The Department should review and update the Emergency Reception Center Manual to include expectations of follow-up workers taking children to the ERC.

Fire Damage

Administrative Procedure 13 provides for payments to foster parents for damage occasioned by foster children. It is limited to $5000, but circumstances, such as fires, could result in damages far in excess of this amount. Currently there are no guidelines provided for when the reimbursement maximum may be waived. The Procedure should be expanded to include circumstances for permitting discretionary reimbursement over $5000.

Interstate Compact
When an Illinois child is placed in an out-of-state placement, the Interstate Compact Office should notify the Illinois worker and supervisor of the availability of the Illinois Interstate Compact Office for consultation. The notification should include a contact number for the Interstate Compact Office and refer the worker and supervisor to Rule and Procedure 328, Interstate Placement of Children.

Older Caregivers
The current contract amount of $3,000 allocated in FY 2000 for client assistance (40 cases) should be increased to meet the current program needs (75 cases).

The Program Plan for the Older Caregivers Program should be amended to allow for flexibility in service provision to include a full array of services for 75 families, and limited services to additional families on a fee-for-service basis.

Problematic cases involving elderly caretakers should be referred for a Child and Youth Investment Team (CAYIT) staffing to determine if the case should be referred to the Older Caregiver Program for either a full assessment or provision of limited services tailored to the family's needs. In conjunction with Department Training and Development staff, the OIG will deliver the *Kids and Older Caregivers* training for CAYIT, ACR and Help Unit personnel.

The OIG will provide training to Cook County court personnel, ACR and HELP Unit staff about the Older Caregivers Program.

A private agency responsible for providing services to older caregivers should revise its practices to include an immediate process through which the referral issues are identified and agreed upon by all parties involved in the case. The agency should also issue timely reports with clearly stated recommendations ensuring that case conferences occur prior to any significant court event, but at least every six months. Additionally, agencies should provide the child's GAL with written information about any known safety or risk of harm concerns.

Parent Education
Effective parenting education must go beyond classroom-based training and be applied in the home. In cases of physical abuse, the worker should ensure that the services offered to the parent address specific family problems. Either the worker or the parent education agency should assess the parenting skills by observing the children and the parents in the home. Home observation also allows the worker to offer feedback directly to the family and document progress.

The Substance Abuse Waiver Demonstration Project Staff should be trained on providing integrated services to clients that address the family's well being and emphasize parental involvement while the child(ren) are in foster care. Parents should be supported in establishing parental relationships and taking an active role with their child(ren)'s school and pediatrician. The OIG Project Initiatives staff will convene this training.

Copies of *A Helpful Guide for Parents and Caregivers* should be provided to both the child welfare and substance abuse agencies.

When literacy is a problem, caseworkers should make referrals to appropriate literacy intervention programs, preferably family literacy programs. Caseworkers should inform service and treatment providers when an individual's literacy problem poses an obstacle to effective interventions.

Placement Disruption
A private agency should consider enhancing their current after hours procedure for placement disruption. This procedure should require that the on-call worker obtains key child information from the foster parent, obtain a clinical consult to determine whether the child can safely remain in his/her current placement for 24 hours with services, attempt to locate and secure a new foster home for the child, and arrange for the child's move with the child's assigned agency worker to assist with the transition to a new placement.

Psychotropic Medication
The Division of the Guardianship and Advocacy should conduct a review of wards, ages 12 and under, who are receiving both psychotropic and non-psychotropic medications, to assess the safety of drug interactions, i.e., beta-blockers are contraindicated for patients taking asthma medication.

The Guardianship Administrator should review all wards, ages 6 and under, receiving four or more psychotropic medications to ensure treatment is appropriate and safe.

The Division of the Guardianship and Advocacy should regularly obtain information from Medicaid Prescription Use Screens to better service wards who are prescribed multiple medications.

The Division of Guardianship and Advocacy should maintain reliable data on wards prescribed psychotropic medications. The data maintained should permit analysis of psychotropic medication that is not administered for psychotropic treatment (i.e. psychotropic medications are indicated for treating epileptic seizures.)

The Division of Guardianship and Advocacy should address a lack of resources, i.e., license for Microsoft Access, that would enable the Division and its contractual employees from the University of Illinois at Chicago to sort, track and monitor data collected on wards, especially young children, ages 10 and under, who are prescribed psychotropic medication. The Guardianship Administrator should proactively track and monitor wards with significant health issues, i.e., medically complex conditions.

The Guardianship Administrator should ensure that wards receiving psychotropic medication be taught how to use mood diaries to develop self-monitoring skills. The Inspector General has made this recommendation in prior reports.

The Department should review wards who are in traditional foster homes and receiving two or more psychotropic medications to determine whether they warrant a specialized foster care designation that would offer specialized services to foster parents and enhance the child's well being.

Split Case Management
The Department should prohibit *ongoing management* of split cases among private agencies. When consolidating a split case, the agency that has the licensing responsibility should be considered for full case management responsibility. The agency that relinquishes a case through case consolidation should not be penalized and should be moved up for case assignment. Under extenuating circumstances, such as a caseworker's long-term relationship with assigned foster children, a waiver could be issued by Agency and Institution Licensing managers based on a presentation of the circumstances at a staffing that must take place at the licensing agency. For each waiver granted, an Agency and Institution Licensing representative must attend a case staffing.

Agencies should provide in-service training to its foster care staff on its procedures for handling split cases with emphasis on communication and interagency staffings. When possible, interagency staffings should also include outside service providers servicing the child.

Agencies should develop written procedures for placing a child in the foster home of a different private agency and for receiving a child from a different agency for placement in an agency foster home. The protocol should require a face-to-face interagency staffing prior to a placement decision. The staffing should address procedures for achieving a mutually beneficial fit. When possible, interagency staffings should include outside service providers servicing the child. In-service training should be provided to the foster care staff on the protocol for handling split cases with emphasis on communication and confidentiality rules and procedures.

Substance Abuse Recovery

With the growing concern of methamphetamine abuse in Southern Illinois, the public has a reasonable expectation that county and state agencies (parole, probation, DASA, and DCFS) collaborate to optimize service outcomes when providing services to shared clients. In the interest of improving interagency communication and cooperation, the Department should require interagency case staffings. In addition, at a minimum, DASA/DCFS Initiative providers should adopt weekly random urine and breath-alcohol testing, and include family therapy and family education when working with methamphetamine abusers. DASA and DCFS also need to develop funding mechanisms that will adequately support the additional drug testing, monitoring, and transportation costs associated with treating methamphetamine abusers.

DASA/DCFS Initiative providers should adapt their treatment approaches to include interventions that have demonstrated statistically significant reductions in drug and alcohol use, improvements in retention and treatment completion, and improvements in psychological indicators and functioning. Empirical evidence has demonstrated that the Matrix Model treatment approach significantly improved treatment attendance and retention, increased methamphetamine-free urine samples during treatment, reduced drug use, and improved functioning. The Department should utilize the Matrix Model.

For child welfare cases involved with the Illinois Substance Abuse Waiver Demonstration Project, the Department should require quarterly team meetings for the child welfare staff and recovery coaches or other substance abuse treatment staff. Additional meetings should be convened at critical times in a case, such as during periods of relapse, the birth of a subsequent child, or case progress setbacks.

RECOMMENDATIONS FOR DISCIPLINE AND CONTRACT TERMINATION

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 Program Director assigned a worker who had not obtained a Child Welfare License to an active caseload and failed to respond to allegations that the worker had not been visiting the home. The Director also failed to respond to allegations that another worker perjured herself and encouraged another worker to do the same.

- A Senior Public Service Administrator failed to disclose his secondary employment to his supervisor that put the Administrator in contact with wards. The Administrator participated in staffings about a ward in which he provided misinformation and advocated for a position that promoted his self-interest contrary to the child's best interests.

- A private agency supervisor jeopardized the safety and well being of a child by failing to ensure the child had all prescribed psychotropic medications at the time of a placement change, and failed to document critical information in the child's case record.

- During a child protection investigation involving allegations of cuts, welts, and bruises to a one-year-old child, a Child Protection Advanced Specialist violated the Department's Paramour Policy and LEADS procedures by failing to ensure that a criminal background check was performed on the paramour, who was a violent offender.

- A Public Service Administrator permitted waste of state resources by failing to monitor a private agency contract and authorizing payments to the agency without documentation that services had been provided.

- During an investigation of a head injury to an eight-month-old infant a Child Protection Specialist failed to follow the Department's LEADS Protocol, as well as Rule and Procedure 300. The investigator did not ensure that an out-of-state criminal background check was performed on both parents, despite knowledge that both had lived out-of-state, and failed to ensure the safety of a sibling at the close of the investigation.

- During a child protection investigation involving a substance-exposed infant, a Child Protection Advanced Specialist violated the Department's LEADS Protocol by failing to obtain out-of-state LEADS checks when available information suggested the need for a check. Further, the investigator did not assess risk associated with the parents' involvement in drugs and alcohol use, criminal activity, violent behavior, and lack of prenatal care. While the investigator opened an intact family case for the substance-exposed infant, an eight-month-old sibling was not included in the intact family case and was left with a relative caregiver. The relative caregiver had no legal relationship with the child.

- A Child Welfare Advanced Specialist conducted an inadequate initial assessment of the parents (rating them as low risk drug users) and failed to acknowledge the mother's lack of prenatal care as a risk factor. The worker failed to acknowledge the father's relationship in the family and his admission to drug use; failed to inquire about the parents' backgrounds when assigned to the family case or during contact with the child protection investigator; and did not verify the legal status of an eight-month-old-child or assess the child's safety through a CERAP.

- A private agency caseworker communicated misleading information to the courts during the adoption process including inaccurate statements regarding housing issues of the pre-adoptive foster home.

- A private agency program supervisor failed to ensure that the Guardian *ad litem* and the court received critical information on a timely basis that was relevant to a child's adoption.

- A private agency supervisor did not provide adequate supervision to a case manager by failing to critically assess the worker's conclusions; failing to seek and corroborate additional information; failing to assess, or consider, a child's well-being after a sibling's removal from the same foster home; and inadequately responding to safety concerns in the foster home.

- A private agency worker did not respond to safety concerns in the foster home; failed to inform court personnel of reported safety concerns to the foster children; failed to inform court personnel of written/verbal recommendation from out of state child welfare professional that the foster children be immediately removed; and failed to maintain case notes.

- Two Public Service Administrators failed to comply with Department Rule 328.5, Interstate Compact, which requires removing children whenever the accepting state notifies the Department of ongoing safety concerns.

- A Child Protection Supervisor failed to enforce supervisory directives, and approved closing a parallel investigation without a completed safety assessment.

- A Child Protection Advanced Specialist failed to assess whether the alleged perpetrator had continued access to children in a facility investigation.

- During a facility investigation of sexual abuse allegations, a Public Service Administrator determined that it was not necessary to notify the employer of the formal child protection investigation based on the Administrator's assumption that the alleged perpetrator's attorney would notify the employer. The Public Service Administrator also gave final approval to close the facility investigation of sexual molestation without a completed safety assessment of children who may have been at risk of harm by the alleged perpetrator.

- A private agency manager declined to attend to a ward who had been taken to a hospital emergency room during school hours asserting that the child was not the agency's responsibility until after school dismissal time.

- An intact family services worker minimized a mother's parenting deficiencies and failed to respond to the mother's requests to surrender her children.

- A Child Protection Advanced Specialist did not contact either an intact family worker or supervisor during an investigation of a case that had been closed just four and a half months earlier, and did not contact the extended family worker who had relevant information on the mother. In addition, a Child Protection Advanced Specialist failed to contact extended family members who had previously cared for the children as part of an earlier safety plan.

- A contract monitor failed to disclose the conflict of interest created when his wife accepted a position with an agency that he monitored. The monitor, who was required to file a Statement of Economic Interest, also failed to disclose his wife's employment on his statement.

- During a child abuse investigation involving allegations of environmental neglect to an eight-month-old child, a Division of Child Protection supervisor failed to recognize risk to the child from the parents' paranoid behavior consistent with methamphetamine use.

- A Child Protection Investigator suggested to a teenage victim of domestic violence that her father had been angry with her mother because of a lack of sexual relations. The investigator also made comments to the girl about how attractive her mother was. In an unrelated investigation, the same investigator suggested that the roommate of an informant move in with him.

- During a Child Protection Investigation involving allegations of bone fractures and medical neglect to a three-year-old, a Child Protection Investigator failed to pursue information on children with open cases and notify the licensing agency of a pending abuse investigation. Further the investigator placed children in the home of a convicted felon whose background suggested a propensity for violence.

The OIG recommended the termination of Department contracts for the conduct detailed below.

- A private agency that contracted with the Department could not account for over $100,000 of state funds.

- A Department contractual employee failed to carry out primary job functions by delaying transmission of background checks to Department staff. Specifically, one criminal history on an extended family caregiver was delayed for several months.

- A private agency with unstable executive management had questionable financial practices.

- A Department manager arranged for a contract with a private agency. Soon after the contract was paid, the agency issued a check to a corporation controlled by the Department manager. The agency could not provide evidence that supported appropriate expenditure of state funds.

LAW ENFORCEMENT CASES

In FY 06, the Inspector General referred 12 cases to law enforcement agencies and received 6 requests for assistance from law enforcement agencies. Five of the cases involved misconduct and 13 involved theft or fraud.

Case 1
The OIG provided assistance during state's attorneys' prosecution for theft of state funds from Local Area Networks. The OIG had referred the individuals for criminal prosecution during the previous fiscal year. Three parties were indicted early in 2006 on charges of theft and the former worker was indicted for official misconduct. The criminal cases are pending.

Case 2
The OIG investigated a former private agency employee who allegedly transferred funds from the agency account into her personal account. The case was referred to the Cook County State's Attorney. The employee was indicted on theft charges. The criminal case is pending.

Case 3
Within two weeks of receiving a contract from the Department, an agency issued a check for $35,000 to a company controlled by the DCFS manager that had arranged for the contract. The matter was referred to law enforcement.

Case 4
The OIG referred a complaint of misuse of a Department credit card to the Illinois State Police for investigation. The OIG assisted the Illinois State Police in securing necessary documentation. After completing the investigation, the Illinois State Police secured indictments on two persons; one had been a temporary employee of the Department. The indictments were for misuse of a credit card and forgery. The criminal cases are still pending.

Case 5
Federal prosecutors had contacted the OIG for assistance investigating an allegation that a private agency worker had illegally shared Social Security Numbers of DCFS wards. The worker pled guilty and was sentenced to probation.

Case 6
The Illinois State Police referred for administrative follow-up a complaint alleging a breach of confidentiality. The Illinois State Police did not find evidence to charge the employee. The OIG reviewed the Illinois State Police investigation and found no basis to discipline the worker.

Case 7
A DCFS administrator was referred to the Executive OIG for alleged violation of the Gift Ban Act.

Case 8
The OIG referred a DCFS administrator to law enforcement after the OIG investigation revealed that the administrator had diverted almost $250,000 of Department funds into an account for which the administrator had sole authority.

Case 9
The OIG received a complaint regarding improper state hiring procedures. OIG investigators referred the complaint to law enforcement.

Case 10
Housing and Urban Development requested assistance in their investigation of a foster parent for Section 8 housing fraud. The OIG was unable to substantiate the information provided by HUD.

Case 11
The Illinois State Police requested assistance to obtain information on a child protection report involving a state trooper. Pursuant to Rule, the Illinois State Police was informed of the outcome of the child protection investigation.

Case 12
During an investigation, the OIG learned of a ward held in the county jail for whom a pre-sentence investigation was ordered. The OIG provided information that could be shared with the probation department, pursuant to Rules and statutes.

Case 13
An Assistant Attorney General requested assistance in securing information regarding the improper use of LEADS by a DCFS worker. Information was obtained and forwarded to the Attorney General's Office.

Case 14
A Department worker complained of receiving a threatening voicemail. The OIG referred the complaint to the Illinois State Police for investigation. The investigation is still pending.

Case 15
A DCFS administrator received a letter that she perceived as threatening. The letter was forwarded to the Illinois State Police. After reviewing the letter, the Illinois State Police declined further investigation.

Case 16
The Chicago Housing Authority forwarded a complaint to DCFS alleging that someone in Illinois was receiving childcare funds for children who were living in another state. A review of DCFS records revealed that the Department was not making the payments. The OIG referred the case to the Department of Human Services.

Case 17
Homeland Security Immigration and Deportation Enforcement requested assistance in a deportation case involving the investigation of a former day care center provider for child abuse. The OIG provided assistance.

Case 18
Housing and Urban Development referred to the OIG a question of whether an adoptive parent committed fraud regarding Section 8 housing. The OIG found no evidence of fraud.

Department Update On FY 05 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 Department must develop a protocol for assisting its own personnel office, as well as those of POS agencies, in retrieving underlying criminal documents to assess truthfulness and suitability for child welfare employment (from OIG FY 05 Annual Report, General Investigation 2).

FY 05 Department Response: A Protocol brochure was sent to the Office of Child and Family Policy for review on November 28, 2005. It will be sent to the OIG for review immediately following the Office of Child and Family Policy's review.

FY 06 Department Update: The OIG, in conjunction with the Department, developed and will distribute an informational pamphlet for private agencies concerning hiring practices, which includes information on retrieving underlying criminal history information on applicants.

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 (from OIG FY 05 Annual Report, General Investigation 34).

FY 05 Department Response: 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 begun meeting with the OIG on this issue as it relates to accessing underlying arrest and case reports from the Chicago Police Department specifically, and the state in general. The workgroup, chaired by the Division of Child Protection, anticipates completion by the first quarter of 2006.

FY 06 Department Update: The committee continues work on revisions to AP 6. Issues leading to development of this workgroup have been incorporated into the current draft. The Illinois State Police reviewed a recent draft and their comments have been included. The Legal Division representative is reviewing the draft in light of the Adam Walsh Act to ensure appropriate provisions are included in the LEADS protocol. Completed revisions are anticipated by the beginning of 2007.

The Department should 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 (from OIG FY 05 Annual Report, General Investigation 12).

FY 05 Department Response: 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 begun meeting with the OIG on this issue as it relates to accessing underlying arrest and case reports from the Chicago Police Department specifically, and the state in general. The workgroup, chaired by the Division of Child Protection, anticipates completion by the first quarter of 2006.

FY 06 Department Update: The committee continues work on revisions to AP 6. Issues leading to the development of this workgroup have been incorporated into the current draft. The Illinois State Police reviewed a recent draft and their comments have been included. The Legal Division representative is reviewing the draft in light of the Adam Walsh Act to ensure appropriate provisions are included in the LEADS protocol. Completed revisions are anticipated by the beginning of 2007.

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 AP6 (from OIG FY 05 Annual Report, General Investigation 34).

FY 05 Department Response: 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 begun meeting with the OIG on this issue as it relates to accessing underlying arrest and case reports from the Chicago Police Department specifically, and the state in general. The workgroup, chaired by the Division of Child Protection, anticipates completion by the first quarter of 2006.

FY 06 Department Update: The committee continues work on revisions to Administrative Procedure 6. Issues leading to development of this workgroup have been incorporated into the current draft. The Illinois State Police reviewed a recent draft and their comments have been included. The Legal Division representative is reviewing the draft in light of the Adam Walsh Act to ensure appropriate provisions are included in the LEADS protocol. Anticipated completion of revisions should be by the beginning of 2007.

The Department should amend procedures and the CERAP to require that LEADS checks be used to inform CERAP decision-making (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 7).

FY 05 Department Response: The CERAP Committee is reviewing this report to use in drafting revisions to CERAP.

FY 06 Department Update: The Safety Workgroup continues to review the CERAP project. Target completion date: Spring 2007. Domestic Violence Procedures and Practice Guide, Policy Transmittal 2005.07, and registration for training, which is being offered through June 2006 was posted on the D-Net in September 2005.

The Child Endangerment Risk Assessment Protocol (CERAP) should be amended to require that workers 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 (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 9).

FY 05 Department Response: A workgroup has convened to review all CERAP/Safety Assessment recommendations from various entities and assess how Department staff use 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.

FY 06 Department Update: The committee revising the safety assessment continues to work on the safety framework protocol. Targeted completion date is June 2007.

The Department should ensure that, once the Teen Parenting Service Network (TPSN) is notified by Unusual Incident Report of a pregnant or parenting ward who is 14 years of age or younger, TPSN must arrange for Title X counseling of that ward within 48 hours (from OIG FY 05 Annual Report, General Investigation 10).

OIG Note: Subsequent to an OIG investigation, the OIG learned that although the Unusual Incident Report appeared to have been sent to the TPSN, it was never received.

FY 05 Department Response: Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available.

FY 06 Department Update: The Department will work with the OIG to develop a protocol and training for caseworkers to enable them to arrange prompt Title X counseling for teen wards.

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 (from OIG FY 05 Annual Report, General Investigation 26).

FY 05 Department Response: Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available.

FY 06 Department Update: Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available. Target Date: September 2007.

