OFFICE OF THE INSPECTOR GENERAL

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

ANNUAL REPORT TO THE GOVERNOR

&

THE GENERAL ASSEMBLY

JANUARY 2021

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INTERIM INSPECTOR GENERAL

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

January 1, 2021

To the Governor and Members of the General Assembly:

I respectfully submit the Annual Report of the Office of the Inspector General (OIG) for the Illinois Department of Children and Family Services (DCFS).

In March 2020, the Governor asked me to take the helm of OIG after I had served the Illinois Human Rights Commission for about a decade in several legal and leadership roles, including Administrative Law Judge, Acting General Counsel, and Deputy General Counsel. Before that, I was a litigator for many years at Winston & Strawn LLP, where I practiced in, among other areas, the firm's renowned corporate internal investigations practice. In sum, I came to OIG with extensive experience as a public servant and in conducting sophisticated, independent investigations.

My background outside the child welfare community has given me a perspective different from that of my two predecessors. I acknowledge and own the "outsider" label. Before leading OIG, I had no relationship of any kind with any of DCFS's past or current leadership. I am knowledgeable about DCFS's most notorious failures, but that knowledge does not cloud my perspective regarding *today's* DCFS.

In short, my eyes are experienced, but fresh. And my eyes see progress.

1. Child death cases have decreased by 17% (from 123 to 102) since last year's Annual Report.

OIG's most important work is our review and investigation of child deaths that meet OIG's criteria for case opening – that is, child deaths where DCFS had contact with the family within the preceding year. Indeed, it was the 1993 death of three-year-old Joseph Wallace that led to the creation of OIG in the first place. Of course, the fact that a child's death may have met our criteria for case opening does not necessarily mean DCFS has any culpability for it. Sometimes, tragedy strikes due to external or natural causes having nothing to do with DCFS. Nevertheless, child death case numbers are one metric OIG tracks for a snapshot of the state of the child welfare system.

There were 123 child death cases opened in fiscal year 2019, which we correctly described in last year's Annual Report as "unacceptable to every citizen." In fiscal year 2020, there were 102 child death cases opened, a year-over-year decrease of 17%.

As we noted on page 178 of last year's Annual Report, the average number of child death cases per year from 2000-2019 was 105. One might argue, therefore, that the FY 2019 total of 123 was an outlier, and the FY 2020 decrease to 102 simply represented a regression back to the mean. However, two factors make us optimistic that the year-over-year decrease represents real progress and not the appearance of progress caused by a mathematical anomaly.

The first is the COVID-19 pandemic. At the outset of Illinois's first wave of the pandemic, when the Governor issued his March 20, 2020 Executive Order shutting down parts of the economy and ordering

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Illinoisans to stay home except to conduct essential business, over a quarter of FY 2020 remained. We at OIG braced ourselves. We did not know for certain how the unfolding pandemic might affect child welfare, and we still do not, but we suspected that the pandemic could lead to a dramatic increase of child death cases for FY 2020. Our concern was that at-risk children would be confined for more time than usual within the walls of unstable, dangerous homes, and out of sight from mandated reporters of abuse and neglect, with disastrous results. That child death cases did not increase sharply in FY 2020, but instead decreased to 102, tells us that the year-over-year decrease is likely real.

The second is the current case-opening pace for FY 2021. As of late November 2020, OIG had opened 40 child death cases. At that pace, OIG projects to open approximately 96 child death cases in FY 2021, which would represent a decrease of 6% from FY 2020's total and 22% from FY 2019's total. Moreover, 96 cases would be far below the historical average of 105. While there certainly is no guarantee the current pace will continue throughout the rest of FY 2021, this peek ahead provides additional evidence that child death cases appear to be trending downward.

Of course, child death case numbers are still far too high. As Illinoisans, we can never, ever accept an "average" year of 100-plus child death cases. We all agree that one preventable death is one too many. Moreover, the nascent downward trend will reverse quickly without continued diligence and vigilance by everyone in the child welfare system. In addition, as noted above, the raging pandemic adds another risk factor for already at-risk Illinois children.

2. DCFS has accepted, and begun or completed implementing, 100% of OIG's pending recommendations from FY 2020 and prior years.

OIG effects change at DCFS by making case-specific and systemic recommendations after conducting thorough investigations. OIG recommendations are tracked and monitored, and full implementation is verified through a review of relevant documentation. In addition to child death case numbers, DCFS's record on accepting and implementing OIG recommendations is another important metric that OIG tracks. Here, too, OIG notes significant improvement from the last fiscal year.

In last year's FY 2019 Annual Report, DCFS provided no implementation status for five recommendations from prior years. There also were many unresolved or rejected recommendations, some of which had been pending for four years or longer. The DCFS Director and I and our respective staffs recently reaffirmed our commitment to work collaboratively in connection with OIG recommendations. As a result, DCFS provided an implementation status for all recommendations made by OIG for FY 2019 and prior years. In addition, we worked together to address and begin implementing the backlog of recommendations that had yet to be implemented, were previously unresolved, or had been rejected by prior DCFS Directors.

In this year's Annual Report, there are 96 recommendations for FY 2020, and DCFS has accepted and already implemented, or provided an implementation plan, for all of them.

To be blunt, OIG recommendations save lives. Here are some recent examples of our systemic recommendations:

a) We recommended that DCFS appoint a domestic violence coordinator in each region of the state to serve as a liaison with domestic violence providers and enhance information sharing. *OIG rationale: Domestic violence often is a factor in child death cases.*
b) We recommended that DCFS management review cases involving any family with three or more child protection investigations within a year to ensure that underlying issues are being

addressed. *OIG rationale: This recommendation was made in several different investigations to highlight the need for increased managerial oversight when there are multiple child protection investigations involving the same family in a short period of time, a clear sign of a family in crisis.*

c) We recommended that DCFS include in-home parenting services in all service plans for pregnant and parenting youth in care (including non-custodial fathers). In the event a provider determines the youth would benefit from further in-home, skill-based training, we recommended that DCFS offer the training, utilizing the Family First Prevention Services Act, to emancipating youth as a continued service beyond emancipation. *OIG rationale: This recommendation addresses the needs of pregnant and parenting teens and how DCFS can help prevent deaths and serious injuries after youth emancipation.*

d) We recommended that regional DCFS Legal Department staff meet with local State's Attorneys at least annually to discuss the use of protective orders in cases that do not rise to the level of urgent and immediate necessity. *OIG rationale: This recommendation addresses situations where: 1) the allegations do not justify removing a child from his/her parent; 2) the family remains unstable or in crisis and therefore puts a child at risk of future harm; and 3) the parent has refused intact family services from DCFS. One solution is to mandate parental compliance through a protective order; however, some local State's Attorneys have denied this request from child protection investigators. This issue must be addressed through communication and collaboration with the local State's Attorneys.*

OIG believes the downward trend in child death case numbers and DCFS's acceptance and plan for implementation of all pending OIG recommendations constitute real progress toward everyone's goal of improving and strengthening Illinois's child welfare system. Again, much work remains, child death case numbers are still too high, and too many families remain in crisis. Regrettably, high-profile, preventable tragedies, like the AJ Freund case, and many more that go uncovered by the media, will continue to occur. However, any fair and objective assessment of DCFS in FY 2020 must recognize this undeniable, year-over-year progress.

Finally, I must publicly acknowledge my OIG team. A grateful state and I thank you for all you do and have done for the children of Illinois, both during this unprecedented year and in the creation of this important summary of our year's work. I am honored to work beside you, and to serve the Land of Lincoln, my home, as the Inspector General of DCFS.

Lester G. Bovia, Jr.
Interim Inspector General

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

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INTRODUCTION

The Office of the Inspector General (OIG) of the Illinois Department of Children and Family Services (DCFS or Department) was created by a unanimous vote of the Illinois General Assembly in June 1993 to reform and strengthen the child welfare system. The mandate of OIG is to investigate misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by DCFS employees, foster parents, service providers and contractors with the Department. *See* 20 ILCS 505/35.5 – 35.7. To that end, OIG conducts investigations and makes recommendations to protect children, uncover wrongdoing, improve practice, and increase professionalism within the Department.

INVESTIGATION CATEGORIES

Death and Serious Injury Investigations

OIG investigates deaths and serious injuries of Illinois children whose families were involved in the child welfare system within the preceding 12 months. The Inspector General is an *ex officio* member of the Child Death Review Team Executive Council. OIG receives notification from the Illinois State Central Register (SCR) of all child deaths and serious physical injuries where the child was a youth in care, the family is the subject of an open investigation or service case, or the family was the subject of a previous investigation or closed case within the preceding 12 months. The notification of a child death or serious injury generates a review in which the Critical Event 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. OIG created and maintains a database of child death statistics and critical information related to child deaths in Illinois. The following chart summarizes the death cases reviewed in FY 2020:

FY 2020 CHILD DEATH CASES REVIEWED

CHILD DEATHS IN FY 2020 MEETING THE CRITERIA FOR REVIEW	102
INVESTIGATORY REVIEWS OF RECORDS	87
FULL INVESTIGATIONS	15

Summaries of death investigations where a full investigative report was submitted to the Director in FY 2020 are included in the Investigations Section of this Report. It should be noted that these full investigative summaries may be deaths or serious injuries that occurred in a previous fiscal year. Later in the same section, there are summaries of all child deaths reviewed by OIG in FY 2020.

General Investigations

OIG responds to and investigates complaints filed by the state and local judiciary, Department and private agency employees, foster parents, biological parents and the general public. Investigations yield both case-specific recommendations, including disciplinary recommendations, and recommendations for systemic changes within the child welfare system. OIG monitors compliance with all recommendations.

Child Welfare Employee Licensure Investigations

In 2000, the General Assembly mandated that the Department institute a system for licensing direct service child welfare employees. The Child Welfare Employee License (CWEL) 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 maintain accountability, integrity, and honesty of those entrusted with the care of vulnerable children and families.

A child welfare employee license is required for Department and private agency investigative, child welfare and licensing workers and supervisors. The Department, through the Office of Employee Licensure, administers and issues Child Welfare Employee Licenses.

A committee composed of representatives of 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). OIG investigates and prosecutes CWEL complaints and hearings.

When a CWEL investigation is completed, OIG, as the Department's representative, determines whether the findings of the investigation support possible licensure action. Such allegations that could support licensure action include conviction for specified criminal acts, indicated findings of child abuse or neglect, or egregious acts that demonstrate incompetence or a pattern of deviation from a minimum standard of child welfare practice. Department Rule 412.50 (89 Ill. Adm. Code 412.50) specifies the grounds for licensure action. When licensure action is appropriate, the licensee is provided an opportunity for a hearing. 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 2020, 22 cases were referred to OIG for Child Welfare Employee License investigations.

FY 2020 CWEL INVESTIGATION DISPOSITIONS

FY 2020 CWEL INVESTIGATIONS	22
MONITORING	12
PENDING INVESTIGATIONS	4
LICENSE REVOCATION	1
LICENSE RELINQUISHED	3
PENDING ADMINISTRATIVE HEARING	2

Criminal Background Investigation and Law Enforcement Liaison

OIG provides technical assistance to the Department and private agencies in performing and assessing criminal history checks. In FY 2020, OIG answered case requests for criminal background information from the Law Enforcement Agencies Data System (LEADS). Each case may involve multiple law enforcement database searches and may involve requests on multiple persons. In FY 2020, OIG conducted 9,305 searches for criminal background information.

In addition, in the course of an investigation, if evidence indicates that a criminal act may have been committed, OIG may notify the Illinois State Police. OIG may also investigate the alleged act for administrative action only.

OIG assists law enforcement agencies with gathering necessary documents. If law enforcement elects to pursue a criminal investigation and requests that the administrative investigation be put on hold, OIG will retain the case on monitor status. If law enforcement declines to prosecute, OIG will determine whether further investigation or administrative action is appropriate.

Referrals from the Office of the Executive Inspector General for the Agencies of the Illinois Governor

In FY 2020, OIG received 88 referrals for investigation from the Office of the Executive Inspector General for the Agencies of the Illinois

Governor. After initial review, a referral may be closed, opened for further investigation, or transferred for further review by Department management, Office of Affirmative Action, Labor Relations, or the Advocacy Office.

INVESTIGATIVE PROCESS

OIG's investigative process begins with a Request for Investigation, notification by the State Central Register of a child's death or serious injury, or a referral for a Child Welfare Employee License investigation. Investigations may also be initiated when OIG learns of a pending criminal or child abuse investigation against a child welfare employee.

In FY 2020, OIG received 4,233 Requests for Investigation or technical assistance.[1] Requests for Investigation and notices of deaths or serious injuries are screened to determine whether the facts suggest possible misconduct by a foster parent, Department employee, or private agency employee, or a need for systemic change. If an allegation is accepted for investigation, OIG will review records and interview relevant witnesses. The Inspector General reports to the Director of the Department and to the Governor with recommendations for discipline, systemic change, or sanctions against private agencies. OIG monitors the implementation of accepted recommendations.

OIG may also 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, OIG 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.

[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.

OIG is mandated by statute to be separate from the operations of the Department. OIG files are not accessible to the Department. The investigations, investigative reports, and recommendations are prepared without editorial input from either the Department or any private agency. Once a report is completed, OIG will consider comments received and the report may be revised accordingly.

If a complaint is not appropriate for full investigation by OIG, 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 Financial and Professional Regulation.

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 OIG, or anyone providing information, may request that their identity be kept confidential. To protect the confidentiality of the complainant, OIG will attempt to procure evidence through other means, whenever possible. At the same time, an accused employee needs to have sufficient information to enable that employee to present a defense. 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 OIG.

Reports issued by OIG contain information that is confidential pursuant to both state and federal laws. As such, OIG reports are not subject to the Freedom of Information Act. Annually, OIG prepares several reports redacting confidential

information for use as teaching tools for private agency and Department employees.

Impounding

OIG is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." 20 ILCS 505/35.5(b). In order to conduct thorough investigations, while at the same time ensuring the integrity of records, investigators may impound files by immediately securing and retrieving original records. 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 an OIG investigator. Impounded files are returned as soon as practicable.

REPORTS

OIG reports are submitted to the Director of DCFS. Specific reports also are shared with the Governor. An OIG report contains a summary of the complaint, a historical perspective on the case, including a case history, and detailed information about prior DCFS or private agency contact(s) with the family. Reports also include an analysis of the findings, along with recommendations.

OIG uses some reports as training tools to provide a venue for ethical discussion on individual and systemic problems in child welfare practice. The reports are redacted to ensure confidentiality and then distributed to the Department or private agencies as a resource for child welfare professionals. Redacted reports are available on the OIG website or by calling OIG at (312) 433-3000.

Recommendations

OIG may recommend systemic reform or case-specific interventions in the investigative reports. Systemic recommendations are designed to strengthen the child welfare system to better serve children and families.

Ideally, discipline should have an accountability component as well as a constructive or didactic one. It should educate an employee on matters related to his/her misconduct while also functioning to hold employees responsible for their conduct. 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.

OIG presents recommendations for discipline to the Director of the Department and, if applicable, to the director and board of the involved private agency. Recommendations for discipline may be subject to due process requirements. In addition, 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, OIG may investigate further to determine appropriate recommendations for systemic reform.

When recommendations concern a private agency, appropriate sections of the report are submitted to the agency director and the board of directors of that agency. The agency may submit a response. In addition, the board and agency director are given an opportunity to meet with OIG to discuss the report and recommendations.

OIG is a small office in relation to the child welfare system. Rather than address problems in isolation, OIG views its mandate as strengthening the ability of the Department and private agencies to perform their duties.

OIG monitors implementation of recommendations made to the Director of DCFS and private agencies. Monitoring may take several forms. OIG will monitor to ensure that Department or private agency staff implement the recommendations made. OIG may consult with the Department or private agency to assist in the implementation process. OIG may also

develop accepted reform initiatives for future integration into the Department.

OIG HOTLINE

Pursuant to statute, 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 OIG Hotline to request assistance in addressing the following concerns:

- Complaints regarding DCFS caseworkers and/or supervisors ranging from breaches of confidentiality to failure of duty;
- Complaints about private agencies or contractors;
- Child Abuse Hotline information;
- Child support information;
- Foster parent board payments;
- Youth in College Fund payments;
- Problems accessing medical cards;
- Licensing questions;
- Ethics questions; and
- General questions about DCFS and OIG.

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

The following chart summarizes OIG's response to calls received in FY 2020.

CALLS TO OIG HOTLINE IN FY 2020

TOTAL CALLS	1384
INFORMATION AND REFERRAL	978
REFERRED TO SCR HOTLINE	135
REQUEST FOR OIG INVESTIGATION	271

DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS

OIG collaborated with Department administration to address the backlog of OIG recommendations that had yet to be fully implemented. OIG and Department staff also reached agreements on how to move forward with the implementation of recommendations impacting child safety that had been previously rejected or unresolved by the Department. The following recommendations and the response provided by the Department are the remaining pending recommendations from previous fiscal years with an implementation plan. The current implementation status of these recommendations is detailed below in the following categories:

- **CHILD PROTECTION**
- **DOMESTIC VIOLENCE**
- **EDUCATION**
- **FOSTER HOME LICENSING**
- **INTACT FAMILY SERVICES**
- **MEDICAL**
- **MENTAL HEALTH**
- **OLDER YOUTH IN CARE**
- **PERSONNEL**
- **SERVICES**

CHILD PROTECTION

FY 2018 and 2019

Any family with three or more child protection investigations within a year (for one or more persons living in the home) should be reviewed by DCFS management to ensure that underlying issues are being addressed (from OIG FY 18 Annual Report, Death and Serious Investigation 1 and OIG FY 2019 Annual Report, Death and Serious Investigations 2, 3 and 7).

FY 2020 Department Update: The recommendation was incorporated in a Department-issued memo, *Subsequent Oral Reports* (SOR) issued in February 2020. Child Protection management conducted a statewide overview of the SOR memo and continues to make recommendations for training revisions to address the role of subsequent oral reports in the assessment of youth. The SOR memo was forwarded to the Office of Child and Family Policy for incorporation into procedure. The Crisis Intervention Team also continues to review all child deaths and egregious harm investigations involving SORs. In addition, the Division of Operations receives monthly feedback and addresses the feedback with the field. Training revisions are also pending.

FY 2019

Child protection staff should be required to utilize the CFS 968-90, *Questions for Mental Health Professionals,* when interviewing mental health professionals regarding an alleged perpetrator (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 2).

FY 2020 Department Update: The Department agrees and will revise the form to be utilized as an investigative tool for child protection.

FY 2019

The Department should consider strengthening Procedures 300.80, *Child Protection Supervisor/Area Administrator Waivers*, when an alleged child victim is inaccessible and ensure investigators are trained accordingly (from OIG FY 2019 Annual Report, General Investigation 13).

FY 2020 Department Update: The recommendation has been incorporated in the draft of Procedures 300, *Reports of Child Abuse and Neglect*.

FY 2019

The SACWIS version of the Adult Substance Abuse Form should be amended so that the collateral section cannot be bypassed without a waiver. The waiver should only be given if there is no indication of substance abuse (from OIG FY 2019 Annual Report, General Investigations 6).

FY 2020 Department Update: Child Protection Administrators will work with staff from the Department of Information Technology to implement this recommendation.

FY 2019

In cases of violence and risk of violence, the CERAP should include an assessment of the custodial parents' protective capacity, which could change as new facts are learned. In this case, had the mother's protective capacity been noted as positive because of her decision to get an order of protection, backtracking on that decision warranted a reexamination of her protective capacity (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 5).

FY 2020 Department Update: The Department continues to engage in the selection of a replacement safety assessment tool. In addition, assessment of parental capacity was most recently addressed in the Engaging and Assessing Paramour training that launched in June 2020. In the training, the staff works through a case study based on and adapted from an OIG case. The learning focus of the activity was for the supervisor/staff to accurately assess the parental protective capacity.

FY 2019

The Department should consider adding an alternative on the Child Endangerment Risk Assessment Protocol (CERAP) to allow a finding of "conditionally safe" – identifying factors where if there is a change in circumstances court intervention may be warranted (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 2).

FY 2020 Department Update: The Department continues to engage in the selection of a replacement safety assessment tool. This recommendation will be addressed as part of those efforts.

FY 2019

The DCFS Office of Legal Services should assist with clarifying policies and practices regarding safety plans and orders of protection. Once developed all staff should be trained accordingly.

Although an order of protection can be considered a mitigating factor in a CERAP, it cannot be the sole reasoning to close an investigation. Safety plans should be considered as a tool that DCFS staff can utilize to better ensure compliance with orders of protection by both the offending and non-offending parents (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 5).

FY 2020 Department Update: Safety planning has been included as part of the Department's Safety First, Safety Always training series which launched in July 2019. The Safety First, Safety Always series started with a Safety Reboot focused on workplace and field safety for staff and safety assessment of children. Training was rolled out to direct service staff and supervisors in Division of Child Protection, Intact, Permanency, Foster Care Licensing and Adoptions on underlying conditions and key safety assessment factors. The 2nd installment in the series, Engaging and Assessing Paramour Involved Families launched in June 2020 and addresses the use of safety plans. Although this specific item is complete, the Home Safety Checklist will continue to be incorporated in future trainings in this series for reinforcement of the practice. Child Protection Management also developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations, including safety planning.

FY 2019

The Department should train supervisors on how to assess the full history of the family and how it can be used in the evaluation of the family. When a child protection investigation commences, a family history should be completed, maintained and updated each time the Department receives a subsequent hotline report. The family history should be available to subsequent investigators/caseworkers (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 7).

FY 2020 Department Update: Specialty training in Problem-Based Learning launched with child protection and intact supervisors. Permanency supervisors will also be trained in April 2021. The Problem-Based Learning training uses virtual simulations to walk through critical decision-making in order to assess the total circumstances of the family history. In addition, this issue is addressed in quarterly child protection supervisor meetings.

FY 2019

The Department should evaluate the current Child Welfare Services referral system for efficacy and responsiveness. The evaluation should include reviewing timeframes for a CERAP, a response time frame, and service provision time frames and determine needed improvements (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 7).

FY 2020 Department Update: In February 2020, a CERAP workgroup was developed to address Child Welfare Services (CWS) referrals/Intake Evaluations and update procedure in order to provide timeframes and specific instructions on how CWS Referrals/Intake Evaluations are to be assigned and managed in the field. The workgroup continues to review and finalize the proposed changes to assignment and management of CWS Referrals/Intake Evaluations. Changes will need to be made to both Procedures 300 and 304, to accommodate the proposed improvements. In March 2020, a practice memo was also issued to provide guidance to the field on how to manage CWS Referrals in light of the COVID-19 pandemic – specifically in person contacts with family members. This guidance was updated on October 9, 2020. Additionally, Policy Guide 2020.08 was issued April 13, 2020, which outlines when the hotline must take a CWS referral; requires-

parent cooperation or another hotline report will be considered; and requires the Department to assess the home and the children.

FY 2019

The Department should reevaluate the child protection investigation extension rule and procedure, develop a new clear procedure instructing supervisors and area administrators on good cause for case extension, and train staff on good cause for case extension (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 10).

FY 2020 Department Update: On November 4, 2019 a memo was issued to all Child Protection Area Administrators and Regional Administrators which addressed extensions for good cause and the parameters for approval. At the time the memo was issued, there were 1486 extended investigations, as of June 2020, the number of extended investigations was at 580. Extensions continue to be monitored and measured.

FY 2019

If a subsequent oral report (SOR) of abuse and/or neglect is received on an open Intact Family Services case, the child protection investigator and supervisor, as well as the Intact Family Services caseworker and supervisor, should discuss the case, and document in SACWIS, within two days of the SOR and ensure a method of maintaining ongoing communication is established as required by current procedure, which should include attendance at all Child and Family Team Meetings (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 2).

FY 2020 Department Update: There are already procedures in place requiring a timely discussion between the intact worker and investigator. There are also alerts on desktops for intact and investigations workers and supervisors to alerting them to a subsequent oral report (SOR). The Department issued a memo addressing *Subsequent Oral Reports* (SOR) in December 2019 and in February 2020. Child Protection management conducted a statewide overview of the SOR memo and continues to make recommendations for training revisions to address the role of subsequent oral reports in the assessment of youth. The SOR memo was forwarded to the Office of Child and Family Policy for incorporation into procedure. The Crisis Intervention Team also continues to review all child deaths and egregious harm investigations involving SORs. In addition, the Division of Operations receives monthly feedback and addresses the feedback with the field. Training revisions are also pending.

FY 2019

DCFS Office of Legal Services should retrain child protection staff in this region on use of the CFS 600-5*, Release of Information for Child Protection Investigations*, and the CANTS 7, *Administrative Subpoenas* (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 9).

FY 2020 Department Update: DCFS Legal met with child protection staff in the region to address the use of the CFS 600-5 and CANTS 7.

FY 2018

Management should conduct an enhanced review of families with investigations over C sequence child protection investigations (the OIG provided a draft tool). The review should evaluate whether

chronic issues in the family are being addressed or are capable of being addressed (from OIG FY 18 Annual Report, Death and Serious Investigation 4).

FY 2020 Department Update: With the input of statewide workgroups and the Regional Administrators, Child Protection management developed a Subsequent Oral Report (SOR) Protocol and corresponding practice memo. The SOR practice memo was issued to the field in December 2019 and February 2020. Child Protection conducted a statewide overview of the SOR memo and continues to make recommendations for training revisions to address the role of SORs in the assessment of kids. The SOR memo was forwarded to the Office of Child and Family Policy for inclusion in procedure. Additionally, the Crisis Intervention Team continues to review all child deaths and egregious harm investigations involving SORs. The Division of Operations also receives monthly feedback and addresses the feedback with the field. Training revisions are also pending.

FY 2018

The Department's child protection investigation into the death should be closed as "undetermined" pending completion of the criminal investigation and the Department should explore further use of the "undetermined" category for cases where there are ongoing criminal investigations or other extenuating circumstances to allow staff to focus on other investigations (from OIG FY 18 Annual Report, Death and Serious Injury Investigation 1).

FY 2018 Department Response: An investigation should not be closed in this manner. Undetermined is statutorily permitted but is not utilized. When a case is placed in undetermined status, it is still pending. The Department cannot hold cases open for years, as it infringes on a person's basic rights. The Department always has the option to open a new investigation if new information comes in.

FY 2019 Department Response: No update provided.

The prior OIG and DCFS administration had reached a stalemate regarding implementation of this recommendation.

FY 2020 DCFS Update: The current administration agrees that cases should not be left open any longer than is necessary. While setting the disposition of a case as "Undetermined" is allowed, it does not close the case and the investigation is still pending so it does not address the root issue. The Department will address this issue through additional practice steps. New guidelines are being released that require Area Administrators to receive approval from their Regional Administrator to approve additional extensions for any investigation that is pending for longer than 180 days.

FY 2010

Child protection managers should track and maintain data on cases presented to the State's Attorney's Office for filing of petitions and the State's Attorney's Office's response. Child protection offices should share this information with DCFS Office of Legal Services (from OIG FY 10 Annual Report, Death and Serious Injury Investigation 7).

FY 2020 Department Update: DCFS is aware of its right to file petitions in juvenile court and is working to improve the present circumstances, including efforts to improve communication and

understanding among various court stakeholders across the State – which is critical to the success of such petitions. State's Attorneys are charged with prosecuting the petitions, and DCFS will continue to work collaboratively with State's Attorneys to ensure that petitions are not only filed, but that all evidentiary issues are addressed – which appears to be the main cause of petitions not being filed by State's Attorneys. Although, DCFS Legal is currently unable to track and maintain data on cases presented to State's Attorneys for filing petitions and State's Attorneys responses, DCFS Legal and Operations are working together to address the root cause of this issue across the state by analyzing cases as they arise in order to advocate as appropriate. DCFS Legal is also in the process of developing a county-by-county approach to juvenile court matters in order to, among other things: (i) build and maintain relationships with court stakeholders in each county; (ii) address issues that are particular to each juvenile court jurisdiction; and (iii) build on strengths and innovative ideas across juvenile court jurisdictions.

FY 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 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 2018 Department Update: It is not necessary to amend the CERAP to require that workers note when a risk factor cannot be answered because of insufficient information. Part of an ongoing investigation is to collect information and evidence as it relates to risk and safety. At any time, as safety threats are identified over the life of the investigation, the CERAP can be updated and that information included-there is a milestone within the CERAP that allows this. Risk and the subset of safety are continually addressed over the course of an investigation. In addition, if there are service needs related to risk, an intact case can be opened, or referrals made to community services when that risk factor is identified. The Department has concluded its response to this recommendation.

FY 2019 Department Update: No update provided.

The prior OIG and DCFS administration had reached a stalemate regarding implementation of this recommendation.

FY 2020 Department Update: The current administration has agreed to share the report with the CERAP committee to address the issues identified during the investigation. Additionally, the Department is currently evaluating the CERAP and will either revise or replace the CERAP with another tool.

DOMESTIC VIOLENCE

FY 2016

In cases of severe domestic violence, Department procedures should require safety plans that include the involvement of shelter staff or other family support agreeing to contact the Department if the family leaves the shelter (from OIG FY 16 Annual Report, General Investigation 4).

FY 2020 Department Update: The use of safety plans in cases of domestic violence has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2015

The Department should develop guidelines identifying behavior that calls into question the protective capacity of a non-offending caretaker. When protective capacity issues are identified, the Department must review available records and conduct a clinical interview to assess protective capacity. Recommendations from the Assessment must be included in any service plan (from OIG FY 2015 Annual Report, Death and Serious Investigation 3).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2012

The Department should examine the continued utility of the Domestic Violence Screen and determine whether the Screen assists in assessing safety and risk to children (from OIG FY 2012 Annual Report, General Investigations 1).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2012

The Department should consider requesting the assistance of Child Advocacy Centers (CAC) to interview children in investigations where there is chronic violence in the home and parents have failed in the past to cooperate with services (from OIG FY 2012 Annual Report, General Investigations 1).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2012

Policy Transmittal 2010.23, which issues revisions to Procedures 302.260, *Domestic Violence Practice Guide,* and Procedures 300, Appendix J: *Domestic Violence*, allows for batterers to remain in the home with a domestic violence safety plan. This policy should be amended to clarify that when domestic violence has occurred in the home, it is presumed that the home environment is too dangerous for the child to remain, unless the perpetrator of violence is out of the home. Policy Transmittal 2010.23 should make clear that establishing a domestic violence safety plan for children should not preclude taking protective custody (from OIG FY 2012 Annual Report, General Investigations 1).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2011

The Department's Domestic Violence Protocol should be revised to address the cumulative effect of domestic violence and strategies for addressing cases of chaotic family life in which the

victim/abuser dynamic results in an incalculable emotional toll to the children, including collaboration with DCFS Clinical and the Office of Legal Services (from OIG FY 2011 Annual Report, Death and Serious Injury Investigation 11).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence*.

FY 2011

The Department should integrate into its domestic violence protocol the need for increased scrutiny and heightened risk when a person suspected of being a victim of domestic violence has provided false information to protect an abuser of his or her child (from OIG FY 2011 Annual Report, Death and Serious Injury Investigation 12).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence*.

EDUCATION

FY 2019

The Department should create clear procedures for workers to have when confronted with an issue pertaining to the ever-growing field of electronic access to school records, particularly when the Department has custody and guardianship of a minor. Caseworkers should have clear direction as to when it would be appropriate to request a non-custodial parent's access be denied or restricted to school records. Further, the Department should determine whether caseworkers should request that the access be restricted from the school or through a court order. This should be developed in consultation with school districts and/or the Illinois State Board of Education (from OIG FY 2019 Annual Report, General Investigations 13).

FY 2020 Department Update: The Department continues to engage in discussions with the Illinois State Board of Education and local school districts to develop a policy that will address this issue. Given the complexity of this issue and the number of school districts in the State, this will be an ongoing process.

FY 2019

The Department should develop a method/tool for child protective investigators to quickly reference ANCRA from their Department issued cell phones when they are denied access to a child for an interview so that they may provide the statutory authority allowing access to a child (from OIG FY 2019 Annual Report, General Investigations 13).

FY 2020 Department Update: The DCFS Director and the State Superintendent of Education for the Illinois State Board of Education (ISBE) signed a joint letter addressing this recommendation on in November 2019. This letter was shared on the D-NET in September 2020. The D-NET announcement included instructions for how workers can download the letter to their work cellphones using the Adobe Sign app on their phones. The letter can be emailed to school officials directly from the Adobe Sign app.

FY 2019

The Department should consider a legislative change to amend ANCRA and the Illinois School Code to require schools to allow child protection investigators to speak with children at school, without notifying the alleged perpetrator (from OIG FY 2019 Annual Report, General Investigations 13).

FY 2020 Department Update: The DCFS Director and the State Superintendent of Education for the Illinois State Board of Education (ISBE) signed a joint letter on in November 2019. The letter specifically states "Child protection specialists have the legal authority and duty under ANCRA to interview and take photographs of the alleged child victims without the consent or presence of a parent or guardian when required to assure the safety of the child. Child protection specialists· also have the legal authority and duty under ANCRA to take protective custody of a child without the consent or presence of a parent or guardian." This letter was shared on the D-NET in September 2020. The D-NET announcement included instructions for how workers can download the letter to their work cellphones using the Adobe Sign app on their phones. The letter can be emailed to school officials directly from the Adobe Sign app.

FY 2018

In return home cases, the Department's Office of Legal Services should ensure that an additional condition be incorporated in the Order of Protection requiring that all preschool aged children are enrolled in and actively attending the appropriate state pre-kindergarten or Head Start program (from OIG FY 2018 Annual Report, Death and Serious Investigation 2).

FY 2020 Department Update: The Office of Legal Services will review the Order of Protection forms used in each county and consider on a case-by-case basis the possibility of requiring pre-kindergarten or Head Start for youth returned home. The DCFS Office of Legal Services (OLS) is also in the process of developing a county-by-county approach to juvenile court matters in order to: (i) build and maintain relationships with court stakeholders in each county; (ii) address issues that are particular to each juvenile court jurisdiction; and (iii) build on strengths and innovative ideas across juvenile court jurisdictions.

FY 2018

In return home cases, prior to the child's scheduled return home date, the case worker should meet with the parent(s) and school professionals to introduce the parent to the school, begin the registration process, and identify additional community programs that may be available to the family for social engagement of the children (from OIG FY 18 Annual Report, Death and Serious Investigation 2).

FY 2019 Department Update: No update provided.

FY 2020 Department Update: Procedures 314, *Educational Services* outlines all requirements and timeframes for education enrollment and transfers. In addition, in the Foundations for Placement training Facilitator's Guide, the trainers use Policy 315.250(c), *Health, Safety and Education Requirements*, to underscore the worker's responsibilities to support parents in the child's educational endeavors.

FOSTER HOME LICENSING

FY 2010

The Department should amend Procedures 301, Appendix E, *Placement Clearance Process*, to provide guidelines for the monitoring and resolution of involuntary placement holds. These guidelines should include instructions for requesting the removal of an involuntary placement hold. The guidelines should also require that when an involuntary placement hold is placed on a foster home, the licensing worker and licensing supervisor should re-evaluate the placement hold every six months (from OIG FY 2010 Annual Report, General Investigation 4).

FY 2020 Department Update: The Department drafted changes to Procedures 301, Appendix E, which addresses the need for monitoring and re-evaluating placement holds. OIG and Licensing administration provided additional feedback which will be included in a new proposal to Procedures 301 and 383. The new CFS 109 and draft procedures will be submitted in December 2020 and include additional language that provides further clarification and detail related to requesting and removing involuntary placement holds.

INTACT FAMILY SERVICES

FY 2019

The DCFS nurse should be assigned for the duration of intact family services cases involving medically complex children. Their duties should include attending home visits with the intact caseworker to meet with the family, attending medical appointments with the family and the intact service worker, communicating with medical providers, assisting with the medical and health related sections of the integrated assessment, and participating in Child and Family Team Meetings to help the family develop a plan to ensure that the children receive their required medical care (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 6).

FY 2020 Department Update: An Information Transmittal was drafted but had to be revised due to new procedures related to COVID-19. Also, there needs to be additional meetings to bring staff up-to-date on the requirements for IT staff as well as share input. This will be done by the end of the 3rd quarter 2021.

FY 2019

As previously recommended, at the transitional visit in Intact Family Services cases with a medically complex child, the child protection investigator and the intact family services caseworker should request that the parent sign consents for the worker to communicate with the child's medical home regarding the child's health and medical care management (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 6).

FY 2020 Department Update: DCFS Procedure 302.388, *Intact Family Services*, is awaiting approval for Proposed Policy Review (PPR). In addition, Policy Guide 2020.16 addressing medically complex children was issued on November 20, 2020.

FY 2019

The Department should create a form similar to the CFS 600-5, *Release of Information*, for Division of Child Protection (DCP) Investigations for Intact Family Service Cases, to allow intact family services caseworkers to obtain medical information from medical providers without a consent (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 6).

FY 2020 Department Update: Intact services are voluntary. Procedure 302.388 was revised November 20, 2020 and now specifies "Intact Family Services workers will obtain consents for release of information for all medical providers of medically complex children at the first contact with the family; upon change of medical providers or when a new condition is diagnosed, discovered, or suspected." When a family refuses to sign consents, there is an existing mechanism in DCFS Procedure 302.388(l) for staffing the case with the supervisor and considering screening the family into Juvenile Court. Initial consents for medical providers as well as general consents shall be obtained at the transitional visit in the proposed draft of DCFS Procedure 302.388.

FY 2019

Intact family services providers should have full access to case/family history for families they serve (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 3).

FY 2020 Department Update: Caseworkers have access to the case history once the case is assigned to them. In December 2020 and January 2021, the Department is rolling out Person Search training to Intact caseworkers to assist them in viewing and accessing SACWIS history on a family. Person Search training is also being integrated into Foundations Training.

FY 2019

Due to the complexity of confidentiality and consents, the Department needs to provide clear and specific guidance, beyond written procedures, for Intact Family Services caseworkers to understand what information can be shared and who can share information with providers with and without consents (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 6).

FY 2020 Department Update: Procedures for Intact Family Services requires intact workers to obtain client consent to obtain and/or disclose any/all information related to the Intact Family Services Case. The DCFS Office of Learning and Professional Development will also incorporate the language into all Foundations curricula, where Procedures 431, *Confidentiality* is discussed.

FY 2019 and FY 2017

As previously recommended, in Intact Family Services cases involving medically complex children, the caseworker must convene a staffing, within 30 days of receiving the case, with the health care professionals involved with the family and parent(s) to discuss the child's care and assess parents' needs for tangible and emotional support (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 6 and OIG FY 2017 Annual Report, Death and Serious Injury Investigation 8).

FY 2020 Department Update: DCFS Procedure 302.388, *Intact Family Services*, is awaiting approval for Proposed Policy Review (PPR). In addition, Policy Guide 2020.16 addressing medically complex children was issued on November 20, 2020.

FY 2018

The Department must develop protocol that requires intact workers to identify family needs that are critical and time sensitive and management must track those cases to ensure the needs are met (from OIG FY 18 Annual Report, Death and Serious Injury Investigation 1).

FY 2018 Department Response: The Department will not develop another protocol. The Department has other processes which address this. Identification of family needs is a regular part of supervision. In addition, there are already many other processes implemented to track this. In the local area, a process called 360 has been developed to bring community providers and local agencies together. The purpose is to discuss issues and concerns regarding families they are working with and identify resources available within the community, working together to help vulnerable families. In addition, there is an immediate review of all intact cases with a new investigation to ensure divisions discuss the case and any identified needs/concerns are addressed. General reviews are performed by Quality Assurance, Intact Utilization, and APT to also ensure families' needs are being met and safety addressed. Service plans are reviewed with the family on a regular basis to assess completion and barriers to services and with the core practice model rollout, the emphasis is in conducting Child and Family Team Meetings with the families as active participants in identifying what they need.

FY 2019 Department Update: No update provided.

The prior OIG and DCFS administrations had reached a stalemate regarding implementation of this recommendation.

FY 2020 Department Update: The current DCFS administration agrees to address the recommendation through training efforts. The Core Practice model and the Child and Family Team Meeting trainings include how to better identify critical and time sensitive family needs which is in the process of being rolled out with permanency and intact workers at immersion sites and is planned to be rolled out state-wide. In addition, an updated foundations training for new intact staff will be rolled out in the first half of FY22 and will include this recommendation.

FY 2018

The Department should explore expanding the Child Welfare Training Academy Simulation residential home for intact family workers and supervisors (from OIG FY 18 Annual Report, Death and Serious Investigation 1).

FY 2020 Department Update: Intact supervisors began specialty training in Problem-Based Learning (PBL) in November 2020. The PBL training uses virtual simulations to walk through critical decision-making to assess the total circumstances of the family history. Intact staff will also be offered simulations in March of 2021.

MEDICAL

FY 2013

When there is a question about a youth in care having seizures or whether to discontinue a youth in care's seizure medication, the Department should assure that a sleep deprived EEG has been conducted as part of the evaluation (from OIG FY 13 Annual Report, Death and Serious Injury Investigation 3).

FY 2018 Department Update: The Department maintains its original and ongoing disagreement on the use of a sleep deprived EEG in every case where anti-seizure medication is being discontinued. An EEG will be done if recommended by the treating physician. The Department has concluded its response to this recommendation.

FY 2019 Department Update: No update provided.

FY 2020 OIG Comment: The current OIG administration agrees to limiting the requirement for conducting a sleep deprived EEG to cases in which it is recommended by the treating physician.

FY 2011

HealthWorks should obtain the results of newborn genetic metabolic screens on all children, regardless of their age, upon entering Department care. If the results of the genetic screen are unavailable, the Department should ensure that the screen is completed during the HealthWorks comprehensive exam or by the child's primary care physician (from OIG FY 2011 Annual Report, Death and Serious Injury Investigation 9).

FY 2020 Department Update: Illinois Department of Public Health is currently sending the new fields to OITS. Additional Birth Data Fields include Birth Weight, Gestational Age, Apgar Score 5, Apgar Score 10, Plurality, Birth Order, Abnormal Conditions, and Congenital Abnormalities. The newborn metabolic screening is not complete. The Office of Information Technology Services plans to incorporate the newborn metabolic screening into SACWIS in June 2021.

MENTAL HEALTH

FY 2018

Whenever the facts suggest the possibility of significant developmental delays, mental illness or other issues that can affect the caregiver's ability to benefit from standard interventions, management must ensure that the delays are assessed and that referrals address identified delays (from OIG FY 18 Annual Report, Death and Serious Investigation 1).

FY 2020 Department Update: Supervisors in all specialties are now required to enroll in and complete the Model of Supervisory Practice. In addition, the Department developed a 360 model which aims to meet the needs of the DCFS client population by streamlining a process by which all agencies exchange information, know resources, and can bring case or client challenges to the table to problem solve them. The parties can talk about service needs that are missing, and jointly problem-solve. They can refer from one agency to the other. Involved stakeholders include public/ private agencies; community service organizations including: substance abuse, homeless shelters, counseling centers; local community action groups, schools, daycares, early childhood organizations and law enforcement. 360 meetings were face-to-face on a monthly basis from January through March of 2020. Meetings were postponed after March due to COVID-19 and virtual 360 meetings began in July, and took place July, August and September.

FY 2012

Access to means, specifically firearms, is predictive of suicide completion. Research has shown and as noted in two adolescents' deaths, those at risk of suicide will break into locked rooms and locked cabinets to access the firearms. When the Department is placing an adolescent at risk of suicide in a

foster home or facilitating a return to the biological home where there is a gun, the Department should conduct a clinical staffing to educate the parents (biological and foster) that the risk of suicide doubles if there is a firearm in the house, even if the gun is locked up. The staffing should utilize the materials developed by The University of Illinois at Chicago Institute for Juvenile Research for their Youth Suicide Prevention program. If the family has firearms, they should be asked to store the guns outside of the home. If the parent will not store the firearm elsewhere, they must store firearms with a trigger lock in a lockbox. The keys should be kept in a secure or supervised setting. In return home situations of a suicidal youth, where the biological parent refuses to store the gun with a trigger lock in a lock box, the caseworker should contact DCFS Legal for assistance in presenting the case in Juvenile court for purpose of obtaining a court order (from OIG FY 12 Annual Report, Death and Serious Injury Investigation 14).

FY 2020 Department Update: The Department engaged in rulemaking for Rule 402, *Foster Family Homes*, pursuant to the provisions of the Family First Preservation Act, to enact the national model Foster Family Home Licensing Standards, which require that weapons and ammunition be stored separately and be locked, unloaded, and inaccessible to children. Rules 402 were updated by Policy Transmittal 2020.04 to implement the Family First requirements. In addition, procedure related to Reunification Planning, requires that when a child has signs of depression and/or suicidal ideation and one or more guns are stored at the parent's home, the Reunification Service Plan shall include a requirement that the parent ensures all guns are equipped with functioning trigger locks and are stored in a locked safe or a locked cabinet. In addition, the Home Safety Checklist also addresses firearms in the home. If parent(s) refuse to comply with gun safety as required in the service plan, depending on the current status of the case, case workers can contact the state's attorney office with concerns or, if appropriate, contact the hotline or law enforcement for assistance.