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. Staff from NAMI have offered to work with the teen parent initiative to set up and pilot a short-term psycho educational mental health and peer support group for appropriate teen parents with mental health problems (from OIG FY 05 Annual Report, General Investigation 26).

FY 05 Department Response: Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available.

FY 06 Department Update: Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available. Target Date: September 2007.

The collaborative training by the Chicago Department of Health, TPSN, 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 (from OIG FY 05 Annual Report, General Investigation 26).

> *FY 05 Department Response*: 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.
>
> *FY 06 Department Update*: Four pilot trainings were held in March 2006 to obtain feedback regarding content. Refinement of training has been completed and staff is currently registering for trauma training.

Family mediation sessions should be initiated for teen-parent families to specify the voluntary terms of alternative or back-up caregiver arrangements (from OIG FY 05 Annual Report, General Investigation 26).

> *FY 05 Department Response*: Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available.
>
> *FY 06 Department Update*: Due to staff vacancies in Teen Parent Services in the Department's Service Intervention Division, a response is not available. Target Date: September 2007.

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 (from OIG FY 05 Annual Report, General Investigation 26).

> *FY 05 Department Response*: Due to conflicts in scheduling, no meeting has yet been held. Target date: December 2005.
>
> *FY 06 Department Update*: Draft protocol will be ready for the panel's review by December 2006.

Because of 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:

- **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. It is necessary to have an expert opinion outside of the opinion and evaluation of the family's nursing agency in order to minimize bias possibly rooted in relationship conflict. 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.**

This report should be shared with the Division of Child Protection Administrator, who is the Chair of the work group that is developing a protocol for investigations involving medically complex children (from OIG FY 05 Annual Report, General Investigation 13).

> *FY 05 Department Response*: The Medically Complex Protocol is in its final review with workgroup members. It is anticipated that Division of Child Protection 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.
>
> *FY 06 Department Update*: A protocol developed with the Division of Child Protection as the lead division has been completed. The document has been forwarded to Clinical Division for final approval and proceeding with implementation. The Department submitted the draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007.

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 (from OIG FY 05 Annual Report, General Investigation 13).

> *FY 05 Department Response*: The Medically Complex Protocol is in its final review with workgroup members. It is anticipated that Division of Child Protection 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.
>
> *FY 06 Department Update*: A protocol developed with the Division of Child Protection, as the lead division is complete. The document has been forwarded to Clinical Division for final approval and proceeding with implementation. The Department submitted the draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007.

The Department should amend Procedure 300.80 Taking Children into 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 a history of severe medical conditions should have special arrangements made to prepare for taking protective custody. The DCP investigator should involve a DCFS 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 DCFS nurse recommends review of medical information or identifies sources to interview, the recommendations must be followed prior to concluding an investigation (from OIG FY 05 Annual Report, General Investigation 13).**

FY 05 Department Response: The Medically Complex Protocol is in its final review with workgroup members. It is anticipated that the Division of Child Protection 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.

FY 06 Department Update: A protocol developed with the Division of Child Protection, as the lead division has been completed. The document has been forwarded to Clinical Division for final approval and proceeding with implementation. The Department submitted the draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007.

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.**
- **Require that medical records be retrieved in an expedited manner (from OIG FY 05 Annual Report, General Investigation 13).**

FY 05 Department Response: Division of Service Intervention-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by the Division of Child Protection. Several meetings were held throughout the summer and early fall. A final draft has been circulated to committee members for their review and comment.

FY 06 Department Update: A protocol developed with the Division of Child Protection, as the lead division has been completed. The document has been forwarded to Clinical Division for final approval and proceeding with implementation. The Department submitted the draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007.

The Department should review all HealthWorks medical providers statewide to determine which ones are equipped to handle children with special needs and ensure that child protection staff utilize HealthWorks providers accordingly (from OIG FY 05 Annual Report, General Investigation 13).

FY 05 Department Response: DSI-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by the Division of Child

Protection. Several meetings were held throughout the summer and early fall. A final draft has been circulated to committee members for their review and comment.

FY 06 Department Update: The Department submitted the draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007. Division of Child Protection also provided a copy of the protocol to Health Services. Health Services staff will review and discuss with the DCFS Medical Director to determine whether any additional comments need to be submitted.

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 (from OIG FY 05 Annual Report, General Investigation 14).

FY 05 Department Response: 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.

FY 06 Department Update: Draft outline for procedures and questions needing clarification were sent out to the Medical Issues Workgroup (which includes Deputies for Service Intervention and Clinical Services, Guardianship Administrator, Medical Director) and HIV/AIDS Project Coordinator on October 30, 2006. A conference call is scheduled between Health Services staff, the Assistant Guardianship Administrator and the HIV/AIDS Project Coordinator to discuss draft document and questions. Revisions and any additional follow-up will be done prior to re-issuance of draft document to the Medical Issues Workgroup for review/comment. Revised target completion date: December 2006.

Pre-adoptive parents, ages 60 and older or those with serious or chronic illnesses, should be required to meet with their back-up caregivers and the DCFS 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 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 plan, the Liaison should refer the family to the Child Protection Mediation Program (from OIG FY 05 Annual Report, General Investigation 19).

FY 05 Department Response: The implementation of the recommendation will go into effect on January 15, 2006.

FY 06 Department Update: The practice of meeting with the older or chronically ill caregivers and the back-up plan has been implemented as practice in Cook County with DCFS Adoption Staff, as well as POS. OIG Project Initiatives staff have begun providing training to DCFS and POS staff downstate.

When a foster parent's chronic illness becomes acute, licensing workers should consult with the treating physician with the consent of the foster parent (from OIG FY 05 Annual Report, General Investigation 19).

> *FY 05 Department Response*: 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.
>
> *FY 06 Department Update*: The revisions to Procedures 402.15 include the protocol for foster parents with chronic illness.

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 (from OIG FY 05 Annual Report, General Investigation 19).

> *FY 05 Department Response*: 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.
>
> *FY 06 Department Update*: The recommendation for the use of back-up caregivers will be included in the draft Procedure 402.12.

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 DCFS wards, and accept submission of documents electronically (from OIG FY 05 Annual Report, General Investigation 27).**

> *FY 05 Department Response*: A Policy Review Committee, comprised of representatives from the Division of Service Intervention-Education and Transition Services and various other Department Divisions, convened to revise Appendix G - Youth in College/Vocational Training, which will require earlier identification of youth for the program and reduce the required documents needed for the application. The revised Appendix G 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.
>
> *FY 06 Department Update*: Policy Transmittal 2006.03 was issued on February 27, 2006, with the revised Appendix G, Youth in College/Vocational Training Program and two new forms, YIC/VT Application and GPA Education Plan.

The Department should reimburse the 19 year-old ward $1,388.95 for the ward's student loan costs, the difference between the ward's YIC funding eligibility and what the ward actually received in the first year in school. The Department should recoup from the private agency the $868.85 paid to

the private agency for the ward's board payments after he went to school (from OIG FY 05 Annual Report, General Investigation 27).

FY 05 Department Response: A pre-approved Court of Claims form has been mailed to the ward.

FY 06 Department Update: The payment was approved through Court-of-Claims and notice was sent to the former ward, however, the notice was returned. Staff is attempting to contact the former ward to obtain a current address. Reimbursement will be made once he signs and returns the notice form.

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, education issues; any other concerns that directly impact the safety and well-being of the involved children (from OIG FY 05 Annual Report, General Investigation 17).

FY 05 Department Response: 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.

FY 06 Department Update: Policy Guide 2006.01 DCFS HELP Unit - Cook County Juvenile Court was issued on the D-Net on February 1, 2006.

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 Caregivers Project, such as a caregiver demonstrating memory loss (from OIG FY 05 Annual Report, General Investigation 25).

FY 05 Department Response: The designated units are the Regional Clinical Units. The Action Transmittal is in the process of being revised and rewritten.

FY 06 Department Update: The document is still in revision

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 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 drug test were found to be incorrect upon confirmation (from OIG FY 05 Annual Report, General Investigation 17).

FY 05 Department Response: The Service Intervention Division will post a D-Net announcement in December 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. If the Directory has not been received from DASA by the end of November 2005, the announcement will be posted without the DASA provider directory. Information will

also be included on procedures for obtaining and confirming urine toxicology testing results from DCFS contracted sites.

FY 06 Department Update: The Service Intervention Division posted an announcement on the D-Net on February 16, 2006. The resources are available under the Resources link.

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 (from OIG FY 05 Annual Report, General Investigation 15).

FY 05 Department Response: The work group to revise the substance affected family policy has been meeting and revised procedures have been submitted to the Office of Child and Family Policy. 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 the Office of Child and Family Policy by February 2006 and the training developed and rolled out by June 2006.

FY 06 Department Update: The revisions were completed and incorporated. Procedures for Substance Affected Families were issued and are currently posted on the D-Net.

Immediate interim measures should be instituted and the Program Plan for all Local Area Networks (LAN) 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 (from OIG FY 05 Annual Report, General Investigation 15).**

The OIG reiterates the need for a statewide audit of all LAN 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 (from OIG FY 05 Annual Report, General Investigation 5).

FY 05 Department Response: The contract and program plan for LAN 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 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 the 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.

FY 06 Department Update: The contract plans for FY 07 include the revisions. The Department is conducting annual site visits to monitor and audit the programs.

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 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 (from OIG FY 05 Annual Report, General Investigation 14).

FY 05 Department Response: The Department has standard operating Procedures for APT monitoring of agencies, and training is extended to APT staff on new initiatives, and on a necessary basis. A monitoring guide was drafted for Cook POS monitoring and is awaiting review and approval of the Deputy Director. The anticipated date of publication: January 31, 2006. The monitoring guide for downstate is still in draft form. The anticipated release date: June 30, 2006. Competent reviews of foster home files are to be conducted by licensed and certified licensing staff. A 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 and found it is a compilation of forms and does not, as of yet, include any substantive procedures or guidelines for monitoring private agencies. The OIG will work with the Department in further developing the guide.

FY 06 Department Update: The Cook monitoring manual was completed and a copy was given to the OIG. The monitoring guide for downstate will be completed when staff is hired in vacant key administrative positions. Anticipated completion date: January 30, 2007.

OIG Response: As noted in the prior annual report, the manual received by the OIG does not include substantive procedures or guidelines.

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 (from OIG FY 05 Annual Report, General Investigation 31).

FY 05 Department Response: A redacted copy of this report will be shared at the December 2005 Deputy Directors Meeting.

FY 06 Department Update: This matter was discussed at the October 17, 2006 Deputies' Meeting.

Solicitation and acceptance of case and in-kind donations should be coordinated by the Office of External Affairs which could make sure that solicitation efforts throughout the State are handled consistently and avoid conflicts of interest. The Office could also coordinate the receipt and distribution of physical items to make sure that they are distributed.

FY 05 Department Response: The form has been developed and is currently under review by the Deputy Director of Communications who will be handling External Affairs processes now. There have been some information communications regarding the audit process. A meeting between all parties is scheduled for December 2005.

FY 06 Department Update: The individual in charge of the process has left the agency. A new person is being assigned. Implementation date: March 2007.

The Department should conduct an independent review of Quality Assurance's review of this investigation. This report should be shared with Quality Assurance (from OIG FY 05 Annual Report, General Investigation 13).

FY 05 Department Response: From the description of the protocol, the tool referenced in the OIG report is the Child Protection Case Reading Protocol used in Peer Review statewide. From the limited information in the report, we researched the following:

- Travel vouchers were reviewed for all Quality Assurance staff and no Quality Assurance staff were in the Lincoln field office on or near March 19, 2005. The majority of the Field Review Unit's staff were in the Northern Region and the single staff person in the region was not in the Lincoln office.
- We searched all our review databases, including Peer Review, various special reviews, OER Review, and former Federal Preparatory Review, and did not come up with a query hit on this case name or SCR number. Additional searches were completed on the review date alone, as well as by investigative date, and it appears this case was not entered into the Peer Review database.

- We have requested a copy of the protocol to research who completed the protocol referenced in the OIG report.
- The worker ID listed in the report, which was obtained from the review protocol, is not a valid worker ID.

The OIG report recommends, "The Department should conduct an independent review of the Quality Assurance's review of this investigation. This report should be shared with Quality Assurance." From the information listed above, there is no need for an independent review of Quality Assurance, as the review of this file was not conducted by our office. However, the Office of Quality Assurance is recommended to do the following:

- Obtain a copy of the protocol and assess and attempt to identify the field staff person or supervisor who reviewed this case (Note: Peer Review is a process of case file evaluation completed by peers and/or supervisory staff).
- If we are able to identify the reviewer, the Regional Quality Specialist will assess the protocol in question for strengths and weaknesses and follow up with the reviewer in question by providing one-on-one training around deficient evaluation skills. (Note: the one-on-one training will not mention this particular case or OIG involvement).
- We will research why the protocol was not entered into the Peer Review database.

FY 06 Department Update: From the description of the protocol, the tool referenced in the OIG Report is the Child Protection Case Reading Protocol used in Peer Review statewide. After intensive research, the Department confirmed that Quality Assurance did not review this file and therefore there is no need for an independent review of Quality Assurance. Quality Assurance staff met with the OIG regarding these findings.

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 (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 6).

FY 05 Department Response: SACWIS enhancements are in process. The target date of completion is September 2006.

FY 06 Department Update: Implementation of SACWIS enhancements is scheduled for December 17, 2006.

During the course of this investigation, OIG staff was unable to retrieve the 18-year-old ward's sibling's closed case record because the private agency archiving the file had lost it. The Department is ultimately responsible for record retention for DCFS wards. DCFS Rules, Section 401.270(3): Records Retention. DCFS should implement a mechanism by which child and family case files, once closed, are returned to the Department from Private Agencies for archiving (from OIG FY 05 Annual Report, General Investigation 27).

FY 05 Department Response: 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.

FY 06 Department Update: Procedure 436 is still under revision. Target date: June 2007.

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. 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 (from OIG FY 05 Annual Report, General Investigation 22).

FY 05 Department Response: Written notification to non-custodial parents has been incorporated into revision of Rule 302. Revision of the accompanying procedures will provide additional details to workers and adoptive families.

FY 06 Department Update: Policy Transmittal 2006.1 - Rules 302.310 and 302.405 were posted on the D-NET on February 1, 2006.

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 Executive Director and Financial Officer/Accountant at the same agency (from OIG FY 05 Annual Report, General Investigation 4).

FY 05 Department Response: Rule 401 first notices were placed on the Department web site for public comments on October 28, 2005. Rule 404 is complete and was adopted in July. The policy transmittal will be distributed in January 2006 for implementation.

FY 06 Department Update: The Office of Child and Family Policy will file the second notice after the revisions have been returned with recommended changes. Target date: March 2007.

The Department's Clinical Division should develop a protocol on the utilization, monitoring and supervision of student interns (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 2).

FY 05 Department Response: The internship program manual has been returned to the Office of Training for specific revisions requested by the Deputy Director. A work plan is being developed and revisions are expected to be completed by the middle of January 2006. Policy information transmittal is also in draft form awaiting approval from executive levels. Implementation will begin as soon as approvals are finalized.

FY 06 Department Update: The manual has been finalized. The Office of Training has had one internship session and will be meeting with supervisors statewide. The information transmittal

was sent to the Deputy for review. Once approved, it will be forwarded to the Director for his signature. Target date: February 2007

The State Central Register should revise the Notice of Indicated Finding sent to parents to comply with Rule 336.60 (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 6).

FY 05 Department Response: This recommendation is under review by the DCFS Legal Division because of the impact it may have on the DuPuy Federal lawsuit.

FY 06 Department Update: Revisions are on hold pending implementation of the changes required by the DuPuy Federal lawsuit. Changes will be implemented as soon as possible, but no later than July 17, 2007.

The Department should institute a lock down procedure for SACWIS case entries and pending investigation notes when it is informed that a DCFS-involved child has died. The State Central Register could initiate this process upon notification of a child death (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 9).

FY 05 Department Response: 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.

FY 06 Department Update: SACWIS lock down procedure was implemented on September 24, 2006.

The OIG will ask Dr. Barbara Bonner from the National Center on Sexual Behavior of Youth (NCSBY) to assist DCFS clinical on a review of the latest research on assessment and treatment of adolescent sexual offenders, including community safety and supervision issues (from OIG FY 05 Annual Report, General Investigation 30).

FY 05 Department Response: Dr. Bonner was given the new standards to review and provide comments. To date, she has not provided her comments on the SBP Treatment Standards.

FY 06 Department Update: The Standards and Policy and Procedure have been updated to include Juvenile Sex Offender legislation.

All Department supervisors should have access to the Internet for evidence-based research to develop a knowledge based on relevant issues (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 9).

FY 05 Department Response: The Department agrees. Target date: September 2006.

FY 06 Department Update: DCFS managers will be notified via a D-Net announcement of how to request access to the Internet. Target Date: December 2006.

The regional administrator should convene a work group 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 (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 1).

FY 05 Department Response: 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.

FY 06 Department Update: The meetings with Judges and court personnel have been completed and local staff have received related training. There will be ongoing dialogue sessions in these counties with court personnel and Judges.

Management should be provided training to assist in resolving difficult environmental/employee issues (from OIG FY 05 Annual Report, General Investigation 35).

FY 05 Department Response: A tip sheet has been drafted and will be incorporated into training.

FY 06 Department Update: A Tip Sheet was placed on the D-Net on October 30, 2006.

The caseworker should receive training on identifying and neutralizing bias (from OIG FY 05 Annual Report, General Investigation 24).

FY 05 Department Response: The Department continues to search for appropriate training.

FY 06 Department Update: The caseworker received training. Further, staff from the Office of Affirmative Action will be invited to provide an in-house training on civility.

The Department should require the caseworker to submit to an independent medical examination to rule out differential diagnoses of the worker's condition. The physician should have experiences with environmental agents and toxicology (from OIG FY 05 Annual Report, General Investigation 35).

FY 05 Department Response: The worker returned to work with a doctor's statement. An independent medical examination is being scheduled.

FY 06 Department Update: The employee is no longer with the agency.

The child protection investigator should be counseled for failure to investigate this case (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 11).

FY 05 Department Response: This employee has been on leave since this recommendation was given to the Division of Child Protection. Counseling will occur upon the investigator's return.

FY 06 Department Update: Employee received counseling on January 17, 2006.

DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS

The Department should develop policy to address suspected substance abuse in the workplace (from OIG Recommendations made in 2005, 2001 and 1999).

FY 06 Department Response: The Department developed a definition and procedure for Reasonable Suspicion testing. The Department agrees to amend the Employee Manual and the Employee Licensure Rule to address Reasonable Suspicion of substance abuse and will also engage in discussions with the Union.

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.

FY 04 Department Response: The Department agrees. 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 Substance Affected Family 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.

When policy is revised, in-service training in Intact Family Recovery and Substance Affected Family is being planned for the private agencies involved. Completion date: February 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. 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 the Office of Child and Family Policy by February 2006 and the training developed and rolled out by June 2006.

The Division of Service Intervention is currently completing the re-write of the substance affected family policy guide (99.13). The 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.

FY 06 Department Update: The revised Substance Affected Family procedures, including the recommended changes, have been adopted and were posted on the D-Net September 8, 2006, Policy Transmittal 2006.11, Procedures 302, Appendix A, Substance Affected Family. Training on the new procedures is underway as part of the Department's reunification training.

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).

The response and update are the same as for recommendation above.

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 (January 2004, from OIG FY 04 Annual Report, Death and Serious Injury Investigation 23).

The response and update are the same as for the recommendation above.

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 Office of Child and Family Policy 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 the Office of Child and Family Policy by February 2006 and the training developed and rolled out by June 2006.

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.

FY 06 Department Update: The revised Substance Affected Family procedures have been completed and approved by the Director. The training on the procedures will roll out as part of the statewide reunification training. The Recovery Coaches will begin to utilize breathalyzers as part of the expansion of the IV-E waiver project. Projected implementation date: July 2007.

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, private agencies ensure that prior to a child specific placement for an employee, the agency should conduct a review to ensure a child's case will be transferred to an objective decision maker (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.

FY 06 Department Update: The Case Transfer Approval form revisions are complete and the form will be available in the templates in December 2006.

The Department must immediately implement the OIG's previous recommendations for the Sexually Aggressive Children and Youth 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 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.

FY 06 Department Update: Staff has received training and practice has been implemented. The Department has received comments from the Public Guardian on draft Procedure 302 and is currently making revisions. Target completion date: February 2007.

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 January 2005 to develop a process. Implementation date: March 2005

FY 05 Department Update: Procedure revisions are in process.

FY 06 Department Update: Discussions on how to handle split cases are under review.

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.

FY 06 Department Update: Submission of Rule 383 for rulemaking is deferred, pending the outcome of ongoing proceedings in federal court. Further revision is also being considered based on comments submitted by OIG staff who reviewed the draft. Legal Services will notify the Department of changes needed when the federal case is completed.

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 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 the Office of Child and Family Policy.

FY 06 Department Update: Submission of Rule 383 for rulemaking is deferred, pending the outcome of ongoing proceedings in federal court. Further revision is also being considered based on comments submitted by OIG staff who reviewed the draft. Legal Services will notify the Department of changes needed when the DuPuy case is completed.

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: Rule 401.25 is being amended to incorporate OIG recommendation requiring DCFS and 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 and will be posted on the D-Net by November 30, 2005.

FY 06 Department Update: Policy Transmittal 2006.02 issued amendments of Rule 401 was posted on D-Net on July 24, 2006. Both DCFS and POS licensing staff are required to conduct semi-annual monitoring visits.

As previously recommended in a July 2003 OIG report, 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.

FY 06 Department Update: Revised Procedure 402 has been sent out for comments. Target completion date: February 2007.

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 Department's computer network. Quality Assurance 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.

FY 06 Department Update: A workgroup comprised of QA and Licensing staff convened in July and August 2006 to review the Central Office of Licensing's (COoL) procedures for notification of new CANTS investigations in foster homes. COoL has developed an electronic system for this process which provides much more timely notification than the manual process that was in place

at the time of the OIG recommendation. COoL receives a daily electronic report of all new CANTS investigations. For investigations involving a licensed facility, notification is then sent via email to the licensing supervisor within 48 hours. Quality Assurance has been given a copy of COoL's procedures and QA has also been granted access to the daily reports received and notifications sent to supervisors.

Quality Assurance has met with licensing staff, has reviewed their system for identifying CANTS reports on licensed foster homes, and has been granted access to their daily licensing reports. The current licensing system of monitoring CANTS reports on licensed foster homes should alleviate the original problem identified by the OIG. Quality Assurance will return to COoL in order to conduct reliability checks in June of 2007.

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 Inspector General 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 the Office of Child and Family Policy. The revision includes language allowing the Director to place an emergency hold on a home without notice for up to 60 days.

FY 06 Department Update: Procedures 301, Appendix E Placement Clearance Process, were distributed to DCFS and POS child welfare staff on July 24, 2006. The revised procedures include a provision enabling the Director to place a 60-day emergency hold on a home without notice.

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 child protection 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.

FY 06 Department Update: Meetings continue with the three community based hospitals to work out standardized medical procedures and referrals. The group is continuing efforts to develop and finalize a 24-hour coordinated response by DCFS, law enforcement, Child Advocacy Center staff and state's attorneys. Downstate Regional Administrators will compile a list of local hospitals and facilitate the designation of various Investigation Supervisors to serve as liaisons to local hospitals in their areas continues. Target date for completion of this task: December 2007.

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 endocrinologist. 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 the Office of Child and Family Policy 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 the Office of Child and Family Policy in April 2005. Division of Service Intervention-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by the Division of Child Protection. 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 the Office of Child Family Policy, Division of Service Intervention-Health Services staff will meet with Office of Child and Family Policy staff, DCFS Medical Director, Clinical and others to determine what changes are required to the draft nurse referral policy guide.

FY 06 Department Update: The draft protocol has been provided to the OIG for review. They will provide comments to the draft in January 2007.

The Department nursing staff, when asked to consult on a medically complex child, should conference with other medical professionals as part of the consultation and ensure 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 to the Office of Child and Family Policy by January 2005.

FY 05 Department Update: The Division of Service Intervention-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 the Office of Child and Family Policy, the Division of Service Intervention-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.

FY 06 Department Update: The Department submitted the medically complex draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007. DCP also provided a copy to Health Services of the protocol that had been sent to Clinical. Health Services staff will review and discuss with the DCFS Medical Director to determine whether any additional comments need to be submitted. Once the protocol is released, the draft nurse referral policy guide will be reviewed to identify needed changes in order to conform to medically complex protocol.

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

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

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 the Division of Child Protection 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.

FY 06 Department Update: A protocol developed with DCP as the lead division is complete. The document has been forwarded to Clinical Division for final approval and proceeding with implementation. The Department submitted the draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007.

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, 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 the Office of Child and Family Policy by January 2005.

FY 05 Department Update: The Division of Service Intervention-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by the Division of Child Protection. 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 the Office of Child and Family Policy, the Division of Service Intervention-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.

FY 06 Department Update: The Department submitted the draft protocol to the OIG for comments. The OIG expects to submit comments in January 2007. Once the protocol is released to OCFP, language regarding targeted feeding assessment will be reviewed and integrated as appropriate.

OIG FY 04 Annual Report, Death and Serious Injury Investigation 24 included the following six recommendations (labeled below a-f). The responses and updates follow the six recommendations.

a) The Procedure for the allegation of Poisoning (#6/56) should include information from literature:

- **Common sources of intentional poisoning of children include: ipecac, laxatives, black and red pepper, salt, water (intoxication), acetaminophen and aspirin, insulin, adult prescription drugs (e.g. barbiturates, antidepressants, diuretics), alcohol and illicit drugs, and arsenic;**
- **Common symptoms associated with intentional poisoning include: chronic diarrhea, vomiting, lethargy, dehydration, and seizures;**
- **Intentional poisoning has an extremely high mortality rate and when found, children who are intentionally poisoned should not be left with the perpetrator.**

b) 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.

c) Department Procedures should acquaint workers with the following critical information necessary to investigate Factitious Disorder by Proxy:

- **Critical to any investigation of poisoning, and especially Factitious Disorder by Proxy, is a detailed determination of who provides care for the child when;**
- **Investigators must retrieve all available medical records for the affected child and siblings; an affidavit of history care, completed by the parents, will be a useful first step in attempting to get all available records;**
- **While not dispositive, the typical perpetrator is a mother who has some medical background;**
- **Typically, perpetrators of Factitious Disorder by Proxy appear particularly bonded with their children and are particularly adept at convincing professionals of their sincerity and abiding interest in their children;**
- **Most victims of Factitious Disorder by Proxy are infants and toddlers;**
- **As much as 98% of the time, the perpetrator continues victimizing the child in the hospital;**
- **The most common presentation of Factitious Disorder by Proxy is apnea. Other common presenting conditions include seizures, bleeding, central nervous system depression, diarrhea,**

vomiting, fever (with or without sepsis or other localized infection), and rash. Probably the most common cause of death in homicidal Factitious Disorder by Proxy is suffocation, but there are many causes of death, among which are poisoning with various drugs, inflicted bacterial or fungal sepsis, hypoglycemia, and salt or potassium poisoning;

- **Factitious Disorder by Proxy is not limited to directly causing conditions (e.g. poisoning and suffocation); it may also include, over and under reporting signs or symptoms (e.g. exaggeration of symptoms), creating a false appearance of signs and symptoms (e.g. tampering of specimens) and/or coaching the victim or others to misrepresent the victim as ill (Ayoub, et al., 2002). The presence of valid illness does not preclude exaggeration or falsification (Ayoub, et al., 2002).**

d) A Factitious Disorder by Proxy investigation should include a thorough review of available medical records for all children in the family. If a child abuse team is available at the treating hospital, they should conduct the review. If a child abuse team is not available, this review should be conducted by DCFS nurses and should be subject to the following procedures:

- **Interview medical personnel regarding symptoms. If intentionally caused, how long after administration would symptoms be expected to occur? How long would symptoms be expected to last per dose?**
- **Determine context of onset of symptoms. Who is present prior to onset of symptoms?**
- **Prepare a medical chronology of symptoms, charting the onset of symptoms and the access of possible perpetrators;**
- **Do siblings' records contain evidence of false pediatric reporting?**
- **Interview treating doctor to determine whether appropriate laboratory tests have been ordered to detect the presence of poisons or emetics.**

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

f) 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.

FY 04 Department Response: A workgroup was convened to revise/update Procedures 300. Reference to allegations 5/56, 15/65 and 10/60 will be included in the draft protocol for conducting investigations when Factitious Disorder by Proxy is suspected. 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.

FY 06 Department Update: The Division of Child Protection Committee has not completed its review and final revisions to Procedure 300. Once completed, these will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

This Report should be shared with Division of Child Protection and State Central Register 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 training for call takers at SCR is planned. Procedure 300 already has provisions for adding and investigating additional allegations if deemed appropriate. Completion date: February 2005.

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.

FY 06 Department Update: The DCP Committee has not completed its review and final revisions to Procedure 300. Once completed, these will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

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, 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.

FY 06 Department Update: The Division of Child Protection Committee has not completed their review and final revisions to Procedures 300. Once completed, the procedures will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

Procedures for investigations of Cuts, Welts and Bruises should be amended to provide that when suspicious bruising is reported (indicative of fingerprints, implements or otherwise suspect based on developmental age of child or location of bruise), and investigator does not see the bruise, the 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 11/61 cuts, bruises, welts, abrasions and oral injuries if deemed appropriate. Completion date: February 2005.

FY 05 Department Update: This recommendation was incorporated into the current revised draft of Procedures 300, Appendix B. The Department's Legal Division is currently reviewing these procedures.

FY 06 Department Update: The Division of Child Protection Committee has not completed their review and final revisions to Procedures 300. Once completed, the procedures will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

The Department should 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: The Department hopes to be working with the new Juvenile System and will meet with the new Director of Juvenile Corrections when that person is named.

FY 06 Department Update: Department staff continue to work closely with the new Director of the Department of Juvenile Justice to ensure that wards get the care they need while incarcerated and are released on time. The Department of Corrections liaison has made two presentations to the Prisoner Review Board, describing new Department programs and protocols as well as a program specifically designed for wards leaving the Department of Juvenile Justice. Both presentations were well-received. Negotiations have started with the Department of Corrections to secure data on both juveniles in the Department of Juvenile Justice as well as adults in the Department of Corrections and on parole to find wards who are incarcerated in the adult system as well as the parents of wards who may be incarcerated. The Department of Corrections liaison continues to work closely with the regional liaisons as well as her counterpart from the Department of Juvenile Justice. Recently a decision was made that a Child and Youth Investment Team will be convened when each ward in the Department of Juvenile Justice is six-months away from release to ensure that comprehensive planning starts early.

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 independent living and transitional living specialty contracts, which include Pregnant and Parenting Teens and the mentally ill, are being revised and amended for FY 06. Completion date: July 2005.

FY 05 Department Update: The independent living and transitional living redesign was postponed and will be implemented July 2006 for FY 07 contracts.

FY 06 Department Update: This agency's FY 07 contract includes the OIG's recommended language.

DCFS Rule 315, Appendix A should be amended to require a CERAP be completed when a parent who has an open DCFS case and whose children have previously been removed from his or her care has another child. The Teen Parent Service Network 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 Procedures 315 will be completed by March 2005.

FY 05 Department Update: The CERAP Committee is reviewing procedure.

FY 06 Department Update: The committee revising the safety assessment continues to work on the safety framework protocol. Targeted completion date: June 2007.

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 the parent's cooperation with services and the extent to which services provided address the allegation (from OIG FY 04 Annual Report, Death and Serious Injury 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 2006.

FY 06 Department Update: The Division of Child Protection Committee has not completed its review and final revisions to Procedures 300. Once completed, these will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

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 Teen Parent Service Network and DCFS need to develop and make available specialized crisis foster placements that can accept a teen parent and his or her children on an emergency basis while an emerging, potentially violent situation is de-escalated and the safety and well-being of the parent and child is 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 independent living and transitional living contracts to

reflect level of need for special populations that includes Pregnant and Parenting Teen 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

FY 06 Department Update: The committee convened to review and revise the safety assessment instrument and process is still working and has a target completion date of June 2007.

When a home study is requested through Interstate Compact, the request should include asking the local child welfare worker conducting 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.

FY 06 Department Update: The Interstate Compact Workgroup is currently reviewing all Interstate Compact procedures. This recommendation will be included in their review. Implementation date: July 2007

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.

FY 06 Department Update: The Department is currently reorganizing all of the CANTS/LEADS activity for the agency to consolidate and make the system more efficient. Signed determinations of decisions will be addressed in this consolidation.

APPENDICES

Appendix A: Henry Foster Death Investigation

Appendix B: Child Endangerment Risk Assessment Protocol Investigation

APPENDICES

OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

REDACTED REPORT

The Office of the Inspector General is releasing this report for training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File: 041525

Child: Henry Foster (DOB 6/2002; DOD undetermined; body found 3/2004)

Subject: Death Investigation

COMPLAINT

In March 2004, the OIG received notification of the death of 20-month-old Henry Foster. Henry's maternal aunt discovered Henry's mother's body, 39-year-old Teresa Foster, on Henry's toddler bed. The aunt called the police and reported her sister's death and her nephew missing as she could not find Henry. Police later discovered Henry's body underneath the bed. The police initiated a death investigation.[1] At the time of discovery the two bodies had already begun decomposing. Both bodies were transported to the Coroner's facility. The coroner convened an inquest. Because of the state of decomposition and negative toxicology the cause and manner of death for Teresa was undetermined. Henry's cause of death was dehydration but the manner undetermined. DCFS had a pending DCP investigation and an open intact family case at the time of death.

INVESTIGATION

Background

The Department became involved with Teresa and Henry through a Child Welfare Service referral in June 2002 following Henry's birth. DCFS opened an intact family case that remained active until September 2003. During the course of that intact case, in May 2003, the Department conducted an investigation for substantial risk of physical injury that was ultimately unfounded in July 2003. A second report was received for investigation of substantial risk of physical injury on December 29, 2003. During the course of the investigation the family was referred to intact family services and a second case was opened on January 13, 2004 a month and a half before the deaths.

[1] The authorities initially believed that Teresa may have been strangled, but the pathologist did not find evidence to support this theory. Decomposition causes bloating and discoloration of the face. Police interviewed a number of people regarding the death trying to determine if foul play was involved.

Child Welfare Service Referral

In June 2002, following Henry's birth, hospital staff called the hotline for a child welfare service ("CWS") referral. The social worker reported that the baby did not seem to be at risk but Teresa appeared delusional and refused to take psychotropic medication. The social worker made the CWS referral as Teresa agreed to receive services, counseling or parenting that would help her care for the baby. The hospital made an appointment for her to see Dr. Wyler, a psychiatrist.[2] The Department assigned Brigitte Joanis to the case who sent a letter to Teresa.

On June 24, 2002, after meeting with Teresa, Dr. Wyler called the local DCFS Field Office because of his concerns. Dr. Wyler spoke to Julia Frazier.[3] Ms. Frazier documented:

> Dr. Wyler called regarding the safety of infant child belonging to Teresa Foster (sic). As Ms. Foster has serious mental health issues and she refuses to take her medication. She has a newborn child and he is not aware of any specific incidents where she has harmed the child, but does feel there is great risk, due to mother's failing to follow his recommendation for meds, which she greatly needs. Ms. Foster has incidents of paranoia and she believes people are following her and trying to get her. He saw Ms. Foster on this date. She is in a mania right now. Ms. Foster is from Montana and her paranoia is that people from Montana are coming after her. It is Dr. Wyler's concern that she will try to hid (sic) the baby to keep it safe, but in reality will be placing harm on the child.

Ms. Frazier spoke with Ms. Joanis' supervisor about Dr. Wyler's concerns. During an interview with OIG investigators Ms. Frazier stated that she knew about the practice of local DCFS offices being able to take calls for investigation though usually she redirected callers to the hotline.[4] She could not recall if she had given Dr. Wyler the number to the hotline.

Visits to the Home

During the course of the first intact case the worker conducted 21 visits with Teresa at the home and attempted 11 additional visits. On June 27, 2002, Ms. Joanis went to the home for her first in-person contact. She completed a CERAP. The worker indicated the presence of the factor relating to mental illness that may seriously affect a person's ability to supervise, protect or care for a child. She noted Teresa's diagnosis of schizophrenia and her refusal to take medication. In the family strengths and mitigating circumstances section the worker wrote:

> There are no documentations that she has ever threatened to harm the child to either her psychiatrist, pediatrician or DCFS. She did see the pediatrician yesterday who did not call in a report and she saw her psychiatrist on Monday who did not call in a report. The case was screened by the Assistant State's Attorney and the regional

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[2] Teresa saw Dr. Wyler on an outpatient basis twice after the birth of Henry but then refused to return. Teresa's psychiatric history including two psychiatric hospitalizations is discussed later in this report.

[3] Ms. Frazier worked as a supervisor at that time. Dr. Wyler's call was directed to her, as she was the only supervisor in the office that day. She had previously been a child protection investigator. In December 2003 she chose to return to an investigator position.

[4] In an April 2000 OIG Report #971513, a DCP investigator received a call from a grandmother who reported bruises on her infant grandson. The investigator had already closed his earlier investigation so he passed the information on to the intact worker rather than assuring that an investigation was initiated. OIG investigators pointed out that a CPI, who is a mandated reporter, should assure that a report is taken when contacted with information about the safety of a child as directed by the Abused and Neglected Child Reporting Act (ANCRA) and DCFS Rule 300.30 (Reporting Child Abuse or Neglect to the Department): [Persons] who have reasonable cause to believe that a child known to them in their professional or official capacity may be abused or neglected shall immediately report or cause a report to be made to the Department.

DCFS attorney who did not feel we had a case for the shelter care. Child appears healthy.

Ms. Joanis marked the CERAP safe and signed it on June 27, 2002. Her supervisor signed the CERAP on June 28, 2002.

During that first visit the worker noted several concerns regarding Teresa not following the pediatrician's instructions on feeding Henry. Ms. Joanis observed a baby bottle containing thick yellow cereal. Teresa had fed Henry peas the day before. Teresa supplemented Henry's diet with Pedialyte because she feared he was not taking in enough nutrition. The worker advised her not to give Henry cereal or juice even though Teresa thought he was fussy without the cereal.

Teresa discussed her concerns about people spiritually abusing her son. She spoke of black magic and a woman in Montana who killed her baby and was coming to take Henry to replace the dead baby. Her fears caused Teresa to spend time spiritually cleaning the home. Teresa informed the worker that she had come to Weston because the Police Department in Montana had relocated her because of involvement in a murder investigation.[5] The worker asked if she could visit again. Teresa agreed though warned Ms. Joanis that those who try to help often become victims of "the other side."

Upon returning to the office Ms. Joanis met with her supervisor, relating that she believed the case posed "huge risk issues." She worried that Teresa could attempt to harm Henry during a psychotic episode. She told her supervisor that Teresa needed medication, case management, counseling and parenting skills training.

Ms. Joanis conducted collateral contacts for more information. The worker spoke with Dr. Wyler of Memorial Hospital's psychiatric unit. Dr. Wyler voiced great concern about Teresa's ability to care for Henry because of her schizophrenia. Dr. Wyler tried to work with Teresa for a year but she refused to take medication. Dr. Wyler felt Henry was at moderate to high risk because of Teresa's poor judgment. Teresa, he opined, had no concept of what was real and what was fantasy, twice telling the worker that Teresa may flee with the baby if confronted. Ms. Joanis contacted Henry's pediatrician who would not give information without a release of information.[6] The staff confirmed that Dr. Crookes saw Henry the day before, June 26, 2002. The worker contacted the Weston Police Department. An officer told Ms. Joanis they were familiar with Teresa, known by the last names of Foster and Twine. Teresa had sent letters to the police. Ms. Joanis could have copies.[7] Teresa had slept in the police parking lot. Ms. Joanis staffed the case with the Assistant State's Attorney ("ASA") who felt there was not enough to maintain custody at a shelter care hearing. DCFS Legal was consulted. They advised DCFS to continue to make visits to build a case, as there was not enough for custody at this time.

Three days later the supervisor visited the home. The supervisor observed a healthy looking Henry laying in his car seat. Teresa reported that Henry had gained weight and rolled over by himself. Teresa discussed her spiritual delusions and Henry's conception through asexual reproduction. She then told the supervisor that the father, who lived nearby, was in the middle of a divorce but had no interest in the baby. She reiterated the story about her ex-husband kidnapping her older son. The supervisor asked if she understood why she confused other people. Teresa felt people did not see she had a gift that the police and others could use. She continued to talk about people coming to Weston to hurt her or her child. When asked how she would protect Henry, Teresa replied that she solicited police protection and they provided surveillance. Teresa made no threats of harm to Henry. Teresa told the supervisor she needed financial

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[5] Ms. Joanis clarified that Teresa's mother moved her because she feared Teresa would be homeless in Montana.
[6] Ms. Joanis obtained a signed release later that day when she dropped off diapers at Teresa's home.
[7] Copies of letters to the police from Teresa Foster were contained in the DCFS file.

assistance. She reported her income from Social Security[8] as $545 a month and $229 in food stamps. The rent was $300 a month and she was behind on her utilities. She needed, but could not afford, car insurance as she was paying off a fine for driving without insurance. The Department provided Norman Funds in the amount of $121.30 for Teresa's water, gas and electric bills.

On July 2, 2002, Ms. Joanis completed a service assessment. She noted that Teresa communicated well and appeared to be of average intelligence. However Teresa was convinced she had the ability to communicate with "the other world" and that people were coming to get her. Teresa spoke freely of her black and white magic associations.