OLDER YOUTH IN CARE

FY 2019

The Department should develop transition procedures and interagency collaboration similar to Procedures 302, Appendix N, *Transition Planning for Wards with Developmental Disabilities*, for pregnant and parenting youth in care with significant mental illness who are aging out of care. Policy Transmittal 99.14 discusses creating interagency agreements, which might also be helpful with this population (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 3).

FY 2020 Department Update: DCFS is now a member of the Illinois Longitudinal Data System, which has the capability of identifying youth with behavioral health issues. The Office of Education and Technology Services will convene a meeting with clinical to review a new Intergovernmental Agreement and/or Longitudinal Data System information to address this recommendation.

FY 2015

From OIG FY 2015 Annual Report, Special Investigations, *Shelter and Runaway Report:* The Shelter System should be revamped to include the following:

- **The Department should determine the number of older Cook County shelter youth with histories of serious mental illness who cycle in and out of the present shelter system. The Department should develop a specialized stabilization center for this population of youth.**

- **In addition to clinical services, this stabilization center should have an outreach unit that functions similarly to homeless mental health delivery services.**
- **The stabilization center should host supportive NAMI (or similar) groups for relatives or other child centered collateral of the youth who are willing to partner with stabilization efforts.**
- **The Center should tightly coordinate educational services to assure the residents' educational rights are secured. This is crucial for those youth who are eligible or up for redetermination for SSI benefits. The center should also provide alternative educational programming similar to Education Options program at the Madden Center.**
- **The Department should determine the annual number of Cook County shelter youth 15 years old or older who are involved with the juvenile justice system or adult probation and who cycle through its shelter system. The Department should develop a restorative justice stabilizing center for this targeted population, working closely with Juvenile Court personnel and Probation. The staff of the shelter should have the ability to network with the various detention alternative programs including Electronic Monitoring and Evening Reporting Centers and substance abuse programs. Clinical services should be provided for those youth who have mental health or adjustment problems.**
- **The Department should develop a violence-free stabilizing center for the older youth (over 17) involved with the criminal court system or dually involved with adult and juvenile courts. The programming of the shelter should model a Safer Foundation approach. The staff should work with Cook County Sheriff, Criminal Court personnel and Probation. The stabilizing center should clearly define a nonviolence contract with each youth who enter the program. If the terms of the center's nonviolence contract are violated the Department should immediately inform the Juvenile Court and Adult Probation of the violation and the intention of the Department to request termination of the adult's wardship.**
- **The Department should develop a specialized clinical and educational stabilization/shelter program for female youth who have or are at high risk of being victims of trafficking. The Department should consider the Cook County Sheriff's Office offer of prevention work with potential trafficking victims.**

FY 2019 Department Update: No update provided.

FY 2020 Department Update: To address the recommendation, the Department has contracted with a private agency to develop a short-term care center that has increased clinical and therapeutic capacity and provides a variety of clinical support and diagnostic services. The center provides trauma informed treatment services and offers family engagement and after care support services. The center intends to maintain youth at their home school which requires that staff provide transportation to the youths' schools, or to work with the home school district to schedule other forms of transportation services. This program utilizes individualized treatment plans to address the specific needs of youth they serve. The Department has also developed a partnership with a social service agency to provide re-entry and stabilization services for youth stepping out of juvenile detention centers or Illinois Department of Juvenile Justice Centers in Cook County and neighboring counties. The staff at the re-entry program have working relationships with Cook County Probation and the Cook County Juvenile Temporary Detention. The agency also has experience providing detention alternative programming for over 20 years. The re-entry program incorporates restorative justice practices within the milieu, along with individual clinical and group therapy. The Department has developed a contractual relationship with another social service agency which provides a safe house for sex-trafficking victims rescued from law enforcement rescue operations. In addition, the Department is also in the process of developing a specialized clinical and stabilization sex-trafficking treatment program, which will be launched in

FY21. The Department is continuing to build relationships with providers statewide to ensure that youth in care have access to enhanced stabilization services.

FY 2015

From OIG FY 2015 Annual Report, Special Investigations, *Shelter and Runaway Report:* The Department should redefine its search procedure including the following:

- **The Department should amend Rules to eliminate adult youths in care, who are not high risk (developmental disabilities, mental illness, human trafficking, in critical need of medication or bona fide missing) from Rules and Procedures 329.**
- **Adult youths in care without disabilities who chronically absent themselves from voluntary placements should be transitioned out of Department responsibility.**

FY 2018 Department Update: The Department disagrees with this recommendation. The Department will continue to work with all youth, including older youth, until they have achieved permanency or a permanent connection.

FY 2019 Department Update: No update provided.

FY 2020 OIG Comment: The current OIG administration agrees that the Department has a duty to work with all youth, including older youth, until they have achieved permanency or a permanent connection.

FY 2015

From OIG FY 2015 Annual Report, Special Investigations, *Shelter and Runaway Report:* The duties of the DCFS specialized unit for tracking and locating missing children should be limited to those children under 18 and disabled or Bona Fide missing adults. With lower caseloads, the Unit can provide more technical assistance searching databases and assist in contacting extended family and friends. For frequent runners, shelter staff, in consultation with the Specialized Unit, should complete the De-Briefing Form when a youth in care returns to the shelter system.

FY 2018 Department Update: The Department disagrees with this recommendation. The Department will continue to track and locate missing children of all ages, as long as they are under the Departments' care. For frequent runners, shelter staff can assist in completing the De-Briefing form when a youth in care returns to the shelter system.

FY 2020 OIG Comment: The current OIG administration agrees that the Department has a duty to track and locate all missing youth in care.

FY 2014

In FY 2014, the OIG made the following recommendations (from OIG FY 14 Annual Report, General Investigation 13):

- **Colleges and universities offer an orientation week for all incoming students. Similarly, the transitional living program should provide a two-week orientation period for all teen parents. The orientation should focus on building family and community support using a task-centered/ecological approach. During this orientation period, the transitional living program case manager and family support worker will jointly introduce a young parent to community-based resources in the area and begin building the foundation of a support system. (a) Family**

support worker duties include: introducing a youth and her child to local Head Start programs and supporting progress through monthly visits; introducing a young parent and her child to libraries, WIC offices, park districts; establishing a pediatric medical home for a young parent's child; (b) Case manager duties include: supporting the youth in their educational setting through monthly visits to the young parent's school or job to assist the youth to overcome obstacles that hinder achievement. If the young parent is without a medical home, accompanying them to a local Title X Clinic/medical home; and exploring recreational, physical fitness and arts programs in the community with the youth. The case manager should diligently assist the young parent in maintaining and strengthening their extended support system, including inviting a young parent's family or friends to an orientation meal and visiting with a young parent's emergency caretaker.

- **When a young parent transitions into a transitional living program, the receiving case manager shall introduce themselves to school staff within the first ten days and ask to be notified via email of any absences. To support the case managers efforts to sustain attendance, case managers must arrange to have access to the applicable education notification system portals for absences or cuts. If the school does not have a portal system (such as the Alternative School Network), the case manager should arrange notification through available mentors or teachers. If a young parent has two consecutive absences from school, the case manager must immediately make in-person contact. The Teen Parent Support Network Education Support Department shall be consulted before absenteeism becomes a chronic issue. This recommendation should be incorporated into Procedures 302, *Services Delivered by the Department,* Appendix J, *Pregnant and/or Parenting Program*.**

  FY 2019 Department Update: The recommendation has been incorporated in Procedures 302, Appendix J, *Rights, Standards and Best Practices for Pregnant and Parenting Youth.*

FY 2014

Anticipating college enrollment, a case manager should assist a young parent in beginning the application process for grants and federal aid when high school graduation or high school equivalency testing (GED) completion is imminent. Youths in care should not have to confront the daunting and complicated process of applying for Pell grants and federal aid (FAFSA) without hands-on assistance. The Teen Parent Support Network Education Support Department or Youth in College should assist any parenting youth who has completed high school or earned a GED in completing these required applications. This recommendation should be incorporated into the Procedures 302, *Services Delivered by the Department,* Appendix J, *Pregnant and/or Parenting Program* (from OIG FY 14 Annual Report, General Investigation 13).

FY 2020 Department Update: The recommendation has been incorporated in Procedures 302, Appendix J, *Rights, Standards and Best Practices for Pregnant and Parenting Youth.*

PERSONNEL

FY 2019

The issue as to what a child welfare professional can or cannot do in advising non-professionals (i.e. providing expert advice to a friend) should be referred to the Ethics Officer for a determination as to what is permitted or not permitted to be discussed (from OIG FY 2019 Annual Report, General Investigation 18).

FY 2020 Department Update: DCFS is currently promulgating a new rule, DCFS Rule 437 (Employee Ethics and Conflict of Interest). The DCFS Ethics Officer will create a training based on the new Rule 437 and incorporate applicable elements from the child welfare training materials and the Code of Ethics for Child Welfare Professionals to cover the issue in this OIG recommendation. This training will take place after final adoption of DCFS Rule 437.

FY 2019

The Department should create a timekeeping process with a form separate from timesheets to formalize and document temporary assignments (from OIG FY 2019 Annual Report, General Investigation 16).

FY 2020 Department Update: In February 2020 DCFS Payroll became a participant in the IL Acts ERP Program HCM Project. This new timekeeping platform is projected to improve efficiency, enable statewide transparency for both timekeeping and payroll processes, and will include temporary assignment approval/tracking. The Department also developed a new Temporary Assignment form that has been submitted to the Office of Child and Family Policy for approval.

FY 2016

Employers should get a copy of the Child Protection Investigation Summary along with the Notice of Indicated Child Abuse/Neglect Report when an employee has been indicated for abuse/neglect (from OIG FY 16 Annual Report, General Investigation 11).

FY 2020 Department Update: Procedure 300.110, *Special Types of Reports*, Procedure 300.160 *Notifications*, and Procedure 385.50, *Background Checks* require notification to DCFS and POS employers when there is a pending DCP investigation against a DCFS or POS employee. Additionally, if the employee has a child welfare employee license, the DCP investigator must notify the DCFS Office of Employee Licensure of any pending DCP investigation. Rules and procedures also require employer notification of the outcome of the investigation.

FY 2014, 2010, 2008, 2005, 2001, 1999

The Department should develop policy to address suspected substance abuse in the workplace (from OIG Recommendations made in 2014, 2005, 2001 and 1999). In FY 2008 and FY 2010, OIG also recommended that the Department amend Rule 412, Licensure of Direct Child Welfare Service Employees and Supervisors to add "failure to timely comply with an order for drug or alcohol testing after a finding of reasonable suspicion" as a basis for licensure action under Rule 412.50, Grounds for Suspension, Revocation, or Refusal to Reinstate a License (from OIG FY 2010 Annual Report, General Investigation 21 and OIG FY 2008 Annual Report, General Investigation 32).

FY 2018 Department Update: Reasonable Suspicion Drug Testing was an item negotiated during the 2015-2016 AFSCME Master Contract negotiations. The State of Illinois and AFSCME are at a stalemate in terms of negotiating. Since this is a topic covered by a union contract, the Department cannot do anything further on this recommendation. The Department has concluded its response to this recommendation.

FY 2019 Department Update: No update provided.

The prior OIG and DCFS administration had reached a stalemate regarding implementation of this recommendation.

FY 2020 Department Update: The current DCFS Administration agrees with this recommendation. Reasonable Suspicion Drug Testing was an item negotiated during the current AFSCME Master Contract negotiations. The State of Illinois and AFSCME agreed to drop this from the contract. Since this is a topic covered by a master union contract, the Department is unable to make further progress on this recommendation. DCFS will raise this issue again when the Master Contract is next negotiated. In addition, while not specifically addressing the recommendation, the Employee Handbook in the Code of Personal Conduct and the Use of Intoxicants and Narcotics sections speaks to a drug free workplace and the use of discipline when appropriate.

SERVICES

FY 2019

All placement supervisors and caseworkers must be trained on Policy Guide 2019.04, *Requirements for Reunification and After Care Services* (from OIG FY 2019 Annual Report, Death and Serious Investigation 1).

FY 2020 Department Update: A training will be developed in FY 2021 for permanency supervisors. This recommendation will be incorporated in the training for supervisors on content regarding reunification and after care services. Supervisors will then train staff in supervision and in team meetings on this issue. Agency Performance Team staff will also be included to train private agency supervisors.

FY 2019

The involved private agency should reimburse the Department for all costs associated with toxicology screens that were conducted for the client as part of his service plans (from OIG FY 2019 Annual Report, General Investigation 3).

FY 2020 Department Update: The Department plans to gather client information related to the toxicology requests/service delivery imposed on said client. The Department will work with the private agency to obtain payment of toxicology services, dating back to 2009.

FY 2019

The Department should reinforce and re-train staff regarding the Home Safety Checklist to ensure it is satisfactorily completed at appropriate milestones, and specifically before a child protection investigator or caseworker permits a child to be placed in a home. This reinforcement and retraining should also include obtaining background checks for all the home's adult residents (from OIG FY 2019 Annual Report, Death and Serious Investigation 8).

FY 2020 Department Update: A review of the Home Safety Checklist requirements was included as part of the Department's Safety First, Safety Always training series which launched in July 2019. The Safety First, Safety Always series started with a Safety Reboot focused on workplace and field safety for staff and safety assessment of children. Training was rolled out to direct service staff and supervisors in DCP, intact, permanency, foster care licensing and adoptions on

underlying conditions and key safety assessment factors. Although this specific item is complete, the Home Safety Checklist will continue to be incorporated in future trainings in this series for reinforcement of the practice. In addition, requirements of the Home Safety Checklist were included in training that was developed by Child Protection Management and provided to the field in November 2020.

FY 2019

The DCFS Office of Legal Services should review the practice of requesting law enforcement to take protective custody for interviewing purposes and retrain staff accordingly (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 9).

FY 2020 Department Update: Operations provided guidance to the field to address the issues raised by this case regarding protective custody and the role of law enforcement. The Office of Legal Services will remain available to the field should the need for further guidance arise.

FY 2019

The State Central Register (SCR) call operators should be further trained on options and resources available when a hotline call does not rise to the level of initiating a child protection investigation, such as Child Welfare Services referrals and police well-being checks (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 1).

FY 2020 Department Update: The Department developed a training, *Managing Callbacks: Creating & Completing Callbacks,* for call floor staff that addressed this recommendation. The training was also incorporated into the Foundations-SCR specialty training for new staff hired.

FY 2019

Consistent with Public Act 101-0237 that amends the Abused and Neglected Reporting Act, and is effective January 1, 2020, when a report is made by a mandated reporter and there is a prior indicated report or a prior open service case involving any member of the household, the Department must, at a minimum, accept the report as a child welfare services referral (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 1).

FY 2020 Department Update: The Department developed a training, *Managing Callbacks: Creating & Completing Callbacks,* for call floor staff that addressed this recommendation. The training was also incorporated into the Foundations-SCR specialty training for new staff hired.

FY 2019

In OIG FY 2019 Annual Report, General Investigation 1, the OIG made the following recommendations regarding the State Central Register:
(1) During times of high call volume, when a mandated reporter contacts the State Central Register hotline, call floor staff should be instructed to obtain a brief description of the situation in order for management to prioritize the call back.
(2) Call floor staff should request specific times that the reporter will be available for a callback.
(3) Anytime law enforcement contacts the hotline to report abuse and neglect the call should be returned as soon as possible but no longer than five hours to ensure a return call occurs during their work shift.

(4) In cases in which the call floor worker is returning a call, the call floor worker should be instructed to document in the hotline narrative when the initial call was made to the hotline.

FY 2020 Department Update: The Department developed a training, *Managing Callbacks: Creating & Completing Callbacks,* for call floor staff that addressed these recommendations. The training was also incorporated into the Foundations-SCR specialty training for new staff hired.

FY 2019

The Department should complete a review of the drug testing resources in this region to determine its availability to families and ensure immediate drug testing resources for the area are readily available (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 9).

FY 2020 Department Update: The Department developed toxicology services through a toxicology collection site for the region. In order to address the need for testing that arise across the state, the Department is also implementing oral fluid drug testing that can be completed by investigators and caseworkers in the field, with lab testing for presumptive positive results. The virtual training has launched and use of the screening tools can begin immediately after a worker is trained.

FY 2018

The Department should conduct an audit of split custody cases (i.e. cases in which some of the children are in state care and some are at home). A review should determine if the children at home need more intensive services (from OIG FY 18 Annual Report, Death and Serious Investigation 4).

FY 2020 Department Update: Procedure 315 requires workers to see both youth in care and children at home in person. The Deputy Director of Permanency issued a practice reminder to staff on the requirements of Procedure 315 in November 2020. The Division of Quality Enhancement has also committed to completing a quality assurance review by March 2021.

FY 2017

The Department should develop a policy for accessing publicly posted social media for information relevant to investigative, intact and/or placement cases (from OIG FY 2017 Annual Report, General Investigations 4).

FY 2018 Department Update: The Department needs to address how to use social media better, but we must work within the confines of state policies regarding the use of social media. The Department has had numerous conversations with the Illinois Department of Innovation and Technology regarding implementation of the recommendation. Initially the Department was going to have each field office identify a liaison who would have access to all social media for the office, but the plan was rejected by the Illinois Department of Innovation and Technology. There are caseworkers and supervisors who access social media on their own electronic devices, but there is no mechanism to do so Department wide.

FY 2019 Department Update: No update provided

The prior OIG and DCFS administrations had reached a stalemate regarding implementation of this recommendation.

FY 2020 DCFS Update: The current administration agrees with the recommendation and believes social media can be useful while investigating or providing casework. DCFS will continue to explore options for allowing investigators and caseworkers to access social media as part of their practice without violating Illinois Department of Innovations and Technology's policies.

FY 2017

Prior to return home, caseworkers must develop a reunification plan that identifies basic necessities that must be in place before return home (food, beds, diapers, etc.); support services that must be in place before return home (homemaker, visiting nurse, counseling, early intervention, Head Start, day care, school, respite care, etc.); and community resources appropriate and available within two miles of the family's home (WIC, food pantry, local library, etc.). The Department must ensure that the family is securely anchored to supportive services (from OIG FY 2017 Annual Report, Death and Serious Injury Investigation 2).

FY 2020 Department Update: The recommendation will be incorporated in training planned for permanency supervisors in fiscal year 2021.

FY 2017

The Department must develop resources, including funding for residential treatment centers, to develop their own step-down foster homes (from OIG FY 2017 Annual Report, Death and Serious Injury Investigation 6).

FY 2019 Department Update: No update provided.

FY 2020 Department Update: In FY 2018 the Department began offering the Foster Care Placement Enhancement/Enhanced Wraparound Program as an incentive to agencies that are willing to develop homes specifically for youth stepping down from residential treatment programs to specialized foster care. Through this program, the agency can receive a financial incentive for each youth they accept that is stepping down from a residential program and for each new foster home they develop that successfully takes a step-down youth. Once the youth has stayed in the home for 30 days, the new foster parent can also receive a financial incentive every month for 12 months for sustainability and support. Unfortunately, agencies have not responded to the incentives offered by this program on a consistent basis. In FY 2020, no foster care agencies applied for these financial incentives and in FY 2019, one agency developed two homes and applied for the incentive on both homes.

FY 2017

The Department should fund transportation to daycare or Head Start programs in return home cases where there are multiple young children and the parents, because of poverty or increased stress, cannot transport their children (from OIG FY 2017 Annual Report, Death and Serious Injury Investigation 2).

FY 2019 Department Update: No update provided.

FY 2020 Department Update: Private agencies have flexibility in how they use their reunification aftercare funds to provide goods/services (such as bus passes, etc.) during the aftercare phase of reunification (usually first six months, minimum). There is currently no process in place through the Office of Education and Technology Services (OETS) to pay for transportation for daycare or

head start for reunified families. This issue will be discussed by the DCFS School Readiness Unit Administrator at the Governor's Office of Early Childhood Development Inter-Agency Team meeting which convenes monthly to discuss transportation options for reunified families with other state agencies.

FY 2016

Similar to the Rosecrance model, the Department should develop a supportive recovery transitional living program for its young adults in Cook County who are in their early stages of recovery. The program should offer individual, group and family counseling, educational and employment services with incentivized goal setting in these areas (from OIG FY 16 Annual Report, Death and Serious Investigation 10).

FY 2019 Department Update: No update provided.

FY 2020 Department Update: To address the recommendation, the Department has contracted with a private agency to develop a short-term care center that has increased clinical and therapeutic capacity and provides a variety of clinical support and diagnostic services. The center provides trauma informed treatment services and offers family engagement and after care support services. The center intends to maintain youth at their home school which requires that staff provide transportation to the youths' schools, or to work with the home school district to schedule other forms of transportation services. This program utilizes individualized treatment plans to address the specific needs of youth they serve. The Department has also developed a partnership with a social service agency to provide re-entry and stabilization services for youth stepping out of juvenile detention centers or Illinois Department of Juvenile Justice Centers in Cook County and neighboring counties. The staff at the re-entry program have working relationships with Cook County Probation and the Cook County Juvenile Temporary Detention. The agency also has experience providing detention alternative programming for over 20 years. The re-entry program incorporates restorative justice practices within the milieu, along with individual clinical and group therapy. The Department has developed a contractual relationship with another social service agency, which provides a safe house for sex-trafficking victims rescued from law enforcement rescue operations. In addition, the Department is also in the process of developing a specialized clinical and stabilization sex-trafficking treatment program, which will be launched in FY21. The Department is continuing to build relationships with providers statewide to ensure that youth in care have access to enhanced stabilization services.

INVESTIGATIONS

This Annual Report covers the time period from July 1, 2019 to June 30, 2020 (FY 2020). The Investigations section has three parts. Part I includes summaries of child death and serious injury investigations reported to the Department's Director in FY 2020. Part II contains aggregate data 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 the Department's response. In the "Recommendations" section of each case, OIG recommendations are in bold and the Department's responses to the recommendations follow.

PART I: DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

DEATH

The mother admitted leaving her medically complex two-year-old son, who had difficulty swallowing, alone in a pack-and-play crib from Friday to Monday morning. The mother claimed she left food and water for the toddler, but police found no water in the crib. The death was ruled a homicide due to severe dehydration and malnutrition. The Department indicated the mother for death by neglect, inadequate supervision, environmental neglect, and malnutrition. The mother pled guilty to first-degree murder and was sentenced to 20 years in prison.

INVESTIGATION

The mother and her two siblings came into care after 19 child protection investigations, of which seven were indicated. After the maternal grandmother relinquished parental rights, the mother and her siblings were adopted. The mother was diagnosed with Type-1 diabetes in childhood, refused to manage her diabetes, was repeatedly hospitalized for Diabetic Ketoacidosis, and left the hospital against medical advice. At age 20, the mother gave birth to the child now deceased. The father was never involved.

After the child was born at 34 weeks gestation, he stayed in the Neonatal Intensive Care Unit for two months due to right atrial thrombus, which required daily anticoagulant administration, and his inability to take liquids, which required a gastrostomy tube. After he came home, the mother failed to take him to multiple medical appointments for hematology, cardiology, surgery on the gastrostomy tube, NICU follow-up and well-child checkups at nine and twelve months. She frequently missed physical, developmental, and speech therapy appointments for the child's significant motor, developmental, and feeding delays.

When the child was seven months old, an anonymous reporter called the SCR Hotline (the Hotline) and reported that the mother and child were living in unsanitary conditions. The report was taken for investigation against the mother for environmental neglect. The child protection investigator observed the home to be appropriate and clean. Additionally, the child was receiving early intervention services in the home, and the provider had never seen the home inappropriate. The investigation against the mother was unfounded for environmental neglect.

When the child was 11 months old, a nurse made a report to the Hotline after his mother missed appointments to change his gastrostomy tube and conduct a swallow study. The mother threatened to take out the gastrostomy tube herself. The Department took the report for an investigation of medical neglect against the mother. During the investigation, the maternal grandmother, who sometimes helped care for the child while the mother worked, reported that the mother was leaving the child with different people for days at a time and giving him Tylenol to make him sleep. The report against the mother was unfounded for medical neglect to the child because the pediatrician did not diagnose medical neglect.

While this report was pending, the Department received another report of the home being unsanitary after the police were called to the home because the mother was getting sick in the front yard. The Department opened an investigation for environmental neglect against the mother. The mother was admitted to the hospital for dangerously high blood-sugar levels as a result of not managing her diabetes. The child was placed in a safety plan with the grandmother while the mother was hospitalized. The grandmother told the child protection investigator that the mother had left the child with her for days at a time while binge-drinking and failed to take the child for physical therapy and medical appointments. The mother's sister also confirmed that the mother was not managing her diabetes, abusing alcohol, and leaving the child with other family members when she did not want to care for him. The mother told the child protection investigator that she had obtained an insulin pump to manage her diabetes, scheduled doctor visits, and was allowing an early-intervention specialist into her home. The child protection investigator warned the mother that she risked losing custody if she did not stop missing the child's medical appointments and developmental services. The child protection investigator observed the home twice during the investigation and noted it to be appropriate. The report of environmental neglect was unfounded.

Seven months later, the grandmother reported the child was left all day in a room alone and pulled out his feeding tube. When the grandmother advised the mother to take the child to the emergency room, the mother said the tube had been out so long the incision had closed and a surgeon would have to replace it. The grandmother also reported that the home was unsanitary and unsafe for the child. The Department opened an investigation against the mother for inadequate supervision, medical neglect, and environmental neglect. The child protection investigator spoke to the pediatrician who reported that the mother still had not scheduled a swallow study to determine if it was safe to remove the child's gastrostomy tube. Additionally, the cardiologist had made three attempts to contact the mother, who did not respond.

Over three days, the child protection investigator made multiple attempts to contact the mother. The police were called for a well-being check and when they arrived, they had to push open the apartment door, which was blocked with piles of garbage and clothes. Small items that a toddler could ingest and choke on littered the floor. The mother agreed to allow the child to stay with the grandmother while she cleaned the apartment. The mother cleaned the apartment, and the child protection investigator told the mother that the child could return home.

Approximately a month later, while the investigation was still pending, the grandmother sent photos to the child protection investigator of the child's raw, blistered bottom. The grandmother was concerned that the mother was not tending to the child's diaper rash. The child protection investigator accompanied the mother and the child to a walk-in clinic so the diaper rash could be examined. The nurse at the clinic observed the photos taken a few days before seeing the child and determined that the diaper rash was improving, and the mother was attempting to treat the rash, and therefore the nurse could not say this was medical neglect. During the investigation, the child protection investigator spoke with staff at the local WIC, where the mother reported receiving services. WIC staff informed the child protection investigator that the mother was not cooperative and had not followed through with services. The child protection investigator also spoke to the child's pediatrician, who reported that the mother had not followed through on appointments with any of the

specialists. The pediatrician determined that this rose to the level of medical neglect. The investigation against the mother was indicated for medical neglect and environmental neglect. The mother refused intact family services from the Department.

The child protection investigator and supervisor told OIG investigators they worried about the risks in this case, but they did not believe they had urgent and immediate necessity to take protective custody. When the mother refused intact family services, they saw no option to keep DCFS involved with the family. They did not ask the local State's Attorney to seek a protective order because he was reluctant to file a petition solely to obtain a parent's cooperation with DCFS.

Less than two months later, the mother left the child alone in the home for three days while she went out with her boyfriend and friends for the weekend. She told the police that she left the child with food and water in his pack-and-play. The child died of severe dehydration. At autopsy, the medical examiner found that the child had such severe diaper rash that the skin was falling off and rotting. The mother eventually admitted to leaving the child on Friday night and returning Sunday night. She stated she opened the door to the child's room, observed him to still have food, so she closed the door and went to sleep. She found him unresponsive on Monday morning when she went to check on him.

This case is not unique in that the Department struggles to work with families who are refusing services despite significant concerns. It is problematic for the Department when a parent demonstrates that they cannot care for themselves, and therefore cannot care for their children, and the child protection staff cannot demonstrate urgent and immediate necessity to remove the children. This case was appropriate for at least an Order of Court Supervision. The mother was deteriorating in her ability to parent and care for herself and was refusing services. The last investigation prior to the death was the fourth investigation for environmental and medical neglect within 15 months. While the first three investigations were unfounded, the repeated calls for similar issues indicated that there were on-going and increasingly problematic issues.

In cases where there is no urgent and immediate necessity to remove a child and a parent is refusing intact family services, a tool already exists that allows court oversight. The Juvenile Court Act provides for three different types of protective orders to be used in cases where the children remain in the home of their parents but have court involvement to require services and interventions. Additionally, the State's Attorney is not the only party who can file a petition or court order of supervision in Juvenile Court. Any party, including DCFS, can file an abuse, neglect, or dependency petition and request an order of protection or supervision. The State's Attorney has sole authority to prosecute petitions. Almost 20 years ago, however, the Illinois Supreme Court ruled that a State's Attorney may not dismiss an abuse, neglect, or dependency petition unless the court hears evidence and determines dismissal is in the best interests of the child. See *In re J.J.*, 142 Ill. 2d 1 (1991).

RECOMMENDATIONS

1. The Department should develop a statewide training with Child Protection Staff and DCFS Legal around the availability and use of the three types of court supervision orders.

The Administrative Office of the Illinois Courts and other partners are in the process of developing a training that will address this issue. The Department is involved in the discussions and planning for this training. The DCFS Office of Legal Services will continue to collaborate with Operations regarding the availability and use of orders of protection and continuances under supervision.

2. DCFS Legal should meet with local State's Attorneys at least annually to discuss the use of supervision and protective orders in cases that do not rise to the level of urgent and immediate

necessity.

The DCFS Office of Legal Services is in the process of developing a county-by-county approach to juvenile court matters in order to, among other things: (i) build and maintain relationships with court stakeholders in each county; (ii) address issues that are particular to each juvenile court jurisdiction; and (iii) build on strengths and innovative ideas across juvenile court jurisdictions. In its meetings and other correspondence with local State's Attorneys, the Office of Legal Services staff agrees to discuss the use of protective orders in cases that do not rise to urgent and immediate necessity.

3. DCFS Office of Legal Services should develop a process to determine when it is appropriate for DCFS to file petitions in Juvenile Court, if the State's Attorney declines to do so.

The Department's procedures currently direct child protection staff to consult with the DCFS Office of Legal Services (OLS) when they have questions and concerns related to legal screening of child protection cases. Child protection staff routinely consult with OLS attorneys, and OLS will continue to work with DCFS Operations to collaborate on understanding and satisfying the legal requirements related to legal screening and considering the possibility of OLS attorneys filing petitions in juvenile court when State's Attorneys refuse to file petitions in cases where the legal requirements for legal screening have been satisfied.

4. This report should be shared with the Administrative Office of the Illinois Courts.

DCFS has shared the redacted report with the Administrative Office of the Illinois Courts.

DEATH AND SERIOUS INJURY INVESTIGATION 2

SERIOUS INJURY

Medical staff contacted the Hotline to report that a three-year-old had almost drowned. The child's mother, a former youth in care, initially reported that she had left the child unsupervised in a bathtub but later admitted that she attempted to drown her son. Upon the conclusion of the child protection investigation, the mother was indicated for torture and substantial risk of harm. The mother was criminally charged with aggravated battery to a child and attempted murder. Four months prior to the near-drowning incident, the mother aged out of DCFS care. While a youth in care, the mother was indicated three times for substantial risk of harm for ongoing domestic violence between the mother and the father of her youngest child.

INVESTIGATION

The mother became a youth in care at the age of nine, after her own mother, who was addicted to drugs, left her and her siblings with her 85-year-old grandmother without a care plan or way of reaching her. At the age of 15, the permanency goal was changed to substitute care pending independence due to her biological mother's failure to cooperate with services.

In 2015, after finding out that she was pregnant, the mother moved into a transitional living program specializing in teaching independent living skills to pregnant and parenting teen girls between the ages of 17-21. The transitional living program provided both housing and case management services for the expectant mother. Shortly after moving to the transitional living program, the 18-year-old mother gave birth to her first child. Assessments following the birth noted that the mother appeared bonded to the infant and responsive to the child's cues. There were no concerns of mental health or substance abuse noted. The assessment also noted that the infant's teen father was a positive support but unable to care for the child on his own.

A year later, while still living at the transitional living program, the mother gave birth to her second child. The second child's father was in his mid-forties, had a criminal record involving drug possession and domestic violence and six years earlier had been indicated for sexual molestation to previous girlfriend's nine-year-old daughter.

A month after the second child was born, the Hotline was called alleging ongoing domestic violence between the mother and the father of the second child. The caller also alleged that the mother was choked by the father in the presence of the mother's 13-month-old child. While the child protection investigation was pending, a second call to the Hotline was made alleging that the police were called to the father's home while the mother and children were present. The caller alleged that the mother attacked the father in front of the police and the police returned the mother and her children to the transitional living program. Both the mother and father were indicated for risk of physical injury by neglect for their involvement in the domestic violence incidents.

Following the incidents, the mother agreed to sign a client contract agreement with the transitional living program agreeing to participate in therapy, parenting services, domestic violence services, developing a visitation plan with her youngest child's father and agreeing to refrain from visiting or having physical contact with the father. The young mother participated in therapy, parent coaching and domestic violence services however continued to frequent the father's home with both of her children.

Five months prior to her scheduled emancipation from DCFS, the mother informed transitional living staff that she had enrolled in the Army National Guard and was scheduled to leave for basic training outside of Illinois. The staff assisted the mother in developing a plan for her children. The mother agreed to allow the children to stay with a Safe Families host parent while she was at basic training. The Safe Families model provides support for parents in crisis, giving them time to get back on their feet while their children are cared for in a safe environment by volunteers who host children in their homes.

Four months prior to her emancipation, the mother was involved in another domestic violence incident that occurred at the father's home. The reporter to the Hotline alleged that when police arrived at the father's home, police saw the mother hitting the father across the shoulders and in his face. Both children were present but not injured. The mother's caseworker from the transitional living program went to the police station to pick up the mother. The police agreed not to press charges and the mother was released. The Hotline was called following the incident and a child protection investigation against the mother was initiated. The mother was staying in an unauthorized placement when the child protection investigator went to the transitional living program to interview the mother and observe the children. The investigator documented additional failed attempts to interview the mother at the father's residence and again at the transitional living program but ultimately was unable to interview the mother prior to her departure for basic training.

While the child protection investigation was pending and just days before the mother was expected to leave for basic training, another domestic violence incident occurred outside of the transitional living program. Transitional living program staff observed the father punch the mother in the face through the program's security cameras. Staff contacted the police and the mother's caseworker assisted the mother in securing an order of protection against the father. Criminal charges against the father were initiated but later dropped because the mother was at basic training and could not testify against the father. The Hotline was not contacted following this incident and the child protection investigator assigned to the pending investigation remained unaware of this domestic violence incident.

The children were placed in a Safe Families home and the mother left for basic training. According to Safe Families records, the mother's caseworker from the transitional living program made visits to the Safe Families home and arranged for the children to stay with their maternal grandmother on the weekends.

Neither the children's placement with safe families, nor the mother's departure for basic training was documented in the DCFS case record by the transitional living program caseworker.

The child protection investigator contacted the transitional living program caseworker and was informed that the mother had left for basic training and the children were placed in a Safe Families home. The investigator then interviewed the children at the Safe Families home. The investigation was indicated for substantial risk of physical harm against the mother and closed while the mother was at basic training.

The mother had planned on returning just prior to her emancipation date however had difficulty passing the two-mile run in the required time and was allowed to remain an extra two weeks. During this time the children remained with Safe Families and the mother was legally emancipated from the Department. Unfortunately, the mother did not complete the requirements to pass basic training and when she returned, she moved into an apartment building near her biological mother and the father of her youngest child.

In an interview with OIG investigators, the transitional living program supervisor described the mother and father's relationship as conflictual and toxic. The supervisor reported that the father had a lot of influence over the mother and while the mother was at the transitional living program, staff would often overhear the mother get into verbal arguments with the father on the phone and staff would then process it with her. The supervisor stated that when the mother emancipated, she did not believe that the mother had safe people to process things with. The supervisor reported that the drowning incident was surprising because the mother was very protective of her children and was one of the few mothers in their program that had a routine for their children and staff never had to intervene as far as her parenting was concerned.

According to police records, three months after the mother emancipated, another altercation took place between the mother and the father of her youngest child. Police were called to the home and the mother was aggressive and making verbal threats to the father. The mother was arrested and charged with assault but not convicted.

Two months later, the mother's oldest child was involved in the near drowning incident. The mother admitted to police that prior to the drowning she lied to her youngest child's father and friends by telling them that her oldest child had cut his finger in a blender and died while having emergency surgery. The mother reported that when it was discovered she had lied about the death, the mother pushed her three-year-old's head under the water and held it there until foam came out of his mouth and then called 911.

Following the near drowning, the three-year-old was placed in the care of his biological father and the mother's two-year-old child was taken into protective custody and placed in a foster home.

RECOMMENDATIONS

1. To better support the pregnant and parenting youth population post emancipation, the Department should utilize the provisions of the Family First Prevention Services Act (FFPSA) allowing for reimbursement of in-home parenting skills for this population in order to establish services for this population. The Department should add participation in an in-home parent skill-based program to all pregnant and parenting youth service plans (including non-custodial fathers) prior to emancipation. If a service provider determines a pregnant and parenting youth would benefit from further in-home skill-based training, the Department should offer the service to emancipating youth as a continued service beyond emancipation.

The Department agrees. Procedures 302, Appendix J and current practice requires that upon completion of the New Birth Assessment (NBA) the assigned permanency worker should include all NBA recommendations in

the client services plan which may include participation in an in-home parent skill-based (including non-custodial fathers) prior to emancipation. If a service provider determines a pregnant and parenting youth would benefit from further in-home skill-based training, the Department will offer the service to emancipating youth as a continued service beyond emancipation through our collaboration with the Department of Human Services, as well as linking pregnant or parenting youth to community resources, community preventative resources, and providing youth with contact information for Family Advocacy Centers in the event they need assistance as a former youth in care.

2. As previously recommended, if the Department plans to continue to utilize Safe Families for the children of youth in care as well as during intact family services and child protection investigations, then the Department must review the contract program plans to address the need to share information by way of a staffing with all involved parties (i.e., Safe Families staff, child protection investigator, child protection supervisor, intact worker and supervisor, and placement worker and supervisor etc.) and ensure that the return home plan does not create an unsafe environment for the children.

The Department amended the program plan for Safe Families to include provisions that allow for the sharing of information by way of a staffing with all involved parties.

3. This report should be shared with the transitional living program staff.

OIG shared the report with the private agency.

4. The report should be shared with the supervisor from the transitional living program and used as a teaching tool to improve supervision.

The report as been shared and reviewed with the supervisor.

5. Staff from the transitional living program should receive additional mandated reporter training to ensure that the Hotline is contacted when a child is at risk due to domestic violence.

DCFS Agency Performance Team supervisor and monitor addressed this issue with the agency.

DEATH AND SERIOUS INJURY INVESTIGATION 3

DEATH Eight-year-old girl was transported to the emergency room with life threatening injuries, including symptoms of abdominal pain and concern for seizures, after collapsing in front of her father's paramour. She underwent emergency surgery and died the following morning. An autopsy revealed that the eight-year-old had multiple scars, bruising and abrasions on her entire body, which were indicative of abuse. The Department indicated the father's paramour for death, cuts, bruises, welts, abrasions and oral injuries, torture, and internal injuries. The father was indicated for torture, death by neglect, internal injuries by neglect and cuts, bruises, welts, abrasions and oral injuries by neglect.

INVESTIGATION While the deceased's mother and father were married, there were four unfounded child protection investigations from 2013 through 2015, all involving the mother's children/half-siblings to the deceased child. In 2015, the parents separated, and the deceased child continued to live with the mother and her half-siblings. In February 2016, the Department unfounded the mother for mental injury to her children, ages five (deceased child) and nine years, after it was reported that the mother

sent the father videos of her telling the children that he died in a car accident; and the children were visibly upset. In 2016, there were three additional unfounded investigations against the mother. In September 2016, the mother was arrested for selling drugs with the children present and the father obtained full custody of the child. The mother's older children were placed with relatives while she was incarcerated. After she was released, there were three additional child protection investigations against the mother to her other children. The Department was granted custody of one of her other children after she was incarcerated a second time in 2019.

The child went to live with her father in 2016 after the judge in the parents' custody battle awarded the father sole custody. After the girl went to live with her father and his paramour, there were three additional investigations for abuse and neglect against the father and his paramour prior to the girl's death in early 2019. The father's paramour had a long history with the Department dating back to 2002. There were six child protection investigations involving the father's paramour, three of which were for cuts, bruises and welts to her children.

In July 2017, the Department investigated the father's paramour for substantial risk of physical injury/environment injurious to health and welfare – incidents of violence or intimidation to the then-seven-year-old child after the mother reported that the seven-year-old said the father's paramour regularly whips her with a belt; and that the father also hits her. The police were involved, but found the mother not credible, and upset about recent developments in the custody battle in court. The child reported that the father's paramour had hit her with a belt in the past but could not identify when or for what reason. The father and his paramour denied that the paramour hit the child; the father stated he did the disciplining, and he would give time outs. The investigation was unfounded, as no marks were observed on the child, and it appeared the allegations were due to the custody dispute between the parents. This investigation closed quickly, never reaching the formal investigation stage.

In April 2018, the Department investigated the father and his paramour for cuts, bruises, welts, abrasions and oral injuries to the child, after the mother reported to the Hotline that the she went to the child's school and observed the child to have injuries to the face and she was afraid to go home. The investigator went to the school and was informed that the mother was not supposed to have in person contact with the child; she was only to speak with the child by phone. The mother entered the school by walking in with another mother and signing in under a different name. The investigator met with the child and observed her to have a scab over her eyebrow, a canker sore on her lip and a broken tooth. She told the investigator that she hit her eye on the bathroom counter; and she broke her tooth by tripping over a dresser drawer, which she demonstrated for the child protection investigator. She denied that anyone was hitting or hurting her at home. The child protection investigator spoke to the father, who reported that the child chipped her tooth months ago and the injury to her lip was due to her biting her lip. He reported that sometimes the child got cold sores on her lip. He also reported that his paramour was home when the child hit her head on the counter, and his paramour texted him when the incident occurred. The father told the investigator the child was accident prone. The child protection investigator contacted the child's pediatrician, who stated they could not comment on any concerns, as the child had not been seen at their office since 2016. In June 2018, the investigation was unfounded.

In December 2018, the Department investigated the father and father's paramour for cuts, bruises, welts and oral abrasions to the eight-year-old (deceased child) after a school nurse contacted the Hotline and reported that the child came to school with two black eyes in various stages of healing. The child had not been in school on Thursday or Friday the prior week. The investigator met with the child, who reported that she hurt her face on the left side by her eye, when she tripped over a toy and accidently fell on a toy box. The investigator noted the child to have bruising under the right eye and the area above the left eye was swollen. The investigator contacted the father and his paramour; the father stated he was not home when the injury

occurred. The child protection investigator told the father to take the child to the doctor on the date of the report. The father contacted the investigator a few hours later and reported that they had taken the child to the doctor; the father told the child protection investigator that the doctor had no concerns. The paramour reported that she had to take off work to bring the child to the doctor. She stated that the doctor told her "the blood stream is being pulled across [the face] and this is how come you see the bruising on the other side of the face." The child protection investigator went to the home to observe the home environment and the other children. The father and his paramour would not let the child protection investigator interview the other children in the home. The father and his paramour insisted on being interviewed together; they declined to complete substance abuse or domestic violence screens. The child protection investigator observed boxes in the home as the family was in the process of moving, but she did not interview the child at the residence and did not complete a scene reenactment of the injury with the child. The father and his paramour also refused to allow the child protection investigator to complete a Home Safety Checklist including a walk-through of the home. Prior to the investigation closing, the child protection investigator verified that the child was seen by the doctor at a clinic. The staff at the doctor's office told the investigator that x-rays had been ordered, but not completed. The child protection investigator faxed the body chart form to the office; the doctor completed it stating that the child had two black eyes, but could not note any risk factors as it was the first time he had seen the child. The investigation was unfounded eight days after the Hotline call was made. The child protection investigator and the supervisor told OIG investigators that intact family services were not discussed because it was clear that the family would not cooperate with services.

Less than a month later, the child died due to child abuse by the father's paramour. The medical examiner found multiple injuries on the child's body that were consistent with child abuse. The police detectives assigned to the case conducted forensic interviews of the paramour's children who lived in the home. They reported the father's paramour would whip the deceased child with a belt and kick the child in the stomach. The police also interviewed other minor relatives, who frequented the home; they reported that the father's paramour had hit the child's head against a dresser when she got in trouble. The children had also witnessed the child have to hold cans above her head as punishment; the father and paramour withheld food and isolated the girl from the rest of the family. The police obtained phone records and videos from the father's paramour that showed her abusing the child. The paramour was charged with first degree murder of the child.

RECOMMENDATIONS

1. This report should be shared with the child protection investigator, the supervisor, and Area Administrator for a focused review on specific parts of procedure that were not followed and for additional training purposes.

The report was shared and discussed for training purposes.

2. This report should be shared and reviewed with the former child protection investigator.

The report was shared and reviewed with the employee.

3. The former child protection investigator should participate in supervisory training.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations. In addition, supervisors in all specialties are now required to enroll in and complete the Model of Supervisory Practice.

4. The Department should pursue disciplinary action against the former child protection investigator.

The employee received a suspension.

5. This report should be shared, and specifics of this case reviewed (noting specific failures for remedial purposes) with the child protection supervisor.

The employee is no longer with the Department.

6. The supervisor should be retrained on supervisory practice.

The employee is no longer with the Department.

7. The Department should pursue disciplinary action against the child protection supervisor.

The employee is no longer with the Department.

8. This report should be shared with staff at the local field office to address issues identified such as interviewing other household children in schools, protocol for completing the final Child Endangerment Risk Assessment Protocol, and use of investigative tools including, but not limited to, the Paramour Assessment Checklist, Home Safety Checklist, and CANTS 65-A, 2A/2B forms.

The new Area Administrator discussed issues identified in this report with staff at the local field office.

9. The Area Administrator and the DCFS Medical Director should meet with the involved Medical Group to facilitate communication and sharing of information between child protection investigators and medical professionals.

The Department's Medical Director is reviewing the case to determine the next steps. The Associate Deputy Director of Child Protection is also following up on this issue.

DEATH AND SERIOUS INJURY INVESTIGATION 4

DEATH

A two-year-old boy died as a result of multiple injuries due to child abuse including a lacerated liver, lung contusions, several broken ribs, abdominal injury, healing and healed broken bones, and bruises. At the time of the boy's death, there was an open intact family services case involving his family and several unfounded child protection investigations. A child protection investigation opened in response to the boy's death resulted in indicated findings of death by abuse and cuts, bruises, welts, abrasions and oral injuries against the mother and her paramour. The paramour was charged with first-degree murder and the mother was charged with child endangerment.

INVESTIGATION

The deceased was the fourth child born to his mother, who had a long and significant history with the Department, which included her three oldest children being removed from her care, two of whom she never regained custody. The mother also had a significant and on-going history of domestic violence with multiple partners and was fleeing a domestic violence relationship prior to the opening of her intact family services case, as well as a history of substance abuse.

The mother's first child was removed from her care in 2010 after reports that mother had substance use issues and repeatedly left her then eight-month-old daughter to be cared for by family members for days without

their consent. Her second and third children were removed following their births in 2012 and 2013 as mother continued to have an open case with DCFS and was non-compliant with services. The deceased child was born after court involvement.

In November 2017 the mother was investigated and unfounded for substantial risk of physical injury/environment injurious to health and welfare and environmental neglect to her four-year-old and one-year-old sons after an anonymous reporter said she witnessed the mother slap and choke the four-year-old; and observed the home to have a mice infestation. Mother told the investigator she believed this to be a false report. She reported the father of her children was in jail for domestic battery and showed the investigator an emergency order of protection. She stated that since he has been in jail, his sister has been harassing her, telling lies, and sending the police to her home for well child checks. The mother denied she had an infestation of mice. The investigator observed the children with no marks or bruises.

In May 2018 the mother was investigated and unfounded for substantial risk of physical injury/environment injurious to the deceased minor and his sibling after a reported domestic battery incident in her home. The mother admitted her paramour grabbed her, pushed her five-year-old son, and cut his arm while breaking a window. While the child protection investigation was pending, the mother obtained an emergency order of protection. She also requested an emergency move from the Housing Authority noting that she was involved in a domestic incident and did not feel safe. She moved with her children temporarily to a shelter. While living at the shelter, mother enrolled in a program, where she was assigned a case manager, therapist, and a peer navigator.

The Hotline was contacted again approximately one month after the last child protection investigation closed, when the mother picked her children up from daycare and noticed a red mark on the deceased child's buttocks and a bite mark on his five-year-old sibling; the shelter case manager urged the mother to take the kids to the ER. Four daycare employees were unfounded for allegations of human bites by neglect to the five-year-old and cuts, bruises, and welts to the deceased. The employees denied abuse and explained that the five-year-old had been bitten by a classmate after an argument over a toy; the origin of the mark to the younger child was unknown and had not been observed by employees. A hospital child abuse team consult was inconclusive; physicians in three specialties (Burns, Dermatology, ER) reviewed the case and were unable to determine what the mark was. During the investigation, the investigator was informed that the mother had successfully completed the program at the shelter and no longer resided there. In an attempt to locate the family and close her investigation, the investigator made an unannounced visit to an address previously provided by the mother. While standing outside of the apartment door, the investigator heard a male voice and heard smacking sounds. Subsequently, a male answered the door and went to get mother from the back of the apartment. The investigator explained to mother what she heard; she completed a body chart and observed numerous raised welt/lash marks on the minor's buttocks. The male denied striking the minor and had no explanation for the marks. Mother denied that anyone hit her son and said the marks were from the minor laying on a coat. The investigator contacted her supervisor, and they made a critical decision to contact the Hotline and have the child seen at the nearest hospital.

A new child protection investigation opened for allegations of cuts, bruises, and welts to the two-year-old child by mother's paramour. Although the welts were no longer visible when the minor was examined at the hospital, medical records noted "unclear history concerning for physical abuse as well as pattern of previous injury (per photo by DCFS on site that has since resolved on presentation) that could be aligned with pattern of abuse." The five-year-old sibling was also evaluated for physical abuse with no signs of injury on exam. The sibling told the investigator that the paramour whipped him and his brother, but his mother told him he would be in trouble if he reported this. While the investigation was pending, the minors were placed in a safety plan and placed with a host family through the Safe Families Program and the mother agreed to intact

family services. The report against the paramour was ultimately unfounded noting that the minor was examined by a physician and there were no marks or signs of abuse present.

Mother was already engaged in services when the intact case opened, including individual therapy to address her domestic violence history. Although she no longer resided at the shelter, she continued to regularly see her therapist, case manager, and peer navigator. Despite the involvement of both systems, there was limited communication and collaboration between the two systems. The worker confirmed the mother participated in therapy but obtained no other information. The therapist told OIG investigators that she was unaware of the reasons for the family's involvement with the Department. There is no documentation that the worker knew that a case manager and peer navigator were also assigned through the program.

When the intact family services case first opened, the safety plan remained in place and the minors continued to reside in a Safe Families home. All visits with mother were supervised by the Safe Families coach as part of the safety plan. Prior to the minors return to mother, the host family made several calls and documented concerns related to the safety of the minors if they were returned to mother; and the trauma the boys were experiencing related to witnessing violence between their mother and her paramours. Prior to the minors return home, mother obtained orders of protection against her former paramour. The intact worker and her supervisor participated in a staffing with the child protection investigator and supervisor to discuss the concerns raised by the Safe Families host and coach and it was decided that mother's home was safe and appropriate for the children to return home. Safe Families staff and the case manager, peer navigator and therapist from the agency providing services to the mother were not included in the staffing. The minors returned to their mother's care approximately three-and-a-half months prior to the toddler's death.

The intact worker made regular visits to mother's home, her last visit occurring three days before the toddler's death. The intact worker told OIG investigators that she never observed any signs of a male living in the home. She stated that mother knew that she was not to have any adult males around her children; she frequently questioned mother who denied having paramour in the home.

The importance of collaboration and communication between systems is paramount when working with families experiencing domestic violence. Each system has a specified identified role, and it may not be intuitive to each system what information may be needed to the other. Victims of child abuse and neglect need protection from further harm. No one system serving the needs of abused and neglected children can work effectively by itself, and no one system can work when information is siloed even within the agency itself.

RECOMMENDATIONS

1. If the Department plans to continue to utilize Safe Families for the children of youth in care as well as during intact family services cases and child protection investigations, then the Department must review the contract program plans to address the need to share information by way of a staffing with all involved parties (i.e. Safe Families staff, child protection investigator, child protection supervisor, intact worker and supervisor, and placement worker and supervisor etc.) and ensure that the return home plan does not create an unsafe environment for the children.

The Department has amended the program plan for Safe Families which now has a provision that allows for the sharing of information by way of a staffing with all involved parties.

2. The Department should appoint a domestic violence coordinator in each region to act as a liaison with domestic violence providers to enhance information sharing.

As of September 2019, the Domestic Violence Intervention Program is fully staffed and has a Clinical Domestic Violence Specialist (a total of 4) in each region of the state. Domestic Violence Specialists attend stakeholder meetings with domestic violence providers to share information regarding the Domestic Violence Intervention Program and child welfare policies and procedures for domestic violence. The Domestic Violence Intervention Program Administrator provides leadership on behalf of child welfare with the domestic violence community and relevant government agencies to identify systemic issues, solicit feedback from the community, help coordinate systems, programs, policies and practice initiatives, resources and training plans.

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

OIG shared the report with the private agency.

4. This report should be shared, as a teaching tool, with the intact family caseworker and supervisor.

The report was shared and used as a teaching tool with the employees.

5. This report should be shared with the social service agency involved in this case.

The report was shared with the agency.

6. This report should be shared with the DCFS domestic violence coordinator and the Illinois co-location program manager.

The report was shared with the DCFS domestic violence coordinator and the Illinois co-location program manager.

7. As part of the Department's Safety Reboot Training, the Department should ensure that Appendix H, Paramour Involved Families, as well as Appendix J, Domestic Violence, are reviewed and incorporated in assessing risk to children, when they are exposed to domestic violence and/or a paramour is present or suspected of abusing or neglecting the children.

Appendix H, Paramour Involved Families, and the underlying issue of Domestic Violence have been included as part of the Department's Safety First, Safety Always training series which launched in July 2019. The Safety First, Safety Always series started with a Safety Reboot focused on workplace and field safety for staff and safety assessment of children. Training was rolled out to direct service staff and supervisors in DCP, intact, permanency, foster care licensing and adoptions on underlying conditions and key safety assessment factors. The second installment in the series, Engaging and Assessing Paramour Involved Families, launched in June 2020 and focuses specifically on Appendix H and assessment and intervention in families with a co-occurrence of Domestic Violence.

DEATH AND SERIOUS INJURY INVESTIGATION 5

DEATH

The mother of a four-month-old infant contacted 911 reporting that she found her baby turning blue and not breathing. The infant was pronounced deceased the same day. The cause of death was ruled undetermined. The Department indicated both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect, environmental neglect, and death by neglect. No criminal charges were filed.

INVESTIGATION

The baby lived with her parents and her two older siblings. The Department became involved with the family in September 2014 when the parents were unfounded for substantial risk of harm to their then three-year-old child. Two and a half years later the mother was investigated in February 2017 after overdosing on painkillers that had not been prescribed for her. The father, instead of calling emergency medical services, called a friend to administer medication to reverse an opioid overdose. Another friend dropped the mother at the hospital where she declined medical treatment. During the child protection investigation, the oldest child shared that the father had also previously been treated for an apparent overdose. The mother was indicated for Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect and agreed to intact family services. The family lived with the paternal grandmother who agreed to supervise contact with the parents.

The intact family services case was open from February to June 2017. During the intact family services case both parents enrolled in substance use treatment programs. The mother completed one level of an outpatient program and it was recommended she complete one more level. The father was unsuccessfully discharged from an inpatient program after two weeks. He then participated in another substance abuse assessment which recommended outpatient treatment. He also participated in an assessment for medically assisted treatment. Other recommendations included securing employment and housing. The worker closed the case when the mother reported that she had been accepted to a program, two hours away, that provides transitional housing, case management, and supportive services for women. The worker did not speak with anyone at the program to confirm the mother's report, as the mother had found the program on her own. The worker offered to transfer the intact case to an agency near the program, but the mother declined the option and the case was closed. The father did not complete treatment prior to case closure. The worker completed a closing risk assessment, classified as safe, without observing the children.

Eighteen months later, in December 2018, a healthcare prenatal provider reported the mother, who was 30 weeks pregnant, had earlier tested positive for cocaine and marijuana and was now testing positive, with very high levels, for a partial opiate blocker used to treat opioid use disorders. In addition, the healthcare provider noted the mother was seeking anti-anxiety medication. The Department opened an investigation for substantial risk.

When the investigator met with the parents and children three days later, the investigator noted the children to appear well. The mother denied using marijuana and cocaine and reported that she was in a medically assisted treatment program for which she is prescribed the partial opiate blocker. The mother also denied requesting anti-anxiety medications. The mother stated that she and the father had completed services during their intact case in 2017. The father reiterated the mother's report. The investigator did not seek corroboration of the mother's enrollment in a treatment program and did not request toxicology screenings, assuming that the program would be testing the mother. The investigator also did not confirm the services completed during the prior intact case. The investigator did not have any investigative contacts for almost two months, having received due date extensions from the Area Administrator, at which time she spoke with the paternal grandmother who was caring for the two older children while the mother gave birth. The investigator did not observe the new baby, citing a high caseload as being a detriment to having the time to do so. The investigator unfounded the investigation noting the grandmother did not have concerns and law enforcement

had no recent contact.

Less than three months after the close of the above child protection investigation, the Department initiated an investigation on the death of the baby. The baby had been sleeping on a pallet on the floor next to the mattress where the parents slept. On the floor around the baby were several blankets, a bottle of prescription pills and a cosmetic bag. Other items found in the home included drug paraphernalia, more bottles of prescription medications and a bag of pills. The parents gave varying accounts. The parents completed toxicology screenings; the mother tested positive for methamphetamines; the father's test was negative. Both parents reported being prescribed a partial opioid blocker. The older children were taken into custody.

RECOMMENDATIONS

1. Supervisors in the Local Field Office should be retrained on how to properly conduct supervisory consultations with their workers. Supervisors should be required to complete courses in the Department's "Model of Supervision" series.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations. In addition, supervisors in all specialties are now required to enroll in and complete the Model of Supervisory Practice.

2. All investigations pending more than 60 days in the Local Field Office should be reviewed to assure family and child contacts have occurred in a timely manner and the children are safe. This review should also include looking at assessments to ensure they are timely and properly completed, proper supervision is occurring, and there has been follow up on supervision directives.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations. In addition, supervisors in all specialties are now required to enroll in and complete the Model of Supervisory Practice.

3. All extensions approved in the Local Area, should be reviewed to assure extensions are warranted.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations.

4. The Department should retrain staff in the Local Field Office on adequate completion and use of assessments. (Safety, Risk, Domestic Violence, Substance Abuse, and Home Safety checklist).

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations.

5. The involved Child Protection Investigator should be disciplined for failure to follow Rule and Procedure 300 when conducting an investigation.

The employee was discharged from the Department.

6. This report should be shared with the agency that assisted the mother after she moved.

OIG shared the report with the private agency.

DEATH AND SERIOUS INJURY INVESTIGATION 6

DEATH

Three-month-old was found unresponsive by her mother in the evening. The mother called 911 and resuscitation efforts were made. The baby was taken to the hospital and pronounced deceased. After an autopsy, the cause of death was determined to be asphyxia due to co-sleeping. The child protection investigation was unfounded and no criminal charges were filed.

INVESTIGATION

The deceased was the only child in common between the parents; both parents had older children from other relationships. The mother had two children who lived with their paternal grandparents and the father had an older daughter who lived with her mother. The mother had seven prior unfounded investigations involving her older children from another relationship. Those children lived with relatives at the time of the death

The mother's involvement with the Department began in May 2010 when it was reported that she initiated a physical altercation with the father of her older children while holding her then one-year-old child. The investigation narrative noted that the mother was not taking her prescribed psychotropic medications and would act erratically when not taking them. The investigation was initially indicated but later unfounded by appeal following a court decision on the substantial risk of harm allegations. An intact case was opened for a year following the investigation. According to records the mother was cooperative with services and the child was assessed as safe throughout the case.

After an unfounded allegation of medical neglect to the mother's oldest child in February 2012, the mother's two older children were placed under the guardianship of their paternal grandparents. The mother still had visits with the children. Two investigations for substantial risk of harm by abuse and substance misuse against the mother for incidents during visits were unfounded in June and September 2018.

In December 2018 the parents of the deceased were investigated for two separate incidents. In the first investigation, the mother was unfounded for substantial risk of physical injury by abuse to the father's seven-year-old daughter. During a child advocacy center interview the seven-year-old reported that her father and his girlfriend were arguing, which they often did. The girlfriend threw a cup at the windshield then smacked it with her hand, cracking the glass which then shattered and fell in the car. The seven-year-old was not injured and the investigation then closed without an interview of the father and girlfriend. Later that month the father was unfounded for cuts, bruises, welts and abrasions against the seven-year-old after a report came that the child had bruises on her arm after a visit with her father. The seven-year-old again participated in a child advocacy center interview where she reported that a cousin had grabbed her arm leaving marks. The child denied that her father or his girlfriend hurt her. The father told police that he had not caused the marks. He explained that they went to a large holiday gathering and he had not seen anyone grab his daughter and he had not known about the marks. The child protection investigation was closed based on using the child advocacy center and police interviews.

Six months later, in June 2019, the Hotline was contacted with reports of domestic violence incidents with the children, the mother's two sons, and the one-month-old baby present. The father reported that the couple had been arguing all day when the mother left. The mother returned in the pre-dawn hours, intoxicated, took his phone and threw a phone charger at him. He then drove to the police station and officers came to the home with him. The mother told the officers that the father had punched her. Police noted that both parents had bruising consistent with their stories, and both were arrested. Police shared that the children were picked up by grandparents.

The assigned child protection investigator went to the home in an attempt to see the parents five times over five weeks. The child protection investigator spoke with the father's older daughter, who lived with her

mother, about a week after the investigation opened. She only recalled the November 2018 incident with the broken windshield. She said she was scared to visit her father's home because of the fighting between her father and his girlfriend. The father called the child protection investigator a month into the investigation reporting that the mother had been aggressive towards him on multiple occasions, but he could not recall if the older children were there. He reported he wanted the mother to move out of the house, but she refused. Almost two months after the investigation began the child protection investigator made contact with the mother and the baby at the maternal aunt's home. The mother refused to allow the investigator inside the home to complete a Home Safety Checklist and would not provide the aunt's last name. The mother stated that there had been a domestic violence incident in June and that the father's older daughter was at the home, but she denied any physical aggression towards the father and refused to elaborate on her arrest. The mother reported that there had been no other incidents except for when she broke the windshield in November 2018. Despite not getting in the home, the child protection investigator marked the risk assessment as safe. Approximately seven weeks after the investigation began the child protection investigator met with the mother's older children at their grandparent's home. Both reported witnessing their mother break the windshield several months earlier and seeing their mother punch her boyfriend in June. The children stated their parents often fought.

Earlier in the day of the baby's death, the child protection investigator completed activities to move towards closing the investigation. The child protection investigator obtained police reports and called the baby's pediatrician. The doctor expressed no concerns except for having to caution the mother not to give the baby water, which she had done in May. The investigator spoke with the mother on the phone, who was upset that the child protection investigator had spoken with her older children. The mother reported that she had made a decision to separate from the father and planned to move in with her mother. She reported that she has a crib for the baby. She refused to provide her mother's address. The maternal grandmother's address had been noted in earlier investigations, but the investigator did not refer to them. The mother later begrudgingly agreed to intact services. The investigator noted that she planned to refer the family for an intact case and request an appearance at juvenile court. The child protection investigation was indicated after the death.

RECOMMENDATIONS

1. Child protection investigator should be disciplined, up to and including discharge.

The employee received a suspension.

2. The second child protection investigator should be disciplined, up to and including discharge.

The employee is no longer with the Department.

3. Child protection supervisors in the Local Field Office should be retrained on how to properly conduct supervisory consultations with their workers. Supervisors should be required to complete courses in the Department's "Model of Supervision" series.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations. In addition, supervisors in all specialties are now required to enroll in and complete the Model of Supervisory Practice.

4. The Department should retrain staff in the Local Field Office on adequate completion and use of assessments. (Safety, Risk, Domestic Violence, Substance Abuse, and Home Safety checklist).

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations.

5. The Department should retrain the child protection staff in the Field Office on requesting police reports promptly during an investigation, especially in cases involving domestic violence.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations.

6. The Department should retrain child protection staff in the Field Office on the tools available to assist in the location of child victims and alleged perpetrators.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations.

7. Child protection staff in the Field Office should be retrained on proper documentation of contacts/notes, and fully assessing the totality of the family's circumstances in making a final decision.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations.

8. The Department should communicate a more consistent application of "blatant disregard" to child protection staff.

The Department plans to write a practice memo to the field on blatant disregard and its application on neglect allegations. The recommendation will also be addressed through training.

DEATH AND SERIOUS INJURY INVESTIGATION 7

DEATH

A five-year-old boy was reported missing by his parents. Law enforcement's suspicions of foul play were confirmed six days later when the boy's father led police to the field where he had buried his son's body. An autopsy determined the boy's cause of death was craniocerebral trauma due to multiple blunt-force injuries. The manner of death was homicide. The boy's parents pleaded guilty to criminal charges related to his death. The family was the subject of two unfounded child abuse/neglect investigations within one year of the boy's death.

INVESTIGATION

The mother's involvement with the Department spanned over nine years. The boy's mother was 27 years old when she became a foster parent. The foster child was placed with the mother for 16 months when the Department received the first allegation of her substance abuse. The mother, her eldest child, and foster child were the subjects of the unfounded child protection investigation for inadequate supervision. The foster child's removal from the mother's care two months later required assistance from two police jurisdictions.

The mother was 29 years old when she and her eldest child moved to the father's home. The mother and father had a troubled relationship from the start with frequent law enforcement contact. Within four months, the Department received a report of child neglect and substance abuse by the mother and the father. The investigation was unfounded. The mother, however, lost custody of her eldest child.

The boy was born substance exposed the following year. The Hotline was called, and the mother was indicated for substance misuse by neglect in the A sequence investigation. The parents lost custody of the boy after both tested positive for illegal substances. A permanency case was opened. The parents complied with substance abuse treatment, medication management, individual therapy, mental health assessments, and parenting education to regain custody of their son. The mother reported to her treatment provider she experienced mood dysregulation and difficulty coping with anger when she was actively using drugs. The permanency case was pending for one year when the mother gave birth to her third child. The baby remained in the parents' care under the supervision of child welfare professionals assigned to the permanency case. The permanency worker observed the parents to be loving and attentive to both of their children. The boy was returned to his parents' care under a protective order 20 months after the permanency case was opened; the boy remained a youth in care. The parents were receiving medication management services when the permanency case closed 10 months later. The mother relapsed two years after the permanency case closed.

Thirteen months prior to the boy's death, the 35-year-old mother was the subject of two police contacts and two hospital visits resulting from her drug use. A mandated reporter called the Hotline after observing odd bruising on the boy's face and forehead. The boy and his three-year-old sibling appeared disheveled and guarded with their father. The mother was unconscious and presented with observable signs of drug use. The B sequence child protection investigation was initiated for allegations of environment injurious to health and welfare by neglect and environmental neglect. The assigned child protection investigator did not investigate the core issues of the B sequence allegations. There were significant delays in seeing the children and weeks without investigative activities.

The investigator did not seek information from the reporter other than to confirm the Hotline narrative. The investigator did not speak with or observe any family member for over five weeks. The investigator did not pursue information explaining the boy's reported injuries. The bruising would have faded by the time the investigator saw the boy, but the investigator never asked him about it. The investigator did not ask either child about discipline in the home or whether their parents hit them. There was no documentation in the investigative file that the investigator spoke to the children at all. There was no documentation the investigator spoke to the mandated reporter who observed boy's injuries or the condition of both children. The investigator concluded the children were safe because they were observed laughing while playing outside of their parents' home and were clean and appropriately dressed. The investigator did not observe the home environment until two months after the initiation of the investigation.

The investigator approached the B sequence investigation as a drug case but did not consider the mother's reported drug use as a relapse or assess the risk posed to the children. Although the investigator communicated with the family's previous placement worker and had information about their DCFS history, the investigator did not make any connections between the B sequence investigation and the family's past DCFS involvement. By the time the investigator spoke with the mother, she had enrolled in out-patient drug treatment. The investigator payed scant attention to the father's drug abuse history, and how that too posed a risk to the children's safety. Child centered collaterals were not sought, and questions were not asked about who the children spent time with, including if they were in daycare/preschool.

The investigator's supervisor did not provide adequate supervision in the B sequence investigation. The supervisor did not ensure that the investigator assessed the children's safety in a timely manner and ignored the bruising to the boy's face and forehead. The supervisor's explanation of relying on the experience of seasoned investigators was an abdication of supervisory responsibility to direct and guide investigators so that they may capably perform their tasks. The B sequence investigation was unfounded because of insufficient evidence.

Five months prior to the boy's death, the C sequence investigation was initiated as an emergency response for allegations of injuries by abuse and environmental neglect after law enforcement took protective custody of both children following contact with the mother. The mandated reporter observed suspicious bruising on the boy's torso and did not believe the mother's explanation for the injury. The reporter stated the family's home was uninhabitable and was aware of the mother's history with illegal substances. The assigned child protection investigator committed errors in C sequence investigation that were not challenged or corrected by the investigator's supervisor, the same supervisor in the B sequence investigation.

A police officer took protective custody of the boy and his three-year-old sibling after determining the children would not be safe in the care of their parents. The officer did not believe boy's explanation for his injuries and observed the mother tell the boy what to say to the police. In the interview with the officer, the investigator simply confirmed the narrative of the Hotline report and did not seek additional information. Had the investigator questioned the officer more thoroughly about the mother's explanation for the injury and the officer's rejection of that explanation, the investigator might have learned the officer witnessed the mother direct the boy's explanation of his injuries.

The C sequence investigator allowed protective custody of the children to lapse before determining the cause of the boy's injuries, observing the home environment and interviewing the father. The investigator allowed the mother to take both children to the hospital for an examination of the boy's injuries prior to conducting sufficient investigation to determine the children would be safe in the sole care of either or both of their parents. Couple this with the parents' previous DCFS history which included serious substance abuse and allegations of child mistreatment, and there was little evidence established to justify changing the status of protective custody at the initial stage of the investigation.

The medical exam bolstered the need for continued investigation and assessment. The results of the medical assessment by an emergency department physician did not offer a concrete explanation for the boy's injuries. The physician, who was not a pediatrician, was not able to provide an informed cause of injury citing a lack of expertise in physical child abuse. The physician made it clear in writing and to the investigator verbally, as documented in the investigator's note, that the boy should be seen by a medical expert in child abuse and/or forensics. The investigator failed to give proper weight to alternative explanations for the boy's bruise. The investigator ignored the boy's statement, "maybe someone hit me with a belt. Maybe mommy didn't mean to hurt me," choosing instead the explanation created by the mother. The medical report also stated that the boy answered "yes" when questioned if a belt made the mark. There was no follow up to explore the meaning of these statements.

The investigator did not request nor review the full written clinical report prepared by the emergency department physician. This report corroborated the information the doctor relayed, both verbally and through the DCFS Referral Form for Medical Evaluation of a Physical Injury to a Child. Documented in the clinical report was the physician's request to the investigator that the boy undergo a forensic interview because the physician did not want to compromise the integrity of the boy as a witness. Further, the investigator gave the doctor the impression that he understood and would follow-up on all concerns.

The investigator, however, failed to communicate with law enforcement the physician's request for the boy to be forensically interviewed. The investigator also failed to seek another medical opinion as required and as suggested by the physician. The investigator's explanation that the boy's injuries did not meet the criteria for a Medical Evaluation Response Initiative Team (MERIT) involvement was weak and not supported by facts. Given the lack of clarity of the cause of the boy's injuries, a child welfare professional, in fulfilling their fiduciary duty, should continue to investigate. An OIG interview with MERIT staff contradicted the investigator's assertion that the facts in this case did not meet the criteria for a referral to MERIT.

In the C sequence investigation, the supervisor abdicated the supervisory role relying almost exclusively on the information and assessment conveyed by the investigator. The supervisor did not question the decision to allow protective custody to lapse, and in fact gave it little consideration. The supervisor did not provide critical guidance or supervision to the investigator. The supervisor observed a photo of the boy's injury in a text from the investigator and acknowledged it "looked nasty." Ultimately, the supervisor accepted the explanation that the supervisor knew had been rejected by the police and not fully supported by the medical examination. A professional child welfare supervisor, again, has a fiduciary duty to direct their investigator to keep probing until a more definitive determination could be reached by a child abuse expert. This would most likely have been achieved had the supervisor directed the investigator to make a referral to MERIT.

Despite reports from mandated reporters of environmental neglect in the B and C sequence investigations, neither investigator completed a Home Safety Checklist. Both investigators failed to obtain critical records including medical and law enforcement documents. Neither completed a body chart and the supervisor did not review or analyze hard copy documents prior to approving final finding determinations.

The family's significant history with the Department should have been factored into determining the children's safety in both the B and C sequence investigations. Each sequence was investigated in isolation without assessing the totality of circumstances adequately to ensure the safety of these children. The parents' history of substance abuse should have led minimally to toxicology screenings for the parents and further assessment of the risks that are known to be associated with drug lifestyles. The lack of a closing Child Endangerment Risk Assessment Protocol (CERAP) on the C sequence investigation is an example of the limited assessment in these investigations.

Finally, observation and interviews of the children were lacking and not considered to be of importance. The B sequence investigator observed the children outside the home and decided their apparent healthy appearance was enough to mitigate any possible concerns about their care, despite their mother's recent drug usage and extensive substance abuse history. The B sequence investigator did not attempt to interview the boy about bruising that had been reported in the Hotline narrative deciding that he would not recall. The C sequence investigator did not consider the boy's statement that maybe his mommy did it and did not mean to hurt him. The C sequence investigator chose instead to accept the boy's report that the dog hit him because the boy's explanation matched the mother's self-report. The investigators and supervisor relied on brief observations and the parents' self-reports in making final determinations of abuse/neglect. The mother and father, however, resorted to deceit and manipulation during most of their interactions with DCFS. Without supervision and a system of accountability, the parents' substance abuse became more dangerous to their children.

The parents' deceptive behavior continued when they reported the boy missing. The Department took protective custody of the surviving sibling during the subsequent child protection investigation in which both parents were indicated for their son's death and neglect of both children. A permanency case was opened, and the sibling was placed in a relative's care. The then pregnant mother tested positive for illegal substances on the day the father led law enforcement to the boy's body; a separate child protection investigation was initiated and both parents were indicated for child neglect. The birth of the mother's fourth child initiated yet another separate child protection investigation that was indicated for child neglect. The baby was taken into protective custody and placed in a relative's care. The mother consented for both children to be adopted by their respective foster parents. The baby's father is deceased. The surviving siblings were living in pre-adoptive foster homes with permanency goals of return home when OIG's final report was issued.

RECOMMENDATIONS

1. The investigator in the C sequence investigation should be discharged from the Department.

The investigator was discharged from the Department.

2. The supervisor should be discharged from the Department.

The supervisor was discharged from the Department.

3. The investigator in the B sequence investigation should be discharged from the Department.

The investigator is no longer with the Department.

4. The Department's Office of Legal Service should immediately pursue adjudication in juvenile court in order to move toward termination of the father's parental rights and adoption of the surviving sibling.

The Department agrees. As the actions of the parents can be determined to be egregious, this case meets the grounds for expedited termination of parental rights. The parents will also be incarcerated for some time and the child is with a long-term caregiver. Therefore, the Department agrees to pursue adjudication and expedited termination of parental rights. The Department has communicated and will continue to communicate with the local State's Attorney's Office to ensure progress toward this goal. The criminal conviction of the parents strengthens the likelihood of expedited termination of parental rights.

PART II: CHILD DEATH REPORT

OIG investigates the deaths of children whose families were involved in the Illinois child welfare system within the preceding 12 months. OIG staff receive notification of the death of a child from the Illinois State Central Register (SCR) when the death is reported to SCR.[1] OIG staff investigate the Department's involvement with the deceased and his or her family when: 1) the child was a youth in the care of DCFS; 2) the family is the subject of an open investigation or service case at the time of the child's death; or 3) the family was the subject of an investigation or service case closed within the preceding 12 months. Whenever OIG investigators learn of a child death meeting these criteria, the death is investigated.[2]

Notification of a child's death initiates an investigatory review of records. OIG investigators review the death reports and information available through the Department's computerized records. The investigator then obtains additional records, including the child's autopsy reports.[3] Records may be requested, impounded, or subpoenaed. The majority of cases involve an investigatory review of records, often including social service, medical, police, and school records, in addition to records generated by the Department or its contracted agencies.

When warranted, OIG investigators conduct a full investigation, including interviews. A full investigation may result in a report to the DCFS Director. Individual cases may not rise to a level necessitating a full investigation, but collectively can indicate systemic patterns or problems that require attention. OIG staff may address systemic issues through a variety of means, including cluster reports, initiatives, and trainings.

In Fiscal Year 2020, OIG investigated 102 deaths of children who died between July 1, 2019 and June 30, 2020, meeting criteria for review. A description of each child's death and DCFS involvement is included in this Annual Report. During this fiscal year, an investigatory review of records was conducted in each of the 102 deaths, leading to 15 full investigations; 11 of those investigations are pending. Comprehensive summaries of death investigations reported to the Director in FY 2020, which may include deaths that occurred in earlier fiscal years, are included in the Investigations section of this Annual Report.

Sixty-three of the 102 child deaths reviewed by OIG also underwent a child protection investigation of the death. Twenty-nine deaths (46%) were indicated, 30 (47%) were unfounded, and four (6%) remain pending. Twelve of the deaths were ruled homicide in manner. Fourteen deaths had an undetermined manner. Thirty deaths had a manner of accident. Forty-one deaths had a manner of natural causes. Five deaths had a manner of suicide.

[1] SCR relies on coroners, hospitals, medical examiners and law enforcement to notify them of child deaths, even when deaths are not suspicious for abuse or neglect. Some deaths may not be reported. As such statistical analysis of child deaths in Illinois is limited because there is no central repository that includes the total number of children that die in Illinois each year. The Cook County Medical Examiner's policy is to notify the Department of the deaths of all children autopsied at the Medical Examiner's office.

[2] Occasionally, SCR will not receive notice of a child death and OIG staff learn of it through other means.

[3] OIG acknowledges all the county coroners and the Cook County Medical Examiner's Office for responding to our requests for autopsy reports.

SUMMARY

Following is a statistical summary of the 102 child deaths investigated by OIG in FY 2020, 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 child protection death investigations by result and manner. The second part presents a summary of deaths classified in five manners: homicide, suicide, undetermined, accident, and natural.[4] Please note that the term "coroner" is used for both coroners and the Cook County Medical Examiner in the individual summaries.

KEY FOR CASE STATUS AT THE TIME OF OIG INVESTIGATION:

Youth in Care:	Deceased was a Youth in Care.
Unfounded DCP:	Family had an unfounded child protection investigation within a year of child's death.
Pending DCP:	Family was involved in a pending child protection investigation at time of child's death.
Indicated DCP:	Family had an indicated child protection investigation within a year of child's death.
Child of Youth in Care:	Deceased was the child of a youth in care, but not in care themselves.
Open/Closed Intact:	Family had an open intact family services case at time of child's death / or within a year of child's death.
Open Placement/Split Custody:	Deceased, who never went home from hospital and had sibling(s) in foster care, or child was in care of parent with siblings in foster care.
Return Home:	Deceased or sibling(s) returned home to parent(s) from foster care within a year of child's death.
Child Welfare Services Referral:	A request was made for DCFS to provide services, but no abuse or neglect was alleged.
Preventive Services/Extended Family:	Intact family services case was opened to assist family, but not as a result of an indicated child protection investigation.
Former Youth in Care:	Child was a youth in care within a year of his/her death.

[4] The causes and manners of death are determined by hospitals, medical examiners, coroners, and coroners' juries.

TABLE 1: CHILD DEATHS BY AGE AND MANNER OF DEATH

CHILD AGE		HOMICIDE	SUICIDE	UNDETERMINED	ACCIDENT	NATURAL	TOTAL
Months of Age	At birth			1	3	3	**7**
	0 to 3			7	6	8	**21**
	4 to 6	1		2	1	2	**6**
	7 to 11	1		1	3	4	**9**
	12 to 24	3			2	5	**10**
Year of Age	2			2	3	1	**6**
	3				3	2	**5**
	4					2	**2**
	5					1	**1**
	6				1		**1**
	7						**0**
	8	1	1		1	1	**4**
	9				1	1	**2**
	10					1	**1**
	11	1				1	**2**
	12					4	**4**
	13				1	1	**2**
	14				1	1	**2**
	15	1	1		2	1	**5**
	16	2			1		**3**
	17	1		1			**2**
	18 or older		3		1	2	**7**
TOTAL		**12**	**5**	**14**	**30**	**41**	**102**

TABLE 2: CHILD DEATHS BY CASE STATUS AND MANNER OF DEATH

REASON FOR OIG INVESTIGATION*		HOMICIDE	SUICIDE	UNDETERMINED	ACCIDENT	NATURAL	TOTAL
DCP	Pending	1			3	7	**11**
	Unfounded	1	1	3	13	11	**29**
	Indicated	2	1	2	3	6	**14**
Youth in Care		4	3	3	4	7	**21**
Closed CWS					1		**1**
Open Placement				1		1	**2**
Open CWS				1			**1**
Pending CWS						1	**1**
Open Intact		2		2	5	4	**13**
Closed Intact				1		4	**5**
Child of a Youth in Care					1		**1**
Child of a Former Youth in Care		1		1			**2**
Return Home		1					**1**
TOTAL		**12**	**5**	**14**	**30**	**41**	**102**

** When more than one reason existed for OIG investigation, the death was categorized based on the primary reason.*

TABLE 3: CHILD DEATHS BY COUNTY OF RESIDENCE AND MANNER OF DEATH

COUNTY	HOMICIDE	SUICIDE	UNDETERMINED	ACCIDENT	NATURAL	TOTAL
Adams				1		**1**
Cass				1		**1**
Champaign	1			2	4	**7**
Coles	1					**1**
Cook	5	3	9	5	10	**32**
DeWitt				1		**1**
DuPage				1	1	**2**
Franklin					1	**1**
Henry				1		**1**
Iroquois				1		**1**
Jackson				1		**1**
Jefferson					1	**1**
Johnson				1		**1**
Kane					1	**1**
Kankakee					1	**1**
Lake			1		2	**3**
Lawrence			1	1		**2**
Macon	1				1	**2**
Macoupin			1		1	**2**
Madison				1	1	**2**
McHenry				1		**1**
McLean					1	**1**
Peoria	1			4	4	**9**
Rock Island				1		**1**
Sangamon	1	1			2	**4**
Shelby, IN				1		**1**
St. Clair				2	2	**4**
Vermillion				2		**2**
Wayne					1	**1**
Will		1	2	1	3	**7**
Williamson					1	**1**
Winnebago	2			1	3	**6**
TOTAL	**12**	**5**	**14**	**30**	**41**	**102**

TABLE 4: CHILD PROTECTION DEATH INVESTIGATIONS BY RESULT AND MANNER*

FINAL FINDING	Homicide	Suicide	Undetermined	Accident	Natural	Total
Indicated	4		8	13	4	**29**
Unfounded	1	1	3	11	14	**30**
Pending	1		2	1		**4**
TOTAL	**6**	**1**	**13**	**25**	**18**	**63**

**Child deaths in which at least one person was indicated or unfounded for death by abuse or death by neglect. Note that persons indicated for death will stay on the State Central Register for 50 years.*

FY 2020 DEATH CLASSIFICATION BY MANNER OF DEATH

HOMICIDE

Twelve deaths were classified as homicide in the manner of death.

CAUSE OF DEATH	NUMBER
Blunt trauma due to child abuse	2
Gunshot wound	8
Asphyxia	1
Pending	1
TOTAL	**12**

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ALLEGED PERPETRATOR INFORMATION*

PERPETRATOR	NUMBER
Mother	2
Father	1
Mother's Former Paramour	1
Sibling	1
Unknown/Unsolved	5
Unrelated Household Member	1
Unrelated Person	1

*Some deaths have more than one perpetrator

UNDETERMINED

Fourteen deaths were classified undetermined in the manner of death.

CAUSE OF DEATH	NUMBER
Undetermined	11
Asphyxia	1
Gunshot Wound	1
Pending	1
TOTAL	**14**

ACCIDENT

Thirty deaths were classified as an accident in the manner of death.

CAUSE OF DEATH	NUMBER
Acute Alcohol Intoxication/Alcohol Abuse	1
Asphyxia/Suffocation/Sleep-Related	14
Carbon monoxide intoxication/Thermal injuries	3
Choking/Suffocation	3
Drowning	5
Extreme Prematurity due to Placental Abruption	1
Hanging	1
Motor Vehicle Accident Related	2
TOTAL	**30**

NATURAL

Forty-one deaths were classified natural in the manner of death.

CAUSE OF DEATH	NUMBER
Cancer	3
Chronic Respiratory Disease	3
Complications Related to Cerebral Palsy	2
Complications Related to Epilepsy/Seizure Disorder	2
Complications Related to Prematurity	6
Congenital abnormalities/Chronic Progressive Illness	9
Hemorrhage from Esophageal Ulcer	1
Hypoxia/Anoxic Injury	4
Multi-Organ System Dysfunction	1
Pneumonia/Viral Illness	6
Pulmonary Thromboembolism	1
Sudden Infant Death	2
Unknown Natural Causes	1
TOTAL	**41**

SUICIDE

Five deaths were classified as suicide in the manner of death.

CAUSE OF DEATH	NUMBER
Hanging	4
Ligature Strangulation	1
TOTAL	**5**

HOMICIDE

Child No. 1	DOB: 07/2018	DOD: 07/2019	Homicide
Age at death:	11 months		
Cause of death:	Air pellet wound of the chest due to a shot by another person		
Perpetrator:	Sibling		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-month-old was shot, while sleeping on the couch, by her two-year-old sibling, who found a BB gun and pulled the trigger. The mother called 911. The infant was transported to the hospital, where she was later pronounced deceased. The mother reported that while cleaning the house, the father was cleaning a closet where the BB gun was stored, took it out, and left it leaning on the couch. The father left the room, as he thought the children were playing in another room. He was talking with other adults in the kitchen when the shot rang out. The mother reported she heard the infant scream, went to her on the couch, lifted her shirt, and saw she was bleeding. The mother began CPR until EMS arrived. The Department indicated the parents for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by abuse to the other children.

Prior History: The family was involved in three child protection investigations from February 2017 through May 2019; two investigations were unfounded, and one was indicated. In February 2017, the Department investigated the mother for medical neglect of the infant's then nine-year-old stepbrother who was diabetic and had been hospitalized for diabetic ketoacidosis. The physician wanted to transfer the child to a children's hospital. The mother refused, insisting on his transfer to a hospital close to the family home. The physician took protective custody and transferred the child to a children's hospital. The physician at the children's hospital and the primary care physician reported having no issues with the family and the report against the mother was unfounded. In March 2018, the Department investigated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's sibling and three stepsiblings, between the ages of one and ten years old, after a report of drug selling and use in the home. The parents denied the allegations, and the investigator did not observe any concerns in the home. The verbal children denied the allegations and reported feeling safe. In May 2019, the Department investigated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect of the then 10-month-old infant and the other four children after law enforcement reported a physical altercation between the parents. The mother was initially argumentative and uncooperative with the child protection investigator, insisting she and the father only had an argument and misunderstanding. The investigator observed a bruise on the mother's right cheek, but the mother would not say how she got the bruise. The mother said there was a no-contact order that she and the father were abiding by, all charges were dropped, and the children were safe. The mother reported the children were in a bedroom with a family member and did not witness anything. She added she and the children were going to stay with family. The mother said she had been with the father for four years and this was the first time something like this had happened. The mother said they had information and planned to follow through with counseling. The investigator met with the father who gave the same account as the mother. In June 2019, the investigation against the parents was indicated.