Teresa told Ms. Joanis that she wanted to be a good parent. Teresa told the worker that she had an older son who was kidnapped by her ex-husband. She had not seen her older son for two years.[9] Teresa gave Ms. Joanis consent to speak with Henry's pediatrician, Dr. Crookes. Dr. Crookes shared his concern that Teresa fed Henry foods he could not yet digest, though Teresa seemed amenable to the worker and the doctor advising her on this issue. Teresa denied the use of drugs and alcohol, reporting that she had been sober for six years with the support of 12-Step programs. Ms. Joanis did not find evidence of threats of harm to the child but noted that Dr. Wyler, Teresa's psychiatrist, expressed concern about the safety of Henry. He stated because of Teresa's desire to protect him, combined with her refusal to take medication, it could cause her to put her child at risk. Ms. Joanis assessed the need to open a case in order to monitor the infant's condition, the mother's mental health condition and link her with services to address the mental health/parenting issues.

Ms. Joanis returned to the home on July 10, 2002. Teresa again discussed her delusions of someone harming her. The day before she had spent several hours sitting on the courthouse steps believing it was a safe place while Henry spent the night in the hospital for Respiratory Syncytial Virus (RSV). The worker noticed a scratch on Henry's face from a kitten Teresa had recently brought home. The worker advised that a kitten might not be a good idea. The worker asked about Henry. Teresa admitted to feeding him cereal with Pedialyte though the worker again cautioned her that Henry was too young for cereal. The mother attempted to nurse Henry throughout the visit while the worker gathered social history information.

Teresa and her baby lived in a two-bedroom rental unit in Weston. Teresa's mother and maternal grandmother also lived in Weston and provided support. In fact, Teresa had lived with her mother upon moving to Weston but moved out of her mother's home when she found out that she was pregnant.[10] Teresa was the youngest in a sibship of six, two of whom were deceased and one was adopted out of the immediate family. Teresa reported that her mother raised her, as her parents were divorced when she was born. She never lived with her father but reportedly had an excellent relationship with him. Teresa was guarded with further information regarding the extended family.

Teresa denied any mental health problems though she had a diagnosis of schizophrenia, paranoid type with current delusions and hallucinations. She expressed delusions, from the time of the worker's first

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[8] Teresa told the supervisor she received social security disability because of an injury she received to the arm while training horses.

[9] OIG investigators learned from Montana Child Protection that Teresa's former husband was granted full custody of their son, Jacob Twine Jr., during divorce proceedings. Teresa was initially allowed one hour a week of supervised visitation. She was then restricted to phone contact only with the child and the father was pursuing a no contact order with her older son.

[10] Teresa's mother told OIG investigators that she helped Teresa move from Montana to Illinois around 2000 when Teresa's mental illness seemed to be getting worse. The maternal grandmother raised her children in Montana but moved back to Weston, where she grew up, when her children became adults. She hoped that moving Teresa to the Weston area would allow her and other relatives to help Teresa.

contact until the end of the case. The delusions included black magic playing a role in her brother's death and people stalking her but being unable to kill her because of her spirituality. The worker noted that because Teresa refused to participate in any psychiatric or psychological evaluation DCFS did not have an accurate description of her cognitive functioning. Though Teresa was able to provide basic care for herself the worker assessed that Teresa's mental illness impaired her judgment.

Teresa admitted to heavy drug use in her past, starting with cocaine at the age of 18 years. She stopped using cocaine around 1995 when she began using methamphetamine. She reported that her last drug use was August 26, 1997, with some participation in treatment programs though she was a vague historian in this area.

Teresa married Jacob Twine in 1986. The marriage produced one child, Jacob Twine. She reported some domestic violence during the marriage though qualified that it was not serious.[11] The reason for the divorce, she told the worker, was that "they were using my soul." They were "black magic." She and her husband divorced in 1996 and her husband received custody of the child. She had visitation rights, she told the worker, until "they lied on me."

Her source of income was Social Security, which she said she received because she "cannot work around people." She refused the offer of daycare services. Teresa told the worker she agreed to DCFS services because the Department could assist her with utilities. The worker assessed Teresa's prognosis for change as poor because Teresa refused psychotropic medication. While the worker recognized the need for medication, counseling and mental health case management Teresa refused those services. The worker noted her concern that if she pushed Teresa too far in regard to those services she would not allow the worker back in the home.

On July 16, 2002, the supervisor received a call about Teresa from a DHS worker who voiced concern about Teresa's bizarre statements and discussion of the occult. The supervisor informed the DHS worker that DCFS was new to the case, but provided oversight and tried to bring the case to court. Three days later when the worker went to the home she noted several concerns. She found three men there, two working on a car and one, Drake, with Teresa and Henry in the home. The worker learned that Drake and Teresa met the day before. Drake asked Teresa to go for drinks, but she refused because of nursing. Instead they met later at Wal-Mart. Teresa had her neighbor[12] watch Henry. When she could not start the car she got Henry, walked to the fair, met new friends and spent the night with them. Teresa showed the worker a letter she had written to country singer Kenny Chesney requesting financial backing for a restaurant in Nashville. She talked about moving with Drake to Nashville. The worker advised Teresa that she needed to be careful and pointed out problems that might occur in trying to move. The worker noted that Teresa had taken her earlier advice by getting rid of the cat and feeding Henry only formula and breast milk. Yet, the worker was hesitant to discuss a service plan as Ms. Joanis feared Teresa would become unreceptive to DCFS intervention.

The following week the worker visited the home twice. On July 25, Teresa admitted to the worker that she drank four shots of Tequila Rose the night before and several beers last week when she went out with Drake. Teresa left Henry with a 15-year-old, though she did not think the babysitter was spiritually strong enough to protect Henry so she planned to not use her again. Also she expressed concern because Henry had an erection after the babysitter watched him. Ms. Joanis had difficulty following the conversation. The worker advised Teresa not to drink while nursing.

[11] Montana LEADS information indicated that Teresa was arrested for battery several times and in August 1994 she was arrested for inflicting corporal injury to spouse/cohabitater.
[12] Ms. Joanis believed that the neighbor may have had her children in the care of DCFS.

The next morning Ms. Joanis returned to the home. Teresa admitted she finished the Tequila Rose the night before because she did not want to throw it away. Teresa tried to feed Henry but he did not eat and she wanted to take him to the doctor. The worker transported Teresa and Henry to the doctor that afternoon. Dr. Crookes asked what Henry had been eating; Teresa did not mention baby food or juice until prompted by the worker. The doctor reiterated only breast milk or formula for at least the next two weeks when he would see Henry again. Henry had gained five pounds in less than two months. In the car Teresa told the worker that she had concerns about Drake, who had been staying with her. He told her that his brother killed someone but Teresa feared it could really be him and he escaped from prison. The worker offered to do a background check and informed Teresa that if she felt uncomfortable she should ask Drake to leave. When they arrived at home Drake refused to give information needed for a criminal background check. Ms. Joanis noted that his eyes were red and he seemed confused as if he had been using drugs. Ms. Joanis voiced her concerns to Teresa. By the next visit, on August 2, 2002, Teresa had asked Drake to leave. He brought alcohol in the house and Teresa knew she would drink it if in the home.

The worker accompanied Teresa and Henry to the pediatrician's office on August 12 for his immunizations. The doctor again chastised Teresa for feeding Henry cereal and baby food. She would not agree to stop feeding him those. She was advised that Henry should sleep on his back not his stomach. Teresa told the worker and the doctor that people from the other side were trying to get to Henry through her breast milk. In documenting the visit the worker noted that while Teresa had poor judgment, was confused easily and did not follow directions, she had never threatened harm to Henry. She did not treat him negatively and spoke of protecting him.

During the visit on August 23, the worker noted that Teresa was especially agitated. The police had been called to her home the night before because of her conviction that people were in the house. The police arrived, told her nothing was wrong and maybe she should move back to Montana. Teresa continued to report that people were trying to get to Henry through her breast milk. The worker noted that Henry was chubby. Teresa said she was feeding him three meals a day of baby food, four ounces of milk and juice. The worker reminded her the baby should not have juice, and if she was going to give Henry baby food it should only be one meal a day. Teresa replied that Henry was hungry and she would not let him starve. She admitted that she went out drinking the night before and had a male friend watch Henry for about three hours. The worker pointed out that the person she chose for a babysitter was not appropriate nor was Teresa after drinking. Teresa retorted that she only had a few drinks and was fine by the time she walked home. The worker discussed the service plan; Teresa agreed to the infant care tasks but refused any mental health tasks.

Over the Labor Day Weekend, the worker attempted to visit twice as Teresa left a message saying she had an emergency. On Tuesday, following the holiday, the worker located Teresa at the maternal grandmother's home, where she and Henry had spent the night. Teresa told the worker that someone was using her social security number, whispering that it was related to her brother's death and people from the other side, though her mother did not fully understand the situation. Teresa then apologized to Ms. Joanis, noting that she had been victimized as well. Teresa later came to the office with her bills wanting the worker to pay them. Ms. Joanis informed Teresa that was not possible.

The worker went to Teresa's home the next day. Teresa talked about the man she had earlier allowed to live with them being the root of her problems. She believed he escaped from prison. Ms. Joanis noted that it seemed Teresa talked about getting an order of protection but the worker had difficulty following the story. Teresa denied any alcohol use, or leaving Henry with anyone. She worked on not feeding Henry as much, though the worker noted that Teresa seemed to feed the baby every time he cried. When Henry began crying the worker suggested trying the pacifier, which quickly calmed the baby. The worker moved onto budgeting as Teresa complained that she could not pay all of her bills. The worker suggested that

cable and renting a computer might be items she could cut, but Teresa insisted they were necessities. Teresa stated she might be willing to have Henry go to daycare if the Department paid.

Ms. Joanis took Teresa and Henry to the pediatrician on September 12 for immunizations and then to the maternal grandmother's home. The worker took the opportunity to talk with the grandmother. The grandmother shared that Teresa had suffered several losses that may have precipitated her mental illness. Teresa's brother died when he was 13 years old. He was camping with friends and one of the boys took out a gun he thought was unloaded and accidentally shot her son. Shortly thereafter a maternal aunt, uncle and cousin were killed in a car accident. A family friend became a heavy drug user and died, which Teresa took very hard. Additionally there was a family history of suicide and mental illness. The grandmother began noticing problems in 1998 but as Teresa was using drugs she did not know if it was the drugs or a mental health issue. The grandmother said she tried to confront Teresa about her delusions, but Teresa truly believed them. Teresa became upset by the conversation until the worker calmed her. Both the worker and the grandmother asked Teresa to consider going to a psychiatrist, but she refused. As Teresa and Ms. Joanis left the home Teresa whispered that her mother was not strong enough to fight and was the one who was mentally ill. In documenting the visit the worker reiterated her concern about the risk issues noting that Teresa did not threaten to harm herself or anyone else so an involuntary hospital admission would not be possible. Ms. Joanis feared it was a "no-win" situation.

The supervisor and Ms. Joanis staffed the case on September 13, 2002. The supervisor documented the need to talk with Henry's maternal grandmother without Teresa present and get information on her parenting as observed by the grandmother. While risk issues continued they could only be addressed by mental health intervention, which Teresa continued to refuse. The plan was to continue to monitor the case as long as Teresa allowed them to visit.

Teresa was hallucinating and delusional, appearing to respond to voices during the visit on September 25. She cursed at the worker for not recognizing that others were hurting her. Teresa became angry when Ms. Joanis told her she should not feed Henry animal crackers, as he was too young. By October 10, Teresa had moved in with her mother, as she did not have enough money to pay her utility bills. The grandmother spoke with Ms. Joanis, noting that Teresa refused to take advice but was patient with Henry and had not done anything inappropriate.

After Teresa moved in with her mother, the worker and the grandmother communicated regularly. The grandmother would call and report when Teresa's delusions and behavior seemed to be worse; for example, when evil spirits were coming through the telephone lines. The grandmother qualified that Teresa was patient and good with Henry. On October 18, 2002, the grandmother informed the supervisor that the great grandmother told a relative that Teresa claimed voices told her to kill the baby but she did not listen to them. The supervisor called the great grandmother who reported that Teresa did not say the voices had told her to hurt her baby. Rather Teresa believed the voices were causing Henry to be upset and uncomfortable. The great grandmother stated that Teresa loved Henry though she would not take advice from people in regard to caring for him. The supervisor asked that the grandmother call the worker if she heard Teresa make threats toward Henry or discuss voices saying they want to hurt Henry.

Over the following months the worker continued to visit Henry and Teresa at the grandmother's home. Case notes documented Teresa's persistent delusions. The worker provided transportation to the doctor and information about housing assistance. Ms. Joanis told OIG investigators she referred Teresa to County Housing at her request but wanted Teresa to stay with her mother. She felt it was best for Henry and Teresa to have the family support and monitoring. Ms. Joanis pointed out though that Teresa could be verbally abusive to her mother so it was stressful for Henry's grandmother who had health problems. Teresa's mother noted that Teresa became angry with her, and threw things at her, but Teresa always put Henry down first to assure he did not get hurt.

On December 18, 2002, Julia Fraziera, DCP investigator took a call at the Weston Field Office from Dr. Crookes, Henry's pediatrician. Dr. Crookes inquired about the Foster family receiving services. Though Henry did well, he had concerns about Teresa's serious psychiatric issues. She had "distorted ideas on just about everything" and he expressed concern about the safety of the child while in his mother's care. He qualified that he was not a psychiatrist but he wanted DCFS to know of his concerns. Ms. Frazier passed the information onto Amber Fundora, Ms. Joanis' temporary supervisor.

In January 2003, Mildred Barr became the supervisor. On January 13, Ms. Joanis visited Teresa and Henry at the grandmother's home. Though Henry appeared fine Teresa was delusional, hallucinating and irritable. She referenced voices during the conversation and responded to Henry as if he had said something to her. She attributed Henry's crying to people trying to get him. She admitted she had been drinking. That afternoon the worker contacted the State's Attorney's Office.

During a visit on March 14, 2003, Teresa informed the worker that over the weekend she was charged with DUI and failure to have insurance. She did not have Henry with her at the time of the arrest and she believed she would be able to get out of trouble. Teresa agreed to place Henry in daycare. Ms. Joanis received approval for funding, three days a week, at the licensed home of Mia Anglen. The worker noted the reason for daycare as mother being a non-medicated paranoid schizophrenic needing respite. Ms. Joanis told OIG investigators that Henry attended daycare at the home only briefly. The daycare provider eventually asked that Henry not come back because Teresa had made some bizarre statements about another parent. The other parent was in law enforcement, which set off Teresa's delusions, and Ms. Anglen did not want Teresa confronting the parent at the daycare home. Teresa told the worker that the daycare provider could not watch Henry because her ex-husband's family controlled Ms. Anglen. The worker did not feel as though she would be able to find a daycare match for Teresa's child.

SCR #1 Sequence A

On May 27, 2003, Henry's maternal aunt called the hotline. The aunt reported that she and Henry's maternal grandmother live with Henry's mother, Teresa, who is bipolar and schizophrenic but refused treatment and medication. Teresa believed that people were trying to murder her. Teresa believed that Henry had been cloned and that he was conceived through parthenogenesis.[13] In the computer the aunt found that Teresa had typed that she wanted to tie Henry up and spank him. The mother had spanked Henry. Teresa slept with Henry in the cab of a truck outside because she was afraid of the light sockets in the residence. The aunt stated that Teresa fed 11-month-old Henry only a bottle, no solid food. There were times when Teresa was alone with Henry. Teresa had an older son, Jacob Twine, age 13, who was removed from her in the state of Montana.

The investigation was assigned to Grace Hackaby and staffed with Ms. Joanis on the day the report came into the Weston Field Office.[14] Supervisor Mildred Barr spoke with Ms. Joanis who reported that Teresa had delusions but she had never seen her do anything to hurt the baby. Rather she was very good with him and appeared quite bonded. The grandmother, with whom they lived, said that when Teresa got upset she put Henry down. She had never seen her get rough with him. Ms. Barr documented that she advised the child protection investigator that they had spoken with the State's Attorney about the case who stated there was not enough to take to court. Ms. Barr told OIG investigators she could not recall if she was referring to a conversation with the State's Attorney after the investigation began or if she was referring to previous contacts with the State's Attorney. Ms. Barr said that she did not have any contacts with the State's Attorney, rather she directed Ms. Joanis to contact him. Ms. Joanis could not recall specifically

[13] The Merriam-Webster Dictionary defined parthenogenesis as "Reproduction by development of an unfertilized egg usually female gamete that occurs especially among lower plants and invertebrate animals."
[14] Grace Hackaby resigned from the Department effective December 2003.

when the State's Attorney was contacted except for the January 2003 letter she sent him.[15] Teresa refused to engage in counseling or to take medication.

Ms. Hackaby phoned the maternal aunt, who reported that Teresa was diagnosed as schizophrenic in Montana. Teresa thought her former parents-in-law had cloned her ex-husband. She said that Teresa sometimes slept in the truck because she believed evil spirits came through the walls. She reported that Teresa did not allow anyone to feed Henry. Teresa exhibited rages and isolated herself. She received a DUI in March 2003.

Ms. Hackaby went to the home where she saw the baby, noting he appeared well nourished and clean with no marks or bruises. Teresa held the baby for most of the visit and breast-fed him. The investigator spoke with Teresa who said that she believed her son was conceived through parthenogenesis. She said she has worked with Dr. Wyler and he understood her. She stated that she did not need medication and that people just did not believe in spirituality. She had an appointment with Dr. Wyler on August 29. She admitted that she slept in her truck but only two times in six months and that was to get away from her family. She spanked Henry with an open hand but had never left marks or bruises and denied ever losing control.

Ms. Hackaby spoke to the maternal grandmother who expressed concerns about Teresa. She thought Teresa was a good parent but had odd behaviors and much of what was reported was true. She said Teresa fed Henry other things besides breast milk. Teresa kept Henry clean. She kept the baby away from the family for days at a time and thought the baby was possessed. Teresa could be mean but had never done anything to harm the baby; rather she took her aggression out on family members.

Investigator Grace Hackaby completed a CERAP on May 27, 2003. All of the safety factors were marked "no" except for #12) "Any member of the household's alleged or observed physical/mental illness or developmental disability may seriously affect his/her ability to supervise, protect or care for the child." That factor was not marked either yes or no. The safety decision was marked safe. The investigator noted that Henry appeared to be healthy, well cared for and developmentally on target. Teresa appropriately cared for the child. Additionally Henry's maternal grandmother and aunt resided with the family and provided support. The family supervised to assure Henry's safety. The investigator, caseworker and family witnessed Teresa's references to delusions and paranoia. A referral for a psychiatric assessment with Dr. Wyler had been scheduled for August 29, 2003. Ms. Hackaby had Teresa sign a consent for Dr. Wyler. No written information was ever sought from the psychiatrist.

The next day, May 28, 2003, the maternal aunt called the office reaching the supervisor, Mildred Barr. The aunt said Teresa was upset and throwing things. The aunt said the baby was there but Teresa was not holding him. The supervisor advised the aunt to call the police immediately, which the aunt agreed to do.

At 4:00 p.m. that day, Teresa called the hotline herself. Teresa told the SCR operator that she was being harassed with false reports. Teresa went on to describe her sister as a drug-abusing Satanist who drank potions and used black magic with her one year old. Teresa said she told the investigator that her sister did not use drugs because she did not want to get her in trouble. Teresa told the operator she had been approved for public housing and wanted to move because she was fearful of her sister's antics. She admitted that a previous worker wanted her to have a psychiatric evaluation. Teresa requested DCFS assistance in relocating.

On May 29, 2003, the investigator consulted with the caseworker, Brigitte Joanis. Ms. Joanis expressed her concerns about Teresa but said she had always observed Teresa providing good care for Henry. Ms.

[15] For a full discussion on this issue, see the section on communication with the State's Attorney.

Joanis had observed Teresa responding to internal stimuli, having a conversation with Henry as if he was speaking back to her and if Henry got into something she said someone was trying to control him. Ms. Joanis had documented delusional stories, including how Henry was conceived, and Teresa's agitation when confronted about the delusions.

Ms. Hackaby spoke with Teresa's psychiatrist, Dr. Wyler who expressed difficulty in helping Teresa because she refused to comply with medication. He heard her delusions and had real concern about Teresa. He was willing to admit Teresa to the hospital that day and start her on a liquid anti-psychotic. He would follow her on an outpatient basis and monitor her blood levels to assure she complied with medication therapy.

Ms. Hackaby obtained a copy of the Weston Police Department report that confirmed that Teresa had a DUI arrest on March 9, 2003. The police officer assisting her reported they were aware that Teresa had some mental problems.

Ms. Hackaby and Ms. Joanis then conducted a joint visit at home with Teresa and her family. The workers discussed concerns about the mother not being able to care for Henry because of her mental health issues. They suggested Teresa participate in an immediate psychiatric evaluation, saying that Dr. Wyler agreed to admit her and start her on medication. Teresa refused to see Dr. Wyler. Teresa would not acknowledge that her behaviors were bizarre or that she was having delusions. Ms. Hackaby noted that she continued to verbally attack family members and accused them of being possessed and on drugs. Teresa spoke of her brother's death insisting he was murdered while her family said it was an accident. Ms. Hackaby wrote that Teresa was observed getting agitated when confronted, but never put the baby at harm. Teresa told the workers that they along with her family were harassing her.