Child No. 2	DOB: 02/2018	DOD: 07/2019	Homicide
Age at death:	16 months		
Cause of death:	Multiple injuries due to child abuse		
Perpetrator:	Mother		
Reason for review:	Child of a former youth in care		
Action taken:	Investigatory review of records		

Narrative: One-year-old was found unresponsive by her 21-year-old mother. The mother called 911, stating that she went to wake the toddler and found her cold and not moving or breathing. The mother told police that she had woken up at 7:00am, checked on the toddler, and saw the toddler was breathing heavily. The mother took the toddler from her crib, laid her on a pad with stuffed animals and blankets and the mother then laid down falling asleep next to her. At 9:45am, the mother reportedly woke up and saw that the toddler's lips were blue. The mother took the toddler to the maternal grandmother's apartment, directly above the mother's, and called 911. The toddler was transported to the hospital and pronounced deceased. The physician noted that the toddler had multiple injuries including bruising on her back and shoulders, a circular burn mark on the inside of her left heel, a bite mark on her back, and small lacerations on her fingers that looked like paper cuts. The autopsy found numerous injuries from child abuse and ruled the death a homicide. The mother was arrested and charged with first-degree murder and is currently awaiting trial. The Department indicated the mother for death by abuse.

Prior History: In December 2011, the mother came into care with the Department at the age of 13 on a dependency petition after being hospitalized for mental health services when she was found to have self-inflicted cuts on her arm. The mother had a history of running away from home and engaging in risky behaviors, including substance use. The mother was placed in a residential treatment program for two years before being placed in specialized foster care. In January 2016, the then 17-year-old mother moved to a transitional living program. At the age of 19, the mother learned she was pregnant. In August 2017, the caseworker noted that the mother was not going on run as frequently. In September 2017, the mother was attending classes to obtain her GED and working full time. The mother attended her monthly prenatal appointments, weekly blood draws, and took her medications as scheduled. The mother gave birth in February 2018. The caseworker noted that the mother had "embraced motherhood" and was doing well with parenting. She completed a new birth assessment which indicated that the mother did not need a parenting coach. In April 2018, the caseworker witnessed the mother and the toddler's father get into a physical altercation that resulted in the father punching the mother in the face. The Department investigated both parents for substantial risk to the toddler, who was present during the altercation. The investigation against the mother was unfounded and indicated against the father. The mother obtained an order of protection against the father. The mother was encouraged to participate in domestic violence classes, become more involved in individual therapy and take safety measures regarding the father. The treatment team arranged for the paternal grandmother to facilitate visits between the father and the infant. The mother split her living arrangements at the transitional living program with her mother's apartment, where she and the infant frequently stayed. In March 2019, the mother moved out of the transitional living program into the apartment below the maternal grandmother. The caseworker completed home safety checks at the maternal grandmother's home and the mother's apartment, and deemed it safe, appropriate, clean, and organized. The worker continued weekly visits until case closure and noted no other concerns. In April 2019, the mother aged out of care and the case with the Department was closed. At the time of case closure, the toddler was attending daycare, the mother was working and had completed her GED, and living in an apartment below the maternal grandmother, who was a positive support for her.

Child No. 3	DOB: 03/2018	DOD: 10/2019	Homicide
Age at death:	19 months		
Cause of death:	Asphyxia due to smothering and compression of the neck		
Perpetrator:	Mother		
Reason for review:	Indicated child protection investigation within one year of the child's death		
Action taken:	Investigatory review of records		

Narrative: Nineteen-month-old was found in his bed unresponsive at approximately 3:00am by his mother. The mother reported that she found the toddler with a sheet and comforter wrapped around his head on a twin-size bed. The mother stated the toddler was cold and unresponsive, so she began chest compressions and called 911. When EMS arrived, the toddler was pronounced deceased at the scene. The mother stated she was checking on him because he had been ill and she was going to give him a breathing treatment, since he had been sick in the past with bronchitis. The mother stated she called the toddler's doctor's office to refill his medication the Friday before his death, but there was no evidence of that call and she was unable to produce the medication for his nebulizer. The autopsy results from the coroner's office list the cause of death as asphyxia due to smothering and compression of the neck. There was no evidence found that the compression of the neck was caused by a sheet and comforter being wrapped around the toddler's neck. The toddler's death was ruled a homicide. After an investigation by the local police department, the mother was arrested. The State's Attorney has charged her with three counts of first-degree murder. The Department indicated the mother for the death by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect to the toddler's four-year-old sibling. Protective custody was taken of the sibling who was placed with the paternal grandmother.

Prior History: The family had been investigated by the Department twice before the death. One was unfounded and one was indicated against father. In April 2018, the mother took the then one-month-old toddler to the doctor after noticing a bump on the toddler's head a few days earlier. The Department investigated the mother for head injuries to the toddler. The doctor sent them to the hospital where it was determined the infant had a cephalohematoma (a collection of blood beneath the periosteum, frequently seen in a newborn as a result of birth trauma). The physician reported that it was not a sign of abuse or neglect and it would resolve over time. The toddler was seen by his primary care physician as well and it was noted that he was on target developmentally and doing very well. In July 2018, the Department's investigation against the mother was unfounded. In October 2018, law enforcement was dispatched to a report of domestic violence between the toddler's mother and father. The responding officer reported that the mother had a half-inch laceration on the top of her head, two small cuts on her nose, a nosebleed, and a noticeable area of swelling to the right side of her forehead. The Department investigated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the children. The investigator noted the mother had yellow bruising on the upper bridge of her nose and the mother confirmed that the father had struck her. The toddler, then seven months old, was in the crib in the room at the time of the incident and the toddler's three-year-old sibling was in a different room. The father was placed in custody. In December 2018, the Department's investigation against the father was indicated.

Child No. 4	DOB: 01/2002	DOD: 10/2019	Homicide
Age at death:	17 years		
Cause of death:	Complications of multiple gun shot wounds		
Perpetrator:	Unknown		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found on a porch with gunshot wounds to his chest from a drive-by shooting. The teen was transported by ambulance to the hospital. Following surgery, he remained sedated and on a ventilator in the ICU. The teen was pronounced deceased five days later. The Department did not investigate his death for abuse or neglect.

Prior History: In June 2018, the Department investigated the mother for inadequate supervision to the teen after a school official reported that he did not show up to school for final exams. The school official said the mother was unconcerned about the teen's whereabouts, had not filed a missing person report, and had turned off the teen's cell phone. The school official requested the mother turn the teen's phone back on, and she did for a short time. The school official contacted the teen, who stated that he was at his aunt's house. The investigation was unfounded as the teen was in a safe place and the mother knew of his whereabouts. In October 2019, the Department investigated the mother again for inadequate supervision to the teen after it was reported that the teen had been absent from school for four days and reported that his mother kicked him out and he had no clothing, shelter, or money. That day, the child protection investigator contacted the reporter who shared that the school resource office spoke to the mother, who denied locking the teen out of the house and said the teen left home after he was accused of stealing from his younger brother. The mother had not spoken to the teen personally but confirmed with family members that the teen was staying with his cousin. The reporter further stated that there had been conflict between the mother and teen since an older sibling was murdered several years earlier in a gang-related incident. The investigator interviewed the mother, the teen, and his younger brother at home. The mother admitted cursing at the teen for stealing money from his brother but said she knew the teen went to stay with a cousin. She stated that the teen was a good kid but was hanging out with the wrong crowd. The teen denied his mother kicked him out, admitting leaving home on his own after his mother accused him of stealing money from his younger sibling. He confirmed he was at his cousin's house. He told the investigator that he planned to stay home and return to school. The teen's 13-year-old sibling denied knowing anything about the incident and reported feeling safe in the home. The next day, the mother contacted the investigator to report that her son had been shot the night before after the investigator left their home. The investigation against the mother was unfounded for inadequate supervision.

Child No. 5	**DOB: 07/2019**	**DOD: 12/2019**	**Homicide**
Age at death:	4 months		
Cause of death:	Skull fractures with epidural hemorrhage and severe edema of brain		
Perpetrator:	Father		
Reason for review:	Return home within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was found unresponsive in his crib by his parents at approximately 7:45am. Emergency services were called. The infant was pronounced deceased on the scene at 8:05am. At autopsy the pathologist discovered multiple brain bleeds and skull fractures. The Department investigated the mother and father for death to the infant and substantial risk. The parents reported the father was the sole caretaker of all three children, ages four months, one year, and three years old, from approximately 1:00pm until 10:45pm the day before the infant had been found unresponsive. Law enforcement interviewed the father who admitted to dropping the infant in the bathtub after the infant became fussy while bathing. The father was charged with two counts of first-degree murder. In February 2020, the Department indicated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the surviving siblings, and indicated the father for death by abuse and head injuries to the infant. Following the death, the infant's siblings came into care.

Prior History: From May 2001 through August 2010, the mother was an alleged victim in six child protection investigations. The Department's first involvement with the mother as a parent occurred in August 2017, when the Department investigated and unfounded the mother for environmental neglect and cuts, bruises, welts, abrasions, and oral injuries to the infant's older sibling, then one year old. In February 2018, the mother was investigated for cuts, bruises, welts, abrasions and oral injuries to the infant's then two-year-old sibling after it was reported the sibling had several marks, bruises, and injuries as well as a bruised and swollen foot. The mother denied knowing how the toddler received the bruises. The Department's investigation against the mother was indicated in March 2018 and an intact family

services case was opened. Recommended services included parenting classes and mental health counseling. In January 2019, the children were placed in the temporary custody and guardianship of the Department after a petition was filed alleging mother was not making progress in counseling services. The children were returned to mother's custody in May under court supervision. There were two subsequent child protection investigations involving the family after the children were returned. In May 2019, the Department investigated the infant's father for substantial risk of physical injury/environment injurious to health and welfare; cuts, bruises, welts, abrasions and oral injuries to the infant's then three-year-old sibling; and substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's then one-year-old sibling after it was reported the three-year-old had a bruise on his bottom. The three-year-old reported that the infant's father punched him in the leg earlier that day. The children were in the father's care while the mother was at work. The three-year-old was seen by his primary care physician for suspected abuse. The physician did not note any bruising consistent with physical abuse. The Department's investigation against the father was unfounded, as there was insufficient evidence to show the bruising was caused by abuse. In September 2019, the Department investigated the mother and father for inadequate supervision to all three children (the then two-month-old infant and his one-year-old and three-year-old siblings); cuts, bruises, welts, abrasions, and oral injuries to the infant; and substantial risk of physical injury/environment injurious to health and welfare by neglect to the one-year-old sibling after it was reported the three-year-old sibling was hospitalized because he had recently caused harm to his siblings. The mother took the infant to be examined and then took the three-year-old to be evaluated. The three-year-old hit the infant in the eye, choked the one-year-old, and threatened his siblings with a knife. The infant was reported to be on the parent's bed when the three-year-old jumped on the bed accidently hitting the infant's face with his hand. The three-year-old told the father he did not know the infant was on the bed before he jumped on it. The infant had a bruise on his forehead and slight swelling to the eye. The parents sought medical treatment the next day and there was no suggestion that the injury was anything other than accidental. The Department's investigation against the mother and father was unfounded.

Child No. 6	**DOB: 06/2001**	**DOD: 01/2020**	**Homicide**
Age at death:	18 years		
Cause of death:	Pending		
Perpetrator:	Unrelated adult		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: The teen was on run and was last seen by her caseworker in December 2019. Her caseworker filed missing person's reports and alerted several local police departments of her disappearance. The Department was alerted when the body of a Jane Doe was found in a rural area in a large suitcase in March 2020. The teen was later identified by her tattoos. Her death was determined to be a homicide. Police questioned and searched the home of a man who stated he met the teen online, picked her up in Missouri, and brought her to his home. He told police that he told the teen to leave his home in January 2020, and that was the last time he had contact with her. A search of the home found blood and bleached spots that also tested positive for blood, and the man's cell phone records showed him traveling to the region where her body was found two months later. The man was arrested and charged with first degree murder, armed criminal action, and tampering with physical evidence in a felony prosecution in Missouri.

Prior History: The teen's first contact with the Department came in 2011 when a relative who had been caring for the then 10-year-old was indicated for sexually abusing her. As a teen, the minor struggled with behavioral health problems and substance use. In 2016 the teen began running from her home. In July 2016, the teen was at a shelter and the father refused to allow her home, as she had been abusing her siblings. The father was indicated for lock-out and the teen came into care. The teen struggled to stay in one placement and moved between shelters, specialized foster homes, unauthorized placements, hospitals,

and detention, interspersed by periods of being on-run. The worker attempted to get the teen to participate in residential substance abuse treatment, but the teen ran within a day of placement. In 2018, the teen was named the victim of an unrelated man in an indicated investigation of human trafficking. In 2019, the teen was named the victim of an unrelated man in an indicated investigation of substance misuse and sexual penetration. In the year leading up to her death, the teen was frequently on run from her placement and had moved between various self-selected unauthorized placements but kept in contact with her caseworker. Her caseworker filed multiple missing persons reports and alerted law enforcement to her disappearance and where she was last seen. The teen's caseworker was last able to reach her three days before she was reportedly kicked out of the home of the man charged with her murder. While in care, the teen gave birth to a son in 2018. Her son never came into care but was the victim in one indicated and one unfounded investigation of the teen. The teen voluntarily left her son in the care of her aunt, who obtained guardianship through probate court.

Child No. 7	**DOB: 03/2003**	**DOD: 03/2020**	**Homicide**
Age at death:	16 years		
Cause of death:	Gunshot wound to the chest		
Perpetrator:	Unknown		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old's body was found by police on the street and had a gunshot wound. He had last been seen the previous evening by his sister, with whom he was placed. He had been released to her home from juvenile detention and was on home confinement but slipped out of the house after she went to sleep. The teen had a history of elopement, and in 2017 and 2018, was listed as missing for months at a time. He became a youth in care through a no-fault dependency petition in December 2018. The Department did not investigate the death for abuse or neglect.

Prior History: The teen was removed from his mother's home as a young child because of substance use and violence in the home. He was returned to his biological family but came back into care in 2008. He was adopted by his foster family in 2012. In 2014, the Department indicated an unknown perpetrator for sexual penetration to the teen's adoptive sister, then two years old. The Department opened an intact family services case. The teen was seeing a therapist for behavioral concerns. His sister was doing well, so the teen's adoptive mother requested the intact case be closed. In 2016, the Department received a report of domestic disturbance between the teen and his adoptive mother but did not open an investigation. In April 2018, the Department received information the teen was arrested for burglary/theft. He had been missing since August 2017 when his adoptive mother reported he ran away and sought help locating him. In December 2018, the teen was on probation for auto theft, mob action, and aggravated battery. He came back into care of the Department on a no-fault dependency petition but was often on run or moving between placements including the homes of biological family and adoptive family. In May 2019 he was arrested and detained. In August 2019, he was sentenced to Juvenile Department of Corrections for seven years, or until the age of 21 years. While there he participated in counseling, was involved in clubs, and did well in school. He was released in December 2019 and placed with another biological sister. The teen initially did well in his sister's home, enrolled in school, and got a job. He ran away for two days in February 2020 and his caseworker, foster parent, and probation officer were concerned about drug use and gang involvement and discussed requesting electronic monitoring. He was picked up by police a few days later for riding in a stolen car and was released to home confinement after a few days in detention.

Child No. 8	DOB: 07/2003	DOD: 05/2020	Homicide
Age at death:	16 years		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unknown		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old's body was found by police responding to a Shot Spotter technology alert indicating that eight rounds had been shot. No one has been charged with his murder. The Department did not investigate the death for abuse or neglect.

Prior History: Between 2013 and 2017, the teen's mother had one indicated investigation and five unfounded investigations. The unfounded investigations included allegations of medical neglect and burns. In August 2013, the mother was indicated for inadequate supervision after leaving the teen, then 10 years old, and the teen's sister, then nine years old, home alone and she was found intoxicated with the teen's then six-month-old sibling. The mother was arrested for child endangerment and the children were left in the care of their paternal grandmother. Starting in October 2016 the teen had several arrests, the first at the age of 13, for defacement to school property and aggravated assault. Over the next several months he was arrested eight additional times for aggravated assault, domestic battery, residential burglary, unlawful use of a weapon, and criminal damage to property. In May 2017, the teen was expelled from school. Between July and September 2017, the teen was on house arrest. Following an overdose on heroin in November 2017, he was detained for three weeks before being released on house arrest. In January 2018, while the teen was in juvenile detention, the teen was ordered into the Department's custody, and he was court ordered into residential treatment following behavioral and substance use issues. In January 2018, he was again detained for not following court orders to attend school. He was placed in a residential facility but eloped the next day. One week later, he was found and placed in detention, remaining there until June 2018, when he was placed in a residential facility. In this placement, he attended school, participated in therapy, and generally did well. His mother also participated in services, including therapy and toxicology screenings. The teen returned to his mother in January 2019. The Department helped the mother enroll him in school, link him with therapy, and link him with medication management. However, the teen struggled at home, attending school sporadically, using substances, and arguing with his mother. In November 2019, the court determined he violated probation, placed him on electronic monitoring, and ordered him to attend treatment, and school. He was moved to a relative's home, began attending school, going to drug treatment, and volunteering. A month later when his electronic monitoring ended, he stopped attending school and treatment, was often leaving the home at night, and the relative expressed concern about gang activity in the neighborhood. In April 2020, the teen was at the emergency room intoxicated. The caseworker informed his probation officer of the incident. The caseworker and probation officer tried to get the teen to remain in his relative's home and into substance abuse treatment until his death in May 2020.

Child No. 9	DOB: 11/2011	DOD: 05/2020	Homicide
Age at death:	8 years		
Cause of death:	Gunshot wound of the chest		
Perpetrator:	Household member		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old was shot with a gun in his foster parent's home. The family reported he had been shot with a BB gun, but it was discovered upon arrival of emergency personnel that he had been shot with a real gun. The child was transported to the hospital and pronounced deceased about 20 minutes later. The Department has a pending investigation into the child's death.

Prior History: The child's family had an extensive history with the Department. Between 1997 and

2009, the child's mother was involved in eight investigations as a minor. Four of those investigations were indicated. The mother was a youth in care from 1999 to 2002 and 2003 to 2006. The child's mother was the alleged perpetrator in six investigations from 2011 to 2019 and was indicated in three of those investigations. In 2016, the mother was indicated for inadequate supervision. In August 2018, the Department investigated a report that she and her paramour were selling drugs out of the home. They had also been pulled over and were found to have drugs and open alcohol in the car while two of the mother's children, ages five and six years, were with them in the car. The mother was arrested and charged with unlawful possession of a controlled substance. The mother told the investigator that none of her children live with her as she had signed temporary guardianship of her children over to relatives because she did not have secure housing. The investigator confirmed relatives were caring for the children who planned to obtain guardianship. The mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. In September 2019, the Department received a report that police had executed a warrant on the home that the mother, her paramour, and the now deceased child lived in, and found drugs, holes in the floor, garbage throughout, and no running water. The house was scheduled to be condemned. The paramour was arrested; the mother was allowed to take the child and go to a friend's home. The respective caregivers for her children reported they had tried to obtain guardianship, but the mother would not follow through. The Department took all three children into protective custody and placed them with two separate families. The mother was indicated for inadequate shelter and substantial risk of physical injury/environment injurious to health and welfare by neglect. The Department opened a placement services case. In January 2020, the child and his brother were removed from their placement due to allegations their caregiver was physically abusing them and were placed with the brother's paternal grandmother.

Child No. 10	**DOB: 08/2008**	**DOD: 05/2020**	**Homicide**
Age at death:	11 years		
Cause of death:	Gunshot wound in the head		
Perpetrator:	Mother's former paramour		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-year-old and his mother were found deceased in their apartment from apparent gunshot wounds. They were victims of a murder-suicide. The Department did not investigate the death for abuse or neglect.

Prior History: In December 2019, the Department opened an investigation following a report the child's mother found the then 10-year-old child in his room, on top of the six-year-old daughter of his mother's paramour, and both children had their pants down. The six-year-old stated the child inserted his fingers and penis into her vagina. The mother had left the children in the care of her paramour while she was away, and her paramour appeared to be asleep in another room when she returned and found the children. A safety plan was enacted. The child's mother and paramour separated during the course of the investigation. The investigation was indicated against the child for sexual penetration and sexual molestation. An intact family services case was opened in January 2020 due to the incident. The family was compliant with services and the child was referred for sex offender treatment. In March 2020, services were maintained through video chat and occasional physically distant in-person visits when COVID-19 safety protocols went into place. The intact worker never met with the mother's paramour, as the mother reported they separated before the intact case opened.

Child No. 11	DOB: 04/2005	DOD: 06/2020	Homicide
Age at death:	15 years		
Cause of death:	Gunshot wound in the head		
Perpetrator:	Unknown		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old teen was in her room at her mother's home, with two friends and her nephew. A gun was discharged, and the teen was shot in the head. An uncle, who had been in another room, called 911 upon hearing the gunshots. She was taken to the hospital by ambulance and pronounced deceased the next day. There were two additional children in the home during the incident and three adults. The teen's mother was not home at the time. There was no evidence of close-range shooting. The Department investigated and unfounded the teen's mother for death by neglect because the mother was not in the home at the time of the shooting and the firearm did not belong to her. The police investigation is pending.

Prior History: In January 2020, the Department opened an investigation following a report that the teen's cousin and the teen's brother had been burning each other with a lighter. The teen's cousin was a youth in care living in an emergency placement with the teen's mother while the worker awaited a group home opening for the youth in care. The mother had requested a new placement for the cousin before learning about the burns and stated she had difficulties managing the cousin. The teen's brother stated he was not being burned, but that the cousin and a friend started burning each other a month before the investigation opened. The cousin and a friend corroborated this. The Department unfounded the investigation.

Child No. 12	DOB: 10/2018	DOD: 06/2020	Homicide
Age at death:	20 months		
Cause of death:	Gunshot wound of chest		
Perpetrator:	Unknown		
Reason for review:	Open intact case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-month-old was shot while a passenger in a vehicle driven by his mother. The toddler was pronounced deceased at the hospital. It was reported that mother was stopped at a red light when a car drove up and started shooting. The offender fled the scene, and no one has been charged with the toddler's death. The Department did not investigate his death.

Prior History: In February 2020, the Department opened an investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse following a report of domestic violence between the child's parents with the child present. The father was indicated for substantial risk of physical injury/environment injurious to health and welfare, and the case was referred for intact family services. The child's mother was cooperative with services, but his father was not. The child's mother later reported that she and his father were no longer together. The intact case was closed a month after the child's death.

SUICIDE

Child No. 13	DOB: 12/1998	DOD: 08/2019	Suicide
Age at death:	20		
Cause of death:	Hanging		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Child No. 14	DOB: 10/2000	DOD: 09/2019	Suicide
Age at death:	18 years		
Cause of death:	Hanging		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Child No. 15	DOB: 01/2004	DOD: 09/2019	Suicide
Age at death:	15 years		
Cause of death:	Hanging		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 16	DOB: 12/2011	DOD: 12/2019	Suicide
Age at death:	8 years		
Cause of death:	Hanging		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 17	DOB: 07/2000	DOD: 04/2020	Suicide
Age at death:	19 years		
Cause of death:	Ligature strangulation		
Reason for Review:	Youth in care		
Action taken:	Investigatory review of records		

UNDETERMINED

Child No. 18	DOB: 04/2019	DOD: 07/2019	Undetermined
Age at death:	3 months		
Cause of death:	Undetermined		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive by her foster parent at approximately 12:55am, when she went into the room where the infant was sleeping to change her diaper. The foster parent began CPR and contacted 911 but stated the ambulance took too long to arrive and she transported the infant to the hospital herself. Upon arrival to the hospital, the infant was pronounced deceased at 1:54am. The Department investigated the foster parent for death by neglect to the infant and substantial risk of physical injury/environment injurious to health and welfare by neglect to the two-year-old and five-year-old surviving siblings. The foster parent stated she gave the infant her final bottle at 10:00pm, put her to bed on her back, and did not notice anything different or strange about the infant at that time. The investigator spoke with the emergency room physician who was present when the infant arrived at the hospital, who stated there were no obvious signs of trauma or physical abuse. In December 2019, the investigation against the foster parent was unfounded.

Prior History: The infant's mother was involved with the Department as a parent and a child. In August 2018, the mother was indicated for substantial risk of physical injury/environment injurious to health and welfare; cuts, bruises, welts, abrasions, and oral injuries; and environmental neglect. The father was investigated for environmental neglect. The mother volunteered information that she beat her four-year-old child. The mother told law enforcement that she believed her four-year-old was raped and that he was gay, so she was beating the "body" out of him. The mother also stated that she had been diagnosed with bipolar disorder but had grown out of it. The home was described as being in "deplorable conditions," lacked furniture, had broken glass, and had dangerous items, such as knives and hammers, lying around accessible to children. Law enforcement took both children to the hospital for an evaluation. The mother was also taken to the hospital for a mental health evaluation. The Department took protective custody of the children who were eventually placed in a relative foster home. From September 2018 through November 2018, parent-child visits were irregular, the father was non-compliant with toxicology screenings, and the mother was not following up on mental health services. The children were receiving speech, physical, and occupational therapy. By February 2019, the mother was participating in services, taking her psychotropic medications, and had begun regular weekly parent-child visits. The mother was also engaging in parenting classes. In April 2019, the mother gave birth. Due to her history with the Department, she was investigated following the birth and was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect to her newborn. Temporary custody of the newborn was granted to the Department due to the mother's history of non-compliance, lack of housing, and her ongoing relationship with the father. The infant was placed with her siblings until her death.

Child No. 19	DOB: 04/2019	DOD: 08/2019	Undetermined
Age at death:	3 months		
Cause of death:	Undetermined		
Reason for review:	Child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old infant was found unresponsive by her siblings, the oldest of whom was 10 years old. It is reported that the infant was found mid-morning, prone, on an adult mattress. An older cousin called 911 and the infant was transported via ambulance to the local hospital, where she was

intubated, then transferred to a children's hospital, where she was pronounced deceased the following day. The siblings reported the infant was placed supine earlier that morning after being fed. The mother left the infant and five other children, ranging from ages three to 10 years, in the care of a 15-year-old cousin while the parents went to work. The Department investigated and indicated the mother for death by neglect and substantial risk of harm by neglect to the other children. This was the mother's second child to die in apparent unsafe sleep situations. Following the death, the surviving siblings were brought into care.

Prior History: In June 2016, it was reported that a three-year-old was wandering the streets unattended. The mother reported that she was at the park with her children when the three-year-old wanted to leave. The mother dropped him off at her cousin's home and returned to the park. The cousin fell asleep and the child left the home. Her cousin denied that the mother told her the three-year-old was in the home. The police cited the mother with child endangerment. During the pending investigation, the police contact reported a domestic incident between the mother and her paramour. The mother reported that the children were asleep upstairs during the incident. The investigation was indicated for inadequate supervision against the mother, who agreed to intact family services. Recommended intact services included parenting classes, domestic violence assessment and treatment, and ensuring her children were always supervised. The mother was minimally engaged in services and repeatedly denied the need for domestic violence services. In May 2017, the mother gave birth to a healthy infant. The worker visited the home once the mother and infant were released from the hospital and discussed safe sleep practices with the mother documenting the home had a pack-and-play for the infant. The day following the visit, the worker was notified by a hospital social worker that the infant had been found unresponsive and was taken to the hospital. A child protection investigation was opened for substantial risk. The mother stated that it had been hot, so she and the children were sleeping downstairs. She put the infant on the couch between two of the children. The following morning, the maternal uncle came by and found the infant under another child. The infant was placed on a ventilator and on life support. The infant's five siblings were placed with relatives or with their fathers. In July 2017, the infant was removed from life support and died. The investigation was unfounded and the children were returned to the mother's care. The worker continued to visit and assist the family following the death of the infant. While the case was open, the worker assisted in getting the children enrolled in school and Head Start and getting counseling, beds, and housing. In May 2018, the case was closed. In April 2019, following the mother giving birth, a social worker contacted the Department to report that the mother did not have a crib and the hospital would not discharge the newborn until the mother obtained one. The Department took the call as a child welfare services referral. That same evening, a worker took a pack-and-play to the hospital. The worker also observed a new car seat in the mother's room. In May 2019, the worker visited the mother at home and observed five of her six children. The worker observed the home to be clean and there were no signs of abuse or neglect to the children. The mother reported that she was unemployed and receiving government aid. The worker offered the mother intact services for assistance, but she declined.

Child No. 20	**DOB: 06/2019**	**DOD: 08/2019**	**Undetermined**
Age at death:	7 weeks		
Cause of death:	Undetermined		
Reason for review:	Open intact services case at time of child's death		
Action taken:	Full investigation pending		

Narrative: Seven-week-old twin was found cold and not breathing. A neighbor called 911 and the infant was pronounced deceased at the hospital. The infant's parents had difficulty recalling that evening's events and told inconsistent stories to law enforcement. Witnesses described the parents acting in a bizarre manner that night and believed they were under the influence of a controlled substance. The pathologist who completed the autopsy noted the infant had abrasions on his anus and bruising to his lower back and testicles. The infant and his twin had been born prematurely at 35 weeks and the infant

spent 12 days in the neonatal intensive care unit following the birth. The Department investigated the death and indicated both parents for death by neglect, substantial risk of physical injury/environment injurious to health and welfare by neglect, and inadequate supervision.

Prior History: The family first became involved with the Department about three weeks after the infant's birth, when the father took the infant and his twin brother to their pediatrician for a newborn wellness visit. Medical office staff reported concerns about the parents' parenting abilities, the father's seeming lack of attention to instructions and information during the visit, believing the infant was not receiving his prescribed formula, as the baby had lost four ounces since going home from the hospital. The father reported concerns about the infant's mother, and the clinic scheduled an appointment to screen for postpartum depression. The parents admitted having problems with getting transportation to appointments and doctor visits because the father lost his license a few years earlier. He wanted help regaining his license and the parents were open to receiving assistance from the Department. At a home visit, the investigator noted no immediate safety issues. The mother admitted to sometimes getting confused between the formulas for the two babies. The investigator made helpful suggestions which the mother followed. The investigation was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect and unfounded for inadequate food. An intact family services case was opened. The intact worker convinced the parents to agree to services and sign paperwork, but the infant passed away later that day. Following the death, the infant's twin brother and four-year-old sister were taken into custody and placed in a traditional foster home.

Child No. 21	**DOB: 02/2019**	**DOD: 11/2019**	**Undetermined**
Age at death:	8 months		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-month-old infant was found unresponsive by his mother after sleeping on an adult bed with his mother and three older siblings, ages two, three, and four years old. The infant was transported by ambulance to the hospital where he was pronounced deceased. The Department investigated the mother for death by neglect to the infant and substantial risk/environment injurious by neglect to the older siblings. The mother admitted to sleeping in bed with her children. She reported the infant was placed on his back on top of a queen-size mattress after feeding him. The mother awoke at 5:30am to check on the infant and found him unresponsive. The mother reported that she had a bassinet but had to throw it away due to a bedbug infestation. The mother was indicated for death by neglect and an intact family services case was opened.

Prior History: The mother was involved with the Department as a child. Her family had several cases opened for neglect between 1988 and 1998. In 2012, the mother was unfounded for substantial risk of physical injury/environment injurious by abuse to her two-month-old and four-year-old children. In October 2018, the school reported that there had been four Screening Assessment and Support Services (SASS) calls in six weeks involving the infant's then six-year-old brother and mother was not following up. The reporter said the child was having extremely aggressive behaviors in the classroom, including kicking, punching, and throwing items at other students. The Department opened an investigation for medical neglect to the six-year-old brother. An allegation of substantial risk of physical injury/environment injurious by abuse to the brother was added after it was reported that the infant's mother went to the school after being contacted about the six-year-old's behavior. She arrived very angry and hit the brother on top and side of his head, and on his back. The brother told the investigator that when he gets angry, he kicks over chairs. The brother stated he felt safe with his mother. The mother stated she received one phone call a couple of weeks earlier regarding her son's behavior and the SASS screening. She stated she followed up with a behavioral center and the brother had an appointment with a behavior therapist scheduled for the following day. The mother denied hitting her children. The

investigator observed all children with no signs of abuse and neglect. They all reported feeling safe living with their mother and grandmother. The investigator met with the six-year-old brother's special education teacher who stated the brother had an IEP and a behavioral plan, but she felt it was not working due to the mother not fully following through with the recommendations by SASS. The teacher said the brother needed more support than they were able to provide. A school counselor confirmed that the mother had scheduled an appointment for the brother with a behavioral specialist. The counselor had not observed the mother hitting the brother. In December 2018, the Department's investigation against the mother was unfounded. The mother followed through with the appointment at the behavioral center.

Child No. 22	**DOB: 09/22/2017**	**DOD: 11/22/2019**	**Undetermined**
Age at death:	2 years		
Cause of death:	Asphyxia due to sleep-disordered breathing as a consequence of Down syndrome		
Reason for review:	Closed intact services case within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Two-year-old was found unresponsive in her crib by her respiratory therapist. Her tracheostomy tube was pulled out, her pulse oximeter was not in place, and the heater for her ventilator was unplugged. The respiratory therapist attempted CPR. The toddler was transported by ambulance to the hospital where she was pronounced deceased following unsuccessful attempts to resuscitate. The toddler had been diagnosed with Down syndrome, vocal cord paralysis, a congenital heart defect, pulmonary hypertension, and hearing loss. She required a gastrostomy tube for feeding and a tracheostomy tube to breathe. The Department investigated the death and indicated the toddler's parents for death by neglect.

Prior History: The toddler's parents each had involvement with the Department as children. The toddler's mother was named a victim in indicated investigations of environmental neglect, sexual penetration, and sexual molestation. She was also a non-involved subject in an indicated investigation of inadequate supervision. The toddler's father was named a victim in indicated investigations of inadequate shelter and environmental neglect. In September 2018, the Department investigated the parents following a report that the toddler, then 11 months old, required a gastrostomy tube for feedings and was on a specific formula for weight gain, but was still losing weight; was being fed fewer times per day than she should; had missed all her appointments with occupational and developmental therapists; and was living in a home dirty with animal feces, urine, trash, and old food. The investigation was unfounded for inadequate food, environmental neglect, and medical neglect because the home was not unsanitary to the point of impairing the toddler's health, the toddler began gaining weight after her doctors changed her formula, and medical professionals believed the parents provided appropriate and immediate medical treatment when needed. A high-risk intact family services case was opened in the course of the investigation. Service providers involved with the family continued to have concerns about the family's lack of understanding of the seriousness of the toddler's condition, the toddler's cleanliness, and the condition of the home. The toddler was admitted to the hospital in November 2018 for difficulty breathing and again in December 2018. In order to be cared for at home, the parents needed to attend training for her care and home nursing care needed to be in place for 16 hours per day. The intact case was closed in May 2019, before the toddler was discharged from the hospital, because the caseworker was leaving the agency and the toddler's mother did not want a new caseworker assigned to the family.

Child No. 23	DOB: 09/2019	DOD: 12/2019	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Three-month-old was found unresponsive by his mother after they arrived at a friend's home following a three-hour car drive. The infant traveled with his mother, his twin, his older sibling, and his mother's friend. During the drive, the mother reported stopping to check on the children twice. When they arrived at their destination, the mother brought the sleeping twins inside the friend's house. The mother went to make a bottle and returned to find the infant unresponsive. A call was placed to 911. The infant had a history of failure to thrive. The Department investigated the death and indicated the mother for death by neglect and substantial risk to the infant's twin and three-year-old sibling.

Prior History: In September 2019, a week after the infant and his twin were born, the Department opened an investigation because the twins tested positive for opiates at birth. The mother stated she took pain medication that was not prescribed to her once, while she was experiencing pain, and did not consult her doctor. The mother tested negative for illegal substances at the twins' birth. The investigator recommended the Department indicate the mother for substance misuse. An intact family services case was in the process of being opened when the infant died. The investigation was unfounded due to appeal in January 2020.

Child No. 24	DOB: 07/2019	DOD: 12/2019	Undetermined
Age at death:	5 months		
Cause of death:	Undetermined		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive in her bassinet by her foster mother after she put her down for a nap. The foster father performed CPR and 911 was called. The infant was transported by ambulance to the hospital where she was pronounced deceased. The Department investigated the foster parents for death by neglect. The foster mother reported that she checked on the infant shortly after putting her down for a nap and found her unresponsive, face up in the bassinet. There were two blankets in the bassinet, but the infant's face was clear, and she was not swaddled in the bassinet. The foster parents reported the infant had labored breathing and made asthma-like wheezing sounds since she was four days old and that it was worse when they laid her on her back. The infant was diagnosed with nasal congestion in November 2019. The cause and manner of death was undetermined as the medical examiner opined that it was possible that the infant died a natural death, but because the infant was sleeping in a bassinet, with a blanket covering her, asphyxiation was also possible. The Department's investigation against the foster parents was unfounded.

Prior History: The infant's biological mother had an extensive history with the Department dating back to 1991. The mother was removed from her biological family and was adopted in 2000. In March 2004, at the age of 14, the mother gave birth to her first child after being sexually abused by her adoptive father. In 2006, her adoptive father was indicated for abuse after it was learned he was the biological father of the child. The mother went back into care until she aged out in February 2010. In 2007, her child came into care for neglect. Parental rights were terminated in December 2009 and the child was adopted in May 2009. In December 2015, the Department indicated the mother for cuts, welts, and bruises to one of her four-year-old twin girls, after it was reported the mother hit the child in the face with the back of her hand at the daycare center. An intact family case was opened and remained open until March 2016. In August 2018, the Department investigated the mother for inadequate supervision after it was reported the mother dropped off her four children, ages one year, four years, and seven-year-old twins at daycare and never returned to pick them up. The daycare provider allowed the children to spend the night. Police were

notified the following day and the children were taken to the police station. The mother was arrested and charged with child endangerment. Days after the mother's arrest, the Department was granted temporary custody and the children were placed together in the home of fictive kin. In June 2019, the foster parent dropped the children at the agency and stated that she could not care for the children anymore. The sibling group was placed in a traditional foster home. In July 2019, the Department investigated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to her infant, after it was reported the mother gave birth and the mother tested positive for marijuana. The mother reported using marijuana and cigarettes during her pregnancy with the infant. In addition, the mother had not completed services for reunification with the four older siblings. The Department was granted temporary custody of the infant a few days after the report was made and the infant was discharged and placed in the traditional foster home with the older siblings, where she resided until her death.

Child No. 25	**DOB: 08/2019**	**DOD: 12/2019**	**Undetermined**
Age at death:	4 months		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old, co-sleeping with his father in an adult bed, was found face down and unresponsive by his mother after she returned home from shopping. The infant was transported by ambulance to a local hospital where he was resuscitated and intubated. He was then transferred to a children's hospital, where he was diagnosed with a serious brain injury. Three days later, the mother and father withdrew care and the infant was pronounced brain dead. The father was indicated for death by neglect and both parents were indicated for substantial risk of physical injury/environment injurious by neglect to their older child, who was brought into care during the investigation.

Prior History: In January 2019, the Department opened an investigation for bone fractures by abuse against the father after the father brought the infant's then three-month-old brother to the emergency room with a non-displaced fracture of the mid-right humerus. The father reported that he was lying with the brother in bed when the brother tried to roll over and his arm got stuck in a blanket. He heard a snap and the brother started crying. The father said he was lying vertical in the bed and the brother was horizontal. The father demonstrated how they were lying in bed and the brother was lying between the father's elbow and shoulder. The father stated the brother had a crib, but he and the mother had been letting the brother sleep with them for the past two weeks. The father admitted he was tired from working a 12-hour shift and it was possible that he rolled over on the brother, causing the break. The investigator spoke to the emergency room physician, who stated he believed the injury was an accident. The brother was also seen by a child abuse team and a child abuse assessment was completed with no obvious indications of abuse or neglect. The investigator discussed safe sleep and the dangers of co-sleeping with both the mother and father. In March 2019, the Department's investigation against the father was unfounded.

Child No. 26	**DOB: 03/2017**	**DOD: 03/2020**	**Undetermined**
Age at death:	2 years		
Cause of death:	Undetermined		
Reason for review:	Youth in care		
Action taken:	Full investigation pending		

Narrative: Two-year-old youth in care was found unresponsive in bed by foster parent's paramour. The paramour reported that the child fell down the stairs earlier that day and was given a bath, fed, and put down for a nap afterward. The autopsy revealed many contusions and abrasions on the body and scarring

of the heart. Due to the severity of the injuries to the child and the lack of explanation for all the injuries, a child protection investigation and police investigation were initiated. Both the police investigation and the Department's investigation remain pending.

Prior History: The child's biological mother had a history of mental health issues, aggression, and was chronically homeless. From 2010 to 2014, the mother was investigated four times for substantial risk of physical injury of her two older children. The two older children were removed from her care; one in 2010, and one in 2014. Both children were adopted and their cases were closed. After the birth of the mother's third child, the mother was investigated and unfounded twice in 2018 for substantial risk of harm. The child's biological father was also investigated and unfounded in September 2018 for substantial risk of harm to the toddler. Following an indicated investigation for substantial risk of harm to the toddler in January 2019, an intact family services case was opened. The intact family services case was closed in June 2019, after the mother had successfully participated in individual counseling and completed anger management and parenting classes. In September 2019, five months prior to the death, the Department opened a child protection investigation alleging risk of harm by neglect against the toddler's mother. It was reported the mother started a fight with someone while the toddler was present. The mother was homeless at the time and the Department was unable to locate her for three months. Once located, the Department indicated the mother for risk of harm and took custody of the toddler. The toddler was placed in the home of a relative, where he remained for two months until his death. For the two months the placement case was opened, the biological mother was cooperative with visitation.

Child No. 27	**DOB: 04/2003**	**DOD: 04/2020**	**Undetermined**
Age at death:	17 years		
Cause of death:	Gunshot wound to head		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found in his bedroom, slumped over and bleeding from a gunshot wound. He had been home alone while his mother was at work. His mother called 911 and began chest compressions. A bullet hole was also found in the closet door and a gun was found in the room. The mother does not own a gun and the serial number of the gun had been scratched off. The teen's mother reported he did not have a history of depression or illness and had not had a recent change in demeanor. The Department did not investigate the death for abuse or neglect.

Prior History: In April 2017, the Department opened an investigation following a report about someone brandishing a gun. When police arrived, the teen's stepfather ran inside. Police were allowed inside and found the stepfather had a BB gun. Police found 25 marijuana plants in the home and arrested the stepfather. The parents were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. In October 2019, the Department opened an investigation following a report the teen's six-year-old sister disclosed there are guns in the home and children have access to them, her brother shot her with one of the guns but it did not hurt too much, and her brothers play with fire and lighters in their room. The investigator went to the home that day with police. The mother was reluctant to let them in but stated she had taken away the teen's BB guns and denied that she smoked when asked about the lighters. Additionally, the police determined that the two younger children, six and eight years old, were home alone for an hour and a half that day until the teen came home from school. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect because the mother disposed of the teen's BB guns. The investigations was also unfounded for inadequate supervision because the children were only home for approximately an hour and a half, were able to warm up their own food, and were able to contact help if they needed it during that time.

Child No. 28	DOB: unknown (05/2020)	DOD: unknown (05/2020)	Undetermined
Age at death:	7 – 10 days		
Cause of death:	Pending		
Reason for review:	Open placement case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn was discovered in a stroller, wrapped in a blanket, with no signs of life when police responded to a call of possible mental disturbance for the newborn's mother, who was observed walking with the stroller in a car lot attempting to get into cars. The newborn was pronounced deceased, but it is unknown exactly when he died. The Department is investigating the death; the investigation is pending as the autopsy report remains pending and the Department has been unable to locate the mother.

Prior History: The newborn's mother has an extensive history with the Department. When she was a child, the mother was removed from her mother's care due to allegations of neglect and was raised by her maternal grandmother who obtained guardianship in 1993. The mother first came to the attention of the Department as a parent in 2011, when her then one-year-old daughter came into care after the mother was indicated for head injuries by neglect due to her failure to seek prompt care for her daughter, who required surgery for a detached retina. In 2012, the mother was unfounded for death by neglect after she contacted 911 and reported delivering twins at home. Paramedics found the babies clean and dressed, but blue, and their umbilical cords had been cut or ripped, not tied or clamped. The mother gave birth to four more children, in 2014, 2016, 2017, and 2018. Following each birth, she was investigated and indicated for substantial risk of physical injury/environment injurious to health and welfare to each infant due to her open DCFS case and concerns regarding her mental health. Each infant was taken into care and placed in a traditional foster home. The mother's parental rights have been terminated as to all five of her children with goals of adoption.

Child No. 29	DOB: 04/2020	DOD: 06/2020	Undetermined
Age at death:	7 weeks		
Cause of death:	Undetermined		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old was found unresponsive by his mother after co-sleeping on an adult bed with his twin and two older siblings while in the home of a relative. A call was placed to 911 and the infant was transported by ambulance to the hospital, where he was pronounced deceased. The infant and his twin had been born prematurely. Both twins spent two weeks in the neonatal intensive care unit following their birth and were discharged without complications. The Department investigated the mother for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect to the siblings; the investigation remains pending. The infant's siblings were taken into custody due to ongoing domestic violence between the infant's parents including an altercation the night of his death.

Prior History: The infant's mother was involved with the Department as victim of sexual abuse at the age of four years and in an unfounded investigation of her mother when she was 16. The infant's mother first became involved with the Department as a parent in 2016 when she was unfounded for environmental neglect and substance misuse. In January 2018, the Department opened an investigation following a report that the mother was being beaten by the infant's father in front of her children, the children were afraid of going home, and they were being left unsupervised. The mother and father admitted to domestic violence issues and police had documented reports of ongoing physical altercations between the parents. The Department indicated the report for substantial risk of physical injury/environment injurious to health and welfare by neglect, and inadequate supervision with a referral for community services. The mother agreed the father would leave the home until services were in place. In December 2018, the Department opened an investigation following a report the infant's sister, then 10 years old, had several marks and bruises on her body from being beaten by her mother. The mother

admitted to physically disciplining her daughter for bad grades, being disruptive in class, and bringing knives to school. The investigation was indicated for cuts, bruises, welts, abrasions and oral injuries by abuse. The Department opened an intact family services case before closing the investigation. The infant's mother and father did not complete recommended services and in June 2019, the case was closed due to unsatisfactory progress. In September 2019, the Department received a report alleging the infant's then 11-year-old sister had a mark on her back from being whipped, the infant's father attacked the mother, the children were being left home alone for hours at a time, and the eight-year-old and eleven-year-old were not attending school. Both parents and the children denied the children were left home alone, and the children denied being hit. While the investigation was pending, the mother pressed charges against the father and moved out of the home with the children. The father was arrested and placed on an ankle monitor with an order prohibiting him from being near the mother or children. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect and unfounded the allegations of inadequate supervision and cuts, welts, bruises, abrasions, and oral injuries by abuse.

Child No. 30	**DOB: 03/2020**	**DOD: 06/2020**	**Undetermined**
Age at death:	12 weeks		
Cause of death:	Undetermined		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Full investigation pending		

Narrative: Twelve-week-old was found cold and unresponsive while co-sleeping. The infant's father brought him to the mother, who nursed him in an adult bed she was sharing with the infant's three-year-old brother. The mother fell back asleep. The father told the mother she was too close to the infant, and she moved away. The next morning, the three-year-old told the mother the infant was cold. The mother covered the infant with a blanket. When she checked on the infant later, he was unresponsive. A call was placed to 911 and first responders pronounced him deceased at the scene. An autopsy could not determine whether the death was caused from suffocation due to co-sleeping or natural causes. The Department indicated the parents for death by neglect, and unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the surviving sibling.

Prior History: The infant's mother was an alleged child victim in two investigations, one of which was indicated for cuts, welts, bruises, abrasions, and oral injuries. Before the infant's death, his mother had been indicated for three reports as a parent. In September 2017, she was arrested for two hit-and-run accidents while driving intoxicated with her one-year-old in the car. She was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. An intact family services case was opened, and the mother was referred for substance abuse treatment and mental health counseling. In April 2018, the intact case was closed as the two-year-old was on track developmentally and the criminal court had ordered substance-abuse treatment as a condition of the mother's DUI probation. In June 2018, the Department opened an investigation following a report of domestic violence. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect by both parents. In October 2018, police were called to a public place, where the mother had taken the two-year-old while the father was at work. The mother was intoxicated, crying, and screaming she had been raped. She was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect and inadequate supervision because the infant's two-year-old brother was too young to protect himself. An intact family services case was opened. While the case was open, the mother was discharged from substance-abuse and mental health treatment for non-attendance and failure to report abuse of over-the-counter and prescription medications. The mother became pregnant, failed to make psychiatric appointments, stopped taking medications for severe anxiety and depression, and had withdrawal effects and anxiety attacks. In March 2020, the Department opened an investigation after the infant tested positive for marijuana and benzodiazepines at birth. The mother's medical providers had

cautioned her not to use either substance while pregnant, and she did not have a current prescription for the benzodiazepines. The infant's father stated he was unaware she was using benzodiazepines. The mother was indicated for substance misuse. The Department was granted temporary custody of the infant and his three-year-old brother. Nine days later, a different judge found no abuse or neglect and returned both children to the parents' custody with an order requiring both parents to participate in substance-abuse services and the mother to see a psychiatrist and attend mental health counseling. The case remained open at the time of the infant's death.

Child No. 31	**DOB: 03/2020**	**DOD: 06/2020**	**Undetermined**
Age at death:	3 months		
Cause of death:	Undetermined		
Reason for review:	Child of a former youth in care		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive while lying on a couch in his paternal great-grandparents' home. A call was placed to 911 and CPR was administered. He was transported to the hospital, where he was pronounced deceased. The father reported he made the infant a bottle of formula around 6:00am, fed him, swaddled him, and placed him on the couch on his side with the bottle propped next to him on a pillow. The father admitted he had been drinking and the mother tested positive for illegal substances. The infant had been born at 35 weeks gestation and tested positive for THC. The Department investigated the death and indicated the parents for death by neglect and inadequate supervision.

Prior History: The infant's mother was involved with the Department as a child. There were five unfounded investigations against her adoptive mother between 2010 and 2015 where she was named as a victim. In 2015, the mother came into care, and her case remained open until one week before the infant's birth, when she reached the age of majority. While a youth in care, the mother did not cooperate with services, including substance abuse services, was often on run, and had criminal involvement. In September 2019, the Department opened an investigation after a report that the infant's mother was abusing prescription drugs, was on run from her self-selected placement with her then 15-month-old daughter, who was not being given her necessary daily medication. The mother returned her daughter to her foster placement and arrangements were made for the foster parent to obtain guardianship of the minor. The mother was indicated for substantial risk of physical harm/environment injurious to health and welfare by neglect and medical neglect. Her placement case remained open. Prior to aging out, the mother was offered but was not compliant with services to prepare her for independence.

ACCIDENT

Child No. 32	DOB: 04/2013	DOD: 07/2019	Accident
Age at death:	6 years		
Cause of death:	Complications of drowning		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Six-year-old youth in care was found face down in a pool by her 13-year-old foster sister. Adults ran outside when they heard the foster sister screaming and 911 was contacted. The child was transported to the hospital where she sustained swelling on her brain from lack of oxygen and was placed on a ventilator. Twelve days later, she was pronounced deceased. The adults reported the children never went swimming without an adult present, and the surviving foster children confirmed that they were not supposed to go into the pool unless there was an adult outside with them. The Department unfounded the foster mother for death by neglect and inadequate supervision to the child, and substantial risk of physical injury/environment injurious to the surviving foster children.

Prior History: In August 2018, the family came to the attention of the Department after the child's mother gave birth and both the mother and infant tested positive for cocaine. At that time, the mother reported that the child's maternal grandmother and grandfather had legal guardianship of the child, then five years old, due to her giving birth when she was 16 years old. It was later discovered that the maternal grandparents did not have legal custody of the child. The newborn and five-year-old sibling were placed in a safety plan with a relative and the mother was initially offered intact services. In December 2018, the Department took protective custody of the children and placed them in a traditional foster home after the mother failed to cooperate with services and it was learned that the relative with whom the children were placed had missed several doctor's appointments for the child's infant sibling.

Child No. 33	DOB: 05/2019	DOD: 08/2019	Accident
Age at death:	3 months		
Cause of death:	Asphyxiation due to co-sleeping		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation; Report to Director February 25, 2020		
	See Death and Serious Injury Case 6		

Narrative: Three-month-old was found not breathing after co-sleeping with her mother. The infant's mother called 911, CPR was performed, and the infant was taken to the hospital, where she was pronounced deceased. The parents were unfounded for death by neglect.

Prior History: Between 2010 and the infant's death, the Department unfounded seven investigations involving the infant's parents for allegations including substantial risk of physical injury/environment injurious to health and welfare by neglect and abuse; medical neglect; cuts, welts, bruises, abrasions, and oral injuries; and substance misuse. An intact family services case was opened for the mother from May 2010 to May 2011. In June 2019, the Department opened an investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant as well as to her paternal sibling and two maternal siblings after it was reported that the parents had several domestic violence incidents with the children present, including a recent incident that resulted in both parents being arrested. Police noted the infant and two siblings, who did not reside in the home, were present at the time of the incident. This investigation was pending at the time of the infant's death. While the investigator made good-faith attempts to see the family, she did not locate and assess the infant's safety, obtain police reports, or interview the mother or the two verbal children present during the incident until almost two months after the incident was reported. At her initial contact, mother reported she and the infant were

residing with a relative but refused to allow the investigator into the home to complete a home safety checklist. Mother admitted to the June incident but denied she attacked or punched the father and denied her children were present during the incident. She refused intact family services. The infant was assessed as safe by the investigator. Five days later, the mother told the investigator she would do anything to keep her family together and agreed to participate in intact family services. The verbal children reported witnessing domestic violence between their mother and the infant's father in June. The investigation was indicated in September 2019, following the infant's death.

Child No. 34	**DOB: 01/2019**	**DOD: 09/2019**	**Accident**
Age at death:	7 months		
Cause of death:	Asphyxia due to being wedged underneath a sofa cushion while co-sleeping		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old was pronounced deceased at the hospital. The infant's stepfather initially reported the infant and the infant's two older siblings, ages four and fifteen years, were already asleep in the stepfather's bed, so he slept with them. The stepfather awoke later that night and noticed the infant was not with him, so he went to look for the infant and found the infant's 12-year-old brother asleep on the couch with a cushion slumped over him. When the stepfather lifted the cushion, he found the infant's head directly underneath. The stepfather could not recall if the brother was lying on top of the infant. The stepfather grabbed the infant's legs to get him out and noticed he was not breathing and felt limp, so he started CPR and called 911. The stepfather later told police that he did not go to bed that night. When he went to his bedroom, he did not see the infant in his usual sleeping spot and found the infant on the couch with his brother. The Department investigated the death and indicated the stepfather for substantial risk of physical injury/environment injurious to health and welfare by neglect. The Department unfounded the investigation for death by neglect, inadequate supervision, and environmental neglect.

Prior History: The infant's family had a long history with the Department. The infant's mother was involved with the Department as a teen, when her adult brother was indicated for cuts, bruises, welts, abrasions, and oral injuries by abuse to her sister. Between 2006 and the time of the infant's death, the family had been investigated 15 times. Seven of the investigations had indicated findings, including substantial risk of physical injury/environment injurious to health and welfare by abuse; sexual abuse allegations; cuts, bruises, welts, abrasions, and oral injuries by abuse; substance misuse by neglect; and inadequate supervision. The family had a case open from May 2010 to June 2011 due to domestic violence issues between the infant's mother and her paramour. The mother ended the relationship. An investigation before the infant's death was opened because the infant tested positive for cocaine and marijuana at birth. The mother reported she was willing to work with the Department because she did not want her children removed from her care. She denied using cocaine and said someone must have put something in her marijuana, which she admitted to using during pregnancy. Following toxicology screenings showing the mother tested positive for marijuana and the stepfather tested positive for marijuana, ecstasy, and amphetamine, a safety plan was enacted that required the parents to be supervised around their children. The stepfather stated he only used marijuana, and someone had spiked his alcoholic beverage with ecstasy. In May 2019, the mother was indicated for substance misuse by neglect and an intact family services case was opened. The caseworker noted that the home was small for the number of children and lacked beds, so beds and a pack-and-play for the infant were secured for the family, and the mother reported she had a bassinet for the infant. In August 2019, the mother was arrested due to outstanding traffic tickets and was being held. The children were left in the care of their father, who was the infant's stepfather. When the caseworker went to check on the family the day after the arrest, the children reported they often co-slept with their parents. The worker discussed safe sleep practices with the infant's stepfather and the need to use the pack-and-play. The infant died while his mother was incarcerated.

Child No. 35	DOB: 08/2016	DOD: 09/2019	Accident
Age at death:	3 years		
Cause of death:	Drowning		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old child, who was autistic and non-verbal, was found in a lake by his mother's paramour. The mother reported that she had last seen the child alive at 9:30pm the previous night when she put him to bed. The mother further reported that the child usually woke up around 7:30am. When she awoke at 8:10am, she woke the child's two siblings, ages five and 14, for school and discovered the child was missing. The family members searched outside for the child as they noticed an unlatched gate in the backyard. They eventually discovered the child's body in the lake. EMS attempted to resuscitate the child for nearly an hour before he was pronounced deceased. The mother and her paramour told the investigator that they had been aware that the child had been getting out of the yard, so they put up a fence, but the child learned to open the latch on the gate. They were using a bungee cord to secure the gate to prevent the child from getting out. The 14-year-old sibling told the investigator she was outside the night before and she might not have re-secured the bungee cord. The 14-year-old further reported that the morning of the incident, she got up to work on homework at approximately 5:00am and laid back down at approximately 7:00am. She stated the child was asleep both times. Law enforcement did not find any evidence of the mother or the mother's paramour being under the influence of any drugs the morning of the child's death. The Department investigated and indicated the mother for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect to the two siblings.

Prior History: The child's parents were involved in a total of nine investigations with the Department from September 2011 through the end of 2017, all of which were unfounded. The mother and father had a history of domestic violence, and there were multiple allegations of the mother using illegal substances, including methamphetamines. The investigations included allegations of substantial risk, inadequate food, inadequate supervision, and lock-out. The child's parents were investigated by the Department six times in 2018; five of the investigations were unfounded and one was indicated against the father for substantial risk to the child. In February 2018, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the one-and-a-half-year-old and his siblings, ages three and thirteen, after it was reported that the three-year-old sibling disclosed domestic violence between the mother and father. The investigator spoke with the parents, who denied a domestic violence incident but also stated that there had been a prior incident for which there were pending domestic battery charges with the State's Attorney and a current no- contact order between the mother and father. The father had moved out of the home a few months prior due to a court order. The older children also denied a recent domestic violence incident between the parents. The Department's investigation against the mother and father was unfounded. In June 2018, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the two-year-old toddler and his siblings, ages four and thirteen years, following a reported domestic violence incident involving the police. The mother relayed that the father was high and had kicked in the door, hit her, and grabbed her by the neck. The mother had marks on her neck. The children were present and witnessed the violence. The investigation was indicated against father for substantial risk, and the mother was unfounded. In August 2018, the Department investigated the mother for substance misuse to the 13-year-old sibling after it was reported that a social media post showed a picture of the 13-year-old smoking marijuana in the car with her four-year-old sibling in the back seat. The post stated that the mother had supplied the 13-year-old with the cannabis and was driving the vehicle. The 13-year-old denied the cigar contained marijuana and denied that her mother supplied her with marijuana. The mother stated she had no idea the 13-year-old had smoked a cigar and denied providing her with drugs. The mother completed a toxicology screening that was negative for all substances. The investigation against the mother was unfounded. In September 2018, the Department

investigated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the then two-year-old and his siblings, ages four and thirteen years old, after it was reported that the mother had run one of her 13-year-old's friends over with her vehicle in anger and left the scene. The injured unknown victim broke the windshield. The investigator spoke with the mother who reported that when she went to pick up the 13-year-old, there were children hanging on her van. The mother stated that she got ready to leave, one child did not move out of the way, and the child jumped up instead of moving over when she backed up, so she hit him with the van and busted her back windshield. The mother was not arrested, and the child was not hurt and did not seek hospital treatment. The mother completed a toxicology screening, which was negative for all substances, the day the report was made. The siblings were not in the vehicle at the time of the incident. The mother's story matched the stories of the victim and other witnesses. The investigation against the mother was unfounded. Also in September 2018, the Department investigated the mother for cuts, bruises, welts, abrasions and oral injuries to the four-year-old sibling after it was reported by the father that the four-year-old had bruises on her bottom which the mother said were from her spanking her with a belt. The mother denied spanking the children with a belt. The 13-year-old in the home denied the allegations and the investigator did not see any marks on the four-year-old. The investigation against the mother was unfounded. In November 2018, the Department investigated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the 13-year-old, after it was reported that the mother gave the 13-year-old a cigarette to smoke while the mother and teen were in the anonymous reporter's driveway. The mother and 13-year-old denied that the mother provided the minor with cigarettes. The 13-year-old did admit to smoking cigarettes but denied that the mother supplied them. The investigation against the mother was unfounded.

Child No. 36	**DOB: 08/2018**	**DOD: 09/2019**	**Accident**
Age at death:	12 months		
Cause of death:	Asphyxia due to co-sleeping with overlay		
Reason for review:	Indicated child protection investigation within one year of the child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-month-old, sleeping on a couch with her mother, was found unresponsive by her maternal uncle. The uncle observed the mother awake with the baby at approximately 11:00pm. When he awoke at 2:00am, he discovered the mother asleep on the baby, with her knee over the baby's body in the head and neck area. The uncle contacted 911. The baby was transported to the hospital where she was pronounced deceased. Three days earlier, the uncle brought the baby to his home after he observed the parents smoking methamphetamine in their home. The next day, the mother showed up and wanted to take the baby home with her. The uncle refused but allowed the mother to stay in his home with the baby. The Department indicated the mother for death by neglect. The mother was found to have illegal substances in her system the day that the baby was found deceased.

Prior History: The mother was involved with the Department as a child, as a case involving her family was open for neglect from September 2007 to April 2008. There were three child protection investigations involving the family, one unfounded and two indicated, within a year of the child's death. In December 2018, law enforcement responded to a call for domestic battery with a child present that resulted in the father's arrest. The Department unfounded the father for an allegation of substantial risk of physical injury/environment injurious by neglect to his three-month-old. The mother reported it was a misunderstanding. She stated the altercation took place outside of the car while the baby was strapped in her car seat inside the car. The mother denied that she or the baby was hurt. She said the father accidentally cut her finger while attempting to grab her keys out of her hand. She said the neighbors called law enforcement. The mother denied the need for services and said she had extended family support. The father and a maternal aunt, who was present for the incident, confirmed that the altercation occurred outside of the car, with the baby inside the car. In May 2019, law enforcement responded to the

home for another domestic dispute. Law enforcement reported that the father alleged that mother was using drugs and leaving the baby unattended for 15-20 minutes at a time while she went with men to use drugs. He also stated the mother assaulted him. No injuries were observed, and no arrests were made. The Department investigated the mother and the father for substantial risk of physical injury/environment injurious and investigated the mother for inadequate supervision. The mother denied using drugs. The father told the investigator that he was angry and had made false allegations to the police. He said the mother never left the baby alone and he never observed the mother using drugs. The investigator requested toxicology screenings from both parents, but after obtaining an attorney, the parents refused to comply. While this investigation was pending, the father was arrested for domestic battery. The Department opened a third investigation for substantial risk of physical injury/environment injurious to the baby by both parents. The mother obtained an order of protection against the father. She completed a toxicology screening that came back positive for cannabis and benzodiazepines. Intact services were offered but declined. In September 2019, the parents were indicated in both investigations for substantial risk of physical injury/environment injurious. The case was referred to juvenile court for supervision and the first court date was scheduled for the month after the child died.

Child No. 37	**DOB: 10/2016**	**DOD: 09/2019**	**Accident**
Age at death:	2 years		
Cause of death:	Asphyxia due to hanging		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Two-year-old, medically-complex toddler, who had cerebral palsy, hydrocephalus, developmental delays and required tube feedings, slipped down in his specialized chair, leaving him suspended by a strap pressing against his neck. The chair's strap, which connects to an abductor wedge and went around the abdomen to keep the toddler secured, was broken. The toddler was suspended for 40 minutes before the foster mother discovered him. The foster parents called 911 and the toddler was transported to the hospital, where he was pronounced deceased. The Department investigated the foster parents for inadequate supervision and death by neglect and investigated the foster grandmother for death by neglect and substantial risk of harm to the surviving twin. The twins were placed with the foster family in August 2017. At the time of the incident, the toddler and his twin were being cared for by the foster grandmother, while the foster parents attended a funeral, but the foster grandmother was not listed as a trained caregiver for the children. In March 2020, the foster parents and the foster grandmother were indicated for inadequate supervision, substantial risk of harm and death by neglect.

Prior History: In February 2017, the Department investigated the toddler's 17-year-old parents for substantial risk of physical injury/environment injurious to health and welfare by neglect to their four children, ages four months to four years old, after a social worker from the hospital reported concern for the twins, who were born prematurely and had been in the neonatal intensive care unit since birth. The mother had only visited the babies three times since they were born four months earlier in October 2016. The social worker stated the staff was having trouble locating the mother when they needed to do procedures and were only able to find her when they called her high school. Staff had concerns about the mother's ability to care for the babies and questioned if the mother had stable housing for the children. The social worker added that the father was minimally involved. The teen mother told the investigator that she had not visited because she did not have transportation from her current residence and had trouble finding childcare for her other two children. In March 2017, the toddler's mother reported the maternal grandmother told her to leave, and she and the children were living with the toddler's father and his family. The parents were indicated for substantial risk to their children and an intact case was opened. The parents began to visit the twins at the hospital on occasional weekends and agreed to participate in training on caring for the children. The intact worker assisted the parents in attending the hospital more consistently. Nurses told the worker that they had concerns that the parents seemed to have problems in

applying the training and noticing signs of distress in the babies. The nurse also expressed concern about the parents smelling of marijuana and explained the smoke would be a problem as the twins were on oxygen. In June 2017, the Department was granted temporary custody. The two older children were placed with the paternal grandmother, whose home was not appropriate for the medically complex twins, and the twins were placed in a residential medical care facility. In August 2017, the Department found a specialized foster home for the twins, where they remained until the toddler's death. In February 2018, the mother gave birth to her fifth child. The hospital informed the Department, and the Department took protective custody and placed the baby with the paternal great-grandmother. The parents were indicated for substantial risk of harm as the mother had only completed parenting education, but not a drug assessment or counseling. The father had not completed any services.

Child No. 38	**DOB: 02/2018**	**DOD: 10/2019**	**Accident**
Age at death:	19 months		
Cause of death:	Asphyxia due to food bolus airway obstruction		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: One-year-old was found unresponsive by her mother after she had been fed macaroni and cheese and rice for dinner. After feeding the toddler, the mother laid her down on the couch with a blanket for a nap. Approximately 45 minutes later, the mother checked on the toddler. The mother picked up the toddler, who vomited a small amount and was unresponsive. The mother called 911 and started CPR. EMS arrived and transported the toddler to the hospital. Upon arrival, the hospital suctioned food out of her throat, but she remained unresponsive and was pronounced deceased. The Department did not investigate the death for abuse or neglect.

Prior History: The mother was first investigated by the Department as a parent three times in 2006. Two investigations were unfounded, and one was indicated for failure to thrive to the toddler's then one-year-old sibling. An intact family services case was open from August 2006 to July 2008, when it closed successfully. In 2011, the Department unfounded the mother for cuts, bruises, and welts to her five-year-old. In 2012, the Department indicated the mother for inadequate supervision and inadequate food to her four children. In 2013, the Department indicated the mother twice for inadequate supervision to the children. An intact family services case was open from August 2013 to April 2014. The mother completed parenting classes and the children were enrolled in daycare and afterschool to ensure they would not be left home alone. The family had no other involvement with the Department until 2019. In May 2019, the Department investigated the mother for inadequate supervision after it was reported that several children were home alone without supervision. The investigator went to the home the day the report was made. The father had just arrived home and admitted that the children were home alone for approximately 45 minutes. He stated the toddler's 14-year-old sibling was left in charge of watching the other children, ages three, four, 10, 11, and 13 years old. The father told the investigator that his wife had to take the toddler to the doctor. The investigator met with the 14-year-old who reported that he watched his siblings while his parents were gone. He further stated that he knew to call 911 if an emergency occurred while his parents were gone. The mother reported that she was at the doctor with the toddler. She reported that the father was home when she left. She told the investigator that they only let the 14-year-old watch the other children for very short periods of time. The investigation against the mother was unfounded, as the children were left for a short period of time with the 14-year-old sibling in charge, who knew what to do in an emergency.

Child No. 39	DOB: 08/2016	DOD: 10/2019	Accident
Age at death:	3 years		
Cause of death:	Complications of scalding burns due to running hot water		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old sustained third-degree burns to over 60% of his body when he was left unattended in a bathtub with water in it. The toddler's mother reported she left him in the bathtub while she went outside to help his father with groceries. The toddler's paternal great grandmother, who relies on a wheelchair, was in another room nearby. The mother reported she turned the water off when she left and was not gone for more than two minutes, but when she returned, she noticed the hot water had been turned on and the toddler had his body and face in the hot water. The toddler was transported to the hospital by ambulance and was stabilized. The Department took temporary custody of the toddler and his siblings. Three days after the incident, the toddler suffered cardiac arrest and was unstable for the remainder of his time in the hospital. He was pronounced deceased seven days after the incident. The Department indicated the parents for death by abuse, burns, and substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother was also indicated for inadequate supervision.

Prior History: Between 2004 and 2014, the toddler's mother was involved with the Department as a child due to several reports of neglect that resulted in five intact family services cases being opened. In 2011, the toddler's then 19-year-old father was indicated for sexually abusing his six-year-old cousin. The mother and father's first involvement with the Department as parents occurred in October 2016, following a report that their two-month-old infant was being neglected, living in a filthy home with peeling lead paint, pests and feces, and the parents were smoking marijuana in the home with the child present. The investigation was unfounded for environmental neglect, substantial risk of physical injury/environment injurious to health and welfare by neglect, and substantial risk of sexual abuse – sex offender has access. In January 2017, the Department opened an investigation following a report the police were called to the home twice. The first call was for domestic violence. The second call was because the mother left the toddler, then four months old, unsupervised in the apartment while she went upstairs to harass her neighbor. The mother was indicated for inadequate supervision, environmental neglect, and substantial risk of physical injury by abuse. The father was indicated for environmental neglect and substantial risk of physical injury. The Department opened an intact family services case, helped the parents locate stable housing, and referred the parents for anger management and counseling services, which they completed. In November 2017, the Department opened another investigation following reports the family was living in unsuitable housing, had frequent police involvement for domestic violence, and were using their child to beg for money. The Department was unable to locate the family and eventually received confirmation they moved out of state and became involved with child welfare in the other state when the father was arrested for domestic violence. The investigation was indicated for substantial risk of physical injury/environment injurious to health and welfare due to ongoing domestic violence and unfounded for inadequate shelter. The family later returned to Illinois and the mother gave birth to a second child in May 2018. In June 2018, the Department opened an investigation following reports of continuing domestic violence, sex offender has access, and a report the father attempted to leave his two children at a fire station. In August 2018, while the investigation was pending, the family again moved out of state. The parents were arrested within days of the move for attempted assault on a public bus and both children were placed in foster care. The Department indicated the parents for substantial risk of sexual abuse – sex offender has access because the mother's brother was a registered sex offender and was living with the family while in Illinois. The children were returned to the parents after they participated in parenting and anger management services. The family returned to Illinois shortly after the children were returned to their care, approximately two months before the toddler's death.

Child No. 40	DOB: 07/2019	DOD: 10/2019	Accident
Age at death:	3 months		
Cause of death:	Bedding asphyxia associated with co-sleeping with an adult		
Reason for review:	Child of youth in care		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive by his 21-year-old mother. The mother called 911. The county sheriff arrived at the home and the baby was pronounced deceased at the scene. The Department investigated the mother for death by neglect. The mother admitted to co-sleeping with the baby. She had been provided a crib for the baby and the topic of co-sleeping was discussed. The baby's pediatrician informed the child protection investigator that when the mother was asked where the baby slept, she replied that the baby slept in a crib. In February 2020, the Department's investigation against the mother was indicated for death by neglect.

Prior History: From January 1999 through February 2013, the mother was involved as the child subject in six indicated Department investigations against the maternal grandmother. The baby's mother was a youth in care from 1999 until she was returned home in 2001. Following additional indicated reports, the mother became a youth in care again in 2012. The mother was placed with fictive kin until she moved into an independent living option in 2016. The mother was involved with the youth in college program, and the teen parenting network. In October 2019, six days before the death of the baby, a court hearing was scheduled to close the mother's case, as the 21-year-old mother was doing everything expected of her. She was not present for the hearing, so her attorney moved to close the case in November 2019.

Child No. 41	DOB: 08/2016	DOD: 10/2019	Accident
Age at death:	3 years		
Cause of death:	Asphyxia due to drowning		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was being given a bath, alongside his father's paramour's two-year-old son, by the paramour. The paramour left the boys in the bathtub while she left the bathroom to allow someone else to use it. When she returned, she saw the toddler submerged under water. Her sister called 911. Emergency medical professionals took over performing CPR upon their arrival and the toddler was transported to the hospital, where he was pronounced deceased. The Department conducted an investigation of the paramour for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect. The investigation is pending.

Prior History: The toddler's mother had been the subject of three unfounded investigations between 2005 and 2008. She was indicated for environmental neglect in 2011. The toddler's father was the subject of one investigation that was unfounded on appeal in 2013. In 2015, the father's paramour was the subject of an unfounded investigation. In 2016, the father's paramour was indicated for medical neglect and inadequate supervision. In November 2018, the Department opened an investigation into the father and father's paramour following a report that the toddler's younger sister, then six months old, had not been taken to the doctor since she was born, had a very bad diaper rash. Additionally, the father's paramour had been seen with bruises and admitted the father had hit her; the father admitted using illicit substances. The parents had been treating the child's diaper rash with over-the-counter medication and took the child to the doctor, who stated it was not medical neglect because they were treating the rash. The Department unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect and medical neglect.

Child No. 42	DOB: 05/2011	DOD: 11/2019	Accident
Age at death:	8 years		
Cause of death:	Suffocation due to a prone facedown position on a plastic pillow used to support her body due to cerebral palsy		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old medically complex child was found unresponsive by her mother. The mother reported that she placed the child in her bed on her back, with a gel pillow beneath her ribs. When the mother went to check on her, she found that the child was unresponsive and had rolled onto her stomach, with the pillow under her mouth and nose. The mother performed CPR, while the maternal grandmother called 911. When paramedics arrived on the scene, they were unable to revive the child. The child was pronounced deceased in her home. The child had a medical history of cerebral palsy, seizure disorder, intellectual disabilities, and limited mobility. The child was also non-verbal and required a gastrostomy tube for feeding. The Department unfounded the mother for death by neglect as the forensic pathologist found no pressure sores and no other evidence of neglect.

Prior History: In October 2016, the Department unfounded the mother and father for medical neglect to the then five-year-old child. In January 2019, the Department investigated the mother for medical neglect and failure to thrive to the then seven-year-old child after she was admitted to the hospital and there were concerns that the mother may not be providing the child with needed medical treatment. The child was found to have an acute pressure ulcer on the back of her left thigh. The mother reported that the child acquired the pressure ulcer two days prior, but the physician opined that the severity of the ulcer did not match with the mother's story. The mother also reported that the child was sick for three weeks with vomiting. The physician indicated that since admission to the hospital, the child had been gaining weight. The doctor diagnosed the child with failure to thrive. The physician indicated that if the child was receiving the proper feeding, she should not lose weight. The child's teacher had no concerns, but the school nurse voiced concerns that in about the last three weeks, she thought the child was not being fed appropriately. In January 2019, an intact family services case was opened. The worker assisted the mother in setting up in-home physical and occupational therapy and assuring the mother kept the child's medical appointments. In February 2019, the investigation for medical neglect was unfounded and failure to thrive was indicated; in June 2019, the indicated finding was unfounded on appeal. In July 2019, the intact family service case was closed as successful.

Child No. 43	DOB: 09/2019	DOD: 11/2019	Accident
Age at death:	6 weeks		
Cause of death:	Asphyxia due to prone sleeping position on soft bedding		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was found unresponsive by her 20-year-old mother. The infant's mother admitted to co-sleeping with the infant and her five-year-old son. The Department indicated the mother for death by neglect. The investigation revealed the mother had been counseled on safe sleep practices at a well-child doctor visit two weeks before the infant's death.

Prior History: The infant's mother has a history with the Department dating back to 2014, including four indicated findings for inadequate shelter, substantial risk of physical injury/environment injurious to health and welfare by abuse, and substantial risk of physical injury/environment injurious to health and welfare by neglect. Three investigations involved domestic incidents with family members during which the infant's then one-year-old brother was present. The Department opened an intact family services case in May 2015. The mother did not engage in services. The case was closed as successful in December 2015 when the maternal grandmother obtained guardianship of the brother. In September 2019, the Department opened an investigation for medical neglect to the infant's 22-month-old cousin after the

toddler tested positive for elevated blood lead levels and her mother had not taken her for a recommended follow-up test. At the time of the investigation, the infant lived in a household with her mother, brother, aunt, and two cousins. This investigation was pending at the time of the infant's death and was later indicated because the aunt never took the child for the follow-up blood test.

Child No. 44	**DOB: 11/2019**	**DOD: 11/2019**	**Accident**
Age at death:	10 days		
Cause of death:	Asphyxia due to unsafe sleep environment		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Ten-day-old infant was found unresponsive by her 33-year-old mother. The mother reported feeding the infant around 2:00am, then laying the infant prone on the mother's chest. The mother stated she and the infant were on the floor next to the mattress. The mother awoke at 11:00am and noticed the infant was blue. She stated that she did not remember much after that, but she did call 911. The mother stated to the investigator that she was lying on the floor, as she did not want to wake the infant's father, who was sleeping on the mattress. The Department indicated the mother for death by neglect.

Prior History: The mother had a history with the Department since 2014. In July 2014, the Department investigated the mother's then paramour, who lived with the mother and her three-year-old, after it was reported the paramour was intoxicated, wanted to have sexual relations with the mother, and tried to strangle the mother when she refused. The paramour was arrested. The Department's investigation against the paramour was unfounded. In February 2019, the Department investigated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's seven-year-old sibling, after the sibling's father reported that the mother abuses alcohol and was posting about suicide on social media. The sibling's father reported that the mother called him and said she didn't know where the sibling was. He stated she was seemingly intoxicated, was slurring her words, was angry, and was aggressive, and that this has happened more than once. During the investigation, the mother created a care plan for the sibling to reside with his father. The Department's investigation against the mother was unfounded as the mother recognized her need to get treatment and had the infant's sibling live with his father, who was awarded custody. The infant's father had two children from a prior relationship. There were two prior indicated investigations on the father and his then-paramour from 2011 and 2012. In April 2018, the father was in another relationship, and the Department investigated the father's then-paramour and the father to the then-paramour's child for environmental neglect and cuts, bruises, welts, abrasions and oral injuries after it was reported the father became angry with the child and punched him in the nose. The father's then-paramour reported the child fell off his bike and scraped his hand on a rock. The investigation was unfounded. In May 2019, the Department investigated the infant's father and his then-paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect and the father for mental injury by neglect to the infant's 10-year-old paternal half-sibling. Staff from a behavioral health hospital reported the sibling participated in their partial hospitalization program but was not making progress and the father refused medication for him. The sibling's school also made a related call reporting that the sibling got in a fight, was voicing suicidal ideation, and was banging his head. The investigator met with the sibling, who stated that he felt safe at home and had said those things because he wanted the attention. The father had arranged for the child to be in counseling weekly. The counselor did not have any concerns of child abuse or neglect. The Department's investigation was unfounded for insufficient evidence. After the investigation, the father separated from the paramour and began a relationship with infant's mother.

Child No. 45	DOB: 03/2017	DOD: 11/2019	Accident
Age at death:	2 years		
Cause of death:	Choking due to foreign obstruction (thumbtack)		
Reason for review:	Child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old toddler was found by her 25-year-old mother in her bed unresponsive, stiff, and cold to the touch with blue lips and blood around her nose. The mother called 911 and performed CPR until paramedics arrived on the scene. The coroner pronounced the toddler deceased. The Department initiated an investigation. The mother reported that she put the toddler and her one-year-old sibling to bed between 10:00pm and 11:00pm. The following morning, she found the toddler unresponsive. At autopsy, a push pin was found in the toddler's throat. The mother reported that she had used a thumbtack to hold a blanket to the wall to act as a curtain in the bedroom. After the death, the mother found that the thumbtack was missing. The investigator advised the mother not to use thumbtacks to hold up a curtain and to obtain a rod. The mother was offered intact family services but stated she was already getting assistance. The investigation against the mother for death by abuse was unfounded.

Prior History: In May 2019, a physician contacted the Hotline requesting child welfare services for the family. The mother had recently lost her job when her babysitter quit, and the physician believed the mother could benefit from assistance from the Department. The mother, toddler, and the toddler's one-year-old sister were residing in a shelter. The mother brought the toddler to the hospital for a vaginal irritation and suspicions that the toddler's father had touched her. The mother stated the father helps every other week and the toddler was last with him about two weeks earlier. The mother and grandmother were working on toilet training and thought the toddler's vaginal opening looked enlarged. The toddler underwent an exam, and the hospital reported the toddler was normal. The mother was offered services but declined. The child welfare services referral was closed later that month.

Child No. 46	DOB: 02/2019	DOD: 11/2019	Accident
Age at death:	9 months		
Cause of death:	Probable suffocation		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-month-old was found face down in an adult bed where he had been co-sleeping with his 12-year-old brother. The infant and his siblings were staying at their maternal aunt's home that evening. The infant's uncle called 911 and he performed CPR until emergency services arrived. The infant was pronounced deceased at the hospital. The infant was one of a set of triplets and had been born premature. The Department unfounded the investigation for death by neglect.

Prior History: Prior to the infant's birth, the infant's mother had one prior unfounded investigation in 2003 and one indicated investigation in 2012 for cuts, bruises, welts, abrasions, and oral injuries by abuse. The infant's maternal aunt was involved in one unfounded investigation as an alleged child victim, one unfounded investigation as an adult, and was indicated in 2005 for environmental neglect. In April 2019, the Department opened an investigation when his triplet brother was brought to the hospital after he had been found on the floor, unresponsive. The mother reported she had fallen asleep with the brother in her arms and woke to find him on the floor. She stated she would hold him after he ate because he had bad acid reflux, but she fell asleep that day. The mother called 911 and sought the help of a neighbor. The investigator observed bassinets for each child positioned around the mother's bed and discussed the dangers of co-sleeping with her. The father, who resided out of state but visited once every three weeks, reported no concerns about the mother, nor did the children's doctor. The mother received childcare help from her neighbor and her sister. The investigation was unfounded for cuts, bruises, welts, abrasions, and oral injuries by neglect because the mother took appropriate steps following the injury. The mother also agreed to community-based services.

Child No. 47	DOB: 10/2005	DOD: 12/2019	Accident
Age at death:	14 years		
Cause of death:	Blunt head and chest trauma due to motor vehicle accident		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was one of four girls riding in a utility task vehicle (UTV). The 14-year-old was riding in the front passenger seat of the UTV; one of the other 14-year-old girls was driving the UTV. Two of the girls' fathers were following the girls in another UTV and witnessed the accident. The girls were traveling on a levee when the UTV drove off the side of the levee, causing the UTV to roll and land on its passenger side. Upon being removed from underneath the UTV, the 14-year-old was unresponsive, and one of girls' father performed CPR. The two girls who had been riding in the backseat of the UTV were uninjured and called 911. The 14-year-old was taken to the hospital with serious chest and neck injuries. Medical staff attempted to revive her for over 90 minutes before she was pronounced deceased. The Department did not investigate this death, as no one was under the influence and the collision was ruled accidental.

Prior History: In February 2019, the Department investigated the mother's paramour, who was living in the home with the mother and the teen, for substantial risk of physical injury/environment injurious to health and welfare to his children, ages four and three years. The investigation followed a report the four-year-old let a ferret out of its cage at home, so the paramour screamed at his child and squeezed the ferret before throwing it across the room. The teen, her mother, and the paramour denied the incident occurred. The investigation against the mother's paramour was unfounded due to insufficient evidence to support the allegation.

Child No. 48	DOB: 04/2010	DOD: 12/2019	Accident
Age at death:	9 years		
Cause of death:	Complications of inhalation of products of combustion and inhalation injury		
Reason for review:	Open intact case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old child was transported to a local hospital at approximately 8:11am for burns and difficulty breathing due to a fire that took place at his home. The child was eventually transferred to a children's hospital where he was placed in the pediatric ICU with a significant brain injury and was connected to a ventilator. At the time of the fire, the nine-year-old was in the care of his 16-year-old brother while the mother was at work. The siblings shared a room in the basement, where a space heater caught fire while they were sleeping. The child's brother stated that he was awakened by feeling a burning sensation on his feet, then realized the space heater caught a blanket on fire. The brother stated that he attempted to put the fire out but was unsuccessful because the fire already spread to the mattress. The teen carried the child to the main floor of the residence but was unable to find the keys to open any of the doors. The mother locked the doors from the outside when she went to work because the child was on the autism spectrum and had a history of getting out of the home. The teen remembered that he left the keys in his bedroom in the basement and went back down to attempt to retrieve them but was unsuccessful due to the smoke. When the teen returned to the main floor, he was unable to locate the child and had to break a window to escape the home. Law enforcement personnel arrived on the scene but were unable to enter the home due to heavy smoke. Firefighters found the child in a bedroom closet. He was not breathing and unconscious. Two days later, the child was pronounced brain dead. The Department unfounded the mother for burns by neglect, head injuries by neglect, and death by neglect to the child, and inadequate supervision to the child and his 16-year-old brother.

Prior History: In May 2014 and August 2017, the Department investigated and unfounded the mother and father for inadequate supervision. In September 2019, the Department unfounded the mother for inadequate supervision to the child after it was reported that the child was found unattended,

approximately five blocks from home, at 4:10am. The child had autism and a history of leaving home. The mother had made several attempts to secure the doors and windows in the home but was unsuccessful. The investigator observed the front door had a board nailed across it so that it could not be opened, windows had strong metal screens and screws on the sides to restrict opening, and the back door had a chain lock and dead bolt that was unreachable by the child. The mother informed the investigator that police told her she needed to be sure they would be able to get out of the house in case of a fire. In October 2019, the Department unfounded the mother for inadequate supervision to the child after it was reported that at 6:10am, the nine-year-old was found unattended, running down the street without shoes or socks, approximately five blocks from his home. At that time, it was 46° F outside and raining. The mother was sleeping when the incident occurred and reported that the child's 15-year-old brother forgot to secure the chain on the back door, as the chain lock was out of the child's reach. The mother stated that she had tried alarms and locks that required passcodes, but the child figured out how to disengage the alarms and figured out passcodes for the locks. The mother reported that the school also had similar problems with the child walking out of his classrooms. The family was offered and accepted intact family services. In November 2019, the intact case was opened. It was believed the child needed to be engaged in activities outside of the home due to his high energy level. The caseworker completed the home safety checklist and observed working smoke detectors. The caseworker also reviewed the fire escape plan with the mother, who stated that the family would use the front or back door to leave the home. The mother removed the board across the front door of the home and installed a chain and padlock in its place. During this visit, the caseworker observed the nine-year-old attempting to break the chain before the mother could distract him.

Child No. 49	**DOB: 10/2019**	**DOD: 12/2019**	**Accident**
Age at death:	2 months		
Cause of death:	Asphyxia due to overlaying		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation pending		

Narrative: Two-month-old was found by her mother not breathing, with vomit on her cheek. The infant's mother called 911. EMS did not initiate CPR because rigor and lividity had already set in. The infant's mother fed her three to six hours prior to the 911 call, then she and the infant went back to sleep on an adult mattress with the father and sibling. Authorities reported the mother smelled strongly of alcohol and there were alcohol bottles around the home. The Department indicated the mother and father for death by neglect and for substantial risk to the infant's sibling.

Prior History: In April 2018, the infant's parents were investigated following a report of domestic violence in the home, resulting in the father leaving the home. The mother, who was reportedly too intoxicated to adequately care for a child, refused to let the father take the infant's then one-year-old brother. The mother was unfounded for inadequate supervision to the infant's brother. In November 2019, the police were called to the home after a report that the parents were drunk and arguing. A report to the Hotline was taken for a child welfare services referral to address the ongoing domestic violence and alcohol use by the parents. Four days before the infant's death, a child welfare services worker arrived at the home. The infant's father was asleep with the infant's three-year-old sister at that time. The worker observed multiple open and closed alcohol bottles and cans throughout the home and dirty dishes within reach of the sister. The worker reported the information and a child protection investigation for environmental neglect and substantial risk to the children was opened. The investigator observed a crib in the home, but the infant's parents openly admitted to co-sleeping and the investigator warned them against doing so. The investigation was pending at the time of the infant's death.