On May 30, June 16 and July 1, 2003, supervisor Mildred Barr staffed the case with Ms. Hackaby. The investigator reported that she had seen Teresa agitated and talking about things that did not exist, but she never hurt her child. Rather she interacted appropriately, and appeared bonded. He was not afraid of her nor did he appear to be at risk of harm. The caseworker reported that Henry had been evaluated for Zero-Three services.[16] The mother refused to see her psychiatrist. Teresa stated her sister was behind the report. Her sister, she said, was obsessed with their dead brother. She told the investigator that her family has been cloned. Ms. Barr advised the worker to speak with Dr. Wyler about medication. The supervisor noted that there was not enough evidence to indicate the report but wanted to keep the case open to try to get Teresa to see a psychiatrist. The supervisor noted that the worker should speak with the State's Attorney.

On July 2, 2003, Ms. Hackaby spoke with the Public Aid caseworker for Teresa. The caseworker related that she did not see Teresa and Henry that often but when she had seen them Henry appeared smiling and healthy.

The investigator completed a second CERAP that same day at the close of the investigation. Like the first CERAP, it was also marked safe. The narrative noted that Teresa no longer lived with her family as she had obtained her own trailer. The investigator visited the home, which was clean. Teresa discussed her "project" that involved her delusions about her brother's death being a homicide and her need to prove it to her family.[17] Teresa's mother and sister checked on Teresa and Henry daily. Ms. Hackaby noted that Teresa seemed able to care for Henry despite her mental illness, as he was clean, well cared for and interacted appropriately with his mother. Teresa did not say anything negative about her baby. The

[16] Henry was evaluated for Early Intervention Services and was found to be developmentally on target and therefore not in need of services.
[17] Teresa's brother was playing Russian Roulette and the gun discharged accidentally killing him.

investigator reiterated the Department's recommendation that she seek psychiatric treatment but noted there were no behaviors or verbalizations that would lead the worker to believe that Henry was in immediate danger of moderate to severe harm. The intact case was to remain open and the worker was to talk with Teresa about daycare.

The investigation was unfounded. The investigator Grace Hackaby and follow-up worker, Brigitte Joanis found Teresa cared for and interacted appropriately with her child. They did not find evidence that mental health issues prevented her from caring for Henry's needs. Henry was well nourished, well groomed, showed no fear of his mother, and had no marks or bruises. The investigator, however, noted concerns because of Teresa's behavior. The investigator and the worker suggested that Teresa see Dr. Wyler. Teresa signed a release of information for Dr. Wyler who noted his concerns as well as Teresa's history of non-compliance with medication. The case was brought before the State's Attorney but since Teresa had not harmed the baby and provided adequate care no legal action could be taken.[18]

The Investigator assessed Teresa's strengths as her ability to adequately care for Henry along with the support of her mother and sister with whom she lived. The Department provided casework services to assist with issues that might prevent her from taking care of her child. The Department consulted with Dr. Wyler and the State's Attorney. Dr. Wyler agreed to accept Teresa for treatment but Teresa refused. The State's Attorney felt no legal action could be taken because there had been no harm to the child. The Department unfounded the allegation of risk of physical injury.

Case Closing

Ms. Joanis monitored the family after the unfounded investigation and attempted to meet with Teresa and Henry at their new home in July and August. On September 12, 2003, Ms. Joanis found Teresa at home, but she did not allow Ms. Joanis in the home. Rather she told Ms. Joanis to leave and threatened her saying, " It's a good thing you are pregnant bitch or I'd kick your fucking ass." Ms. Joanis completed a CERAP that day. In her summary of the information she wrote that the risk in the situation of mother's untreated paranoid schizophrenia is obvious. However, there have been no immediate safety concerns for Henry. Teresa had stated since July 2003 that she was not interested in services. Ms. Joanis noted that if mother had a chance to stabilize herself she might be interested in services. The worker observed Henry briefly that day at the mother's home. The worker noted no observations that would lead her to believe that Henry was likely to be in immediate danger of moderate to severe harm. In the closing service plan Ms. Joanis wrote:

> Teresa refuses to have services-last contact with the CPI she indicated she never wanted to see me again. Made attempts to see her in July and August to try and see if she would continue to work (with) DCFS. When I was able to find her at home in September she stated I was not welcome-see case note. Teresa has always denied mental health issues – has no insight into her illness. Her version would be that everyone else in her life is crazy.

Ms. Joanis staffed the case with her supervisor. The case closing form noted that Teresa had not agreed to mental health services, and despite recommendations that she receive such services she would not cooperate with DCFS. Teresa met minimal parenting standards.

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[18] It is presumed that Ms. Hackaby was referring to the case being brought to the State's Attorney at an earlier time since she did not document any contacts with the State's Attorney. The OIG did not interview Ms. Hackaby for this report, as the Department no longer employs her.

SCR #2 Sequence A
On December 29, 2003, three and a half months after Ms. Joanis closed the intact case a Memorial Hospital physician reported to the hotline that Teresa brought Henry to the hospital emergency room asking for a neurological consult. Teresa said her ex-boyfriend's junior high school girlfriend tried to clone Henry. The doctor told the SCR operator that Teresa's delusions were "getting out of control." An investigation for substantial risk of physical injury/environment injurious to health and welfare was initiated.

On December 31, 2003, a second call came into SCR. Henry's maternal aunt reported that she went to Teresa's home the night before and saw several holes in the table. When asked about the holes, Teresa said she had been throwing knives at the table and Henry was in the room at the time. The aunt observed furniture and glass that Teresa had been breaking and throwing, behavior she exhibited when she went into a rage. Teresa had been diagnosed as schizophrenic and bi-polar but refused to take medication. Teresa became angry, called Henry a "fucking bastard" and clenched her fists as if to punch him. The aunt believed that Teresa could kill Henry because of her state of mind. Teresa refused to let the aunt care for the baby because she believed the aunt was a witch who cast a spell on Teresa. The aunt told the SCR operator that an investigator had been to the home on December 29, 2003, but did not think the investigator understood the extent of the problem.

Julia Frazier was assigned the investigation and visited the mother's home in the late afternoon of December 30, 2003. Teresa was initially hesitant to allow the investigator in her home but eventually acquiesced. Ms. Frazier noted that Henry appeared healthy, well fed and appropriately dressed. Teresa talked to the investigator about how important Henry was to her and how she needed him close to her because of parthenogenesis which she explained as her ability to produce the baby on her own with no need for a male partner. She said her first child was also a product of parthenogenesis. Because Henry was produced this way people wanted to clone him. She had witnessed some traumatic events with her family and had to leave states because of people wanting to clone her. She showed the investigator two bedrooms but said that she often slept in Henry's bed because she nursed him and it was easier than getting up to feed him. The investigator asked about other foods. Teresa said he had eaten macaroni and cheese that day. The investigator observed the home and noted it appeared neat and orderly with several toys. Teresa told the investigator that she would be willing to allow a DCFS worker in her home if Henry could go to daycare again. She did not want him to go to a private sitter as she felt he needed more interaction with children his age. Henry was up to date on his shots and medical exams and she had a good relationship with his pediatrician. Teresa talked about getting a job or possibly starting her own business. The investigator brought up her mental health. Teresa stated she felt good, did not take any medications and refused to sign any release of information forms for her mental health history. The investigator noted that Teresa appeared to have no problems focusing on the conversation and made no statements of wanting to harm herself or others. Ms. Frazier ended the interview stating she would return with a caseworker to discuss services.

The investigator completed a CERAP on December 12, 2003, marking it safe. In the narrative the investigator wrote that the child and mother appeared close. The mother held Henry most of the time but he did walk from one side of the room to the other. Henry nursed while the investigator was there. No immediate safety concerns were noted. Teresa was amenable to the opening of a case.

The next day Ms. Frazier attempted to reach the physician from the emergency room who called in the report. She staffed the case with supervisor Michelle Paul. Ms. Paul noted that the mother had mental health issues and was not medicated. The investigator observed the home environment, found it appropriate and the mother willing to accept services. No immediate safety issues were noted but should consider protective daycare.

Ms. Frazier spoke with the maternal aunt by phone on January 2, 2004. The aunt reported she was at Teresa's on Sunday or Monday (December 28 or 29), saw a knife and was concerned that maybe Teresa was throwing the knife at Henry. She thought that because Henry's high chair sits beside the table and figured the knife was being thrown at the table. However, the aunt said, she did not witness her throwing a knife. A week earlier she had been at the home and found broken glass and plates in the patio area. Teresa had never taken medication for her mental illness. The aunt tried to discuss Teresa's delusions about Henry being cloned but Teresa became angry. The aunt feared that Teresa delays Henry by holding him all the time. She and her mother tried to see Teresa and Henry on a daily basis.

On January 8, 2004, Teresa, along with Henry, came to the Weston Field Office to ask Ms. Frazier about enrolling Henry in daycare. Ms. Frazier stated that she would come to Teresa's house in the next week to discuss the process.

On January 13, 2004, Ms. Barr staffed the case with Ms. Frazier and Amber Fundora who would be the assigned worker for the ensuing intact case. Ms. Barr noted that the case had been open before but the mother did not always cooperate. She wrote that the case had been "discussed with Assistant State's Attorney about order of supervision but he had told the prior worker we did not have enough to do so. This report was risk." Ms. Barr advised the investigator and the worker to go to the mother and pursue daycare. Despite the mother's mental illness the prior worker had not seen abuse, rather the mother and child seemed well bonded. Teresa talked about things like cloning but she kept doctor's appointments. Ms. Fundora planned to explore mother participating in a mental health evaluation. Ms. Frazier noted that the family voiced concerns about the mother's ability to parent but the investigator had not seen signs of abuse or neglect.

That afternoon the investigator and the worker went to Teresa's home and discussed opening the intact case. Teresa reported currently receiving WIC assistance and that Henry had a doctor's appointment later that week. Teresa wanted to start daycare and Ms. Fundora offered to start the next day. Teresa told the worker she wanted to start her own business and signed releases for the daycare. The investigator wrote in her notes that she did not see indications of the table being hit with a knife. She noted the presence of a knife near the sink by other dirty dishes.

Ms. Frazier planned to finish and close out the investigation, however all the paperwork had not been completed and the investigation was still pending at the time of the death. On March 1, 2004, the investigator wrote that the daycare contacted Ms. Fundora because Henry had not been in since the Monday prior. A worker from the daycare passed Teresa's trailer and saw that it was surrounded by police cars and called the worker. The police confirmed that Teresa and Henry were deceased.

Rationale of Finding
The allegation of substantial risk of physical injury/environment injurious to health and welfare was unfounded on April 2, 2004. In the section of evidence suggesting an incident occurred the investigator documented Teresa's requests for a neurological consult at the hospital and the family's report of erratic behavior. The investigator noted the mother's strong feelings about cloning and reproduction of people. For the evidence suggesting an incident did not occur section the investigator wrote that the child had no physical signs of being neglected or at risk of harm. The child had attended day care for 1½ months with no significant signs of risk noted by the daycare. The follow-up worker did not see any indication that the child was at risk of harm and the investigator herself did not see any signs that would led her to believe that Henry would not be safe with his mother. Teresa denied any desires or wishes to hurt her child.

Second Intact Family Case
On January 13, 2004, Ms. Barr consulted with Amber Fundora, the assigned worker. Ms. Fundora reported that Teresa agreed to daycare services and seemed pleased about Henry going. The worker had

received approval for full time day care funding and informed the day care provider that Henry would start on January 14, 2004.

Upon receiving the case Ms. Fundora completed a CERAP. No safety factors were marked as present and the safety decision was safe. In the narrative the worker noted:

> Mother is delusional. She believes there are people or forces trying to clone her son. She is not under psychiatric care or on medication. Mother has agreed to place child in protective day care five days a week full time. Mother has a history of mental illness but has never physically hurt Henry there is concern that this child is at risk due to mother's mental state. (sic) There is not enough evidence to refer case for legal screening with SA. Case does need to be closely monitored. Child will be safe at daycare. Daycare has been informed of mother's mental condition and they are to report any concerns to DCFS or report if the children does not attend.

On January 20, 2004, Ms. Fundora attempted a visit at Teresa's home. She noted that Teresa's truck was not in the driveway and the trailer was quiet. Eight days later she met with Teresa at her home. Henry had been attending daycare and Teresa was pleased with the providers. The worker attempted to discuss Teresa's family history but Teresa focused on people coming from Montana trying to clone Henry. She said it took her all day to keep spirits out of the house so having Henry at daycare allowed her to work on that problem. Teresa seemed receptive to the worker, who kept the conversation about Henry and daycare. The worker did not, she noted, try to discuss psychotropic medication or psychiatric care.

Ms. Fundora returned to the home in the afternoon of February 2, 2004. She noted that Teresa's truck was in the driveway but she did not answer the door. No noise came from the trailer. The worker then called the daycare provider. The teacher reported that Teresa brought Henry daily, dropping him off and picking him up on time. Henry had been well behaved, happy and appeared well cared for. Teresa had acted a little strange but never inappropriate.

At 10:00 a.m. on February 4, 2004, Ms. Fundora visited Teresa at home while Henry was at daycare. Teresa liked the daycare but worried that people still tried to clone Henry. She felt Henry could sense when things were going wrong. She talked about finding a new place to live but her landlord would not let her move. Teresa reported that she received a housing voucher from the county. The worker asked about her support system. Teresa replied that her mother and grandmother lived in Weston and they talked frequently but her mother had health problems and sometimes they did not get along. Teresa talked about parthenogenesis explaining how a child was cloned and the mother carried the child to birth.

Ms. Fundora left the home and contacted the County Housing office, who confirmed that Teresa had a housing voucher. Staff informed the worker that Teresa paid $46 in rent and the County provided a subsidy of $245 to the landlord. Ms. Fundora said that Teresa reported her landlord would not let her move. The staff explained Teresa had signed a one-year lease and moving prior to the end of the lease would result in her forfeiting her voucher. Ms. Fundora specified that Teresa said the landlord blocked the driveway not allowing her to physically move. The staff person said they had not had any problems with the landlord in the past. Ms. Fundora said she did not believe Teresa but wanted to explore the issue and report it to the office. Ms. Fundora told OIG investigators that she thought Teresa wanted to move because of problems with the landlord. She recalled other clients of hers that had problems with that landlord. Ms. Fundora then spoke with the caseworker from DHS who confirmed that Teresa received food stamps, medical card and financial assistance for Henry. Teresa herself received Social Security Income. The DHS caseworker did not have frequent contact with Teresa but expressed concern about her mental health status. Whenever she saw Henry he appeared appropriately dressed, clean and happy.

After gathering information from the investigation, the previous case and from Teresa, Ms. Fundora completed the integrated assessment report. Ms. Fundora noted that DCFS did not have documentation verifying Teresa's mental illness though Teresa openly discussed cloning and how the spirits scare people away from her home. Teresa told the worker that a Zero to Three Program worked with Henry but they had to stop as the spirits interfered with their work. Teresa told the worker that Henry had sensed she was coming to their house today. Teresa interspersed her delusions with normal conversation. Teresa admitted that she was not receiving mental health treatment denying that she had any issues despite Dr. Wyler's initial referral because of her delusions. The assessment noted that Dr. Wyler mentioned schizophrenia with paranoia though DCFS lacked written documentation of the diagnosis as Teresa refused to sign a release of information.

Ms. Fundora wrote that Teresa was socially isolated except for the support of family. Ms. Fundora acknowledged that the relationship with the relatives was strained at times because of Teresa's paranoia. Teresa denied current involvement in a romantic relationship. Teresa had her own car for transportation and did not have a problem accessing resources. As a parent Teresa was bonded to Henry. Henry was always clean and dressed appropriately. He appeared developmentally on target walking and beginning to babble. Teresa enrolled herself and Henry in WIC and she took Henry to his pediatrician regularly.

Much of the historical information echoed that of the social history gathered by Ms. Joanis during the first intact case. Teresa minimized her substance abuse history to Ms. Fundora denying any involvement with drugs or alcohol except cocaine at the age of 18. Ms. Fundora wrote that Teresa did not have a criminal history, though she had been arrested for a DUI less than a year before the assessment.

Ms. Fundora assessed, as Ms. Joanis had before, that change seemed unlikely if Teresa's mental illness remained untreated. DCFS, she opined, needed to be careful to offer support without compromising the safety of Henry.

On February 9, the worker stopped by the daycare center where she spoke with the director and observed Henry as clean and well cared for. Daycare staff did not have any problems with Teresa. Two days later Ms. Fundora visited the home. Henry did not attend daycare that day because they both had stomach flu-like symptoms. Teresa and the worker discussed the care plan. Teresa continued to be happy with daycare. The worker asked Teresa if she would consider counseling to assist her with the stress she mentioned. Teresa replied that counseling would not help her deal with "the people" from Montana who tried to get Henry. Dr. Wyler prescribed medication but she felt afraid to take anything that might alter her thought processes as she needed to be alert at all times to protect herself and Henry. Teresa felt that he was protected at daycare and she had a good feeling about the worker not being affected by the dark side. Teresa related that she would like to regain custody of her older son. Ms. Fundora observed Henry running around in a clean t-shirt and diapers, often cuddling with his mother.

On February 16, 2004, supervisor Mildred Barr staffed the case with Ms. Fundora. The worker reported that Henry attended daycare daily. The daycare staff found him clean and well cared for. Teresa continued to refuse counseling, psychiatric and psychotropic medication. Ms. Barr noted that Teresa was more cooperative with this worker than in the past. Ms. Fundora had not seen any inappropriate actions between Teresa and Henry. Ms. Barr advised to continue with daycare as much as possible and work toward getting Teresa to agree to at least an evaluation with the hope of cooperating with outpatient care.

On February 18, 2004, two days after meeting with her supervisor and ten days before the bodies of Teresa and Henry were discovered, the worker visited with Teresa for the last time. Henry attended daycare that morning. Ms. Fundora and Teresa discussed Teresa's progress on budgeting. Teresa had some difficulties with social security and food stamps. Teresa told the worker that people did not realize all that she had to do to keep Henry safe. She checked doors and windows and had to be careful about

who she allowed near him. She believed Henry was a smart child but feared for him as many children who were cloned had a high intellect. The worker noted that Teresa, in talking about Henry, called him the delight of her life. The mother commented that Henry climbed all over. The worker asked Teresa about counseling but Teresa refused to discuss the issue. Teresa told Ms. Fundora she did not need therapy she just needed people to leave her alone. The worker chose not to pursue the issue as Teresa became agitated. In her case note the worker noted that while Teresa talked about the cloning of Henry she appeared to be dealing with reality in other areas such as paying the bills and keeping WIC appointments.

The Death Investigation

The report of Teresa and Henry's death in March 2004 came in as related information to the second hotline call dated December 29, 2003. The investigation was still pending at the time of the death. Teresa's sister discovered her body when she went to check on Teresa and Henry.[19] Teresa's sister called Weston Police. She reported Henry missing, as she had not found him in the trailer. Police discovered Henry's body underneath the toddler bed that held Teresa's body.[20] Teresa was laying on her back with her feet on the floor.

Teresa's sister last saw Teresa alive the last week of February 2004. The sister expected Teresa to bring Henry over to the grandmother's home, so relatives could baby-sit, but she never came. The sister went to the home and found the door locked and no one answered. When the sister and mother returned to the trailer, they found the door open a crack and noticed an odor. Teresa's sister told the police Teresa had been associating with several men in the area, some of whom the police were familiar with. The owner of the daycare Henry attended told police Henry last attended on Monday, February 23, 2004.

Neighbors reported not seeing Teresa for several days. One neighbor had not seen her for two weeks. The last time they spoke Teresa claimed that her mother and sister were clones. Another neighbor related he had seen a truck at her home and a couple of men hanging out.

A police officer recalled seeing Teresa in her truck the morning of Thursday, February 26, 2004. The same truck had been reported abandoned in another part of town, having been there four or five days. People living and working in the area where the car was abandoned confirmed the car had been left there on Thursday. The truck had a broken tie-rod and was not drivable.

The Weston Police initiated an investigation into the deaths. The investigation remains ongoing.

Communication with the State's Attorney

Throughout the case, child welfare staff made references to discussions with the State's Attorney. Shortly after Ms. Joanis was assigned the case (June 2002) she and her supervisor, Hailey Kellogg, documented discussing the case with DCFS Legal and the Assistant State's Attorney, neither of whom felt custody was feasible at that time.[21]

In January 2003 after a visit when Teresa was not only delusional but also actively hallucinating, the worker contacted the Assistant State's Attorney to arrange a meeting. On January 24, 2003, the worker documented a phone call stating she provided the State's Attorney with details of the case. He did not believe there was enough information to prove abuse or neglect. In her case note Ms. Joanis wrote that the

[19] Because decomposition had begun, Teresa's face was discolored and bloated. The sister thought that was an indication that Teresa had been strangled.