Child No. 50	DOB: 02/2017	DOD: 01/2020	Accident
Age at death:	2 years		
Cause of death:	Inhalation injuries due to apartment fire caused by electric malfunction of space heater		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old boy was found unresponsive in a bedroom during a house fire and transported to the hospital. The toddler was pronounced deceased three days later. At the time of the fire, only the toddler and his great-grandfather were home. The Department initiated an investigation for death by neglect to the toddler by the great-grandfather and mother. During the investigation, the great-grandfather was never interviewed, as he was intubated and unable to speak, and he died four days later from injuries sustained in the fire. The mother reported that on the day of the fire, she went to pick up the older siblings from school. When the mother returned to the home, there was a fire engine and an ambulance outside the home. In April 2020, the child protection investigation against the great-grandfather and mother was unfounded, as the cause of the fire was due to an electrical fire and was ruled an accident.

Prior History: In July 2019, the Department investigated the toddler's mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to six children, between the ages of two and thirteen years, after a domestic violence incident occurred between the mother and father which the children were alleged to have witnessed. The mother stated that they had a fight and the father told her to leave the home reportedly because she was stealing from him. The investigator spoke with the verbal children, who all reported that the mother and father fought but did not get into physical fights. All six children appeared safe and free of any observable marks. Approximately two months later, the children were living with the father, as he and the mother were no longer together. The father was allowing the mother to come over and spend time with the children. The child protection investigations, one each against the mother and father, were unfounded. In August 2019, the Department investigated the 13-year-old sibling for sexual molestation to the seven-year-old sibling and substantial risk of sexual abuse – sibling of sex abuse victim to the five-year-old sibling, after it was reported that the 13-year-old touched his sibling inappropriately. It was believed to be occurring when the father was at work and the grandfather was babysitting. The child protection investigator spoke with the children, who denied anyone touched them inappropriately. The 13-year-old stated that the grandmother started the rumor about him touching his siblings. The child protection investigation against the teen was unfounded due to insufficient evidence.

Child No. 51	DOB: 05/2003	DOD: 02/2020	Accident
Age at death:	16 years		
Cause of death:	Closed head injury due to motor vehicle accident		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was involved in an automobile accident. He was reported to be driving at a high speed, not wearing a seatbelt, and lost control of the vehicle. Following the accident, the teen was brought to the hospital where he was pronounced deceased. The Department did not investigate the death for abuse or neglect.

Prior History: In July 2019, the Department opened an investigation for lock out against the teen's mother after receiving a report the teen was staying with his older paternal half-sister after he was kicked out of the home by his mother, and his mother refused to give his medical card to the half-sister. The teen had severe asthma and his mother received a disability check for him, but he had been unable to access any medications and treatments he needed without his medical card. The teen's mother refused to sign short-term guardianship paperwork, stating that the teen was allowed to return home and his medication refill had been ordered. The investigation was unfounded because the mother was not prohibiting the teen

from returning home or retrieving his belongings. The mother and half-sister resided in the same apartment complex. In October 2019, the Department opened an investigation for substantial risk of physical injury/environment injurious to health and welfare against the teen's half-sister. The teen disclosed that he and his half-sister got into a verbal argument that turned physical. The teen reported that his jaw was swollen the day after, but the reporter did not observe any marks. The teen said he was no longer living with his half-sister; he had returned to his mother's home. Four weeks into the investigation, the half-sister stated that she and the teen were arguing because he had been driving a friend's car but did not have a driver's license. She stated he hit her in the face, she held him by the arms and told him to calm down, then she called the police, who took him to his mother's home. The investigation was unfounded because there were no injuries observed on the teen and he was no longer living with his half-sister.

Child No. 52	**DOB: 01/2020**	**DOD: 03/2020**	**Accident**
Age at death:	7 weeks		
Cause of death:	Asphyxia due to prone sleeping position while co-sleeping/bed sharing in an adult bed with adults		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old, born prematurely, was found by his 24-year-old father and 21-year-old mother, face down and unresponsive at 6:00am after co-sleeping with both parents. The infant was declared deceased at the scene. The father reported feeding the infant between 11:00pm and midnight, and again between 3:00am and 4:00am. He initially reported the infant was put to sleep in a pack-and-play but later admitted to placing the infant in the adult bed. The Department indicated both parents for death by neglect based on the rationale that they had been informed of safe sleeping practices and disregarded them. At the time of the infant's death, the family resided in the same household as paternal grandfather, his paramour and four of father's younger siblings. It was determined that the children remaining in the home were safe.

Prior History: The paternal grandfather and his paramour both have extensive histories with the Department. The most recent involvement was an intact family services case opened in 2019 following an indicated investigation of sexual penetration and sexual molestation to the grandfather's paramour's daughter by the grandfather. The indicated finding was overturned on appeal and the intact case closed in January 2020. Parents of the deceased infant also have prior involvement with the Department as children. In 2015, the infant's mother was named as a victim in an unfounded investigation of cuts, welts, and bruises by her brother. The father was named as a victim in an indicated investigation of his mother and in four other unfounded investigations. In December 2019, the father was investigated for sexual molestation and substantial risk of sexual injury to the mother's three-year-old and two-year-old cousins. It was alleged that the three-year-old was having nightmares and made statements to her mother that "the Grinch" touched her. It was further reported that the children were recently resistant to going to their cousin's home (the deceased infant's mother) who frequently watched them, and that the three-year-old identified the cousin's boyfriend (the infant's father) as the "Grinch." Both children were seen by their primary care physician. The three-year-old's medical exam noted some redness/irritation in the genital area. The doctor had some concerns but told the investigator she could not state with certainty that what she saw was the result of sexual abuse and she did not believe the irritation coincided with the children's last visit to the relative in November. In a forensic interview, the three-year-old did not disclose any abuse. The Department unfounded the investigation.

Child No. 53	DOB: 08/2019	DOD: 03/2020	Accident
Age at death:	7 months		
Cause of death:	Asphyxia due to airway obstruction by bedding materials		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seven-month-old infant was found unresponsive by his father, with his face covered by a weighted blanket. The infant's father, with whom he had been sharing a bed, had put him down for a nap around 9:45am and did not check on the baby until 6:45pm. After finding the infant unresponsive, the father was reported to have taken the infant to a friend's house, where the infant's mother was called at work, then 911 was called. The mother arrived at the home prior to the first responders. First responders performed CPR and were unable to revive the infant. The Department opened an investigation. The infant's parents reported he had been having respiratory issues for a few days prior to his death and were concerned he had been infected by the coronavirus. The parents stated they contacted a local hospital who advised them to monitor the infant at home for a few days. The family's home was reported to be dirty, with animal feces, garbage, dirty dishes with rotten food, and dead mice in the home, and the family was running an extension cord from a neighbor's home to their home to power space heaters to heat the family's home. The infant's siblings, ages seven and nine, were not at home at the time of the death. The father was indicated for death by neglect, and both parents were indicated for environmental neglect and substantial risk to the surviving siblings.

Prior History: In March 2015, the infant's mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect and inadequate supervision to the infant's older siblings, then ages two and four, because she and the infant's father were intoxicated with alcohol and controlled substances and involved in a verbal altercation while the children were present in the home. The infant's father was arrested for underage drinking and was not listed in the investigation as an alleged perpetrator, paramour, or adult subject. An intact family services case opened at the closure of the investigation. In July 2015, the intact family services case was closed. In October 2019, the Department opened an investigation following allegations that the infant's two older siblings reported being hungry; living in an unsanitary home; and seeing drugs being used, sold, and bartered in the home. Eight days after the investigation was opened, the allegations were unfounded.

Child No. 54	DOB: 03/2020	DOD: 03/2020	Accident
Age at death:	18 days		
Cause of death:	Suffocation due to co-sleeping		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eighteen-day-old newborn was found unresponsive by her 29-year-old mother on the couch. The mother called 911, while the maternal grandmother began CPR. EMS arrived on the scene and transported the newborn to the hospital where she was pronounced deceased. The mother reported that she laid on the couch with the newborn and fell asleep between 10:00am and 11:00am, when she awoke, she found the newborn unresponsive, took the newborn to the second level of the home to the maternal grandmother who immediately began performing CPR on the newborn until EMS arrived and transported the infant to the hospital. The maternal grandmother reported seeing blood come from the newborn's nose when she was performing CPR. Hospital personnel reported the newborn did not have a pulse on arrival, but they continued to try to resuscitate and were unsuccessful. The blood in the newborn's nostrils was consistent with asphyxiation. The Department investigated the mother for the newborn's death. She was unfounded for death by neglect and indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. The newborn's surviving siblings came into care of the Department.

Prior History: In August 2013, the Department unfounded the mother for environmental neglect to the newborn's then two-year-old sibling. In August 2016, the Department unfounded the mother for

substantial risk of physical injury/environment injurious to health and welfare by neglect to the newborn's then one-month-old sibling. In July 2018, the Department unfounded the mother for burns by neglect and medical neglect to the newborn's then two-year-old sibling. In August 2019, the mother was investigated for substantial risk of physical injury/environment injurious to health and welfare by neglect to the newborn's two-year-old and three-year-old siblings. The Department initiated an investigation against the mother for substantial risk after the mother was arrested and charged with obstruction of justice. She tested positive for methamphetamine while in custody. The mother was previously charged with retail theft and possession of a controlled substance and had a warrant out for her arrest from January 2019. The mother was reported to have custody of her two youngest children, while the older child lived with her father. At the time of her arrest, she was 12 weeks pregnant but reported she did not know she was pregnant and if she had known she would not have used methamphetamine. When the mother was arrested, the children were being cared for by family members. Intact family services were discussed with the mother, but she declined and wanted to give up guardianship of the children. The mother gave short-term guardianship of the two-year-old to the paternal grandmother and the three-year-old went to live with his father. There were no discussions regarding a plan for the yet to be born newborn. The Department unfounded the mother for substantial risk to the children who were in the mother's custody at the time of her arrest.

Child No. 55	**DOB: 11/2019**	**DOD: 03/2020**	**Accident**
Age at death:	4 months		
Cause of death:	Asphyxia due to unsafe sleeping environment		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old's mother left the infant and his five-year-old sister in the care of her paramour when she left for work. The infant had been born premature and had respiratory syncytial virus two months earlier. When the mother returned home five hours later, she found the infant, unresponsive, face-down and pale, in bed with the paramour. The mother and paramour began CPR and their roommate called 911. An ambulance transported the infant to the hospital and the infant was pronounced deceased at the hospital. The infant's mother tested positive for methamphetamine and amphetamine. The mother said her paramour had given her what he said were vitamins to help her sleep, but they kept her awake, so she stopped taking them. She said she suspected her paramour abused substances but had not found any drugs in the home. Her employer reported no concerns of prior drug use. The infant's half-sister was sent to her father's home and a formal safety plan was implemented and the mother was not to have any unsupervised contact with the half-sister. A month later, the mother tested negative in multiple toxicology screenings and the safety plan was ended. The investigator was unable to reach the paramour despite multiple attempts. The Department indicated the paramour for death by neglect, noting that he was in the caretaker role and placed the baby in bed with him, and his involvement with drugs may have contributed to the neglect. The Department also indicated the paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's half-sister. The Department unfounded the allegation of substantial risk of physical injury/environment injurious to health and welfare by neglect by the mother because there was no evidence to support her knowingly using drugs while caring for the children or that she was neglectful.

Prior History: The infant's family had been involved in three unfounded investigations between 2018 and the infant's death. In August 2018, the Department unfounded an investigation against the mother for substantial risk of sexual abuse – sex offender has access, and substantial risk of physical injury/environmental injurious to health and welfare by neglect after it was reported that the mother allowed the infant's then four-year-old sister to be around a registered sex offender, and that methamphetamine and marijuana were being used in the presence of the sister. The mother had texts from an ex-boyfriend who threatened to call the Department because she would not continue the relationship.

The maternal grandmother was in a relationship with a registered sex offender, but no one in the family allowed him to be around the sister. The sister reported she did not know who the man was and had not seen anyone using drugs. The investigation was unfounded. In December 2018, the Department opened an investigation for substantial risk and inadequate supervision to the then four-year-old sister after it was reported that persons with gang affiliation were living in the home and using drugs with the mother. The investigator made two unannounced visits to the home and observed no concerns. The investigation was unfounded. The last investigation before the infant's death opened in November 2019 following a report that the father of the infant's five-year-old sister had asked her to drink alcohol and smoke cigarettes with him. It was also alleged that he made sexual comments and actions toward her, though she did not disclose any inappropriate touching, and she claimed he had hit her with a rock. The sister lived with her mother, and her maternal grandmother watched her when the mother was at work. The sister told the investigator she felt safe with her mother. The sister went to her father's home every other weekend. The mother told the investigator she was not aware of any incident that occurred between the sister and her father, and she did not believe the father would have done the things he was accused of. The father had told the mother that the sister had disclosed to him that her maternal uncle had tried to get her to drink alcohol at her maternal grandmother's home. The mother told the investigator that was not possible because the child was never around her uncle. The maternal grandmother reported that occasionally, when the adults were drinking alcohol, they would put juice in a wine glass for the sister. The investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect was unfounded due to insufficient evidence. The paramour of the infant's mother has a history with the Department as an alleged child victim in two investigations; one investigation was unfounded and one was indicated for inadequate supervision.

Child No. 56	**DOB: 02/2020**	**DOD: 04/2020**	**Accident**
Age at death:	7 weeks		
Cause of death:	Asphyxia due to co-sleeping		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Full investigation pending		

Narrative: Seven-week-old was found unresponsive, face-down on a bed by his 16-year-old mother. The infant and his mother were living with the mother's sister and husband. A call was placed to 911 and the infant was transported to the hospital where he was pronounced deceased. The Department unfounded the mother for death by neglect. The police reported the home to be unsanitary and the Department unfounded the aunt and uncle for environmental neglect but indicated for substantial risk to their children.

Prior History: The infant's aunt and uncle had a history with the Department. In November 2018, the Department opened an investigation following a report the home lacked electricity. The investigation was unfounded for inadequate shelter and environmental neglect after the aunt took steps to restore services. In March 2019, the Department opened an investigation following allegations of domestic violence between the aunt and uncle. The investigation was unfounded because the parents denied the allegations, and although there was a police report for a domestic violence incident two months before the report to the Department, no one else was present for the incident. In May 2019, the Department opened an investigation on the uncle after two of the infant's cousins were found wandering in the neighborhood. The investigation was indicated for inadequate supervision. In July 2019, the Department opened an investigation of the infant's aunt and uncle after a report that the aunt continued leaving the children in the uncle's care and there was continued domestic violence in the home while the children were present. The aunt and uncle were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect and inadequate supervision. An intact family services case was opened in August 2019 for the aunt and uncle's family. The infant's mother moved from Mexico to live with her sister in December 2019. The mother and her infant were added to the aunt and uncle's intact family services case in February 2020 after the infant's birth.

Child No. 57	DOB: 12/2004	DOD: 04/2020	Accident
Age at death:	15 years		
Cause of death:	Acute alcohol intoxication due to alcohol abuse		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old was pronounced deceased at 10:16am after he was found unresponsive by his friends. On the evening prior to the teen's death, a 19-year-old friend had a party at her trailer, where there were seven other teens between the ages of 14 and 18. The friends reported that everyone was drinking, and one of the 18-year-old friends confirmed she brought cocaine to the party. It was further reported the teen used some of the cocaine and was drinking heavily that evening and fell several times due to the level of his intoxication, including falling in the kitchen and hitting his head. An 18-year-old at the party dragged the teen into the 19-year-old's bedroom and positioned him on his side on the floor in case he had to throw up. The following morning, four friends were still at the trailer from the night before. The friends found the 15-year-old unresponsive and cold, and noticed his face was discolored. The friends admitted to waiting approximately one hour after realizing the teen was deceased to call 911, and during that time they disposed of the alcohol bottles from the party. The teen's blood alcohol concentration was 0.326g/100mL and his urine was positive for cocaine and cannabis. The Department investigated and indicated the mother and father for inadequate supervision and unfounded the mother and father for death by neglect.

Prior History: In April 2008, the Department investigated the mother and her paramour for cuts, bruises, welts, abrasions and oral injuries to the teen's then seven-year-old sibling. The Department indicated the paramour and unfounded the mother. In January 2011, the Department unfounded the mother's paramour for sexual penetration to the teen, who was then six years old. In October 2014, the Department indicated the mother and her paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect to the children, ages 10, 11, and 13 years old. In July 2015, the Department unfounded the mother and the mother's paramour for substantial risk of physical injury/environment injurious to health and welfare to the then 10-year-old teen and his 12-year-old sibling. In April 2019, the Department unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the teen and his 16-year-old sibling after it was reported that the mother and the children were playing with BB guns inside and outside their residence for approximately one hour when the teen accidently shot the mother in her left eye. The mother was transported to the emergency room, where she admitted to drinking and smoking marijuana. The mother and children reported the incident was an accident. In May 2019, the mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect after it was reported the police were called at 3:24am to the apartment complex where the mother lived with the teen and his brother, because the mother was arguing with the neighbors and broke another neighbor's window. The teen reported the mother had been drinking since 9:00pm the night before and may have used marijuana but he was not aware of her using any other illegal drugs. The teen reported he attempted to calm his mother down, but she shoved him backwards four to five times and struck him one to two times with her right closed fist on the left side of his face. The teen did not have any visible injuries. The mother was arrested. The teen reported to the investigator that he felt safe at home and stated his mother never used illegal substances in his presence. After the mother's release from jail, she was offered intact family services, but she declined them, as they were duplicates to the services ordered as a part of her probation. In August 2019, the mother was investigated for inadequate supervision to the then 14-year-old and his 15-year-old sibling, and substantial risk of physical injury/environment injurious to health and welfare by neglect to the sibling, after it was reported the teen went to school under the influence of marijuana and the school was unable to reach the mother. The teen and his brother disclosed the mother kicked them out of the home and they had been staying at various homes. The school contacted the father, who was unaware his sons did not have a place to stay. The father picked them up and planned to enroll them in school where he lived. The mother reported that she

never told her sons they could not live in her home, but the teen and his brother did not want to live with her. The teen wanted to live with a friend and friend's mother, and his older brother wanted to stay with his girlfriend. The mother reported always knowing where the teens were on a daily basis. The brother admitted that he had not been staying at the mother's home over the summer by choice and stated that she did not kick him and the teen out of the home. The brother moved back in with his mother and felt safe in the mother's home. The teen reported that he was living with the friend since the mother's arrest in May 2019 because he did not want to live with the mother, because he believed she was using drugs. The mother gave temporary guardianship to the teen's friend's mother. The mother submitted for a toxicology screening and tested positive for cocaine, opiates, fentanyl and THC. The mother admitted to the investigator that during a prior visit, she had been under the influence of heroin and that was her drug of choice. The teens were not allowed to be in the home until she addressed her drug addiction. The mother agreed to a safety plan. The mother completed a substance abuse evaluation and was scheduled to start outpatient services as recommended. The mother also completed two negative toxicology screenings. The safety plan ended and it was deemed safe for the teen's brother to return home. The teen remained in the temporary guardianship of his friend's mother. The mother was indicated for substantial risk, but unfounded for inadequate supervision.

Child No. 58	**DOB: 05/2020**	**DOD: 05/2020**	**Accident**
Age at death:	2 days		
Cause of death:	Extreme prematurity due to placental abruption due to maternal polysubstance abuse (cocaine and methamphetamine)		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-day-old had been born at 24 weeks gestation due to placenta abruption. At the time of birth, the newborn's mother tested positive for cocaine, amphetamine, and THC. Medical staff noted the mother had a prescription that would result in a positive amphetamine test. The Department investigated and indicated the mother for death by neglect.

Prior History: In March 2020, two months before the mother gave birth to the newborn, the Department opened an investigation into the newborn's family following a report of domestic violence. The infant's three-year-old brother was reportedly present during the altercation. After which the newborn's father locked the pregnant mother and brother out of the home around midnight when it was approximately 39° F outside. The father was arrested. The Department indicated the father for substantial risk of harm. A high-risk intact family services case was opened. Caseworkers found it difficult to contact the mother in the weeks leading up to the newborn's birth, as she did not have stable housing at that time, and she frequently missed appointments.

Child No. 59	**DOB: 09/2006**	**DOD: 05/2020**	**Accident**
Age at death:	13 years		
Cause of death:	Drowning		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old went missing while swimming with his mother and friends. Emergency services were called but the teen was found before they arrived. The teen was transported to the hospital by ambulance then transferred to another hospital, where he was pronounced deceased. The Department opened an investigation into the death. The investigation is pending for death by neglect against the mother.

Prior History: The teen's mother and father have an extensive history with the Department. Between 1998 and 2015, the Department investigated the mother 10 times; she was indicated as a perpetrator in

three investigations for inadequate supervision, environmental neglect, and inadequate shelter, and unfounded in seven investigations. The teen's father was investigated and unfounded three times. In May 2019, the Department opened an investigation following a report that a friend of the teen's mother was seen counting a large sum of money in the family home. The mother was home at the time and was known to have a history of drug use. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect due to insufficient evidence. In January 2020, the Department opened an investigation after it was reported that the 13-year-old's mother fed him and took him to the school bus but was otherwise always sleeping and had not had his medication refilled. The mother reported the past year had been difficult due to her paramour's death and she began drinking heavily but started counseling. She took the teen to the doctor to have his medication refilled. She confirmed a friend was living in the home and would cook for the teen when he was hungry. The allegation of inadequate supervision was unfounded due to insufficient evidence and a referral was made for community-based services.

Child No. 60	**DOB: 08/2004**	**DOD: 05/2020**	**Accident**
Age at death:	15 years		
Cause of death:	Drowning		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old, who could not swim, jumped in a lake, close to a dam, with approximately 10 other children. When the other children couldn't find the teen, they called 911. Paramedics arrived an hour later and were unable to revive the teen. The teen's foster parent had last seen him at noon when he left the house with friends. The relative foster parent stated he had recently been leaving the house with friends frequently, without permission, and she was unable to stop him. The Department did not investigate the death.

Prior History: There were three unfounded investigations between 2012 and 2015 where the teen was named as the victim, and one additional unfounded investigation where his infant sibling was named as a victim. In November 2017, the Department opened a preventive services case to assist the family with Norman funding services only. In July 2018, the Department unfounded the mother for inadequate supervision after a report of drugs being sold from the home and the teen's four younger siblings were seen outside the home, unsupervised, multiple times per week. In September 2018, the Department received a report of shots fired at the mother's home while the children were inside. The mother's paramour was involved with a gang and there was believed to be drug activity in the home. The mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect to the teen's siblings. The teen was not named in the investigation because he was living with another relative at the time. The Department opened an intact family services case. The teen lived with various friends and family members throughout the intact case. In January 2019, the Department received a report after the teen told the intact worker that he ran away from home because his mother was a drunk and tries to get him to babysit his siblings. He also stated she hits and chokes him, but he did not report it because he did not want his siblings taken away from her. The investigation was unfounded for cuts, bruises, welts, abrasions, and oral injuries because the teen did not exhibit injuries at the time. In May 2019, the court took custody of the teen and all his siblings because the mother did not cooperate with intact family services and the children had not been attending school. The teen was placed in a relative's home until January 2020, when he ran away. The caseworker had difficulty finding a new placement for him, as family members felt he was too difficult to control. In April 2020, two months prior to his death, he was placed back with the family member he had previously been placed with in May 2019. He remained there until his death.

Child No. 61	DOB: 04/2002	DOD: 06/2020	Accident
Age at death:	18 years		
Cause of death:	Asphyxiation due to tracheal hemorrhage and trachea-innominate arterial fistula, with the contributing underlying conditions of tracheostomy and spinal muscular atrophy		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Eighteen-year-old medically complex youth in care, who was living in a residential facility for medically complex children, was receiving therapy to loosen mucus in her lungs when a staff member of the facility noticed she was bleeding. She was transported to the emergency room. She was bleeding from her stoma on her throat and was infused with two units of blood. Her heart stopped the next morning and she was pronounced deceased after CPR was attempted. The teen had spinal muscular atrophy, was confined to her bed, depended on her tracheostomy tube, was non-verbal, and relied on caregivers for all needs. The Department did not investigate her death.

Prior History: The teen's family had involvement with the Department dating back to 2013 when the Department unfounded the parents following reports that the then 10-year-old's mother was selling drugs out of the home. Both the teen and her then one-year-old sister were reported to be disabled and in need of round-the-clock nursing care. In January 2016, following a report that the teen, who was confined to a bed, was not being properly fed or kept clean, the Department investigated and unfounded the mother for inadequate food, medical neglect and environmental neglect. There were two child protection investigations opened in December 2016 after reports of domestic violence between the mother and her paramour, concerns that the teen was paralyzed and left home alone for the weekend, and that the mother abused drugs. The mother was indicated for inadequate supervision and unfounded for substantial risk in the first investigation. The mother was then indicated for substantial risk following a report that the home was extremely dirty and the mother was abusing drugs. In January 2017 a court-ordered high-risk intact family services case was opened. In late January 2017, the Department opened an investigation following a report that the mother did not check on the teen during the hours that the home health nurse was not in the home. The mother was unfounded for substantial risk. In March 2017, there were two child protection investigations. In the first, the mother was indicated for substantial risk after it was reported that drugs were found in the home and the mother tested positive for drugs. In the second, the mother was found passed out by the home health nurse. The mother was unfounded for inadequate supervision. In July 2017, the Department opened an investigation following a report that the mother had been displaying erratic behavior and had been taken to the hospital. It was also reported that the mother was using drugs and not caring for the teen. During the investigation, the teen was diagnosed with pneumonia and a urinary tract infection. The mother agreed to have the teen placed in a hospital for respite care for a few days, during which time the Department was unable to contact the mother. The Department initiated a safety plan, and the mother was not to be alone with the teen, was to refrain from taking drugs, and was to take her medications as prescribed. The mother needed three negative toxicology screenings to terminate the plan, but the subsequent screenings came back positive. The intact worker discovered the power in the home had been shut off for nonpayment despite working closely with the family on financial issues and securing Norman funds. The teen was entirely dependent on machines to help her breathe. The Department took protective custody and was granted temporary custody and guardianship. The investigation was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect, and unfounded for medical neglect, environmental neglect, and malnutrition. An additional investigation was opened in July 2017 because the mother signed the teen out of the hospital against medical advice. The investigation was unfounded for medical neglect. The teen resided in children's hospitals until May 2018, when she was transferred to a residential treatment facility to care for her medical needs. In August 2019, the mother gave birth to a new baby. The mother and baby tested negative for all substances, though there were concerns the mother was still using substances. The mother refused to comply with service plan recommendations and toxicology screenings. The investigation was

indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. The Department took protective custody of the baby. The teen remained at a residential facility until her death in June 2020. She was reportedly stable and doing well until her death. Her baby brother remains a youth in care.

NATURAL

Child No. 62	DOB: 06/2019	DOD: 07/2019	Natural
Age at death:	1 month		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: One-month-old infant was found unresponsive by his mother at approximately 3:30am in a hotel where the family was staying temporarily. The father called 911 and the parents performed CPR until the police arrived. EMS transported the infant to the hospital where he was pronounced deceased. The Department investigated the mother and father for death by neglect. The mother stated that at approximately 1:30am she fed the infant and then laid him in the portable bassinet and found him unresponsive when she awoke. The mother stated that she contacted the clinic two days before the infant's death when the infant seemed to be breathing strangely but they told her as long as the infant did not appear ill or seem like his heart skips a beat, she did not need to bring him in until the next appointment, which was scheduled for the day after his death. In November 2019, the Department's investigation against the parents was unfounded.

Prior History: The parents had 13 prior child protection investigations dating back to January 2013, four of which were indicated, and nine unfounded. In January 2013, the Department investigated and unfounded the father and grandfather for substantial risk of harm by abuse and substantial risk of harm by neglect to the deceased infant's then five-year-old sibling. In March 2013, the Department investigated the father for cuts, welts, bruises, abrasions, and oral injuries when the deceased infant's five-year-old sibling returned to school after several days of absence with obvious makeup on and a bruise near her right ear. She reported that the father was drunk and repeatedly slammed her into a wall until the mother stopped him. The investigation against the father was indicated and an intact family services case was opened. In March 2014, the intact family case closed successfully. During the intact case, the sibling received mental health services and medication management; the parents received counseling, substance abuse services, and housing assistance. Between August 2014 and July 2017, the Department unfounded the parents four times for allegations including inadequate supervision and substantial risk of harm. From October 2017 through October 2018, the Department investigated the parents seven times for inadequate supervision to the deceased infant's then 10-year-old sibling who continually ran away from home. The Department unfounded the parents on four of the investigations and indicated the parents on three of the investigations. The deceased infant's sibling had a history of behavioral problems and told investigators that she runs away to get attention from her parents because they did not take her out to do fun things, since they did not have much money. After the last indicated investigation in October 2018, an intact case was opened in November 2018. The family was relinked with the mental health agency that had worked with them before. At the time of the infant's death, the intact case was ready to close successfully. The worker reported that the parents were looking into homes in the same school district so the 12-year-old could return to the same school. The parents continued to have negative toxicology screenings. The sibling had not run away since January. The worker had talked to the children's pediatrician less than a week before the infant's death, and there were no concerns reported.

Child No. 63	DOB: 05/2018	DOD 07/2019	Natural
Age at death:	14 months		
Cause of death:	Chronic respiratory failure due to gangliosidosis		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Fourteen-month-old medically complex child died in his maternal grandmother's home while in home hospice care. In December 2018, the child was diagnosed to have GM-1 gangliosidosis, a rare neurological progressive disorder that causes low muscle tone and decreasing brain activity and development. The child's life expectancy was two to four years, with slow deterioration. The Department did not investigate the child's death.

Prior History: From December 2011 to March 2016, the Department unfounded five investigations against the mother. In July 2016, the Department investigated the mother for substantial risk of physical injury/environment injurious by neglect to her children, ages one, three and four years old, after the mother sought an order of protection against the father. The mother alleged the father physically and verbally abused her daily and months earlier had attempted to stab her with a screwdriver. The mother stated that she and the father stay in the garage, but the children stay in the main house with the grandmother and great-grandmother. The mother reported that she and the father fought about caring for the children and she called the police, who told the father to leave. The mother then obtained the order of protection against the father. She said the children were with relatives during the fight. The father told the investigator that he suffered from mental health and substance use issues but had started counseling and had been sober for six weeks. The father admitted to verbal arguing but denied physical altercations. The mother did not extend the order of protection and allowed the father to return. The parents were indicated for substantial risk of harm. In September 2016, while the prior report was still pending, the police found the three-year-old and five-year-old wandering the street unsupervised. Law enforcement found the home to be in deplorable condition and unsafe for the children. The Department initiated an investigation for inadequate supervision and environmental neglect. The father told the investigator he left the children playing on the deck while he worked in the house. He had checked on them five minutes before he noticed them gone. Neighbors told the investigator that the children regularly wandered. The Department took protective custody of the children placing them with the paternal grandfather and paternal great-grandmother. The parents continued to have problems with substance abuse and domestic violence. In January 2018, the father told the worker he had moved and planned to divorce the mother. The mother reported that she was 20 weeks pregnant and due in May. Following the birth of the baby, the Department investigated and indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant. The investigator took custody and placed the baby in a traditional foster home. Three days later, the baby was readmitted to the hospital when the pediatrician noticed the baby was not maintaining appropriate oxygen saturation. The baby continued to have respiratory problems and was unable to eat by mouth. After a month in the hospital, the baby was discharged to a specialized foster home where he reportedly did well. As the baby's illness progressed, it was anticipated the baby would need braces, a wheelchair, and have limited communication skills. The baby received vision, physical, feeding, and developmental therapies in which the foster parent participated. The baby was eventually transferred to a children's hospital in November 2018. In December 2018, the baby was diagnosed with gangliosidosis. The baby was eventually placed with the maternal grandmother in June 2019 with home hospice care nursing in place until his death in July 2019.

Child No. 64	DOB: 07/2019	DOD: 08/2019	Natural
Age at death:	9 days		
Cause of death:	Sepsis due to prematurity		
Reason for review:	Pending child protection investigation at time of the child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-day-old infant, who had been born at 23 weeks, 4 days gestation, was transferred to a children's hospital the day of his birth. He was born with multiple medical conditions due to his prematurity. The newborn was on approximately 20 medications to treat his conditions. The mother had been hospitalized due to intermittent leakage of fluid. The mother tested positive for controlled substances when she entered the hospital but there was nothing implicating that substance abuse was the cause of the prematurity. The Department unfounded the mother for death by neglect.

Prior History: In July 2019, the Department investigated the infant's mother for substantial risk after it was reported that the mother was actively using drugs while having a two-year-old child and ten-year-old child in her care. The mother was five months pregnant and receiving methadone treatment. She told the staff where she was receiving obstetrics care that she locks herself in the bathroom and uses drugs. The mother tested positive for fentanyl, methadone, cocaine, and opioids. The mother stated the last time she used substances was a week and half prior, and that her drug of choice was fentanyl. The mother denied using drugs in front of the children, stating that she uses in the bathroom while the children are in their rooms. The mother also stated that when her paramour is home, she will go for a drive and use drugs. The mother stated that she has been seeking help for her drug use because she is five months pregnant. A home safety plan was put into place and the children were placed with the maternal grandmother. The mother was required to complete three clean toxicology screenings and be active in drug treatment before the safety plan could be terminated. While this investigation was pending, the mother went into premature labor. The infant died while this investigation was pending. In August 2019, after the death, an intact family services case was opened. In September 2019, the investigation was indicated.

Child No. 65	DOB: 04/2019	DOD: 08/2019	Natural
Age at death:	3 months		
Cause of death:	Heart failure, hypoplastic aortic arch, posterior malaligned ventricular septal defect, and atrial septal defect		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Three-month-old youth in care had been born at 30 weeks gestation, resulting in various medical issues. The newborn remained in the Neonatal Intensive Care Unit until his death from congenital heart failure. The medical report stated the heart failure was due to the newborn's prematurity at birth. The infant's mother used drugs and alcohol during her pregnancy; she admitted that she ingested methamphetamine while pregnant. The Department unfounded the mother for death by neglect, as there was no medical finding to support that the newborn's death was a direct result of his mother's drug use.

Prior History: In January 2016, the Department investigated the mother for substance misuse by neglect after the mother gave birth to an older sibling of the deceased infant, and the sibling tested positive for THC and amphetamines. The mother admitted to marijuana use and amphetamine use during her pregnancy. The investigation was indicated, and the Department was granted custody of the sibling. The sibling was hospitalized for a month due to symptoms of withdrawal. Upon discharge from the hospital, the sibling was placed with fictive kin and was eventually adopted. The parents had an older child who remained in their care. Between October 2016 and May 2018, the parents were unfounded four times for substantial risk and inadequate supervision. The mother gave birth to another child in July 2017, and that child remained in his parents' care. In November 2018, the Department investigated the mother and father for poison/noxious substances by neglect, inadequate supervision, and substance misuse by neglect, after hospital personnel reported that the one-year-old sibling was taken to the hospital via

ambulance because the father stated the four-year-old sibling had poured a kitchen cleaner on the one-year-old and he began to throw up. The one-year-old and four-year-old were tested and found to have methamphetamines and amphetamines in their system. The Department took protective custody and placed them with fictive kin and their then two-year-old sibling. The mother, who was pregnant at the time, entered a psychiatric hospital and upon discharge she checked into a rehabilitative facility for her substance abuse issues. The mother was released in March 2019. After her discharge, she resumed drug use and was observed drinking alcohol and smoking while pregnant. In April 2019, the Department initiated an investigation against the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect and substance misuse by neglect after she gave birth to the deceased and the newborn tested positive for amphetamines and methamphetamines. The investigation was indicated, and the infant was taken into care.

Child No. 66	**DOB: 03/2007**	**DOD: 08/2019**	**Natural**
Age at death:	12 years		
Cause of death:	Pulmonary thromboembolism due to DVT [deep vein thrombosis] of the leg		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old died in the hospital after complaining of leg pain and shortness of breath for multiple days. The mother found the child sitting in a chair, unresponsive, with her eyes rolled back. The mother began CPR until EMS arrived on the scene to transport the child to the hospital, where she was pronounced deceased. The mother had taken the child to urgent care the previous day. Urgent care sent them to the hospital, and the hospital sent the child home with a prescription for tonsillitis. The Department unfounded the mother for death by neglect.

Prior History: In August 2018, the Department investigated the mother after it was reported that the mother sleeps all the time and allows the deceased child's six-year-old sibling to run around outside unsupervised. The six-year-old was reported to have a brain tumor that was mostly removed when he was two years old, and he needed physical therapy and foot braces. The reporter stated the mother fails to make physical therapy appointments and obtain foot braces for the six-year-old. It was reported that the mother abuses prescription medications. The Department investigated the mother for medical neglect to the six-year-old and substantial risk of physical injury/environment injurious to health and welfare by neglect to both children, ages six and eleven. The investigator spoke with the mother at home and she denied that the six-year-old is left unsupervised and stated the 11-year-old goes outside to play with him at the playground. The investigator contacted the six-year-old's physician, who stated that the referral for the six-year-old to participate in physical therapy was never sent. A referral was sent during the investigation and the six-year-old was going to have his first appointment in October 2018. The mother denied any substance abuse and refused a toxicology screening. The investigator noted that the 11-year-old was receiving home counseling assistance. The Department's investigation was unfounded.

Child No. 67	**DOB: 06/2011**	**DOD 08/2019**	**Natural**
Age at death:	8 years		
Cause of death:	Pulmonary emboli due to cirrhosis of the liver due to polycystic kidney disease		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old medically complex child was found unresponsive, lying face up in her bed by her mother. The child was transported to the hospital where she was pronounced deceased. The child had previously been diagnosed with Caroli syndrome and autosomal recessive polycystic kidney disease. She had a gastrostomy tube and required 24-hour care. In 2013, she underwent a kidney transplant. The Department did not investigate her death.

Prior History: In December 2018, the Department investigated the mother for bone fractures by neglect and inadequate supervision after it was reported that the then seven-year-old medically complex child presented to the emergency room with a horizontal fracture and midshaft radius. The mother reported that the seven-year-old was with her siblings, ages one, two, and ten years, while she slept. The mother did not witness the incident and was unable to explain how the injury occurred. Due to the seven-year-old's speech delay, she was unable to report how the injury occurred. The investigator spoke with the treating physician who reported that the seven-year-old was discharged with a referral to a children's hospital for follow-up care. The physician stated that the child's injuries were consistent with an accident and the minor did not have any other signs of abuse or neglect. The investigator went to the home and observed all children with no visible signs of abuse or neglect and observed the seven-year-old medically complex child with a soft cast on her left arm. The 10-year-old sibling stated that she was lying on the couch playing with her tablet and did not observe the seven-year-old fall but heard a thump. The investigator spoke with the children's primary care physician, who had no concerns about the care of the children. She stated the seven-year-old is medically complex and sees many specialists for follow-up care and that due to child's health issues, she is very prone to fractures. In February 2019, the Department's investigation against the mother was unfounded.

Child No. 68	**DOB: 11/2006**	**DOD: 08/2019**	**Natural**
Age at death:	12 years		
Cause of death:	Non-traumatic hypoxia due to cardiac arrest		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old girl was found by her 14-year-old sibling, unresponsive on the floor, near the front door of the home. The sibling immediately started CPR and the stepfather called 911. Upon arrival, EMS took over CPR, obtained a pulse, and transported the child to the hospital where she was put on a ventilator. Medical staff stated that there were no signs of abuse and neglect to the child. The family reported no known health problems with the child. Six days later, the child was pronounced deceased. The child had a cardiac arrest, but the cause was unknown. The Department did not investigate the death for abuse or neglect. The Department investigated and indicated the mother for substantial risk of physical injury environment injurious to health and welfare by neglect because of the history of the mother's substance use and domestic violence in the home. The mother was offered and agreed to intact family services and grief counseling. An intact family case was opened after the death.

Prior History: In June 2018, the Department investigated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect and inadequate supervision to the children, ages eight months, eleven years, twelve years, and fourteen years. It was reported the mother left the home without a care plan for the eight-month-old and the three siblings. The father/stepfather was at work and the children went to a neighbor's house. The mother later returned intoxicated and took the eight-month-old back home. It was also reported the mother drinks daily and is often intoxicated, at times to the point of passing out. The father/stepfather reported that after going to work, the neighbor contacted him and told him the mother was outside fighting with the maternal aunt in the street. The father/stepfather arrived and found the mother intoxicated and she was attempting to go back out in the street to fight again. After he stopped her from going outside, the mother picked up the baby and left, and told him he would never see the baby again. The mother returned 15 minutes later and gave the baby to the father. The father reported he would like the mother to attend Alcoholics Anonymous. He admitted that he and the mother had two physical altercations in the eight years they had been together. The mother admitted to drinking when she got into a physical altercation with the maternal aunt. She denied leaving the baby outside and leaving with another man. The mother agreed to alcohol treatment and the investigator provided referrals. In August 2018, the Department indicated the mother based upon corroborative information given during the investigation.

Child No. 69	DOB: 08/2019	DOD: 09/2019	Natural
Age at death:	1 month		
Cause of death:	Viral pneumonia		
Reason for Review:	Indicated child protection investigation within one year of child's death		
Action Taken:	Full investigation; Report to Director in FY 2021		

Narrative: One-month-old was found cold and not breathing by her mother, with whom she had been sleeping in the bed. The mother reported the infant's face was pressed against a small bassinet designed to be used in the bed, and she fell asleep before putting the infant in the bassinet. The mother dialed 911, and the infant's father fled the residence due to an outstanding arrest warrant for a domestic violence incident that took place approximately two weeks earlier. The Department opened an investigation as a result of the death. The parents were unfounded for death by neglect, but the father was indicated for substantial risk of sexual abuse, and both parents were indicated for substantial risk of physical injury to the children.

Prior History: Between 2016 and the infant's death in 2019, the Department conducted four child protection investigations and opened an intact case due to the history of domestic violence between the infant's parents. In June 2016, the Department opened an investigation following a report that the mother was feeding the then two-month-old brother breast milk that smelled of alcohol and the father had been incarcerated for domestic violence towards the mother. The mother and father were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect due to their extensive history of domestic violence. The father, a registered sex offender, was indicated for substantial risk of sexual abuse-sex offender has access but the mother was unfounded for this allegation because she was unaware of the father's history. The Department opened a case with court supervision for the family. In January 2017, the court granted guardianship and custody of the infant's brother to the Department but gave the Department full discretion for his placement and he remained with his parents. The mother was granted an emergency order of protection against the father, and the father was granted supervised visitation only. In January 2018, the court granted guardianship back to the mother, and determined the father remained unfit. The case was closed the following month. Less than two weeks after the family case closed, in March 2018, the Department opened a new investigation following a report that the mother was using illicit drugs and caring for the infant's brother while drinking. The investigation was unfounded for lack of evidence to support allegations of inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. In August 2019, the Department opened an investigation following a domestic violence incident between the parents while the infant and the infant's brother were home. The Department indicated the father for substantial risk of sexual abuse-sex offender has access because the father had not completed sex offender treatment recommended from a case years before. The Department indicated the father but unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect, because the mother ended her relationship with the father and took steps to protect herself and the children. The infant died the day after the investigation closed.

Child No. 70	DOB: 03/2004	DOD: 09/2019	Natural
Age at death:	15 years		
Cause of death:	Sudden unexpected death in epilepsy		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old was found unresponsive by his mother in the bathroom. His mother had last seen him alive approximately 20 minutes earlier. She contacted 911 and he was transported to the hospital, where he was pronounced deceased. The teen had mental health issues as well as several medical issues including seizures and asthma, for which he was prescribed medications. The Department did not investigate his death.

Prior History: The teen's mother has an extensive history with the Department, consisting of 13 unfounded investigations between 2005 and 2018 for inadequate shelter; inadequate supervision; substantial risk of physical injury/environment injurious to health and welfare by abuse and neglect; inadequate food; environmental neglect; cuts, welts, bruises, abrasions, and oral injuries; medical neglect; and lock out. She had one indicated report in 2018 for inadequate shelter. The Department opened the investigation in April 2018 after the mother called law enforcement reporting the then 14-year-old teen was out of control. Law enforcement found the home in disarray, saw the minors did not have beds, and reported the mother would leave the home with the teen in charge, but the teen had disabilities and was out of control. The mother was unfounded for allegations of inadequate supervision and environmental neglect. She was indicated for inadequate shelter because the house she had been renting was foreclosed on, she had been given a five-day notice to vacate, and she did not have another housing resource available at the time. The mother agreed to participate in intact family services. The mother complied with services and the intact worker helped the mother with the teen's behavior, including locating a therapeutic residential program for him. The intact case closed satisfactorily in November 2018. At that time, the mother had located and maintained permanent housing, the teen was living in a residential facility, and the mother was participating in counseling with the teen.

Child No. 71	**DOB: 07/2007**	**DOD: 09/2019**	**Natural**
Age at death:	12 years		
Cause of death:	Respiratory failure due to chronic restrictive lung disease due to cerebral palsy and scoliosis		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old medically complex youth in care, who required multiple specialized needs for medical conditions that included cerebral palsy, hydrocephalus, seizure disorder and spina bifida, passed away at a specialized care center where she had been living since February 2016. The child was pronounced deceased at the specialized care facility after being found unresponsive by staff during rounds. The Department did not investigate the death for abuse or neglect.

Prior History: In October 2007, the youth's then 16-year-old mother contacted the Hotline to report that the maternal grandmother had threatened to turn her into the Department and have the then three-month-old removed from her care if she did not buy cocaine for the grandmother. The teen mother also reported that the family was being evicted from their home and had no power or gas service. In November 2007, protective custody was taken of the teen mother and baby. The baby was placed in a specialized foster care home with a couple who was equipped to take care of the baby's numerous medical needs. The baby received daily pharmacological treatment and in-home nursing services, weekly occupational and physical therapy, monthly speech therapy, and home-bound educational services multiple days a week. The baby's doctors reported a poor prognosis and predicted the baby would most likely never be able to roll over, crawl, sit or walk. In June 2010, the teen mother surrendered her parental rights. From November 2013 until January 2016, the foster parents continued to care for the child and her medical needs. In January 2016, the foster mother told the case worker that she and the foster father had decided they could no longer care for the child, who was now eight years old, due to the continued challenges of the child's hospitalizations, surgeries, and shortage in nursing to help in the evenings. In February 2016, the child was moved to the specialized care facility. The foster parents continued to visit on a weekly basis. In November 2016, the now nine-year-old child was hospitalized due to respiratory distress. During this hospitalization, plans were put in place to create a DNR for the child. In April 2019 and again in June 2019, she was hospitalized for a few weeks for difficulty breathing. She was discharged to the specialized care facility and she remained there until her death.

Child No. 72	DOB: 08/2019	DOD: 10/2019	Natural
Age at death:	2 months		
Cause of death:	Respiratory distress due to pulmonary hypoplasia due to prematurity		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation; Report to Director in FY 2021		

Narrative: Two-month-old died in the hospital. She was born premature and was in the care of the neonatal intensive care unit since birth. At the time of her death, there were two pending child protection investigations against her 17-year-old mother and the maternal grandmother. The Department did not investigate the death for abuse or neglect.

Prior History: The infant's mother has an extensive history with the Department dating to 2003. The mother was an alleged child victim in six child protection investigations between 2003 and 2018. In 2018, the infant's then 16-year-old mother gave birth to her first child, the infant's brother. When the brother was three months old, the Department investigated the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse. The mother reportedly shook and hit the infant's brother on the head, left the home with him for six hours, and returned with the brother's diaper soaking wet and had the brother clothed in only a onesie when it was 26 °F outside. The mother had not been taking her psychiatric medication during pregnancy and nursing, and the investigation was unfounded after the mother began taking her medication again and there was no evidence that the brother was harmed. A few weeks after the investigation closed, the Hotline was called again after the mother attacked a babysitter who was holding the brother. The mother was psychiatrically hospitalized, and an investigation was opened against the mother for substantial risk to the brother. The brother was initially sent to a maternal aunt's home, then was cared for by the maternal grandmother, who later filed to obtain guardianship. The investigation was unfounded. Two months after that investigation closed, the mother gave birth to the infant. The following week, the Department opened an investigation against the step-grandfather for inadequate supervision to the brother and against the maternal grandmother for substantial risk to the infant, the brother, and the mother, after the mother brought the infant's brother to the hospital seeking medical attention after he fell from a high chair. The mother said the step-grandfather, who was supposed to be watching the brother, was intoxicated at the time. The grandmother had guardianship of the brother and was responsible for the infant and the mother at the time. The mother told hospital staff that she had just given birth to an infant who was in the NICU, and staff were concerned that she did not have the ability to make decisions for an infant in critical condition. While that investigation was pending, the Department opened another investigation against the grandmother for inadequate supervision to the mother after hospital staff reported concerns about the maternal grandmother after the grandmother left the 17-year-old mother at the hospital without a way to get home. Both the mother and maternal grandmother denied the allegations, stating they had agreed the mother's friend would pick her up from the hospital. The mother signed over temporary guardianship of the infant to the maternal grandmother. The infant was pronounced deceased at the hospital four days later. The investigation that stemmed from the brother's fall was unfounded for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. The investigation that followed of the maternal grandmother leaving the mother at the hospital was unfounded for inadequate supervision.

Child No. 73	DOB: 12/2014	DOD: 10/2019	Natural
Age at death:	4 years		
Cause of death:	Respiratory insufficiency due to metastatic neuroblastoma		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Four-year-old youth in care who had been diagnosed with a stage IV neuroblastoma was admitted to the pediatric intensive care unit at a children's hospital for significant difficulty breathing; he remained until his death a month later. The mother visited regularly during his hospitalization and the

youth spoke with his father via phone. The youth's health continued to deteriorate until his death. At the time of his death, the foster parents and mother were present with him at the hospital. The Department did not investigate the death for abuse or neglect.

Prior History: In August 2018, the Department investigated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect and environmental neglect to the then three-year-old youth after it was reported that the youth was hospitalized, and the mother had not visited for four days. It was reported that the mother was abusing drugs and living in deplorable conditions in the home with no running water. A hospital social worker also reported that the mother had been unresponsive to communications from the hospital regarding the youth's care. The youth was diagnosed with high risk, stage IV neuroblastoma. The investigator met with the mother at the hospital and the mother confirmed that her current residence did not have running water and there was currently no toilet. The investigator had the mother submit to a urine toxicology screening in the hospital emergency room before the youth would be discharged to the mother's care. The results were positive for amphetamines and methamphetamines. In October 2018, temporary custody was granted to the Department. The youth was placed with fictive kin, as the father was incarcerated. In October 2018, the investigation against the mother was indicated. A placement case was opened, home visits were regularly conducted with foster parents, and the youth continued to do well at the fictive kin placement. The youth was intermittently hospitalized for chemotherapy treatments and discharged back to his foster placement until he was admitted to the children's hospital a month before his death.

Child No. 74	**DOB: 08/2019**	**DOD: 10/2019**	**Natural**
Age at death:	7 weeks		
Cause of death:	Multi system organ dysfunction syndrome (adenoviremia)		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old died in the hospital six days after being admitted with a temperature of 100.8 °F. The infant was found to have multisystem organ dysfunction. There was no abuse or neglect noted or reported. The Department did not investigate his death.

Prior History: In October 2019, the Department investigated the mother for inadequate supervision to her then two-year-old daughter. The two-year-old was residing with a former foster parent of the mother and had type 1 diabetes that required insulin shots. The child's medical card was expiring at the end of the month, and the mother was last seen in April 2019. It was further reported that the mother was pregnant. The child protection investigator met with the caregiver and observed the child. The caregiver told the investigator that the mother returned to live with her after she became pregnant and had nowhere else to go. The caregiver cared for both the mother and her child. She reported the mother signed consents so she could take the child to her medical visits/treatments for her diabetes. The caregiver was working with an agency to obtain guardianship of the toddler. The caregiver also reported that maternal grandmother contacted her in August and informed her that mother had given birth to a baby boy with multiple medical issues. The investigator contacted the toddler's doctor, who confirmed the toddler had type 1 diabetes and was seen every three months. The toddler had been seen in October and was expected to return to the clinic in January 2020. The investigator made numerous attempts to locate mother and observe the baby boy. In December 2019, an investigator had contact with a family member, who reported the mother lived in the home but was not home at the time and provided the investigator with a phone number for the mother. The family member also reported that the infant was deceased. The investigator contacted the mother who confirmed the infant died in October. The investigation against the mother for inadequate supervision was unfounded, as the mother left the toddler in the care of the guardian, who had been providing care to the toddler since birth.

Child No. 75	DOB: 12/2009	DOD: 10/2019	Natural
Age at death:	9 years		
Cause of death:	Asphyxiation due to complications of asthma		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old child told her father that she was having difficulty breathing due to her asthma. The child was in the kitchen completing a breathing treatment when she collapsed. EMS was called and the child was transported to the emergency room, where she was pronounced deceased. Upon examination, there were no outward signs of abuse or neglect. The Department did not investigate the death.

Prior History: In April 2013, the Department unfounded the mother for cuts, welts, bruises, abrasions, and oral injuries to the then 13-year-old sibling to the deceased. In October 2018, the Department investigated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the then eight-year-old (deceased child) after it was reported that the child told her teacher that her dad yelled and pushed her because he was mad at her. It was also reported that in September 2018, the child sustained an injury from gymnastics and went to school with a cast boot, but shortly thereafter, she showed up to school without the boot and stated her father would no longer allow her to wear it. The child informed the investigator that her father pushed her and her siblings with his hands around their neck and mouth area and would also spank them. The investigator then met with the 11-year-old and 12-year-old siblings, who had very similar accounts of the father's behavior. The investigator noted that there were no observable marks on the children. The mother admitted to the investigator that both she and her husband use "whooping" to discipline the children but denied that it rose to the level of abuse. She denied domestic violence between her and her husband. The investigator met with the father who stated that his children were athletes and his daughter's foot was misdiagnosed, which caused a delay in treatment. He also admitted to spanking the children but denied that it rose to the level of abuse. He denied domestic violence in the home. In December 2018, the investigation against the father was unfounded as there was no evidence that the father's discipline rose to the level of abuse or neglect.

Child No. 76	DOB: 10/2017	DOD: 10/2019	Natural
Age at death:	2 years		
Cause of death:	Unknown natural causes		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was found unresponsive, lying on his back, in bed. The toddler had been sick, had a fever, and was given cough medicine earlier in the day. He was transported by ambulance to the hospital and EMS reported a secretion in his mouth and nose that appeared to be the color of blood. The toddler was pronounced deceased at the hospital. An autopsy revealed the toddler had complications from a cervical spinal cord injury which could have been from a genetic condition. The Department unfounded the death for death by abuse.

Prior History: The toddler's mother was previously involved in three unfounded investigations where she was named as a child victim. In the eight months prior to the child's death, there were five unfounded investigations involving the child's family. The parents were in a custody battle in court during that time. In March 2019, the Department opened an investigation after the toddler's mother reported to police that the toddler's father sexually assaulted her, and a similar incident had happened nine months earlier. She stated she had not sought legal or medical help because she was afraid. Both parents were unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect. In March 2019, while the first investigation was still pending, an additional investigation was opened following a report the mother had brought the toddler's then three-year-old sister in for a medical exam after noticing

bruises on the back of her legs. It was alleged the paternal grandfather hit and molested the sister while he was in a caretaker role. The sister made no disclosure of physical or sexual abuse. The primary care doctor also had no concerns of abuse or neglect. The investigation was unfounded for cuts, welts, bruises, abrasions, and oral injuries; sexual penetration; and sexual molestation. In April 2019, the mother reported to police that she saw red marks and bruising on the toddler's sister, and stated the sister said her paternal grandfather hit her. A medical exam and forensic interview did not reveal any concerns. Law enforcement declined to pursue criminal charges. The investigation was unfounded for cuts, welts, bruises, abrasions, and oral injuries. In June 2019, the Department opened another investigation of the toddler's paternal grandfather after the mother reported seeing bruises on the sister during a visit; the father had full custody of the children at the time. The investigator observed no bruises on either child, the sister was examined by doctors who voiced no concerns, and law enforcement believed the allegations were false. The investigation was unfounded for cuts, bruises, welts, abrasions, and oral injuries. In August 2019, the Department opened an investigation after it was reported that the toddler's father had a computer hard drive with child pornography on it. Another related information call came in alleging the paternal grandfather had sexually abused the toddler. Child abuse pediatricians were consulted on the case and found no signs of trauma or sexual abuse. Law enforcement did not pursue charges against the father. The investigation was unfounded for sexual penetration and substantial risk of sexual abuse – child pornography.

Child No. 77	**DOB: 09/2016**	**DOD: 11/2019**	**Natural**
Age at death:	3 years		
Cause of death:	Gastrointestinal hemorrhage due to esophageal ulcer		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was found unresponsive in bed, bleeding from the head, with blood in his mouth. The mother reported bathing the toddler when he returned from his father's home the night before, prior to putting him to bed. She said she observed the toddler awake and alert at approximately 6:00am, but found him not breathing later that morning. First responders immediately began CPR and the toddler was transported to the hospital, where he was pronounced deceased. The Department investigated the death, which revealed the toddler swallowed a lithium battery which caused internal bleeding and ultimately caused his death, his teeth were rotten, and he did not receive medical attention while he was dying. The mother was indicated for death by neglect, and for substantial risk to the toddler's surviving siblings, who were taken into the custody of the Department following the death of the toddler.

Prior History: The toddler's mother was a former parenting youth in care who had been taken into protective custody following two reports on her mother in 2010 for inadequate supervision and inadequate food. The mother was initially placed in a foster home with her four-month-old son and later moved to a transitional living program. During this time, she was in and out of the detention center due to delinquent behavior and frequently ran from her placement. The mother was investigated and indicated for inadequate supervision in 2011 when she failed to pick up her son from daycare. In 2012, the Department took her two children, a two-year-old and a six-month-old, into protective custody when the mother was indicated for burns by neglect and inadequate supervision after the two-year-old burned himself on a curling iron. In 2016, the mother surrendered her rights, the father's rights were terminated, and the family's case was closed. The children's adoptions were finalized the next year. The mother later gave birth to three more children. In September 2019, the Department opened an investigation following a report that the toddler and his one-year-old sister were discovered home alone. The mother admitted to leaving the children alone in the apartment for a short time when she went downstairs to hand her infant off to family members. She said the one-year-old was asleep, and the then two-year-old toddler was watching television. The mother was indicated for inadequate supervision. The mother was offered but refused intact services at the conclusion of the investigation.

Child No. 78	DOB: 09/2018	DOD: 11/2019	Natural
Age at death:	13 months		
Cause of death:	Cardiopulmonary arrest due to chronic lung disease due to lissencephaly		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-month-old medically complex child was transported by ambulance to the hospital where she was pronounced deceased after her mother called 911. The 13-month-old had a diagnosis of lissencephaly (a rare gene-linked brain malformation) and a medical history of congestive heart disease, lung issues, respiratory failure, and was dependent on a gastrostomy tube. The mother reported that she was walking her two older children to school when she noticed the 13-month-old to be lethargic in her stroller. She returned home and called 911. EMS responded and the 13-month-old went into cardiac arrest. She was transported by ambulance to the hospital where she was later pronounced deceased. The death was determined to be natural and no autopsy was conducted. The Department did not investigate the death.

Prior History: In 2016, the Department investigated and unfounded the parents for environmental neglect to their two older children, then ages six and three years old. In January 2019, the Department investigated the parents for inadequate shelter and environmental neglect after the Hotline was contacted with concerns about the condition of the home. While responding to a verbal altercation, law enforcement observed dirty dishes, pans with old food, an open bag of garbage, holes in the wall, a broken door, and a broken table. It was also reported that there were three girls, including a newborn on a feeding tube who was being fed by the eight-year-old child. The investigator interviewed the father, who admitted there was an incident with the mother and stated they argued but denied any physical altercation. The mother informed the investigator that she put the father out of the home and obtained an order of protection. The older child stated there was no fighting in the home and her father visited but did not live in the home. She further reported that she helped her mother around the house to keep it clean and her mother told her she would show her how to care for her baby sister when she gets older. The investigator observed the home to have working utilities, with dishes washed and trash taken out. During the investigation, there was concern that the then five-month-old medically complex baby was underweight. The mother was asked to take the child for a well-child check and a DCFS nurse became involved. The nurse confirmed that the mother had identified a community-based primary care physician who would monitor the infant. The primary care physician said the baby was born with lissencephaly, and the baby's low weight was due to her congenital health problems and was normal for the diagnosis. She had no concerns of medical neglect. The physician reported that mom was compliant and cooperative with health care providers and specialty follow up appointments. In April 2019, the investigation was unfounded.

Child No. 79	DOB: 03/2007	DOD: 11/2019	Natural
Age at death:	12 years		
Cause of death:	MELAS syndrome		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: A home healthcare worker reported the death of a 12-year-old medically complex child. The child was diagnosed with MELAS (mitochondrial encephalopathy, lactic acidosis, and stroke-like episodes), Wolff-Parkinson-White syndrome, and an intellectual disability. The child had an extensive care team that included nursing staff in her home and throughout the day at school, including on the bus. On the day she passed away, the minor had a medical issue on the bus. She died at home later that evening. The agency providing care and making the report had no concerns with the child in the care of her parents. The Department did not investigate the minor's death.

Prior History: In September 2018, the Hotline was contacted with concerns about the mother's ability to care for her then 11-year-old child. Both the mother and child were diagnosed with MELAS, a terminal

genetic disorder. It was reported that the mother's health was declining and that she lacked energy to care for her child, may not have dispensed medication at appropriate intervals, and was unable to lift the child in order to move her from her wheelchair to the bed and had been seen dragging her. The child had aide workers to care for her but there were gaps of time when the mother was alone with her because the father worked late hours and often was not home to help with the care of the child. The Department investigated the mother and father for inadequate supervision and medical neglect. The investigation revealed that the child was cared for by the mother as much as she could with her own medical disabilities and the family had various other supports in place. The doctor believed that the mother's physical condition allowed her to care for the child aside from lifting her and said she seemed attentive to the child's needs despite her physical limitations. In November 2018, the investigation was unfounded, and an intact family services case was opened. The intact family case was opened from October 2018 through March 2019. The family was cooperative with intact services. While the intact case was open the child was receiving palliative care and had an aide five days a week. The intact family case closed successfully in March 2019. After case closure, the family continued with palliative care services and continued to have aides come to the home to assist in caring for the child.

Child No. 80	**DOB: 03/2019**	**DOD: 11/2019**	**Natural**
Age at death:	7 months		
Cause of death:	Viral bronchitis and pneumonia		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old was found unresponsive by her father, who was caring for her while the mother was working. The infant was taken by ambulance to the hospital where she was pronounced deceased. The baby had been ill with a fever and upper respiratory issues prior to the death. The father stated that at approximately 4:30pm he took a shower, went into the bedroom to get dressed, and found the baby unresponsive. The father, not knowing what to do, called the mother telling her to come home. The mother arrived home approximately 10 minutes later and tried to rouse the baby. The mother told the father to call 911 while she attempted CPR. EMS arrived and transported the baby to the hospital where she was pronounced deceased. The Department investigated the death. The father was indicated for death by neglect. The mother was unfounded for death by neglect but indicated for inadequate supervision as she was advised as part of the pending child protection investigation not to leave the baby alone with the father but did so anyway because her regular babysitter was unavailable.

Prior History: Both the mother and father were involved with the Department as children. The mother's family had a case open for physical abuse from August 1998 through January 2000. The father's family had a case open for physical abuse from August 2004 through July 2009. Their first involvement with the Department as parents occurred in September 2019 when it was reported that the then six-month-old was found home alone. A maintenance man doing work at the apartment complex found the baby alone in the mother's apartment. Apartment office personnel and law enforcement cared for the baby for an hour before the mother was located at work. The mother came home reporting that she left the baby in father's care when she went to work. The police gave custody back to mom. The Department investigated the parents for inadequate supervision. An apartment complex employee confirmed that maintenance staff found the baby alone. They reported that the mother was a good tenant; they had not ever had problems with her and had not received complaints about her. The investigator viewed video footage showing the father leaving the apartment at 2:02pm. Maintenance staff found the baby alone in the apartment at 2:45pm and brought her to the office where staff cared for her. At 3:58pm, a male was seen walking back into the apartment; the mother confirmed it was the father. The investigator interviewed the mother at her home, observed the infant and noted no concerns. The mother stated she would not allow the father to be a caretaker as a result of this situation and instead would use extended family for childcare. The mother reported that she had an older child who was being cared for by relatives and was not home at the time of

the incident. The management of the apartment complex indicated they were going to change the mother's locks so father did not have access to the apartment. The father was indicated for inadequate supervision; the mother was unfounded for inadequate supervision.

Child No. 81	**DOB: 11/2015**	**DOD: 11/2019**	**Natural**
Age at death:	3 years		
Cause of death:	Complications of multiple congenital anomalies		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Full investigation pending		

Narrative: A medically complex three-year-old was pronounced deceased at the hospital. The baby had been born with congenital diaphragmatic hernia and required a ventilator and a sanitary environment. The alarm on the ventilator starting ringing. The toddler's mother and mother's paramour heard the alarm on the ventilator, called 911 and attempted CPR. The toddler was unable to be revived. The Department indicated the mother for death by neglect, medical neglect, and inadequate supervision to the toddler.

Prior History: In March 2015, the Department opened an investigation following a report the toddler's mother saw a friend of hers give the toddler's 14-year-old brother alcohol and did not prevent it. The investigation was unfounded for substance misuse. In March 2016, the Department opened an investigation following the 14-year-old brother stealing his father's marijuana. The investigation was unfounded for substance misuse. In March 2019, the Department opened an investigation following a report the toddler had been hospitalized seven times between November 2018 and March 2019. The toddler was diagnosed failure to thrive in January 2019, but medical staff did not call the Hotline because they were unable to determine if the toddler's weight loss was organic or inorganic. The investigation was unfounded for failure to thrive. In October 2019, the Department opened an investigation after the home health nurse arrived at the home and noticed the toddler accidentally unplugged her ventilator, which resulted in loud beeps, and her parents had to be woken forcefully by the nurse. The toddler's dressing had also not been changed all weekend and the toddler had developed a sore on her neck. There were also concerns the toddler's medications were not being administered properly and the mother admitted to not giving her the medications. The toddler's doctor did not see effects of not receiving medications and said she had been gaining weight. The investigation was unfounded for medical neglect one week before the toddler died.

Child No. 82	**DOB: 09/2018**	**DOD: 11/2019**	**Natural**
Age at death:	1 year		
Cause of death:	Complications of intracranial hemorrhage due to premature birth		
Reason for review:	Indicated child protection investigation within one year of the child's death		
Action taken:	Investigatory review of records		

Narrative: One-year-old, medically complex twin baby was found unresponsive by his mother at approximately 7:15pm. The mother transported the baby to the emergency room and reported to hospital staff that at approximately 6:15pm, she fed the baby through his gastrostomy tube and laid him down. At approximately 6:45pm, she heard the baby crying and checked on him, but was unable to calm him down. At approximately 7:00pm the mother noticed the baby was making noise, so she went to check on him again and found him unresponsive. When the baby arrived at the hospital he was not breathing and did not have a pulse. Medical staff were unable to revive him, and he was pronounced deceased at 7:45pm. The Department unfounded the mother and father for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect to the four surviving half-siblings, ages one, three, four, and six years old.

Prior History: In June 2019, the Department investigated the mother and father for medical neglect to the eight-month-old medically complex twins, after a physician reported that the parents failed to

establish a pediatrician for the twins and missed specialist appointments. The twins were born at 24 weeks gestation and required gastrostomy tubes. A nurse monitored the gastrostomy tubes weekly. The physician was concerned that the mother was watering down the formula. The mother was the primary caregiver, as the father worked outside the home. The parents told the investigator that they had only missed two medical appointments. The mother said one she was unaware of since it was not on the schedule of appointments, and the other one she missed because she had car problems. The mother stated that the physician told her he would contact the Department if she missed another appointment. The clinic receptionist informed the investigator that there had been eight cancellations and three no shows for the twins. The mother denied watering down the formula. She also stated that a nurse, a speech therapist, an occupational therapist, and a physical therapist came to the home weekly. The investigator offered the mother intact services, but the mother was not receptive stating she already had numerous services in place. The home nurse stated the mother missed a lot of appointments and did not fill prescriptions for one of the babies. In October 2019, the Department indicated the mother and father, as they were fully aware that the babies had severe health conditions and showed a blatant disregard in their parenting responsibilities.

Child No. 83	**DOB: 11/2019**	**DOD: 11/2019**	**Natural**
Age at death:	22 minutes		
Cause of death:	Extreme prematurity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn, born prematurely at 23 weeks gestation, died in the hospital after only surviving 22 minutes. The Department did not investigate the death.

Prior History: In September 2018, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to their one-year-old, after law enforcement reported a domestic altercation between the parents with the child present. The mother stated that she and the father were arguing about finances and her depression and that the baby was with the maternal grandmother at the time of the incident. Both the mother and father denied any physical altercation. The maternal grandmother confirmed the minor was in her care during the incident and reported no concerns. In November 2018, the Department's investigation was unfounded. In June 2019, the Department investigated the mother and father for environmental neglect after law enforcement reported that while responding to a call to the home, they observed trash and old food on the floor and unrolled cigarettes and supplies within reach of the toddler. The child protection investigator documented the family lived in a one-bedroom apartment. She noted a separate bed in the bedroom for the minor and observed a full ashtray, a pack of cigarettes, and a prescription pill bottle within reach of the toddler. The parents moved the items out of reach at the direction of the investigator. The investigator observed the rest of the home to be clean and free from environmental concerns. The toddler appeared clean and well nourished. The mother informed the investigator that law enforcement was at their home for a verbal altercation between her and the father. Both parents denied any physical altercation. The mother further stated that she suffered from PTSD, separation disorder, and depression. She stated she stopped taking medication because she did not like the way it made her feel. The mother was going to follow up with mental health services. The Department's investigation was unfounded, as the home was not unsanitary in a manner that would harm the child's health, physical well-being or welfare.

Child No. 84	DOB: 08/2006	DOD: 12/2019	Natural
Age at death:	13 years		
Cause of death:	Lesch-Nyhan syndrome		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old medically complex teen was found unresponsive by his mother. He was diagnosed with a genetic disorder (Lesch-Nyhan syndrome), which required the use of a wheelchair and caused self-harming behaviors. Due to recent illness with vomiting and diarrhea, the teen was receiving nutrients through a feeding tube. The father fed the teen at approximately 1:00am. At 6:20am, the mother entered the teen's room to find the teen unresponsive with his head "wedged" between the bed and the foam bumpers, which were on the bed to prevent self-harm. 911 was contacted and EMS arrived on the scene and transported the teen to the hospital where he was pronounced deceased at 7:19am. There were no outward signs of injury or trauma. The Department did not investigate the death.

Prior History: In May 2019, the Department investigated the mother and father for cuts, bruises, welts, abrasions, and oral injuries and substantial risk of physical injury/environment injurious to health and welfare by neglect to the then 12-year-old medically complex child. The investigation was opened after school staff reported that over the previous two months, the child appeared to have lost almost 10lbs; was listless, whereas he used to be active; had been hospitalized in March for a cough; and had a bruise on his cheek which the parent explained was from him falling out of bed. They explained that the child was unable to eat by mouth and was surviving on gelatin at school. The investigator observed the child in his wheelchair at school but could not interview him as he was non-verbal. The teacher stated that the child's eating habits had changed at school due to him choking on food. The investigator took photos of the bruise to his cheek. At the home the mother stated she was home alone with the child and was in the room on the bed with him and they were both sleeping. She then stated that she left to use the bathroom and put pillows to guard the child from rolling and before the mother could come back from the bathroom, the child had fallen. The investigator asked the mother to have the child seen by the doctor, and she agreed. The nurse reported that the physician stated the mother's explanation of falling out of bed was consistent with the injury. The nurse told the investigator that the physician had no concerns about abuse or neglect. In June 2019, the investigator spoke with the child's medical specialist who explained that the disease the child has results in self-harming behaviors including banging his head and biting himself. The doctor stated that the minor has involuntary movements that cannot be controlled. The doctor stated that the fall from the bed likely occurred and it had nothing to do with the parents' caretaking. In June 2019, the Department's investigation against the mother and father was unfounded.

Child No. 85	DOB: 09/2008	DOD: 01/2020	Natural
Age at death:	11 years		
Cause of death:	Pneumonia with cerebral palsy as a contributing factor		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-year-old medically complex child was found unresponsive by her mother. The mother began CPR as she called 911. The child was dependent on a gastrostomy tube and had been seen at a hospital two weeks earlier after the gastrostomy tube became dislodged. The Department unfounded the mother for death by neglect.

Prior History: In 2009, the child's father was indicated, and the mother was unfounded, for cuts, welts, bruises, abrasions, and oral injuries on the child's then seven-year-old twin brothers. At the time of the child's death, the father was not a member of the household. Between 2011 and 2016, the Department unfounded the child's mother five times for allegations including inadequate food, failure to thrive, substantial risk of harm, inadequate supervision, and medical neglect. In October 2019, the Department opened an investigation following a report that the child had a swollen eye with small abrasions around it.

According to the investigation, the child's mother initially stated she thought the injury was from the child falling asleep on a teddy bear with a button and later stated she believed it was from a bug bite. The mother took the child to the doctor to assess the eye injury. The doctor stated there was no evidence the injury was non-accidental. Following the child's death, doctors involved with the family reported concerns regarding the child's weight and several missed medical appointments. The investigator reported the mother did not have transportation, it was difficult to get the child to appointments on public transit, and the child's wheelchair was broken. The Department indicated the mother for cuts, welts, bruises, abrasions, and oral injuries with the rationale that she did not provide a plausible explanation and medical neglect with the rationale that the child had missed several doctor appointments. In December 2019, while the previous investigation was pending, the Department received another report because the heat was off in the home. The mother reported she and the child were staying with a friend since the heat had been turned off and the child's 17-year-old siblings were staying with other friends and family. The child's siblings told the investigator they went elsewhere because the mother did not provide a place for them to go. The mother stated the child's siblings were welcome at the friend's home where she and the child were staying. The Department unfounded the investigation.

Child No. 86	**DOB: 07/2019**	**DOD: 01/2020**	**Natural**
Age at death:	5 months		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive by the father. A call was placed to 911 and the infant was transported by ambulance to the hospital, where she was initially placed on life support and later pronounced deceased. The Department investigated the parents for death by neglect and substantial risk to the infant's 22-month-old sibling. The mother reported after feeding the infant at 5:00am, she laid the infant on her stomach in the pack-and-play and covered her with a blanket. The father awoke at approximately 8:45am and found the infant unresponsive. In March 2020, the Department's investigation against the parents was unfounded.

Prior History: The mother's history with the Department began when she was taken into care shortly after her birth in 1996 and placed with a paternal aunt. In 2001, parental rights were terminated, and the mother was adopted by the paternal aunt. At age 18, the mother became pregnant with her first child, the infant's older sibling, and moved in with her biological mother. In November 2015, the Department investigated the mother for inadequate supervision to the infant's then three-month-old sibling after the mother left the sibling with a friend, with no care plan. The friend contacted the mother's maternal aunt, who cared for the sibling overnight. The maternal aunt noticed the infant's sibling was congested and wheezing. The next morning, she took the sibling to the hospital and the sibling was admitted with a fever and an ear infection and was found to have a broken rib. The Department was granted temporary custody of the infant's sibling, who was placed with a relative. In December 2015, the investigation against the mother was indicated. The infant's sibling was adopted in March 2018, as parental rights were terminated for refusing to engage in services. In March 2018, the sibling's caseworker reported that the mother had recently given birth to another child. The Department investigated the mother for substantial risk to the infant's newborn sibling. In May 2018, the Department unfounded this investigation, as the father was the primary caregiver and they had family support to care for the newborn sibling. In July 2018, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to health and welfare after it was reported that the father was pinching and spanking the four-month-old sibling and the parents were using drugs. The father admitted to using marijuana, but the parents refused to cooperate with toxicology screenings. In September 2018, the investigation was unfounded, as the parents had an appropriate place to live and both parents denied domestic violence. The mother gave birth to the now deceased infant in July 2019. In August 2019, the

Department investigated the mother and father for substantial risk to the three-week-old and one-and-a-half-year-old after law enforcement reported a verbal dispute between the parents, who were reportedly highly intoxicated with the children present. The parents denied the incident occurred, and the paternal grandmother told the investigator that the family was at her home the night in question. In September 2019, the investigation against the parents was unfounded, as there was not enough evidence to support the allegation. The parents agreed to intact family services, and a case was opened in October 2019. The services recommended for the family were substance abuse assessments for the parents, zero to three evaluations for the children, mental health assessments for the parents, and therapy for the parents. The family moved frequently, residing with family members and at shelters. The caseworker had provided the parents with pack-and-plays on two occasions because they did not have proper sleeping arrangements for the children. The caseworker was working with the family to find stable housing and secure Norman funds at the time of the infant's death in January 2020.

Child No. 87	**DOB: 10/1999**	**DOD: 01/2020**	**Natural**
Age at death:	20 years		
Cause of death:	Shock, respiratory failure due to metastatic cancer, pulmonary embolism due to malignancy		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Twenty-year-old was pronounced deceased in the hospital, where she had been transferred by ambulance from hospice care. The youth had been diagnosed with stage four kidney lymphoma the previous month and experienced heart failure, an expected outcome of the disease, the day before she passed away. The Department did not investigate her death.

Prior History: In 2009, the then nine-year-old youth and her siblings came into care as a result of an indicated finding against her father for cuts, bruises, welts, abrasions, and oral injuries to her then seven-year-old sister. The children were placed together in a specialized foster home because the youth's brother, then 12 years old, was autistic and developmentally delayed. The following year, the brother was moved to a residential treatment facility and then to a group home, where he stayed until he aged out of care in 2018. The youth and her sister started having behavioral problems in 2010. Both the youth and her sister were psychiatrically hospitalized multiple times. In September 2013, the youth's sister was placed in a residential treatment facility. Her case remains open with a goal of independence. In 2014, the youth was moved to a residential treatment facility because she continued to have issues, displayed aggression, and went on run from the foster home. In 2015, her goal was changed to substitute care pending independence and the family case was closed. The youth was stepped down to a specialized foster home in 2015, but continued to have behavioral problem, was skipping school, and was refusing to engage in therapy. She was moved to two additional specialized foster homes, but she continued to have issues in her placement due to her aggression and elopement. The youth was placed in a transitional living program in June 2017 and did well in the placement until August 2017 when she was running away and staying at her boyfriend's home. She continued to run from her placement and stay with her boyfriend and his family until September 2019 when she was placed with fictive kin. In December 2019, she was hospitalized for pain. She had a mass on her kidney that had metastasized to her lymph nodes, and was diagnosed with stage four lymphoma, kidney failure, and had pneumonia and acute respiratory failure. In January 2020, she was placed in hospice care.

Child No. 88	DOB: 11/2019	DOD: 01/2020	Natural
Age at death:	2 months		
Cause of death:	Severe hypoxic ischemic encephalopathy		
Reason for review:	Open placement case at the time of the child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was born to his 24-year-old mother via cesarean section. As the physician made the incision, he discovered the mother's uterus had ruptured and the infant had been without oxygen for an undetermined amount of time. The infant was not breathing and was resuscitated. It was determined the infant had gone for an extended period without oxygen, causing brain damage. The infant was placed on a ventilator and remained in the neonatal intensive care unit until his death two months later.

Prior History: In October 2018, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the older siblings, who were one year old and one month old, after it was reported that there was a domestic violence incident between the mother and father. The mother and father were arguing, and the father hit the mother while the one-year-old was sitting beside her. The mother was nine months pregnant at the time of this incident. The mother called the police and obtained an order of protection. In December 2018, the Department's investigation against the mother was unfounded, as she took precautionary measures to protect her children. The investigation against the father was indicated. The mother was offered intact family services but declined. In January 2019, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the older siblings, ages one year old and two months old, after it was reported that the father had struck the paternal grandmother in the face several times, causing her face to bleed and swell. This incident occurred in front of the two children. The father fled the scene when the paternal grandmother called the police. The following day the police found the father hiding under a bed in the mother's home, as they were looking for him for the battery against the paternal grandmother and he was also in violation of the order of protection the mother had obtained in November 2018. Despite the order of protection, the mother allowed the father to live with her, and she admitted to police that the father had previously battered her on several occasions and had a "bad temper." The Department took protective custody of the children and the investigation against the mother and father was indicated. In December 2019, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant (deceased), after the birth of the infant due to the siblings being youth in care. The mother was partially compliant with the service plan, engaging in counseling, visitation and random toxicology screenings, but she never allowed the caseworker in the home, so it was suspected the father lived there despite the previous domestic violence. The father had not been compliant with his service plan and had a history of using methamphetamines and opioids. The investigation against the mother and father was indicated, as the parents continued to be unfit to have custody of the siblings. A safety plan was initiated at the hospital where the infant was born and remained until his death. In January 2020, the Department investigated the mother for inadequate supervision, after the hospital reported the mother had not been to the hospital in two weeks. The mother had participated in a team meeting and it was determined that it would be best to remove the infant from the ventilator due to him being swollen and stiff, with a poor prognosis. The mother signed a DNR but refused to return to the hospital to have the infant removed from the ventilator. The investigation was unfounded, based on the infant being in the hospital under 24-hour care.

Child No. 89	DOB: 12/2019	DOD: 01/2020	Natural
Age at death:	5 weeks		
Cause of death:	Asphyxial event due to upper respiratory obstruction/upper respiratory infection due to rhinovirus/enterovirus and coronavirus HKUI		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old was found unresponsive and turning blue by his mother and father. The father performed CPR while the mother called 911. The infant had been put down on the parents' bed an hour and a half earlier and was reported to be found on his back with a comforter and bottle approximately three feet away. The Department investigated the death and unfounded the investigation for death by neglect and substantial risk of physical harm/environment injurious to health and welfare by neglect.

Prior History: In December 2019, the day before the infant was born, the Department opened an investigation after the infant's 19-month-old sister ingested Tylenol while in the care of her mother. The sister was taken to the hospital. Hospital staff contacted poison control and had her transferred to another hospital by ambulance. In an interview after the infant was born, the mother stated she was having pre-labor contractions the day of the incident and kept running to the bathroom. When she walked out of the bathroom, she saw her daughter in the corner and all the pills on the floor. She checked her daughter's mouth and saw no pills and waited to seek medical care because she did not know if her daughter had ingested any medicine until she started throwing up. The mother reported she had since thrown away all medications in the home and would keep all medications in an out-of-reach cabinet in the future. The father reported the bottle was his and he had left the bottle slightly open. The investigator documented seeing the infant and discussing safe sleep with the parents. The investigation was indicated for poison – noxious substance by neglect because the child was in the mother's care at the time of the incident and the mother did not mitigate the situation beforehand by placing the pills out of the child's reach.

Child No. 90	DOB: 01/2020	DOD: 02/2020	Natural
Age at death:	1 month		
Cause of death:	Probable viral syndrome		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: One-month-old infant was found unresponsive in his bassinet by his 20-year-old mother and 27-year-old father when they awoke at 8:45am. The father called 911 and attempted CPR. The infant was transported to the hospital where he was pronounced deceased at 9:26am. The Department initiated an investigation against the mother and father for death by neglect to the infant and substantial risk to the surviving siblings. The mother reported that she fed the infant at 11:50pm and then laid him on his stomach in his bassinet, with a pacifier in his mouth and his head tilted to the side. The mother stated she checked on the infant before going to sleep at 3:00 am. The autopsy determined the infant died from a viral infection. In April 2020, the Department's investigation against the parents was unfounded.

Prior History: The parents have a history with the Department as children and parents. From 2006-2017, the Department investigated the maternal grandmother eight times, and of those two were indicated. The paternal grandmother was unfounded for sexual exploitation and substantial risk to the father's siblings in 2013. In October 2018, the Department indicated the then 19-year-old mother for substantial risk to her seven-month-old baby and two-year-old maternal sibling after a domestic violence incident between the mother and paramour occurred in the presence of the children. In January 2020, the Department investigated the father of the deceased baby for inadequate supervision to his four-year-old child after the police reported that a four-year-old was found wandering down the street alone around 10:00am, not dressed properly, when the outside temperature was 7^{o} F. The four-year-old did not live with her father but spent a lot of time with him because her mother worked. The father told the investigator that he lived with the mother of the deceased child and three children (ages three, one, and

infant), he was the father of the two youngest children, and he had not gotten much sleep lately caring for a newborn and one-year-old baby. The father stated he woke up around 10:00am and noticed the four-year-old, who normally sleeps in later, was not sleeping. The father searched the apartment and then asked the neighbors, who stated they saw a girl walking toward the apartment gate. The father went to the security gate and was told they called the police because the four-year-old was unable to tell them where she lived or who her parents were. The father was charged with child endangerment and the four-year-old was released to her mother. Two weeks prior to the baby's death, the mother reported to the police that the father had punched her in the face. The police reported this incident to the Hotline, and it was taken for related information to the pending investigation. This investigation was pending at the time of the baby's death. In April 2020, the Department's investigation against the father was indicated.

Child No. 91	**DOB: 05/2019**	**DOD: 02/2020**	**Natural**
Age at death:	8 months		
Cause of death:	Seizure disorder due to post-viral encephalopathy		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-month-old was found unresponsive by her mother at 2:03am. The mother called 911 and started CPR with the direction of the 911 operator and continued until paramedics arrived and transported the baby to the hospital. Staff attempted to revive the baby but were unsuccessful and she was pronounced deceased at 2:53am. The Department initiated an investigation against the mother for death by neglect to the baby and substantial risk of physical injury/environment injurious to health and welfare by neglect and inadequate shelter to the six surviving siblings. The baby and her twin were born premature at 32 weeks. The baby was later hospitalized in December 2019 due to febrile seizures. During this hospital stay she coded on two different occasions and had to be revived. After the death, the mother reported that the heat had been off in the house since 5:40pm the prior evening and she was unable to get in touch with the landlord. All seven children were sleeping in the living room because she was using the oven in the kitchen next to the living room to heat the house. The mother heard the eight-month-old twin sibling cry, so she fixed a bottle but she found it strange that her twin sibling was not crying, so the mother checked on the baby and found her unresponsive. In July 2020, the Department's investigation for substantial risk of physical/injury/environment injurious to health and welfare by neglect against the mother was indicated. The mother was unfounded for death by neglect.

Prior History: In February 2011, the Department unfounded the father of the deceased baby for substantial risk of physical injury/environment injurious to health and welfare by neglect to his six-year-old son from another relationship. The mother also had children from a previous relationship. In June 2014, the Department indicated the father of the mother's other children and his then-paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect and inadequate supervision to the mother's six-year-old after it was reported the paramour dropped off the six-year-old child off at the mother's home in the rain and left, even though the mother was not home. In September 2017, the Department unfounded a caregiver for substantial risk of physical injury/environment injurious to health and welfare by neglect to three of the mother's children after there was a report of a domestic violence incident between the caregiver and her paramour. In May 2019, the Department unfounded the father of the deceased baby for substantial risk of physical injury/environment injurious to health and welfare to his son, after it was reported the father went to the paramour's home and threatened to harm her and the son if she did not terminate the child support order. In June 2019, the Department indicated the father for death by neglect to his then five-year-old son and substantial risk of physical injury/environment injurious to health and welfare by neglect to the father's nine children after it was reported the father took the 10 children to his apartment complex swimming pool; the father was rounding up the children to have dinner in his apartment when he realized the five-year-old was missing. The other children stated that the five-year-old was in the washroom. The father did not find him in the

washroom and asked the apartment manager if she had seen the child. The father called police. During the search for the child, a sibling asked the manager if a doll was in the pool. The police officer jumped into the pool to retrieve the five-year-old's body. Others were swimming but did not see the five-year-old. The police noted that the water was very murky.

Child No. 92	**DOB: 09/2018**	**DOD: 03/2020**	**Natural**
Age at death:	17 months		
Cause of death:	Bronchopulmonary dysplasia due to tracheostomy present due to prematurity of 25 weeks		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seventeen-month-old medically complex toddler was found unresponsive by his in-home nurse when she arrived at the home at 11:00pm. Police were called and the toddler was transported to the hospital, where he was pronounced deceased. The toddler had a breathing tube and needed 24-hour care. The mother reported she went to sleep, and the father was responsible for caring for the child until the nurse arrived. The toddler was on a respiration monitor that beeped when he was in distress, but the in-home nurse and parents reported it beeped frequently, even at times when he was not in distress. The father admitted that he heard the monitor beep. While law enforcement was in the home, the mother yelled at the father that she did not believe he attended to the respiration monitor and the father and the mother's son got into a fist fight. The Department investigated the death. The father was indicated for death by neglect, as he was responsible for caring for the toddler when he died.