[20] A vinyl/foam bumper pad tied to the legs of the bed blocked the view underneath the bed where police located Henry's body.

[21] At the time the supervisor and Ms. Joanis spoke with the State's Attorney, he was an Assistant State's Attorney.

State's Attorney suggested that she may want to keep the case open because if she closed the case "how would that look if something happened." Ms. Joanis noted she would send a letter with case details so the State's Attorney could respond formally.

Enclosed with a letter dated February 25, 2003, to the State's Attorney was a copy of the worker's on-going assessment completed in mid- January. The two-page assessment documented Ms. Joanis' first visit with the mother on June 27, 2002, when Teresa discussed her delusions about black magic, cloning, people coming after her and Henry and her special abilities prompting the local police to move her to Weston.[22] Ms. Joanis noted that she staffed the case with her supervisor that day, as she feared what Teresa might do in a psychotic episode. The worker also contacted Dr. Wyler who believed Henry was at moderate to high risk at this time because of the mother's poor judgment. Ms. Joanis recalled that early in the case she and her supervisor staffed the case with the State's Attorney's Office and DCFS Legal, both of whom felt there was not enough information to maintain custody at shelter care.

From that point forward, Ms. Joanis wrote, Teresa mentioned delusions during every visit. Ms. Joanis described Teresa appearing to respond to internal stimuli. Teresa believed people tried to control Henry. She attributed his crying to people from the other side commanding him rather than him being tired or hungry. The worker opined, "Teresa is so far out of reality that it is difficult to know how she will react to anything anyone says or does." The worker worried that Henry could be hurt in her efforts to save him from the people she believed to be after Henry. The worker included the fact that Dr. Crookes, Henry's pediatrician, called DCFS on December 18, 2002, to assure that services were being provided to the mother as he had serious concerns about the safety of the child in her care. However the doctor indicated the child did well and he did not make a hotline report.

No other documentation of communication with the State's Attorney was noted, even after State's Attorney prosecuted Teresa for the DUI. Ms. Barr mentioned contact with the State's Attorney during the December 2004 investigation. Ms. Barr told OIG investigators that she could not recall if she was referring to contact while that investigation was ongoing of if she was referring to contact during the first intact case. OIG investigators spoke with DCFS Legal who recalled discussing the case but did not have any separate notes on when the case was staffed. DCFS Legal, Ms. Barr, and the State's Attorney did not recall any discussion about considering this case for a dependency petition. The State's Attorney told OIG investigators that he did not recall receiving a letter or discussing the case with the worker or supervisor. The State's Attorney said that dependency petitions were rare; he could only recall filing one or two in the past several years.

LEADS and Police Involvement

An Illinois LEADS check was first conducted on August 1, 2002. In fact, the file contained a piece of paper with a handwritten statement of consent for a CANTS and LEADS check that was signed by Teresa Foster on July 26, 2002. It showed one arrest on September 4, 2001, for criminal trespass to land with no conviction.

On the LEADS checks, completed by OIG investigators, which included an out-of-state criminal background check, Teresa had two drug related and five battery arrests in Montana. The Montana arrests dated from April 1992 to September 1996.

The DCFS intact record contained 17 incident reports and copies of letters Ms. Joanis obtained from the Weston Police beginning November 2, 2000 through July 31, 2001. Ms. Foster had been calling the police asking for extra patrols around her home, as she believed someone from Montana had come after

[22] Ms. Joanis clarifies that Teresa's mother moved her to Weston because she feared Teresa would be homeless in Montana.

her. In December 2000 she brought a 21 page rambling letter to the station discussing escaping on horseback, evil hexes, holy spirits, murder and black magic. The police later obtained other letters from Teresa, all of which described her paranoia. Teresa also called the police to inform them she had slept in the police parking lot for extra protection.

OIG investigators obtained seven incident reports from the Weston Police Department dated between October 20, 2002, and March 2004. The reports documented requests for extra patrols around Teresa's home in order to protect her and Henry from black magic. One report detailed three teenagers complained that they had helped Teresa move furniture and when they asked to be paid she backed up the U-Haul and hit one of the boys in the knee. The minor was not seriously injured and Teresa was issued a citation for failing to report an accident. In October 2003 Teresa's sister reported that Teresa was becoming violent with her child in her arms. The police arrived and Teresa had left the home upon request. On February 16, 2004, weeks before the bodies of Teresa and Henry were discovered, Weston Police received a request for a welfare check from the local police after Teresa contacted them about God, the FBI and cloning. The Weston Police officer advised that they had several contacts with Teresa about the same things and a welfare check would be done. In March 2004 the police received a report about Teresa's truck being abandoned along a roadway for four days.

DUI Charge

According to the Weston Police Report in March 2003 at 1:41 a.m., an officer saw a Ford truck driving with no headlights. The officer stopped the truck, driven by Teresa and told her the reason for the stop. Teresa said the lights have not worked for several days. The officer smelled alcohol on Teresa's breath and observed the passenger also appeared intoxicated. The officer tested Teresa's blood alcohol content with a portable breath test instrument and she registered a .117%. She also did poorly on the field sobriety tests. The officer allowed the passenger to leave and the police transported Teresa to the police station for a second BAC test. She registered a .082%. The officer issued citations for DUI, DUI over .08 and no insurance. She was given a written warning for driving without headlights. Teresa posted her driver's license and $100 cash before being released. On April 7, 2003, documentation was sent to the court indicating that she had not completed an Alcohol and Drug evaluation through the Department of Human services. Teresa was assigned a public defender. In July 2003, she pleaded guilty and was sentenced to a year of court supervision. Teresa wrote a letter to the judge in August, claiming that she had participated in rehabilitation programs in Montana and had six years of sobriety. She did not consider occasional drinking to be a breech of that sobriety. She mentioned the conception of her children through parthenogenesis, cloning and her inability to find someone who could keep Henry spiritually safe. In November the court vacated all fines and returned Teresa's driver's license.

Mental Health Treatment in Illinois[23]

The staff at Memorial Hospital knew Teresa from various emergency room visits and two psychiatric hospitalizations. Teresa received care from Dr. Wyler along with attending Dr. Wyler's outpatient practice but had minimal cooperation.

Most of Teresa's visits to the emergency room were for physical complaints or check-ups while pregnant with Henry. On occasion her delusions caused her problems. On August 16, 2001, the sheriff brought Teresa to the hospital after she went to the courthouse seeking a restraining order against black magic. Teresa refused voluntary admission and denied any suicidal or homicidal ideation. The physician did not find enough evidence to admit her involuntarily and referred her to see Dr. Wyler on an outpatient basis.

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[23] Though OIG investigators were not able to subpoena Montana medical records, investigators spoke with a Detective, whose name she gave to Weston Police, who stated that Teresa would often come into the station to make complaints about people who were after her. The detective said Teresa would talk about black magic and delusions and she would be hospitalized. Teresa also told Memorial Hospital staff that she had been hospitalized in Montana.

In January 2002, while pregnant with Henry, she came to the hospital with cramping. She told staff that people in the back magic ring were trying to get to the baby through the umbilical cord. She refused a referral to both the partial hospitalization program and Dr. Wyler. In March and April 2002 she came to the emergency room several times complaining of abdominal pain and little fetal movement. She often voiced concern about evil people getting to the baby. In May 2003 Teresa feared she was pregnant with sperm controlled by Satan. She left the hospital after a negative pregnancy test.

Teresa was psychiatrically admitted to Memorial Hospital on September 10, 2001 after reporting that a satanic group from Montana tried to kill her with black magic. She discussed her extra powers and that people were envious of her powers. Dr. Wyler, the admitting physician, noted she was delusional, disorganized, grandiose and displayed symptoms of mania such as euphoria, aggressive behavior and being sexual uninhibited. Staff recorded that she described poor impulse control and isolation. Teresa received a diagnosis of schizoaffective disorder, bi-polar subtype and admitted voluntarily for psychiatric hospitalization. During her physical exam she admitted to previously using marijuana, cocaine and methamphetamines. She initially would not agree to take medication though eventually complied with Risperidone[24] and Depakote.[25] She showed gradual improvement, sharing in groups, increasing insight and demonstrated better judgment. Her thinking became more organized; she appeared more relaxed and less irritable. The hospital discharged Teresa with medication on September 20, 2001 with a plan to go to the partial hospitalization program.

Teresa attended the partial program from October 23, 2001, to October 26, 2001. At that point she was five weeks pregnant with Henry. When she called the program to ask about attending she told staff that she was fearful her mother would ask her to leave the house because she was pregnant. She later expressed anger with her mother for letting people from Montana get to her. She named her mother and grandmother as her social supports.

According to the information taken by the partial hospitalization staff Henry was her fifth pregnancy though she had only given birth once.[26] She reiterated the delusions she presented with at the hospital on September 10, 2001. Dr. Wyler noted that he believed Teresa had stopped taking the medication prescribed when she had been hospitalized. Because of her pregnancy she would not take medication.[27] Teresa started in group therapy but stopped coming after a week saying that she would rather sit home because of her pregnancy. Staff documented Teresa as being delusional throughout the week. Staff hoped to stress reality orientation, coping skills, nutrition, rest and exercise during her pregnancy because of inability to take medication. She was asked to come back but refused. Teresa was informed that should she wish to return she could do so. Her discharge diagnosis was paranoid schizophrenia.

Teresa had a second psychiatric admission from February 12 to February 15, 2002, when she was 21 weeks pregnant. She presented with bizarre statements as "The murder victim's assailant refuses to leave my psyche." Dr. Wyler's admission note indicated that though involved in the psychiatric system for over six years in both Montana and Illinois, Teresa did not comply with treatment. "She has not been persuaded that she has any form of mental illness though she suffers from a clear picture of paranoid schizophrenia." She presented with auditory and visual hallucinations and a growing delusional system about people who are in pursuit of her and delusions regarding her ability to read people's thoughts and communicate with dead people and television commentators. She was unable to sleep and had contacted several levels of law enforcement for her safety. She felt being in the hospital would keep her safe. She

[24] An anti-psychotic medication.
[25] A medication often used as a mood stabilizer for people with bipolar disorder.
[26] Teresa indicated that she had one abortion and 2 miscarriages.
[27] There is a note written by staff in the "Patient Centered Interdisciplinary Assessment" which poses the question "possibly got pregnant in order not to take meds?"

reported a family history of schizophrenia. Teresa started Zyprexa, but continued to display poor judgment and insight. Teresa demanded to leave especially after she realized that the staff did not believe her delusions. Teresa did not voice suicidal or homicidal thoughts. Dr. Wyler was reluctant to discharge her but the treatment team generally agreed that she had the right to leave. Dr. Wyler discharged her with a prescription for Zyprexa. Her discharge diagnosis included paranoid schizophrenia and borderline personality disorder.

Teresa's next visit to the hospital was in June 2002 when she gave birth to Henry at 38 weeks gestation by cesarean section. Records indicated that Teresa smoked about a pack of cigarettes a day. Early in her pregnancy she told staff she would probably have alcohol during her pregnancy but that was not later evaluated. On the night of June 7, 2002, the day after giving birth, Teresa began to voice paranoid bizarre delusions to the nurses. She quickly stopped though when the nurse tried to dissuade her. The next day Teresa was easily irritated, yelling and cursing at the nurses. She eventually calmed down. Staff made a referral to DCFS for CWS and for Teresa to see Dr. Wyler outpatient. Teresa and Henry left the hospital on June 9.

Teresa met with Dr. Wyler on June 17 and 24. Dr. Wyler noted that in regard to Henry her severe level of psychosis posed three problems: how the psychosis affects the safety of the baby; choosing medication with the knowledge that she was breastfeeding; and convincing her to take medication since she lacks insight. Dr. Wyler prescribed Seroquel. Teresa agreed to start medication. By the second visit Teresa had only taken the medication twice telling Dr. Wyler it made her tired. Dr. Wyler discussed caring for Henry and Teresa assured him she did fine. However, Dr. Wyler documented concern about her judgment. When Dr. Wyler confronted her on her delusions she became sad and overwhelmed telling Dr. Wyler she would not return. After Teresa left, Dr. Wyler made the call to DCFS that Ms. Frazier documented in the first case.

Henry's Medical Treatment

Teresa brought Henry to the emergency room several times for treatment. In July 2002 Henry required hospitalization for RSV and his pediatrician monitored his care. Eight months later, on March 4, 2003, Henry had scratches from a family cat. Teresa feared that the cat had also scratched a relative who had hepatitis and could then give Henry hepatitis. Doctors consulted with vets and animal control. They spoke to Teresa about not allowing the cat near Henry. Henry had a normal exam. Teresa returned on March 21, because Henry had fever and an upper respiratory infection. On August 13, 2003, Teresa requested Henry's ear be checked as he had been poking at it for the last two months. Doctors concluded Henry was fine and should continue to see his pediatrician. On September 16 Teresa brought Henry to the hospital because of a runny nose. Doctors noted a diaper rash and told Teresa to apply Lotrimin. Three days later, September 19, Teresa presented Henry with a complaint of a runny nose for three days. Doctors diagnosed a cold and advised the use of over the counter medicine. On December 10, 2003, Teresa brought Henry to the emergency room because he had been coughing for two days. She reported no other cold or flu-like symptoms. The exam was normal and the doctor concluded Henry was irritated by cigarette smoke, advising Teresa not to smoke around him. On December 29, 2003, Teresa brought Henry to the hospital fearing he had been cloned. Staff observed a bruise on his forehead consistent with Teresa saying he hit his head on the floor, since he was toddler age. An exam did not find anything abnormal. Staff called DCFS regarding the cloning delusions.

The pediatrician saw Henry regularly. Ms. Joanis accompanied Teresa at times. By Henry's two-week checkup Teresa fed him cereal, peas and juice. The doctor advised her to only feed him breast milk. The pediatrician noted that he did not think Teresa would follow his advice. Henry always appeared well-fed and cared for. At his two-month check-up Henry measured in the fifth percentile for height and the seventy-fifth percentile for weight. That pattern continued until his nine-month check up when Henry's

weight decreased to the fiftieth percentile. The doctor noted that Teresa spoke of her delusions at the visits prompting him to check if she received psychiatric care.

ANALYSIS

Decisions about parenting capacities of mentally ill individuals are rarely clear-cut. People with schizophrenia often exhibit impulsive and at times violent behavior, especially if they are untreated. The problematic behavior is often unpredictable because it is exacerbated by hallucinations. (Saddock and Saddock, 2004). If the parent's symptoms include hallucinations that directly command them to do certain things, or should a parent show florid psychotic symptoms, some assessment of risk must be made including clinical assessment of social support and a review of all pertinent mental health records. When children are incorporated in the psychotic ideation there needs to be an adequate exchange between mental health and child welfare in the planning for potential custody or stand-by guardian. When a parent experiences distressing persecutory delusions that include the child or the support system, the physical risk to the child increases significantly. The child's safety must be monitored throughout the assessment and treatment of the parent. The monitoring should be guided by the parent's mental state and cooperation with mental health services. In reviewing parents who had attacked their children while psychotically disturbed, Anthony (1986) found a pattern of deterioration of judgment prior to the attack. Other factors of relevance are any history of aggression or suicidal behavior and whether there is anyone to monitor the situation.

This was a difficult case with difficult issues. Teresa consistently refused treatment. Teresa never voiced suicidal ideation or had exhibited suicidal behavior but she did have a history of violent behavior as indicated by several arrests for assault. She included her relatives in her delusions, telling a neighbor they were clones, thus not trusting them to help oversee her son's well-being.

In a DCFS decision tree for mentally ill parents, a question posed asks if there are overt negative statements or behaviors by the caretaker involving a child that may result in harm or injury? If no, the worker is to refer to a mental health provider. If yes it prompts the worker to look for others to assist in caring. Parents who experience paranoia may not make negative statements about the child but may in fact present a risk because of the behavior they engage in to protect the child from their perceived dangers. It is important to address any delusions or bizarre behaviors that involve a child, not just overt threats to a child. Workers did not hear Teresa making threats to Henry, though family members had concerns, but Henry was integral to her delusions from how he was conceived to people trying to clone him.

An assessment of risk can be based on three factors: whether a relative is available to monitor and supervise; whether the baby is included in the delusional symptoms; and the absence of rough handling or inappropriate actions towards the baby that imply physical aggression (Oates, 1988). Parents, who have discrete episodes of illness with good functioning and relationships in between delusional symptoms, pose fewer risks to the child than those who have chronic and persistent symptoms. Teresa Foster had persistent symptoms, was not amenable to treatment and her child was incorporated into her delusions. Compounding these risk factors Ms. Foster would isolate herself from her extended family members, had bouts of substance abuse problems, and her sister noted increasing agitated behavior. Teresa's involvement in her older son's life was cut off because Teresa involved her delusions in her contacts with him. While Teresa adequately cared for Henry's physical needs, and never made overt negative statements about him, Teresa's questionable reality was Henrys' reality.

Teresa's case posed problems for professionals involved with her. Clearly all involved wanted a solution. Workers and non-child welfare professionals were concerned about Teresa's ability to care for Henry

even in the absence of evidence of physical harm to the baby. DCFS documentation clearly shows a very disturbed woman. Teresa often exhibited poor judgment in several areas of her life, including relationships and feeding Henry, and an inability to distinguish fantasy from reality. Though she may not have caused actual harm to come to Henry her lack of insight and delusional thinking put him at risk of harm on a daily basis.

Workers and doctors involved consistently questioned the safety of Henry while in Teresa's care. The psychiatrist and the pediatrician called the Weston Field Office to discuss concerns about Teresa's ability to care for Henry. The workers involved assumed that when the professionals called the field office, their concern did not rise to the level of a hotline call. Workers should use caution in making that assumption. The general public may not recognize the division between operations and child protection that those working for the Department do. Unfortunately no one considered, or knew how to go about filing a dependency petition, including DCFS Legal or the State's Attorney.

In order for the State to intervene to remove a child from the care of his or her parent, the State must demonstrate that the child is either abused, neglected or dependent. A minor who is "without proper care because of the physical or mental disability of his parent, guardian or custodian" is a *dependent minor* under the Juvenile Court Act [705 ILCS 405/2-4]. Whether a child is abused or neglected is determined by whether specific allegations of abuse or neglect are met, under Rule 300.

The most relevant Allegation to the facts of this case is Substantial Risk of Physical Injury [Allegation 60]. Substantial Risk of Physical Injury means that the parent "has created REAL AND SIGNIFICANT DANGER of physical injury **which would likely cause disfigurement, death or impairment of physical health or loss or impairment of bodily functions."** (Emphases in the original.)

The Allegation includes "placing a child in an environment which is injurious to their health and welfare." Examples of circumstances that create Substantial Risk of Physical Injury include:

- Parent's/caretaker's or anyone in the home whose mental illness *and* behavior pose a significant danger to the child's health and safety. (NEGLECT) To indicate an allegation based on this factor, the investigator must rule out Dependency as defined in the Juvenile Court Act as the presenting problem (emphasis in original).

Because of the child's age and vulnerability, it is likely that the mother's paranoid processes placed him at substantial risk of harm. However, the Allegations appear to require behavioral components, as well. To analyze whether a caretaker's *behavior* poses a significant danger to a child's health and safety requires professional expertise and a great deal more guidance than is provided in the Allegation. Moreover, it is by no means clear what ruling out Dependency as the presenting problem means. The Rule needs to provide significantly more guidance to an investigator confronted with the problems presented in this case.

RECOMMENDATIONS

1. DCFS Clinical should provide training and consultation for supervisors on risk assessment and decision-making for screening cases of severe mental illness.

2. Although the Juvenile Court Act has a provision for dependency cases it is rarely utilized and requires specialized skills. The Department should explore the State's Attorney's willingness to assist the Department in developing a taped training discussion on how DCFS Legal and DCFS Clinical can prepare cases for protective orders or screening when the field confronts this issue.

3. The procedures for completing the Child Endangerment Risk Assessment Protocol (CERAP) should be amended so that the guidelines for the factor regarding a household member's developmental disability or mental illness direct a worker to consider pursuing a dependency petition.

4. The procedures for completing the CERAP and the decision tree for mentally ill parents should be amended so that the guidelines note the need to assess risk to the child when a parent incorporates a child into their delusional system, even in the absence of overt negative statements.

OFFICE OF THE INSPECTOR GENERAL
Department of Children and Family Services

REDACTED REPORT

The Office of the Inspector General is releasing this report for training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

SUBJECT: Child Endangerment Risk Assessment Protocol (CERAP)
DATE: September 26, 2005

The Director of the Department of Children and Family Services requested that the Office of the Inspector General (OIG) complete a comprehensive analysis of the Child Endangerment Risk Assessment Protocol (CERAP). The OIG previously noted concerns with the CERAP procedures and form in child death investigative reports submitted to the Director. This report provides an analysis of CERAP using multiple methods to examine cases previously investigated by the OIG. The goal was to identify limitations of the CERAP tool, as well as problems in its implementation, focusing on its application by the Child Protection Investigator (CPI) during child abuse and neglect investigations. (See Appendix A, The CERAP Form). OIG investigations included in the analysis had a serious negative outcome for a child and child welfare involvement within one year prior to the hotline call alleging the serious abuse or neglect of a child.[1]

METHODS

Rationale for Analytic Strategies Chosen to Examine CERAP

Child Protection Investigator behaviors, along with the broader context in which safety and risk assessment decisions are made, were considered for examination of the CERAP. The context of protective service investigations presented many barriers to good decision making, including time constraints, limited and uncertain information regarding case events, and the need to accommodate other systems (such as court, police, and other service providers.) Root cause analysis was chosen to sort out the multiple and specific causes of CERAP errors which offered a systematic approach to examining faulty decision-making, based on logic, an emphasis on multi-level organizational processes, and uncovered opportunities for preventing errors in the future. This method identified ways the CERAP process and tool might be improved. Originally designed to examine accidents in other high-risk organizations (e.g., nuclear power plants, airline industry, hospitals), root cause analysis was adapted to examine CERAP errors with cases investigated by the OIG because of the death or serious injury of a child in a family known to DCFS.

Overlapping samples, the use of multiple data sources and analyses allowed for the comparison of results, which provided increased confidence in the findings. However, the sample analyzed was not representative of cases served by DCFS and those not investigated by the OIG. There was no way of

[1] Prior studies of the CERAP were based on statistical analyses measuring reabuse within 60 days of the initial hotline report. Fuller and Poertner [2001]; Fuller and Wells [2003].

knowing whether the CERAP problems identified for this set of cases also occurred in cases where a child was not seriously injured or had died.

Review of OIG CERAP-Related Recommendations

Over the years, the OIG made recommendations to the Department, based on findings from investigations into child deaths and serious injury. For the purpose of analysis, a 3-tiered coding scheme was developed for OIG recommendations that addressed CERAP-related issues, using the recommendation statement as the unit of analysis. Initial coding was based on logic and the principles of root cause analysis. We categorized recommendations according to the general principles of organizational control that each addressed (management/policy, supervisory /implementation, and individual). The second and third rounds of coding permitted further refinement of substantive content (See Appendix B for a detailed description of the coding scheme).

Two coders reviewed the recommendations and applied the coding scheme to the data after achieving an acceptable level of agreement when independently coding a sample of cases. In all, we coded 85 recommendations representing 50 cases from OIG investigations conducted between 1993 and 2004, although most cases were fairly recent (2001 or after).

Data were analyzed using the Statistical Program for the Social Sciences (SPSS). The coded data permitted the identification of common types of problems the recommendations addressed, along with the distribution of these problems across different levels of the organization (policy/management, supervisory/implementation, individual).

Shortcomings of the data were noted that should be kept in mind when drawing conclusions from the results. Findings based on CERAP-related recommendations were likely to be incomplete for two reasons. First, there may be problems with CERAP that the recommendations fail to address; therefore, we chose a multiple methods approach to the data that were available in the OIG office. Second, CERAP related recommendations were pulled from a larger set of OIG recommendations. It was sometimes difficult to determine whether a particular recommendation addressed protective service investigations more generally or was CERAP specific. If a case could be made that the recommendation had a direct impact on CERAP procedures or decisions, it was included in the sample.

In-depth Analyses of Cases

Overlapping samples of cases were also examined by applying three case review strategies: a software tool for examining individual cases using root cause analysis (REASON®) and two additional analyses using the logic of root cause analysis but not the software: one an analysis of cases using data from OIG investigations and the other an analysis of original case material. Eleven cases were reviewed using at least one of the following methods and some were subjected to multiple reviews.

Case Analysis Using REASON®

A team of OIG investigators worked together to analyze a set of four investigations with issues pertaining to the application of CERAP. The team's primary interest in root cause analysis was the potential it held for offering a framework that would help ensure that all avenues of their investigation were exhausted in comprehensive case reviews. Key elements of the software tool, REASON®, included creating a causal tree that incorporated the following:

1) Creation of a problem statement (e.g., child died during pending DCFS investigation)
2) Backwards chaining of events, conditions, and inactions

3) Identification of causal sets
4) Logic testing for accuracy of each causal set
5) Termination of cause-effect chains
6) Identification of prevention principles (Decision Systems, Inc. 2003)

Analysis of the four cases benefited from the multiple perspectives generated through the group process. The combination of group discussion and introduction of multiple perspectives may have helped monitor and control biases, especially hindsight bias which was most likely to influence the OIG investigation. Backward tracking of case events by a group helped prevent the use of information that becomes available only during the death investigation and was not known to child welfare staff while the family was being investigated by protective services. The group process assisted in modeling an accurate sequence of events. Reconstruction of a chronology became increasingly difficult as the analysis moved back in time.

While root cause analysis facilitated judgments about what was important and what was not, it remained possible to overlook factors that contributed to faulty decision-making (i.e. safety assessment). Intimate knowledge of the organizational environment permitted the group to expose factors that may reduce the effectiveness of Department efforts to keep children safe. This knowledge facilitated the identification of hidden disincentives for following DCFS protocol regarding CERAP. It was, however, still possible that personal biases may have influenced the selection of some factors.

Case Analysis Using OIG Investigation Reports as the Data Source

Eleven investigative reports were selected for this analysis based on several criteria. The selected reports had been previously identified by the OIG as being potentially CERAP problematic. All of the cases had negative child welfare outcomes. Ten of the cases selected involved incorrect decisions to permit a child to remain and one involved an incorrect decision to remove. A range of reports was selected to ensure a wide variety of circumstances, complexities, and case variables. The goal was to have a diverse pool of reports to analyze and then to generalize basic thematic findings. The issues included: Serious Injury to Child During Pending DCP Investigation; Death of Child Following an Unfounded DCP Investigation; Death of a Ward's Infant; Child Death With Open Intact Family Case; Inadequate Services to Substance Exposed Infant; DCP Investigation of Medically Complex Child; and Other Child Deaths in DCFS-Involved Family.

Using the logic, philosophy, and key principles of root cause analysis, the goal of this analysis was to aggregate the causes of CERAP failures on different levels to increase the power of the findings from individual cases. For each case, we examined CERAP-related *actions* on the part of staff, *conditions* (contextual factors) that set the occasion for particular actions to occur, and *inactions* (actions that did not happen, but should have) at the policy, supervisory, and individual worker levels (adapted from DECISION systems, inc., 2003). Cases were coded in this way to obtain a multifaceted understanding of organizational processes and individual worker behavior that led to errors in safety and risk assessment.

Next, problems within the CERAP assessment tool were identified that may have contributed to an inaccurate assessment. This was achieved by going through each item on the tool to identify the factors that should have been assessed more fully by the CPI, using information that was accessible at the time. In the final step, we reviewed the case with the OIG staff responsible for the investigation. This meeting allowed for a review of the results of the analysis for accuracy and completeness, to reduce the likelihood of introducing hindsight bias, and to discuss potential implications of the findings.

Case Analysis Using Original Case Material as the Data Source

Three cases were selected randomly from the sample subjected to the case analysis of OIG investigations. These cases were analyzed thoroughly using a data collection instrument that compiled the most relevant factors in CERAP investigations. The instrument was constructed with factors that were determined by OIG investigators. The investigators agreed on questions relevant to the overall performance of the risk assessment protocol and the CERAP tool. Items on the instrument were also informed by the literature on risk assessment and decision-making.

The data collection instrument was designed to be comprehensive and detailed. The analysis of factors only covered the period of time from the hotline call to the completion of the initial CERAP tool. This timeframe was selected to have a more realistic sense of the information available to the CPI at that particular time, and, thus, the resources that the CPI had in order to make a decision regarding child safety.

ISSUES IDENTIFIED

Risk Management -- Failure to Develop or Monitor a Realistic Safety Plan (n=4)

The development and monitoring of a Safety Plan was the Risk Management portion of the Safety Assessment. In four cases, the investigator checked "yes" to one or more safety factor; but, either 1) determined that the safety factor was mitigated, obviating the need for a safety plan, 2) developed a naïve and ineffectual safety plan, or 3) failed to monitor the safety plan. All four of the identified cases presented issues of physical abuse or a past history of violence.

The development and monitoring of the Safety Plan appeared to be the most critical piece of a Safety Assessment, because it occurred in the context of an existing, identified safety concern. There was significant literature supporting Risk Management of Violence, but there was no evidence that it had been absorbed and transmitted to the field of child welfare in Illinois. **The Procedures for CERAP did not contain any directions or guidelines for how to develop a workable and realistic safety plan that targeted the problem of violence and subsequent monitoring of the safety plan.**

Case Examples

- A safety plan required the mother, also a victim of father's violence, to keep the father out of the home. The mother's ability to protect the children from the father was presumed as a *mitigating factor*. The decision to trust the mother's ability to protect, however, was made without reviewing the police report, which was available at the time. The police report would have informed the investigator that, contrary to the denials of domestic violence provided by the mother to the investigator, the mother disclosed significant domestic violence to the police. Had the worker or supervisor analyzed the assumption of the *mitigating factor* in light of the information in the police report, they would have noted that mother had been a frequent victim of father's domestic violence. As such, her ability to protect the children from him should not have been assumed.

- A child was allowed to return home with the parents' promise not to engage in corporal punishment, not to allow the child to sleep on her stomach, and the father's promise not to throw the child in the air.

- A supervisor advised the investigator not to take protective custody, despite a serious history of violent acts by the mother, because the family was receiving intact services.

- A safety plan was not monitored. In the first investigation of serious physical abuse in the family, the CPI developed a safety plan that, by its own terms, expired after two days. The CPI never developed a new safety plan and never communicated to the follow-up worker the need for a new plan.

In the aftermath of two horrific child deaths (not reviewed for this Report) involving prior physical abuse of children, the OIG noted the investigators' failures to credit information from family members or include family members in the Safety Plan. The result of those investigations was new legislation permitting investigators to share information with family members. The current study suggested that the field continued to fail to draw on family resources during the investigative phase.

When a Safety Concern had been identified, consideration of involving family resources was critical. An existing Safety Concern was like a time bomb; no one could predict when it would explode. The Department cannot be with any child 24/7. When family members present as viable and concerned for the child's welfare, their inclusion in a Safety Plan may mean the difference between protection and harm.

A review of existing Rules and Procedures disclosed little guidance on how to develop a Safety Plan. When violence was the presenting issue (including all physical abuse cases), a Safety Plan should include specific components, such as:

- Daily observance of the child by someone outside the immediate family unit who the child trusts and who demonstrated concern for the child, with consideration of protective daycare
- Shared information with persons outside the immediate family who understand all requirements of the safety plan and agree to notify the Department if circumstances change.

There was no guidance in CERAP on how to develop realistic and effective Safety Plans that were capable of being monitored and were targeted to the identified safety concern. Mitigating factors (which permitted children to remain in the home without a Safety Plan) were not analyzed to ensure that the underlying assumptions were correct; nor was there any guidance on specific components of Safety Plans that should be included given specific safety risks, such as violence.

Safety Assessment: Failure to recognize cumulative risk (n=9)

ALCOHOL OR SUBSTANCE ABUSE (N=3/9)

During a CPI investigation, the investigator may learn new information that creates additional risk of harm. The Allegations System permits the investigator to add additional allegations as necessary, such as Risk of Physical Harm. In some of the investigations studied, CPIs failed to recognize cumulative risks created by a combination of historical and current circumstances that posed danger to the child. In three of the cases examined, the potential for future harm arising from significant substance abuse did not result in adding a Risk of Harm allegation.

Case Examples

- A CPI did not identify additional risk despite prior abuse to a medically vulnerable infant, in a home where mother had previously overdosed on prescription medications, the child was born cocaine-exposed and father had admitted to substance abuse (in a previous investigation by the same investigator) and had been diagnosed as bi-polar.

- A CPI did not consider mother's drug use as a safety factor nor was it realized that the mother's substance abuse behaviors led her to use older children to care for the younger ones.

- A mother suffered from poly-substance dependence (cocaine, crack, marijuana, hallucinogenic mushrooms, methamphetamines and LSD) and tested positive for cocaine at a previous birth. The CERAP was completed based only on an allegation of medical neglect, without recognizing the presence of substance abuse as both a causal/contributory factor and an additional risk factor, despite knowing that the mother was addicted to drugs and had moved in with another addict.

DOMESTIC VIOLENCE/PARTNER ABUSE (N=3/9)

A family's present and historical pattern of relating to each other in the home in an abusive manner is a crucial aspect of protecting children from child abuse. Violent partner relationships may provide disincentives for a parent to be truthful about their ability to adequately protect their child, because of fear of their partner or desire to keep the relationship intact.

Case Examples

- An investigator failed to appreciate the additional risk to the child of the documented domestic violence issues between the parents and multiple past incidents of violence by the mother.[2]

- A family had a history of domestic violence and/or partner abuse. Despite professionals' observations that mother had been observed with bruising up and down her arms, and the father was overheard coaching the daughter on how to explain her injuries, the investigator operated on an assumption that the mother's denial of domestic abuse should be trusted. Additional risk factors were also ignored. The family had pulled the child from school and had eluded the Department in a prior investigation. The initiating allegation was a knife fight between the father and his brother.

- A father was alleged to have physically abused a child. The investigator completed a Domestic Violence Screen based only on a conversation with the mother, in which she denied all domestic violence directed toward her. The police report of the child's abuse (available at the time of the CERAP and Domestic Violence Screen) noted that mother disclosed that she, too, was a victim of father's domestic violence. Without this knowledge, the investigator assumed that mother could protect the child from father, who later gained entrance to the home and reabused the child.

MENTAL HEALTH ISSUES (N=3/9)

A parent's mental health status, both historical and current, may affect the parent's stability and/or capacity for caring for children, in addition to assessing current compliance with required medications. Historical factors should be considered as they relate to current problems.

Case Examples

- A CPI did not document in the CERAP completed after a third call to the hotline that the father had a history of Mental Illness/Substance Abuse ["MISA"] dual diagnosis, and had not been medicated for one month. In the past three to four years, the father had been psychiatrically hospitalized for impulsive and aggressive behaviors.

- A father had a history of severe mental illness and had not been medicated for one month. While the CPI had already determined that the father's presence in the home presented a risk, the CPI failed to take the father's mental health into account in developing the safety plan.

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[2] In fact, prior incidents of violence is one of the few factors that can be relied on to predict future violence. [Tardiff 1992].

- A mother's history of mental illness was not viewed as an additional risk factor, warranting a cumulative assessment of risk of harm.

<u>Failure to Use Multiple Sources of Information or Access Available Information (n=9)</u>

The use of multiple sources was crucial for two reasons. First, interviewing multiple sources allows the CPI to get a clear and thorough picture of the problem. Second, it is important to verify information provided by the parent, other caregivers, and family members, whether they accept responsibility for the abuse or not. In five investigations, CPIs failed to draw on available information of previous involvement with DCFS (e.g. substance abuse history), needed external information that could have been provided by physicians and police and in one case conferred expertise on a paraprofessional.

Case Examples

- A CPI relied on the mother's self-report that she was responsible for injuring her child despite contradicting information, available in the hotline report, that she had told the child's grandmother that her boyfriend injured the child. The investigator's unjustified reliance on the mother resulted in an inadequate safety plan based solely on the promise of the mother to keep her boyfriend away from her child, who later killed the child while in his care.

- School personnel called the hotline and reported fingertip bruises around a child's mouth. When the investigator arrived, the bruises were gone and the investigator failed to contact school personnel to corroborate the existence of the bruises before determining that the child was safe at home.

- An investigator failed to contact the police, who would have corroborated a grandfather's statements.

- An investigator failed to review the police report concerning physical abuse of a child by his father. Had the report been reviewed, the investigator would have noted the discrepancies between the mother's reports of domestic violence; she told police that she was a victim of domestic violence, but denied domestic violence when asked by the investigator. The failure to review the police report resulted in the investigator assuming that mother could protect the child against father, who later re-abused the child.

- An investigator assumed that the grandmother was an unreliable source of information, and disregarded all information from her.

- An investigator failed to contact the mandated reporter, on a physical injury case, before making a safety decision based on lack of evidence (the bruises were not observed by the investigator).

- An investigator relied on an interpreter's opinion of child safety instead of seeking information on electrical wiring from a more appropriate source. Consequently, important factors were overlooked, which contributed to an inaccurate assessment of risk.

- An investigator failed to interview the police, who would have provided significant information regarding the mother's ability to protect the child from the mother's paramour.

<u>Failure to Obtain/Consider History of Criminal Background (LEADS) (n=3)</u>

Investigators appropriately accessed the Law Enforcement Agencies Database System ["LEADS"] to check criminal histories of those in the home in all but one investigation. However, two of the

investigations reviewed showed a failure to appreciate the importance of LEADS information in evaluating trustworthiness of information and development of the safety plan.

Case Examples

- An investigator CPI did not obtain a LEADS report on the alleged perpetrator. The perpetrator was identified early on and the investigator believed that the perpetrator no longer had access to the children. Also, the worker did not complete a LEADS check on the woman with whom the family lived. The check would have shown a criminal lifestyle.

- Both the father and mother had a history of criminal behavior/records. The investigator did not complete a LEADS check on the father because the safety plan was based on the faulty assumption that the mother could keep the father out of the home. A review of the father's criminal record may have helped the investigator appreciate the naiveté of this plan.

- A father had a criminal history, including multiple arrests and served time for violation of probation. Although the CERAP was marked unsafe, a review of the father's criminal history may have alerted the investigator to the folly of basing a safety plan on the father's assurances.

Failure to Consider Other Adults with Access to the Child (n=1)

An investigator did not consider another adult (paramour, parent's friend or extended family) having access to the children to be relevant to completion of the CERAP even though all adults with access to children should have been included in this assessment. The woman with whom the family lived was not assessed, despite the worker's professed knowledge that the woman used crack.

Supervisory Input (n=8)

The supervisory function in identifying safety concerns and developing safety plans is critical. In eight of the investigations analyzed, the supervisors had sufficient information to have intervened as a check to investigator error, but failed to do so. In five investigations, it should have been apparent to the supervisor that critical, available information had not been accessed prior to completing the CERAP. In five investigations, the supervisor demonstrated poor judgment in approving the CERAP.

- An investigator completed a CERAP without a LEADS check on the perpetrator and without having read a concurrent police report.

- Two investigators never interviewed the reporters.

- An investigator did not complete a LEADS check on the perpetrator and a supervisor signed off on a Safety Plan in which the physical abuser promised not to use corporal punishment or throw his child in the air again.

- An investigator relied on an interpreter for an opinion about fire risk.

- A supervisor had knowledge of the extensive violent background of the mother.

- A supervisor advised the investigator to take protective custody of a medically complex child without adequate provision for the child's care in custody and without adequate investigation demonstrating the necessity for such removal.

- A supervisor had full knowledge of mother's serious drug use, but did not consider it to be a factor.

- A supervisor failed to note the contradictory information provided by the reporter.

The CERAP tool could benefit from an accompanying form to document that the CPI accessed critical information, such as LEADS and prior CANTs history and contacted necessary sources, such as police and reporters. The investigator should be required to document the sources of information for the safety assessment. For instance, the safety factor regarding a caretaker's drug abuse could be checked "no" based solely on a denial by the caretaker, while ignoring available, objective information, such as a criminal history documenting multiple drug-related offense arrests or convictions.

Prompts or check boxes to assure available critical information was accessed, a requirement that the worker document sources for the particular safety factor, would better enable supervisors to perform a meaningful review of the Assessment.

LIMITATIONS OF THE CERAP PROTOCOL

MANAGEMENT OF SAFETY CONCERNS

The Protocol, Procedure 300, Best Practice Guidelines and Training need to incorporate evidence-based practice information concerning managing specific types of safety concerns.

QUESTIONS INVITE LACK OF CONSISTENCY AND RELIABILITY

Lack of consistency and reliability could arise because many of the factors ask workers to make determinations that are beyond the worker's competence. Many of the questions seek answers that are beyond the capability of even the most educated and trained assessor. Seven of the fifteen CERAP factors require predicting future harm.[3] Three of the seven factors require not only a determination of future harm, but also whether the threat is "immediate" or "imminent."[4] A child protection investigator's job is to assess the likelihood of future harm. Unquestionably, the task is easier through hindsight than during an investigation. The difficulty of the investigator's job is compounded by the fact that there is little concrete research to support such predictions. We know that past violence is a predictor of future violence (Tardiff 1992), but beyond that, there is little clinical support to predict behavior. Thus, questions that require an assessment of the immediacy of future harm are fraught with problems, and may reflect little more than guesswork. Without guidelines to assist workers in determining immediacy, an individual's determination of immediacy of harm will lack consistency and reliability.

Case Examples

- Investigators knew of significant domestic violence between the teen parents, and the mother had often resorted to violence in social situations. While all the factors were present to suggest risk of future harm, no one could determine whether such harm might occur tomorrow or a year from tomorrow. The investigators determined that the risk was not "urgent and immediate" because the family was receiving intact services and was presumed to be able to mitigate the risk to the child.

- Investigators observed a trailer home in winter, in which the family used four electric space heaters connected with extension cords as the sole source of heat. On the day that the CERAP was

[3] Factors 5, 6, 7, 9, 10, 11, and 12 all require the investigator to determine whether the risk factor identified will result in future harm. While some circumstances warrant such a prediction, most facts do not provide more than guesswork about whether future abuse or neglect will occur.

[4] Factors 7, 10 and 13.

completed, the outside temperature may have been 57 degrees. Safety Factor #9 was checked “No.” The child died a month later in a fire caused by one of the faulty extension cords to the heaters. The concept of *immediate* safety was not reliably defined among the different professionals involved, resulting in lack of prompt intervention.

- A CPI overestimated the danger in the home and took protective custody of a medically complex child without having material evidence and a plan that took into consideration the special care needed for a child with complicated medical needs.

QUESTIONS DO NOT PERMIT NEED TO ACQUIRE MORE INFORMATION

The CERAP form does not provide opportunities to mark “uncertain” or “unable to assess” for individual safety factors CPIs are under tremendous pressure to complete the CERAP form within 24 hours to determine whether a child is safe. If they are unable to get all the CERAP information in the time allotted, they may be forced to cut corners in either limiting the number of interviews or arriving at weakly supported conclusions.

In the cases reviewed some vital information was unknown to the investigator at the time of completing the CERAP. The reasons were multiple, and included the fact that the CERAP tool does not prompt the CPI to document unknown but needed information.

The pressure of making critical decisions in a very limited time frame could be aided by prompting both the investigator and the supervisor to question what information is lacking that may assist in a safety determination. Sometimes, the critical information may not be available within 24 hours, but at least, the framework will have been created to ensure that the critical information is retrieved and incorporated into the safety assessment as soon as possible.

Case Examples
A CPI responded to all the safety factors in one visit without having read the history of the family and without having talked to the mother’s therapist and case manager.

An investigator noted the presence of the space heaters in the trailer home, but did not feel competent to determine whether the situation created an immediate environmental safety concern.

A CPI took protective custody of a medically complex child because of a legitimate disagreement between the parents and an in-home LPN regarding interpretation of the doctor’s advice concerning how best to manage the child’s severe medical problems.

MULTIPLE-PART QUESTIONS LIMIT ACCOUNTABILITY

Many of the risk factors and/or questions on the form actually include three questions in one. The use of multiple part questions is designed to ensure that the State does not intervene unless there is an actual safety concern to a child.[5] For instance, prior abuse or neglect may not signal actual safety concern *unless* the prior maltreatment was severe *or* the caretaker’s response to the prior maltreatment makes us doubt

[5] The CERAP distinguishes “safety” from “risk,” defining safety as an immediate threat to the child’s well-being and as a future possibility of harm. The distinction may be easier to grasp in theory than in reality. In actual family situations, it is often impossible to distinguish how harmful future behavior might be and whether it will happen tomorrow or a year from tomorrow. *See discussion, infra.*

the caretaker's ability to protect the child. Thus, Safety Factor #7 asks whether: "[a]ny member of the household has previously or may have previously abused or neglected a child, *and* the severity of the maltreatment, *or* the caretaker's or other adult's response to the prior incident, suggest that child safety *may be an urgent and immediate concern.*" The tool assumes that the CPI has considered all of them. In addition, there is an overuse of modifiers, which makes it particularly tricky for CPIs to tease out the immediate and potential safety risk. It makes it difficult for a supervisor to review the investigator's decision-making. Similarly, when a mistake has been made, the use of multiple-part questions makes it far more difficult to hold an investigator or supervisor accountable.

Safety Factor # 9 also has multiple parts. It states, "Caretaker *has not* (or is unable to) meet the child's immediate needs for food, clothing, and/or shelter; the child's physical *living conditions are hazardous* and *may cause moderate to severe harm.*" In one case, after the child died in the fire, the discretion permitted by Safety Factor 9, in determining whether the conditions were "hazardous," made it difficult to assign responsibility for the fatal error.

THE FORM INCLUDES AN INHERENT BIAS

It is important to note an inherent bias in the form. The form is designed to require workers to establish and monitor a "safety plan" when any factor is checked "yes." Therefore, a "yes" answer will yield considerably more work and responsibility that will fall squarely on the shoulders of the person completing the form. Recognition of bias does not suggest that workers routinely fail to find safety concerns to save themselves work, but strongly suggests the need to develop anti-bias strategies, to ensure that workers, supervisors and managers are aware of the potential for such bias, and implement strategies to guard against such biases. A bias caused by creating more work will likely become a greater concern in times of general increased workload.

CONTEXTUAL FACTORS THAT CONTRIBUTE TO CERAP IMPLEMENTATION PROBLEMS

Guidelines for the implementation of the CERAP process begin at the management level with the expectation that these policies will be implemented in the service of individual cases. The review of the 85 OIG recommendations (from a total of 11 investigative reports) revealed problems with the translation of policy into practice. Policies were lacking in nine instances, 11 recommendations were focused on the need for more specific designation of where and to whom the policy should apply, and eight were directed at inadequate monitoring of the policy. An examination of the links between management level processes and specific types of problems highlight a need to establish policies concerning how to make decisions regarding level of risk (three recommendations); to clearly lay out when, where, and to whom policies should apply, especially those related to the development of safety plans (five recommendations); and to develop more effective strategies for monitoring policies, particularly those regarding compliance with the CERAP protocol and accurately judging risk (three recommendations each). The development of policies regarding caseload coverage and management seems particularly critical. In five case studies, problems were evident because of inadequate staffing. In three cases, work was impeded by a failure to fill open positions within the team; another two cases revealed failures to develop adequate plans for covering unfilled caseloads, and four cases were lacking sufficient supervisory support in understaffed teams and offices.

In addition, the application of policies is compromised by factors at the implementation or supervisory level because of the realities of the work environment. Problems that originate at this level are addressed by recommendations aimed at improving the communication of policies to staff and marshaling the means to improve practice, such as additional training, staff, materials, accessing expert information or other

resources, particularly with respect to CPI failure to follow the CERAP protocol (8 recommendations), failure to identify risk (15 recommendations), and general problems in investigative practices (17 recommendations).

In both the review of the 85 recommendations offered by the OIG and in the individual case analyses, resource shortages impeded risk assessment. The case analyses provided specific examples at the supervisory level. Problems in case assignment were found in four cases: the supervisor assigned an investigator three cases in one day; the investigator was assigned a case while on vacation; an inexperienced investigator was assigned a complex case that subsequently had to be reassigned; and in the final case, the supervisor did not execute a timely transfer in the case which resulted in serious risk to the child.

DISCUSSION and CONCLUSION

The analysis of CERAP problems focused on initial use of CERAP during protective service investigations. Multiple methods were used and overlapping samples drawn from OIG investigations of child deaths and serious injuries in families known to DCFS. Data were analyzed quantitatively in an examination of OIG recommendations emerging from investigations of cases over several years and qualitatively for a smaller sample using three distinct case review processes. Similarities in results across methods and samples enhance the validity of the findings and increase confidence that there has been identification of some important issues in the implementation of CERAP and the instrument itself. However, cases investigated by the OIG are not representative of all DCFS child protection cases and CPIs, since they are limited to cases that had tragic outcomes. The data suggests a need to focus on responding to abusive or violent behavior. It would be instructive for the Department to examine CERAP use within a random sample of cases in which prior physical abuse or violent criminal backgrounds were alleged or indicated.

The issues related to safety and risk assessment using the CERAP protocol have been grouped into distinct domains: (1) failure to establish or monitor a realistic safety plan, insufficient data collection, (2) limitations of the CERAP protocol, and (3) individual failures that were not corrected through supervisory review. In addition, our analysis examined contextual factors that contribute to CERAP implementation problems.

Analysis of these investigations revealed that while the CERAP tool may be useful identifying safety concerns, it provides little assistance in managing safety concerns identified, especially in managing abusive or violent behavior. Lack of effective risk management strategies was found to be problematic in several of the cases reviewed. The CERAP assessment tool would benefit greatly from guidelines and training around the issues of how to develop workable safety plans and how and when to involve family members in monitoring the plan.

In identification of safety concerns, the assessment tool relies heavily on the ability of the investigator to predict the immediacy of future harm, without providing guidelines to assist in the determination. Guidelines need to be targeted to the specific problem identified. For example, to increase reliability and consistency, the Department needs to develop guidelines as to when the presence of domestic violence in the home creates a risk of immediate danger to the child. The form may benefit from revisions or training that sharpen the language, that specify more clearly what constitutes “moderate or severe harm” or “immediate” and provide guidelines for determining individual safety factors.

In the samples reviewed, significant individual errors were found that were not repaired through supervisory review. Despite policies requiring staff to make use of multiple data sources in their assessments, CPIs in the sample tended to make decisions with insufficient information, resulting in

fewer safety plans than needed and continued or increased risk for the children. Evidence for making decisions based on too little information is detailed in this report. They included failure to use multiple sources of information, failure to recognize cumulative risks, failure to consider other adults with access to target children, and failure to identify unknown information, critical to a reliable safety determination

Lastly, the work environment of the CPI has consequences for CERAP implementation. Understanding that policy can go only so far as a guide for practice, other elements of the organizational environment can support or impede sound case decision making. With analysis of OIG recommendations emerging out of investigations of child death cases, as well as case reviews, it can be concluded that CPI safety assessments could be improved with better case supervision. A variety of factors were uncovered that are likely to reduce opportunities for proper supervision of workers, including supervisory staff shortages, lack of monitoring of supervisory practice, insufficient communication of policies and the means to improve practice, such as ongoing opportunities for safety assessment training for both supervisors and the CPIs. Professional development, as well as more effective practice, is best accomplished in a culture where discussion of mistakes is encouraged and used as opportunities to learn from each other.

RECOMMENDATIONS

1. Provide training and written guidelines for mitigation and development of safety plans, including specific components for specific safety concerns, such as violence and physical abuse; the training and guidelines should also address the need to consider inclusion of extended family or protective daycare as partners in implementing the safety plan.

2. Once a risk is identified, workers need more guidance on how to determine whether the risk is “urgent” or “immediate.”

3. Add a third box to each safety factor, acknowledging that information for that factor may be “unknown” or “uncertain” and add a section at the conclusion of the Factors list for identifying information that needs to be gathered in the future to further assess Safety.

4. Devise a supervisory form to accompany the CERAP that would allow a supervisor to determine the source of information that formed the basis of the particular Safety Factor decision and provide a check that basic available objective sources (such as the Hotline Report, prior child protection investigations, police reports and interviews with police, and criminal history information as required by Administrative Procedure 6) have been completed.

APPENDIX A

CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL
SAFETY DETERMINATION FORM

Case Name	**Date of Report**	Agency Name
RTO/RSF	**Date of this Assessment** Date of Certification	SCR/CYCIS #
Name of Worker Completing Assessment		**ID#**

When to Complete the Form:

For child protection investigation and child welfare intake purposes, the safety assessment must be conducted, at a minimum, at the following case milestones (check the appropriate box):

☐ 1. Within 24 hours after the investigator first SEES the alleged child victim(s).

☐ 2. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

☐ 3. Every five working days following the determination that any child in a family is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe **or** all unsafe children are removed from the **legal** custody of their parents/caretakers. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., Would the child be safe WITHOUT the safety plan?).

☐ 4. At the conclusion of the formal investigation, unless a service case is opened. All children in the home, alleged victims and non-involved children, must be included. This provision may be waived by the supervisor if the initial safety assessment was marked safe and no more than 30 days have elapsed since it was completed

☐ 5. At CWS Intake within 24 hours of seeing the children

For intact family purposes, the safety assessment must be conducted, at a minimum, at the following case milestones (check the appropriate box):

☐ 1. Within 5 working days after initial case assignment and upon any and all subsequent case transfers. **Note: If the child abuse/neglect investigation is pending at the time of case assignment, the Child Protection Service Worker remains responsible for safety assessment and safety planning until the investigation is complete.**

☐ 2. Every 6 months from case opening.

☐ 3. When considering whether to close an intact service case, a safety assessment must be done immediately prior to supervisory approval of the critical decision.

☐ 4. Every five working days following the determination that any child in a family is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe **or** all unsafe children are removed from the **legal** custody of their parents/caretakers. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., would the child be safe WITHOUT the safety plan?).

☐ 5. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

For placement cases, the safety assessment must be conducted, at a minimum, at the following case milestones (check the appropriate box):

☐ 1. Within 5 working days after initial case assignment and upon any and all subsequent case transfers **when there are other children still in the home as part of an open family case assigned to the worker**. Assess safety in the child's return home environment and document the conditions or behavior which continue to prevent return home and document the continuous safety of every child still in the home. **Note: If the child abuse/neglect investigation is pending at the time of case assignment, the Child Protection Service Worker remains responsible for safety assessment and safety planning until the investigation is complete.**

☐ 2. When considering the commencement of unsupervised visits in home of parent or guardian. (Assess safety in the child's return home environment.)

☐ 3. Before an administrative case review when a child in care has a return home goal and there are other children still in the home as part of an open family case **assigned to the worker**.

☐ 4. Every six months from family case opening when a child in care has a permanency goal other than return home and other children are still in the home as part of an open family case **assigned to the worker**. The CERAP is to be completed on the children still at home only.

☐ 5. Within 24 hours prior to returning a child home. (Assess safety in the child's return home environment.)

☐ 6. Within five working days after a child is returned home and every month thereafter until the family case is closed.

☐ 7. Every five working days following the determination that any child in a family is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe **or** all unsafe children are removed from the **legal** custody of their parents/caretakers. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., would the child be safe WITHOUT the safety plan?).

☐ 8. When considering whether to close a reunification service case, a safety assessment must be done immediately prior to supervisory approval of the critical decision.

☐ 9. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy in home of foster parent, relative caregiver, or pre-adoptive parent.

Name of caregiver: ______________________________

SECTION 1. SAFETY ASSESSMENT

Part A. Safety Factor Identification

Directions

The following list of factors are behaviors or conditions that may be associated with a child(ren) being in immediate danger of moderate to severe harm. **NOTE: At the initial safety assessment, all alleged child victims and all other children residing in the home are to be seen and if verbal, interviewed out of the presence of the caretaker and alleged perpetrator, if possible. If some children are not at home during the initial investigation, do not delay the safety assessment. Complete a new safety assessment on the children who are not home at the earliest opportunity only if the safety assessment changes. If there is no change, certify the current assessment at the bottom of page 3. For all other safety assessments, all children residing in the home are to be seen, and if verbal, interviewed out of the presence of the caretaker and alleged perpetrator, if possible.** When assessing children's safety, consider the effects that any adults or members of the household who have access to them could have on their safety. Identify the presence of each factor by checking "Yes," which is defined as "clear evidence or other cause for concern."

1. Yes ☐ No ☐ Any member of the household's behavior is violent and out of control.

2. Yes ☐ No ☐ Any member of the household describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.

3. Yes ☐ No ☐ There is reasonable cause to suspect that a member of the household caused moderate to severe harm or has made a plausible threat of moderate to severe harm to the child.

4. Yes ☐ No ☐ There is reason to believe that the family is about to flee or refuse access to the child, and/or the child's whereabouts cannot be ascertained.

5. Yes ☐ No ☐ Caretaker has not, will not, or is unable to provide sufficient supervision to protect child from potentially moderate to severe harm.

6. Yes ☐ No ☐ Caretaker has not, or is unable to meet the child's medical care needs that may result in moderate to severe health care problems if left unattended.

7. Yes ☐ No ☐ Any member of the household has previously or may have previously abused or neglected a child, and the severity of the maltreatment, or the caretaker's or other adult's response to the prior incident, suggests that child safety may be an urgent and immediate concern.

8. Yes ☐ No ☐ Child is fearful of people living in or frequenting the home.

9. Yes ☐ No ☐ Caretaker has not, or is unable to meet the child's immediate needs for food, clothing, and/or shelter; the child's physical living conditions are hazardous and may cause moderate to severe harm.

10. Yes ☐ No ☐ Child sexual abuse is suspected and circumstances suggest that the child safety may be an immediate concern.

11. Yes ☐ No ☐ Any member of the household's alleged or observed drug or alcohol abuse may seriously affect his/her ability to supervise, protect, or care for the child.

12. Yes ☐ No ☐ Any member of the household's alleged or observed physical/mental illness or developmental disability may seriously affect his/her ability to supervise, protect or care for the child.

13. Yes ☐ No ☐ The presence of domestic violence which affects caretaker's ability to care for and/or protect child from imminent, moderate to severe harm.

14. Yes ☐ No ☐ A paramour is the alleged or indicated perpetrator of physical abuse.

15. Yes ☐ No ☐ Other (specify) ______________________________

PART B.1. Safety Factor Description

Directions: **IF SAFETY FACTOR(S) ARE CHECKED "YES":**

- Note the applicable safety number and then briefly describe the specific individuals, behaviors, conditions and circumstances associated with that particular factor.

IF NO SAFETY FACTORS ARE CHECKED "YES":

- Summarize the information you have available that leads you to believe that no children are likely to be in immediate danger of moderate to severe harm.

PART B.2. List Children And Adults Who Were Not Assessed And The Reason Why They Were Not Identify the timeframes in which the assessment will be done.

Certify below if no change in the assessment has occurred due to the assessment of the above persons. If a change has occurred, complete a new assessment.

Worker's Signature: ______________________________ Date: __________

Supervisor's Signature: ______________________________ Date: __________

PART B.3. FAMILY STRENGTHS OR MITIGATING CIRCUMSTANCES

For each safety factor that has been checked "yes", describe any family strengths or mitigating circumstances. This section is not to be completed if no safety factors are checked "yes".

Safety Factor # 1. Family Strength *2. Mitigating Circumstances*

SECTION 2: SAFETY DECISION

Directions: Identify your safety decision by checking the appropriate box below. (Check one box only.) This decision should be based on the assessment of all safety factors and any other information known about this case.

A. SAFE ☐ There are no children likely to be in immediate danger of moderate to severe harm at this time. No safety plan shall be done.

B. UNSAFE ☐ A safety plan must be developed and implemented **or** one or more children must be removed from the home because without the plan they are likely to be in immediate danger of moderate to severe harm.

SIGNATURE/DATES

The safety assessment and decision were based on the information known at the time and were made in good faith.

Worker ______________________________ Date ______________

Supervisor ______________________________ Date ______________

APPENDIX B
Definitions of Codes for OIG Recommendations Related to CERAP

Level and Specific Type of Organizational Process

Each recommendation was coded according to the level and type of organizational process it targeted, as well as the type of problem it addressed.

1. Management/policy: The recommendation describes an addition or revision of policy, procedure, or rules. It is further coded as targeting a specific organizational principle:
   - Command: The establishment of a policy, procedure, or rule.
   - Designate: Elaborates specifically where and to whom the policy should apply.
   - Enforce: Establish and implement a method to consistently and fairly ensure compliance.
   - Monitor: Recommends that a specific means of monitoring compliance to the policy, procedure, or rule be applied.

   The assumption is that this part of the code is hierarchical. For example, if a management/policy recommendation is made at the COMMAND level, then there is also a need for the other three principles to be put in place (DESIGNATE, MONITOR, ENFORCE)

2. Supervision/Implementation: The recommendation describes a way to establish effective organizational control to ensure that desired staff behavior is established and implemented. Each recommendation is further coded as targeting a specific means of control:
   - Communicate: After a policy, procedure, or rule has been established, management/supervisor explains to staff the behavior that is wanted.
   - Marshal: A means to compliance is assured through training, tools, materials, staff, or other resources, as needed.
   - Model: Supervisor models proper performance through their own interactions with staff.
   - Enforce consistently: Consistent enforcement on part of supervisor.

3. Individual: The recommendation targets individual staff performance that exists as an exception to management/policy, supervision/implementation principles of organizational control. A recommendation is coded at the individual level only if a staff member's behavior is in direct opposition to the established and generally implemented policies and procedures. Because there were so few instances of recommendations focused on an individual's behavior, they were not further coded according to specific type of organizational process required for change.

Problem type

Each recommendation was coded for the type of problem it addressed. This coding scheme was developed as themes emerged from the data.

1. Failure to follow CERAP protocol: CPI did not carry out all CERAP steps or did not do so within the required time frame.
2. Failure to establish safety plan: CPI did not develop a safety plan when one was needed.
3. Risk error: The level or type of risk to the child was misjudged or overlooked.
4. Compliance/Cooperation: Parent compliance or cooperation with agency requirements, directives. Also includes cooperation among involved agencies or authorities.
5. Information need: Further information was needed for an accurate assessment of danger, mitigating factors, or overall problem situation. This category was used only when a more specific category (e.g., RISK ERROR) did not seem to apply.
6. Investigation practices: Multiple steps of the investigation process were described in a single recommendation. Usually one or more steps went beyond completion of the CERAP.

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Sorry so late. Thank you Alan.