Prior History: In January 2018, the Department opened an investigation after the child's then three-year-old sister told her mother that her stepbrother had touched her inappropriately. The investigation was unfounded because the sister made no disclosure of abuse when she was interviewed. In May 2018, the Department opened an investigation following a report the child's then 14-year-old brother said his mother had choked him. The mother admitted to the incident and the child protection investigator observed the brother to have bloodshot eyes and some bruising. The mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by abuse and cuts, bruises, welts, abrasions, and oral injuries by abuse. One month after the investigation was closed, it was handed off for intact family services, and the transitional visit occurred in September 2018, one month after the handoff. The mother had just given birth to the toddler when the intact family services case was opened. The mother was recommended to complete anger management classes, domestic violence classes, and counseling. The teen brother was recommended to engage in counseling and substance abuse treatment after he was found to be using marijuana. In July 2019, while the intact case was still open, the Department investigated an allegation that the toddler's father was abusing the toddler's mother in the presence of the mother's children, and the father had threatened the then 15-year-old brother with a BB gun. The investigation was unfounded due to insufficient evidence and because there were no current concerns about the home. The family continued to struggle with domestic violence incidents and the mother attempted to obtain an order of protection against the father in December 2019. One month later, the intact family services case closed because the mother and the teen had completed services.

Child No. 93	DOB: 01/2001	DOD: 03/2020	Natural
Age at death:	19 years		
Cause of death:	Acute hypoxic respiratory failure due to status asthmaticus due to metapneumovirus infection		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old passed away at the hospital after he had been admitted for respiratory issues three days earlier. A decision was made not to intubate him as his caregivers and medical staff did not think his body could handle it due to his scoliosis. The teen had severe hydranencephaly at birth and was not expected to live to his first birthday. He was diagnosed with profound mental retardation, microcephaly, urethra reflex, anemia, scoliosis, wrist drops, seizure disorder, and required a gastrostomy tube for medication and nutrition. He was blind, non-verbal, and confined to a wheelchair. The Department did not investigate his death.

Prior History: The teen became a youth in care as an infant. His mother did not want him discharged to her care and did not have contact with him after his birth, though parental rights were never terminated. The Department took protective custody in February 2001 and was granted guardianship in August 2001. The teen remained in the hospital for almost two months after his birth and was transferred to a specialized care facility, where he remained until his death. The birth family's case was closed in 2011 when the teen's goal was changed to "home environment not appropriate." The court extended DCFS guardianship when the teen turned 18 but did not give the Department the authority to consent to medical decisions. The teen was hospitalized with respiratory distress in December 2019 and the Department was able to amend the order and get consent for medical treatments. In March 2020, while the Department was preparing paperwork for adult guardianship, the teen was hospitalized with respiratory distress again. The caseworker communicated with hospital staff, the teen's primary care doctors, the DCFS Guardian, and the consent unit regarding a decision to intubate the teen.

Child No. 94	DOB: 09/2019	DOD: 03/2020	Natural
Age at death:	5 months		
Cause of death:	Viral pneumonia with focal streptococcus pneumoniae bacterial infection		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Full investigation; Report to Director in FY 2021		

Narrative: Five-month-old was found unresponsive in bed by her parents. The local fire department was dispatched and performed CPR, and she was transferred to the hospital, where she was pronounced deceased. The Department investigated her death and unfounded the parents for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: Between 2016 and 2017, the Department unfounded the infant's father and his then-paramour three times for allegations of cuts, bruises, welts, abrasions, and oral injuries; and substantial risk of physical injury/environment injurious to health and welfare by abuse to the then-paramour's children. In December 2018, the Department opened an investigation following a report of a physical altercation between the infant's parents, during which the infant's then three-year-old and four-year-old maternal siblings were present. The children reported the infant's father had never hurt them. The mother and her children stayed with the maternal grandparents for a week following the incident, and the mother reported she was no longer in a dating relationship with the infant's father. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect because the mother was found to have exercised reasonable precautionary measures to prevent risk of harm to the children. The infant's father had two children from a prior relationship. In June 2019, the Department opened an intact services case involving the father's children from the previous relationship, then three and five years old. The father was listed as a case member, but no services were offered to the father and there was no indication he participated in the case. The case closed in October 2019.

Child No. 95	DOB: 05/2019	DOD: 03/2020	Natural
Age at death:	9 months		
Cause of death:	Pneumonia due to coinfection with novel corona (COVID-19) virus and coronavirus NL63		
Reason for review:	Child welfare services referral within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Nine-month-old had been put to bed in a crib around 11:00pm the previous night and was found not breathing with blue lips around 3:30am. The infant was staying with his maternal aunt and maternal grandmother, as his mother was staying in a shelter. The Department's investigation of the death was unfounded.

Prior History: The infant's mother is a former youth in care. In 2001, the mother's family came to the attention of the Department when the infant's maternal aunt was placed with the Department through delinquency court. The grandmother's other children, including the infant's mother, came into care in 2002 and 2003, and they were placed in the same home as the maternal aunt. In March 2004, the infant's mother was placed in a specialized foster home due to behavioral issues she was exhibiting. In September 2008, the mother's foster parents adopted her (the mother was eight years old at the time). In May 2013, the mother came back into care and participated in residential treatment programs. In December 2015, she returned to her adoptive parents. In February 2018, the Department opened an investigation after the infant's then 17-year-old mother was psychiatrically hospitalized and reported to hospital staff that her adoptive brother beat her and her adoptive parents did not want her. The mother's adoptive parents denied the allegations. The adoptive mother told the investigator that the infant's mother began hitting her sister and the adoptive mother intervened. Her son pulled the teen off of her when the teen turned her aggression toward the adoptive mother. The investigator observed injuries to the adoptive mother. Other siblings corroborated the story. After three weeks, the infant's mother was discharged from the psychiatric hospital to her adoptive parents' home. The investigation was unfounded. In May 2018, after graduating from high school, the mother's adoptive parents allowed her an extended visit with her biological mother. In June 2018, the infant's mother ran away from her biological mother's home. She eventually returned to her adoptive parents. There was no other contact with the Department until November 2019, when the infant's mother reported to medical providers that she had been forced to leave her biological mother's home, was staying at a shelter that did not allow infants, and she worried about him. The Hotline received a report but did not take it for investigation as no safety issues were identified. A second call to the Hotline that day resulted in the case being taken as a child welfare services referral. The infant's mother reported she had been living with the infant's uncle and his girlfriend but left after an argument. Because the shelter did not allow infants, she left the baby with the uncle who relied on the infant's maternal biological grandmother for assistance with childcare. In December 2019, the Hotline received a third call after the mother expressed concerns about the infant's safety, and she believed her mother would not allow her to take her infant back. The worker assigned to the child welfare services referral case was unable to make contact with the infant's mother prior to the infant's death.

Child No. 96	DOB: 04/2006	DOD: 04/2020	Natural
Age at death:	14 years		
Cause of death:	Glioneuronal tumor		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old passed away at the hospital where he had been brought five days earlier for end-of-life care. He had been diagnosed with a glioneuronal tumor in January 2014. The Department did not investigate the death for abuse or neglect.

Prior History: In February 2015, an intact services case was opened for the family after the teen's

mother was indicated for medical neglect for her failure to take the teen, then eight years old, for medical appointments following his diagnosis with a brain tumor. One month later, the teen's mother gave birth and the mother tested positive for cocaine. The Department took protective custody of the teen and his four siblings, then newborn, two years, fourteen years, and fifteen years. Three of the teen's siblings were later returned home and their cases were closed with the Department. In May 2016, the teen's permanency goal was changed to have his foster parents obtain guardianship due to his medical condition, as his mother admitted she would not be able to keep up with his care. The teen stated a desire to see his family more often and live with them. When his cancer went into remission, the court changed his goal to return home, though his foster parents fought the attempt to remove him from the home. In January 2017, he was placed with his aunt. The teen's mother began to demand unrestricted access to him and disagreed with his aunt about his care. In May 2017, his aunt could no longer handle the stress, and the teen was placed in a traditional foster home. Four months later, his cancer returned, and he was moved to a specialized foster home. In March 2018, his youngest siblings, then five and three years old, came into care again and were placed with their cousin. In May 2018, the teen, then 12 years old, was able to return to most of his normal activities because the treatment had shrunk his tumor. The following month, he was removed from his foster home and transferred to a residential facility because of allegations that he had been sexually inappropriate with his five-year-old foster sister. He later started sexual abuse therapy. In August 2019, he returned to his aunt's home. In January 2020, an MRI showed the teen's tumor was growing. His placement worker arranged for his aunt to receive support, such as respite care and counseling. Hospice care began in April 2020. The teen expressed a desire to pass away at the hospital, but his family and hospice nurse kept him home as long as possible to allow his family to continue visiting him, as they would not have been allowed with COVID-19 restrictions at the hospital.

Child No. 97	**DOB: 04/2020**	**DOD: 05/2020**	**Natural**
Age at death:	2 weeks old		
Cause of death:	Necrotizing enterocolitis, respiratory failure, and septic shock		
Reason for review:	Unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-week-old and her twin brother were born at 26 weeks gestation and remained in the hospital following birth. The infant developed necrotizing enterocolitis due to her extreme prematurity and was in the care of ICU doctors and staff at the time of her death. The Department did not investigate the death for abuse or neglect.

Prior History: In May 2019, it was reported that the infant's mother was using a sheet around her then one-year-old brother's neck to teach him to walk. The Department opened an investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse to the then one-year-old by his mother. The mother demonstrated tying a towel under the brother's arms to give him support. The mother explained she used this method due to medical issues that made it difficult for her to get on the floor. The friend who shared the method with the mother stated that he learned the method from his pediatrician. In July 2019, the investigation was unfounded. In March 2020, it was reported that the infant's mother and grandmother hit the then one-year-old brother in the mouth, and another of the grandmother's grandchildren, a 13-year-old cousin, had been burned a week before, but no one took him for medical care. The Department opened an investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse to the then one-year-old against his mother and grandmother. The mother and grandmother denied hitting the child, and the child protection investigator observed no marks or bruises on his body. The 13-year-old cousin stated that he received a burn while cooking and the family was caring for the burn at home. The child protection investigator instructed the family to have the burn examined by a doctor. In March 2020, the investigation was unfounded.

Child No. 98	DOB: 06/2019	DOD: 05/2020	Natural
Age at death:	10 months		
Cause of death:	Hypoxic brain injury		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Ten-month-old was pronounced deceased at the hospital. The infant was born with a complex congenital heart condition and required open heart surgery soon after birth. He was discharged to a transitional care facility in February 2020, but he was brought back to the hospital in March 2020 with a fever and remained in the hospital until his death. Four days prior to his death, he had a brain seizure and his heart stopped. His parents were informed of his medical condition and options and chose to have him removed from the ventilator. The Department did not investigate the death.

Prior History: In 2015, the infant's father was unfounded for substantial risk of physical injury/environment injurious to health and welfare by abuse to his son. In October 2019, the Department opened an investigation following a report of concerns about the infant's safety upon discharge from the pediatric ICU, as his mother, who has a learning disability, was not attending enough classes to learn how to care for him and needed additional time and support to learn. The mother had made comments about being overwhelmed, and she once threw the infant's two-year-old sister into her stroller when she got frustrated. The infant's father did not live with the family, but the mother stated she asked him to complete the training as well because she did not believe she could care for the infant alone, but he had not been attending the classes. The father did not have stable housing or employment at the time. The Department unfounded the investigation for substantial risk because the infant was safe at the hospital and the mother was working to complete her trainings and repeated trainings until she absorbed the information. The Department opened an intact services case before closing the investigation. In February 2020, the infant was ready for discharge following surgery, but the medical staff did not believe the infant's father should be in a caregiver role as he was inappropriate with the child, and it was recommended the infant be placed in transitional care. The parents agreed. A habilitation worker advised on how to prepare the mother's apartment for the infant's arrival and the mother was told she would need to complete more training at the transitional care facility. The child was doing well at the facility but was transported back to the hospital in March 2020 with a fever. He remained in the hospital until his death.

Child No. 99	DOB: 06/2015	DOD: 05/2020	Natural
Age at death:	4 years		
Cause of death:	Trisomy 13 (chromosomal condition)		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-year-old medically-complex child was found unresponsive by his parents at approximately 7:00am. He had been born with trisomy 13, a rare chromosomal disorder. Children with trisomy 13 who survive their first year of life are normally left severely disabled and only live a short life. The father was the last one to observe the child sleeping on the couch, still breathing at approximately 4:00am. The child was pronounced deceased at 7:40am. The Department did not investigate the child's death.

Prior History: In May 2016, the Department unfounded the mother for burns by neglect to the one-and-a-half-year-old sibling to the deceased child after it was reported the toddler was believed to have burns on her thigh. In September 2017, the Department indicated the paternal uncle for wounds to the four-year-old sibling to the deceased child after it was reported the child presented to the hospital with a BB pellet in her head. It was reported the paternal uncle shot the child in the head with a BB gun. The paternal uncle admitted to pointing the BB gun at the child and pulling the trigger. The paternal uncle was also arrested and charged with reckless conduct. In July 2019, the Department investigated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect to the

four children, ages four years (deceased child), five years, seven years, and nine years, after it was reported the mother contacted law enforcement following an argument with the father that turned physical. The father was alleged to have punched the mother in the face, attempted to strangle her, then took her vehicle. The mother reported she had argued with the father over him not cleaning the home. The mother stated that during the incident, she threw a bleach bottle in the father's direction which led to the physical altercation between them. The children were reported to be in the room taking a nap. Law enforcement confirmed the mother had reported the father hit and attempted to strangle her. The children denied witnessing a physical altercation between the mother and father. The father was never located by the Department investigator or law enforcement. The investigation against the mother was unfounded and the investigation against the father was indicated.

Child No. 100	**DOB: 07/2014**	**DOD: 05/2020**	**Natural**
Age at death:	5 years		
Cause of death:	Respiratory failure associated with spinal muscular atrophy, type 1		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old passed away at home. He was diagnosed with spinal muscular atrophy at birth. He was non-mobile and had a tracheostomy tube to help him breathe. His family took him home from the hospital one week prior to receive hospice care at home due to his declining health.

Prior History: The Department unfounded the child's mother eight times between 2007 and 2016. In 2011, the mother was referred for intact family services; the case was closed successfully in February 2012. The Department indicated the mother for substantial risk in July 2017 after a domestic violence incident between the mother and her paramour. In 2019, the child's mother was indicated for inadequate supervision after she left the child's eight-year-old sister, who has the same condition as the child, with a caregiver who had not been approved by doctors. In May 2020, the Department opened an investigation after the child was admitted to the emergency room due to a low oxygen level. The Department received a report he was covered in urine, feces, and dirt, and his hair was unclean. The child's doctor told the investigator the child's diaper was full and overflowing, but he could have filled the diaper on the way to the hospital and he did not have any skin irritation in the diaper area. The doctor was more concerned with the sores, cradle cap, and dandruff on the child's head. The mother explained that she usually washed the child's hair once a week but had run out of the no-rinse shampoo and had ordered more. She had not seen any issues with his nurse not changing his diaper and said he had very sensitive skin and would have skin problems if he had been left in a dirty diaper. The mother was concerned the child's health was declining, as he recently had an EEG indicating concerns and began having seizures. The nurse did not have any concerns about the child's care, had not seen any sores on his scalp, and said his hair was matted from EEG glue. Doctors explained end-of-life care and hospice services to the mother, who agreed to them. The Department unfounded the investigation for environmental neglect.

Child No. 101	**DOB: 04/2010**	**DOD: 05/2020**	**Natural**
Age at death:	10 years		
Cause of death:	Cardiopulmonary arrest due to acute on chronic hypoxic respiratory failure and recurrent aspiration		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Ten-year-old, medically-complex girl with cerebral palsy, who required a gastrostomy tube, was on oxygen, and required breathing treatments and oral suctioning, was pronounced deceased while in hospice care. The child was in hospice care from the end of January 2020 until her death. The Department did not investigate the death.

Prior History: In June 2019, the Department investigated the mother for bone fractures and medical neglect to the then nine-year-old child after it was reported by home health nurses that the mother was not providing the child with the proper care for cerebral palsy. The nurses stated the mother was not suctioning the child at night, requiring the nurses to provide breathing treatments and more suction the next day, and the lack of care could cause the child to choke on secretions. Furthermore, the nurses stated, when they returned to care for the child after the weekend, the child was experiencing pain in her leg and the mother would not tell the nurse what happened. The child was taken to the doctor by the home nurse and was diagnosed with a fractured femur. The child protection investigator spoke to the child's pediatrician who explained the child has several medical complications; one of the complications is osteopenia, making her high risk for bone fractures. The child had suffered a bone break in spring 2018. Both breaks were in the child's right femur area. The pediatrician also stated the area would have been weaker due to the previous injury, the child's bones were brittle, and her extremities were stiff. Additionally, the pediatrician stated there was no way to know how the breaks were caused, and they could have occurred during a diaper change or transfer to or from the car. The pediatrician had no concerns about the child's care. The investigator observed the child and noted that the child seemed comfortable and free of maltreatment. In September 2019, the Department's investigation against the mother was unfounded.

Child No. 102	**DOB: 09/2018**	**DOD: 06/2020**	**Natural**
Age at death:	21 months		
Cause of death:	Anoxic brain injury due to cardiac arrest due to chronic respiratory failure		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-one-month-old was taken off life support and pronounced deceased. The toddler was admitted to the hospital the day before her death. She was medically complex, required a tracheotomy tube and gastrostomy tube, and had been diagnosed with chronic respiratory failure. The Department did not investigate the death.

Prior History: The toddler's father had a history with the Department dating back to 2005, when he was indicated for medical neglect and bone fractures by neglect to children from a previous relationship. The children were taken into care following the investigation. The father's family case remained open until 2016 but the father was not actively involved in the case. In May 2008, the Department opened an investigation regarding the toddler's then three-year-old and four-year-old siblings after a report the father had previously been deemed unfit and had older children who had come into care. The investigation was unfounded. In May 2010, the Department opened an investigation against the toddler's parents after a report the mother had an order of protection against the father but allowed him back in the home, the father was selling drugs, and the father was not supervising the then five and six-year-old children. Both parents were unfounded for substantial risk, but the father was indicated for inadequate supervision. The Department opened an intact family services case as a result of this investigation. In October 2010, the children were taken into care of the Department. The parents completed all services and the children were returned home. The court ordered the case closed in June 2011. The family had no more involvement with the Department until November 2016, when the Department received a report the children, then ages eight months, three years, five years, seven years, nine years, twelve years, and thirteen years, were left home alone while the parents ran errands and the father drove the mother to work. The investigation was unfounded for inadequate supervision against the parents. In August 2019, the Department received a report the toddler's seven-year-old brother had a red mark on his cheek, and the brother said he had been punished by being hit with a belt from his dad for not being nice. The investigation was unfounded because there was no evidence the father was home at the time of the injury, the injury was not consistent with a belt mark, and the child said he had fallen off a bike that day at a time when he knew he was not supposed to be riding his bike.

TWENTY-ONE-YEAR DEATH RETROSPECTIVE

FISCAL YEAR	2000-14		2015		2016		2017		2018		2019		2020		TOTAL		AVERAGES	
CASE STATUS	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	00-20	%
Youth in Care	369	23.4%	24	16.1%	17	19.2%	20	25.0%	16	17.0%	22	17.9%	21	20.6%	489	22.2%	23	22.2%
Unfounded DCP	323	20.4%	30	20.4%	23	28.3%	33	31.3%	37	23.0%	47	38.2%	29	28.4%	522	23.7%	25	23.7%
Pending DCP	187	11.8%	14	12.9%	26	16.2%	22	14.6%	12	26.0%	19	15.4%	11	10.8%	291	13.2%	14	13.2%
Indicated DCP	116	7.3%	5	10.8%	8	6.1%	8	5.2%	15	8.0%	9	7.3%	14	13.7%	175	7.9%	8	7.9%
Child of Youth in Care	53	3.4%	1	0.0%	2	0.0%	1	1.0%	1	2.0%	2	1.6%	1	1.0%	61	2.8%	3	2.8%
Open Intact	231	14.6%	3	7.5%	9	10.1%	15	3.1%	8	9.0%	8	6.5%	13	12.7%	287	13.0%	14	13.0%
Closed Intact	64	4.1%	9	8.6%	7	2.0%	6	9.4%	3	7.0%	7	5.7%	5	4.9%	101	4.6%	5	4.6%
Open Placement/ Split Custody	101	6.4%	6	10.8%	3	13.1%	2	6.3%	3	3.0%	4	3.3%	2	2.0%	121	5.5%	6	5.5%
Closed Placement/ Return Home	24	1.5%	0	4.3%	1	0.0%	0	0.0%	0	1.0%	2	1.6%	1	1.0%	28	1.3%	1	1.3%
Others	112	7.1%	4	8.6%	4	5.1%	1	4.2%	3	4.0%	3	2.4%	5	4.9%	132	6.0%	6	6.0%
TOTAL	1580	100%	96	100%	100	100%	108	100%	98	100%	123	100%	102	100%	2,207	100%	105	100%

FISCAL YEAR	00-14	15	16	17	18	19	20	Totals
Total Deaths	1580	96	100	108	98	123	102	2207
Youth in Care	369	24	17	20	16	22	21	489
Natural	200	10	5	6	5	9	7	242
Accident	54	3	2	3	4	5	4	75
Homicide	76	9	7	6	4	6	4	112
Suicide	18	1	2	3	0	0	3	27
Undetermined	21	1	1	2	3	2	3	33
Unfounded Investigation	323	30	23	33	37	47	29	522
Natural	106	5	8	8	12	8	11	158
Accident	108	12	8	13	11	16	13	181
Homicide	56	4	4	6	4	11	1	86
Suicide	11	2	2	1	0	3	1	20
Undetermined	42	7	1	5	10	9	3	77
Pending Investigation	187	14	26	22	12	19	11	291
Natural	59	3	8	7	2	4	7	90
Accident	50	4	3	8	4	7	3	79
Homicide	37	3	3	1	4	2	1	51
Suicide	3	0	2	0	0	2	0	7
Undetermined	38	4	10	6	2	4	0	64
Indicated Investigation	116	5	8	8	15	9	14	175
Natural	40	1	3	3	4	3	6	60
Accident	41	1	3	3	2	3	3	56
Homicide	15	1	1	1	4	1	2	25
Suicide	2	0	1	0	0	1	1	5
Undetermined	18	2	0	1	5	1	2	29
Child of a Youth in Care	53	1	2	1	1	2	1	61
Natural	23	0	0	1	0	1	0	25
Accident	12	0	0	0	0	0	1	13
Homicide	8	0	0	0	0	0	0	8
Suicide	0	0	0	0	0	0	0	0
Undetermined	10	1	2	0	1	1	0	15
Open Intact	231	3	9	15	8	8	13	287
Natural	108	0	2	5	0	2	4	121
Accident	59	1	2	4	5	0	5	76
Homicide	30	1	1	2	1	2	2	39
Suicide	2	1	0	0	0	1	0	4
Undetermined	32	0	4	4	2	3	2	47
Closed Intact	64	9	7	6	3	7	5	101

FISCAL YEAR	00-14	15	16	17	18	19	20	Totals
Natural	21	3	1	2	1	5	4	37
Accident	22	1	2	1	1	2	0	29
Homicide	13	2	1	2	0	0	0	18
Suicide	0	0	0	0	0	0	0	0
Undetermined	8	3	3	1	1	0	1	17
Open Placement/Split Custody	101	6	3	2	3	4	2	121
Natural	62	4	1	2	2	2	1	74
Accident	16	1	0	0	0	1	0	18
Homicide	11	0	0	0	1	1	0	13
Suicide	0	0	0	0	0	0	0	0
Undetermined	12	1	2	0	0	0	1	16
Closed Placement	12	0	0	0	0	0	0	12
Natural	8	0	0	0	0	0	0	8
Accident	1	0	0	0	0	0	0	1
Homicide	3	0	0	0	0	0	0	3
Suicide	0	0	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0	0	0
Adopted	6	0	0	0	0	0	0	6
Former Youth in Care	20	2	1	0	0	0	0	23
Return Home	22	0	1	0	0	2	1	26
Interstate compact	3	0	0	0	0	0	0	3
Preventive services	35	0	0	1	1	0	0	37
Subsidized Guardianship	1	0	0	0	0	0	0	1
Child of former Youth in Care	4	0	0	0	0	1	2	7
Extended family support	11	2	1	0	0	0	0	14
Child Welfare Referral	23	0	2	0	2	2	3	32

PART III: GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

COMPLAINT

OIG received a complaint alleging that private agency staff proceeded with the placement of an 11-year-old youth in care into a specialized foster home after placement clearance was denied due to capacity limits. The complaint also alleged that agency staff submitted a request for a capacity waiver for the placement almost a month after placing the child.

FACTS

The 11-year-old boy first came to the attention of DCFS in June 2010, when he was three years old. The then three-year-old boy and his six-year-old sister were taken into protective custody after witnessing their mother commit suicide by a self-inflicted gunshot wound to the head. From November 2010 through April 2016, while living in multiple foster homes and a group home, the boy was psychiatrically hospitalized numerous times due to chronic behavior problems, including physical aggression, sexualized behaviors, destruction of property, temper tantrums, and suicidal/homicidal ideation.

In April 2016, the child was placed in a treatment foster family home with licensed foster parents. The foster parents are responsible for providing treatment-level foster care to the children in their home. In addition, the home is paid for by a private agency and the foster parents receive the foster care board rate for the foster children in their care. The private agency responsible for the treatment foster home also assumed case management responsibilities for the youth in the treatment foster family home.

The treatment foster family home was intended to be a short-term placement to prepare youth to transition to a traditional or specialized foster home placement. In July 2018, private agency staff made the decision to place the boy in a specialized foster home. The boy was familiar with the specialized foster home because he had stayed at the home on two occasions when the specialized foster home provided respite care for the boy. No placement clearance was obtained for the two respite visits, which violated Department Procedures.

On August 9, 2018, the private agency foster care program manager contacted the placement clearance desk by phone to request clearance for the boy to be placed in the specialized foster home. When placement clearance desk staff asked the program manager if any of the three children already in the home were specialized, the program manager answered falsely, "no." The placement clearance desk ultimately denied the placement because there would be too many unrelated children in the home. Had the program manager answered truthfully about the two specialized children, the placement would have been denied on the additional basis of being over capacity.

Despite the denial of placement clearance, the program manager and the private agency's foster care director decided to continue with the placement under the guise of a long-term pre-placement visit while they awaited a waiver from the DCFS Director. The boy remained at the specialized foster home during the week, while he attended school, and then returned to the treatment foster home on weekends. The program manager gave the specialized foster parent a handwritten CFS-906 form, *DCFS Placement/Payment Authorization*, to use if the boy needed medical care. The form stated, falsely, that placement clearance had been obtained on August 6, 2018; the placement clearance desk had not approved the placement nor was the placement clearance desk contacted on that date. A month after placement clearance was denied, private agency staff submitted the waiver request form, seeking to have the specialized foster home's capacity increased to accommodate the boy.

On November 6, 2018, two months after placing the boy in the specialized foster home, private agency staff returned the boy to the treatment family foster home after a Hotline call was made alleging that the boy did not feel safe living in the specialized foster home. The boy reported that he had been choked and hit by the other youth in the home. The allegations were ultimately unfounded as it appeared that the boy just wanted to return to his foster parents at the treatment foster family home.

The boy remained in the unauthorized placement 71 of the 81 days between August 10, 2018 and November 6, 2018. He spent a total of 10 days in the Treatment Foster Family Home during this time while the private agency continued to receive the treatment foster family home rate. In addition, while the boy resided at the treatment foster family home, he received weekly home visits, weekly therapy, and mentoring. Those services were cut dramatically while in the specialized foster home.

ANALYSIS

Based on the totality of the circumstances, private agency staff implemented an unauthorized placement, not pre-placement visits. The placement was unauthorized because placement clearance had been denied and no waiver had been secured. Moreover, the program manager was dishonest about the nature of the placement.

RECOMMENDATIONS

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

OIG shared the report with the private agency. OIG met with the agency's administrators and a member of the Board of Directors to discuss the findings and recommendations made in the report.

2. The private agency's foster care director should be counseled in accordance with the private agency's personnel practices for failing to follow Rules and Procedures when she allowed the boy to reside in the specialized foster home without placement clearance.

The agency's CEO met and reviewed the report with the employee.

3. The program manager should be disciplined in accordance with the private agency's personnel practices for: failing to follow Rules and Procedures when she allowed the boy to reside in the specialized foster home without placement clearance; providing false information to the placement clearance desk; for her misuse of the CFS-906 form; failing to document critical decisions in SACWIS; and failure to ensure that the boy had treatment level case management and supportive services while in the specialized foster home.

The employee is no longer with the agency.

4. Both licensing and placement staff at the private agency should be trained on the placement clearance process.

The agency addressed the recommendation with staff. In addition, the report was shared with DCFS Agency Performance Team for monitoring purposes.

5. The Department should review staffing levels at the private agency to ensure adequate staffing levels.

The report was shared with DCFS Agency Performance Team for monitoring purposes.

6. The Department should issue a policy memo clarifying the process for determining capacity based on Rule 402, Licensing Standards for Foster Family Homes, Appendix C and should be consistent with

placement clearance desk procedures.

The expanded capacity chart and narrative explanation for how to calculate expanded capacity shall be developed and issued through an information transmittal. In addition, the document shall be shared via e-mail with all DCFS and POS agency child welfare and licensing supervisors and administrators, as well as DCFS child protection staff. Direction will be provided to fully discuss the expanded capacity document at the next staff/team meeting and ensure that staff understand how to calculate capacity.

GENERAL INVESTIGATION 2

COMPLAINT A social worker called the Hotline to report that the 72-year-old grandmother and adoptive mother of a 15-year-old had passed away. The concern was that the teen, who is autistic and has developmental delays, might be under the care of his biological mother, whose parental rights had been terminated.

FACTS Upon the grandmother's passing, a social worker called the Hotline regarding the teen's care. However, the Hotline staff declined to take the report and, instead, referred the matter to a DCFS post-adoption worker. The DCFS post-adoption worker contacted the back-up caregiver, the teen's aunt, who declined to care for the teen because she had her own child with developmental delays. The DCFS post-adoption worker informed the social worker why the teen had been removed from his mother's care and advised her to contact the Hotline again.

A social worker contacted the Hotline again and relayed what happened regarding the back-up caregiver. She also voiced her concerns to the Hotline staff that if the biological mother had moved into her late mother's residence to care for the teen, the biological mother likely would not be able to afford the rent. She worried that the biological mother and the teen eventually would be evicted and become homeless, which did happen about a month later. The Hotline staff still refused to take the report.

The DCFS post-adoption worker was told by her supervisor that she did not even have authority to visit the home if the Hotline staff would not take the report. All the DCFS post-adoption worker could do was stop the adoption assistance payments to the grandmother due to her passing, which she did. No further action was taken regarding the teen until December 2018, almost two years after the initial Hotline call, when the teen and his siblings were taken into protective custody by the local county sheriff's office due to several indicated findings of neglect and inadequate supervision. DCFS was granted temporary custody eight days later. Eventually, the teen and his siblings were moved to a foster home.

ANALYSIS It is not clear why the DCFS post-adoption worker did not speak to the Hotline staff herself when the social worker was having no success in making a report. The DCFS post-adoption worker should have communicated with the Hotline staff herself and explained biological mother's parental rights had been terminated and that the teen could not be in her care. Due to DCFS's failure to act in February 2017, the teen wrongfully remained in his mother's care for almost two years. Indicated findings of neglect and inadequate supervision, as well as homelessness, put the teen in harm's way and turmoil.

RECOMMENDATIONS

1. DCFS should review and revise rules and procedures regarding guidelines for staff to follow when there is a death of an adoptive parent.

The Subsidy 1800CA outlines the requirement that in the case of death or incapacitation the parent/family is required to contact the DCFS Post Adoption Unit, at which time the Post Adoption worker will get details of who the minor child is in the care of, ask if they are interested in being the Adoptive parent/Guardian and will do an initial CANTS and LEADS. The Department has a contract with a family service agency who will then meet with the child and family to do a CERAP and make an assessment of appropriateness to proceed with a Successor Adoption/Guardianship, which includes a background check. Note that Post Adoption workers do not provide case management or monitoring of families once an Adoption is finalized or Guardianship is transferred as we have no legal authority. We do send a yearly notice as a reminder to the Adoptive Parent or Guardian to report to DCFS if they are no longer financially or legally responsible for the minor child. Updates are being made to Procedures to clarify and reinforce these practices.

2. DCFS should review existing procedures and/or develop procedures to improve communication and information exchanged between the post-adoption staff and the State Central Register staff.

The State Central Register (SCR) has developed a communication system which alerts Post Adoption staff, their supervisors and the Statewide Adoption Administrator when they receive informational reports regarding an adoptive family. The Post Adoption worker will reach out to the family to see if they can identify community services/resources or if an Adoption/Guardianship Support and Preservation Service (ASAP) referral is required. In addition, SCR will notify the adoption unit of any DCP investigations and the Post Adoption worker will provide information they may need to assist with the investigation.

3. Post-adoption staff should be retrained on their role and responsibilities as mandated reporters.

All Adoption and Post Adoption workers are trained regarding their responsibility as mandated reporters. Post adoption workers will be required to retake mandated reporter training by January 31, 2021.

4. DCFS should ensure that the new Comprehensive Child Welfare Information System (CCWIS) has an indicator to alert State Central Register staff when a subject in a Hotline report has had their parental rights terminated. In the interim, this indicator should be added to the existing SACWIS system.

The Department submitted a request to the Department of Technology and Innovation that the new Comprehensive Child Welfare Information System (CCWIS) flag when a subject in a Hotline report has had their parental rights terminated.

5. The investigators and supervisors in the involved field office should be retrained on how to use the "Person Search" on SACWIS to search for previous cases that may not be linked in the current sequence.

Child Protection Management developed a training and provided training to staff via WebEx in November 2020. The trainings addressed issues found in OIG investigations. In addition, supervisors in all specialties are now required to enroll in and complete the Model of Supervisory Practice.

GENERAL INVESTIGATION 3

COMPLAINT

A DCFS employee allegedly accessed confidential information and shared the information with a former partner.

FACTS

OIG received a complaint alleging that an office associate accessed the Law Enforcement Agencies Data System (LEADS) and the Child Abuse and Neglect Tracking System (CANTS) for a non-work-related purpose. The office associate called the DCFS Hotline to report suspected neglect of his former partner's grandson who was left in the care of other family members with no care plan and no way to contact the child's mother. The Hotline call was made in early 2018 and the office associate provided information about the family in an email sent to a child protection investigator weeks after the alleged infraction.

The OIG complaint was preceded by the office associate's breakup with his partner who was related to the child for whom the DCFS Hotline was called; the relationship ended in March 2019 and the complaint was filed in May 2019. The complaint alleged that the office associate used LEADS and CANTS to obtain information about two adults with whom the child was left and two additional adults. OIG investigators obtained a LEADS Validation Report form November 2018 through March 2019 which showed that the office associate had not utilized LEADS to obtain information on the adults with whom the child was left. No tracking system is available within the Statewide Automated Child Welfare Information System (SACWIS) or CANTS showing which background individual users have accessed.

The office associate initially denied sending an email containing information about the family history to the child protection investigator assigned to the case, but when confronted with the email he admitted he sent it. However, the email did not provide any confirmation of non-work-related use of SACWIS, LEADS, and/or CANTS. The office associate told investigators that he did not recall accessing or sharing any confidential information. Due to the denial or non-recollection of all alleged offenses, OIG investigators were unable to substantiate the allegations in the complaint against the office associate.

ANALYSIS

With no definitive evidence, OIG investigators were unable to substantiate the allegations in the complaint against the office associate. The office associate did not provide conclusive answers to whether confidential information was improperly accessed and shared.

RECOMMENDATIONS

1. The Department should be proactive in periodically reminding and training staff that the information they access through CANTS and LEADS is confidential and should not be shared with individuals who are not entitled to that information through the course of their work with the Department.

Staff are continually trained on this issue and there are notices posted in every office regarding confidentiality.

2. **With the development of the new Comprehensive Child Welfare Information System (CCWIS) program the Department should request that the program be able to track the CANTS and LEADS searches of individual users.**

The Department will request that the new Comprehensive Child Welfare Information System (CCWIS) be able to track CANTS and LEADS searches of individual users.

GENERAL INVESTIGATION 4

COMPLAINT Licensed foster parents were alleged to have falsified information on their licensure application. Had they provided truthful information, DCFS would have denied their license application.

FACTS An adult daughter accused her mother, a licensed foster parent, of providing false information on the licensure application for herself and her husband. Specifically, the daughter asserted that the mother failed to disclose that in the 1980s, the daughter was adjudicated an abused minor and removed from the mother's home due to an indicated finding of abuse. SACWIS searches of the relevant names in the "Investigations" and "Person" fields did not reveal the abuse case from the 1980s. The family's case appears when the mother's name is searched in the "Case" field. In fact, the mother did deny to DCFS personnel that she had any prior DCFS cases, and that she had any prior indicated findings. Both denials were false. DCFS revoked the foster home license of the mother and her husband. After a hearing, an Administrative Law Judge recommended that the Director uphold the revocation, and the Director accepted the recommendation.

ANALYSIS There is no question that the mother intentionally provided DCFS false information in an effort to obtain a foster home license. It is equally clear that DCFS would not have granted the mother and her husband a license if the mother had disclosed the indicated finding of abuse involving her daughter.

The falsehoods in the licensure application are only half the story in this case. A systemic failure in the background check process for foster home licensure also must be blamed for the improper licensure of the mother and her husband.

RECOMMENDATION **1. The Department should ensure that SACWIS and/or the new Comprehensive Child Welfare Information System (CCWIS) has all previous history of individuals linked to that person and accessible from clicking on the person's name.**

The Office of Information and Technology is in the process of ensuring this information is addressed in the new Comprehensive Child Welfare Information System (CCWIS).

GENERAL INVESTIGATION 5

COMPLAINT OIG received a Child Welfare Employee Licensure (CWEL) complaint alleging a former private agency foster care worker made threatening phone calls and sent threatening text messages to a foster parent and multiple staff members of the private agency.

FACTS In March 2019, a foster parent and various staff members began receiving suspicious text messages and phone calls. The text messages included profanities and warned the recipients not to talk about the foster parent's case, which was a case on the foster care worker's caseload. OIG investigators found that the phone numbers involved mostly came from a Voice Over Internet Protocol (VoIP) provider. VoIP is a technology that allows a user to make calls and send messages via the internet and, often, allows the user to have a different phone number than her own show up on the recipient's caller identification. Interspersed with the suspicious VoIP calls in the recipients' call and text message histories were calls from what OIG investigators discovered was the foster care worker's personal mobile phone.

ANALYSIS The foster care worker denied sending the suspicious text messages or making the suspicious phone calls. OIG investigators questioned her denials because: 1) someone purporting to be the foster care worker opened the VoIP account in question; and 2) the foster care worker has a history of untruthfulness, including her prior operation of an unlicensed daycare center, lies to licensing workers about it, and lies to the center's parents about the reason for the center's eventual closure. However, OIG could not determine definitively that the foster care worker was responsible for the suspicious text messages and phone calls. Moreover, there did not seem to be a clear motive for the calls and messages.

RECOMMENDATIONS

1. This report should be shared with the foster care worker's current employer, a different child welfare agency.

The report was shared with the child welfare agency.

2. This report should be shared with the private agency, and OIG will meet with agency to discuss the findings.

OIG shared the report with the private agency. OIG met with the agency's administrators and a member of the Board of Directors to discuss the findings and recommendations made in the report.

GENERAL INVESTIGATION 6

COMPLAINT OIG received a complaint alleging that a former private agency caseworker, who is currently a DCFS caseworker, received contact information for a woman in the community, and two days later the private agency placed an unrelated child with the woman under the guise that the woman was "fictive kin" of the child.

FACTS In May 2019, the caseworker was at a restaurant with eight children who had been taken into protective custody by DCFS and were waiting to be placed in foster homes. A woman was at the restaurant the same evening and was approached by the restaurant manager, who had gone to school with the woman's daughter. The manager explained to the woman that the eight children were awaiting foster placements through DCFS. The woman told the manager that she was willing to be a placement option, even though she did not know the children, and gave the manager her contact information. The manager then approached the caseworker and offered to assist, as he also worked at the school the children attended. The manager provided the caseworker with contact information for the woman and stated she might be willing to help with placement.

One week later, the placement of one of the children was disrupted and the child was placed with the woman from the restaurant, who was falsely labeled as fictive kin, which by definition is a person who has close personal or emotional ties with the child or the child's family prior to the child's placement with the person of the child. The woman had no prior relationship with the child or the child's family, nor was she a licensed foster parent.

ANALYSIS The private agency caseworker was alleged to have placed a child in an unlicensed, non-relative, and non-fictive kin home. OIG investigators confirmed that the caseworker failed to follow requirements in Procedures 301.80, Relative Home Placements, by, falsely identifying the woman from the restaurant as fictive kin, which are individuals who should be identified by the parents and children as well as failing to investigate the woman's relationship to the child or the child's

family. During the course of the investigation, OIG investigators found that the caseworker lied to coworkers, DCFS staff, and OIG investigators about the fictive kin relationship that never existed between the woman and the child.

RECOMMENDATIONS

1. The employee, who is currently in her six-month probationary period, should not be certified as a state employee.

The employee is no longer with the Department.

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

OIG shared the report with the private agency.

3. The Agency Performance Team (APT) Monitor for the private agency should examine the agency's practices for assessing placement with fictive kin and should include in that review the agency's procedures in completing Placement-Payment Authorization Forms (CFS 906) and other related paperwork as well as caseloads and staffing levels.

The private agency hired a trainer to provide training to staff on various topics. In addition, APT conducted two trainings, which addressed the family finding process and the family unit. The agency has also developed internal processes to address the recommendation.

4. The staff at the private agency should be trained on the proper manner of completing the 906 forms and related paperwork, including the importance of completing these forms in a timely and accurate manner, and Procedures 301, Placement and Visitation Services, regarding placement selection criteria.

DCFS Agency Performance Team monitor met with private agency staff to address the recommendation.

GENERAL INVESTIGATION 7

COMPLAINT

OIG received a complaint alleging that a Department office associate utilized state equipment for personal use when searching for confidential information on her child's father.

FACTS

The complaint alleged that the office associate had accessed Medicaid records regarding her child's father. OIG investigation revealed that the office associate did not have access to Medicaid records; however, she did have "read only" access to SACWIS.

OIG investigators found that several months prior to the complaint, a co-worker had asked the office associate what she was doing on her state issued computer and the office associate responded by stating that she was "looking up the record of her baby's father." OIG investigation also revealed that there was a two-year emergency stalking/no contact order against the office associate, protecting the girlfriend of the baby's father.

ANALYSIS

The office associate utilized state equipment for personal use in violation of 20.6 (State Computer Equipment Usage) of the Administrative Procedure (AP) #20 Electronic Communication and Distribution. A portion of this procedure states, "Desktop computers, laptop

computers, printers, and other equipment that is issued to employees should only be used for State business." The office associate violated AP 20.8 (Prohibited Use of the SACWIS and Any Other Search Function) which states in part, "The SACWIS search function may not be used to retrieve database information for purposes other than the accomplishment of assigned duties."

Administrative Procedure #20 states, "Misuse of DCFS/State equipment may result in disciplinary action up to and including dismissal." AP #20 also states; "Users of the Department's electronic mail system and/or SACWIS search function must sign a CFS 123 (Electronic Communication and Distribution Certificate of Understanding)." The office associate signed this document on May 2, 2019.

DCFS Professional Conduct Rule 3.1A states "Off-Duty Conduct: Employee conduct occurring off duty may subject the employee to discipline up to and including discharge when the conduct raises reasonable doubt concerning the employee's suitability for continued state employment in the present assignment or position or which adversely affects the confidence of the public in the integrity of the Department of Children and Family Services."

RECOMMENDATION

1. The Office Associate should be terminated and should not attain certified status as a state employee.

The employee is no longer with the Department.

GENERAL INVESTIGATION 8

COMPLAINT

A private agency caseworker initiated a nonprofessional relationship with a client and failed to notify a supervisor of the conflict of interest.

FACTS

After discharge from a neonatal unit for treatment of heroin withdrawal symptoms, a substance exposed infant was placed in a foster home. The infant's father who had left the infant's mother, a chronic substance abuser, completed substance-abuse services and visited the infant with the intention of gaining custody. The mother's parental rights were terminated. After a positive alcohol screen, the infant's father continued supervised visitation while returning to substance-abuse services.

After the father's positive alcohol screen, the private agency assigned the foster care case to a new caseworker. The new caseworker was responsible for ensuring the father submitted random toxicology screens and attended substance-abuse treatment and Alcoholics' Anonymous meetings. The caseworker dropped in on visits supervised by the paternal grandmother to ensure the father acted appropriately. When the father completed substance-abuse services a second time, the caseworker and her supervisor concluded the father should gain custody. All parties, including the foster parents, believed this to be in the best interest of the child.

On the day the caseworker planned to recommend the child's placement with his father to the court, the caseworker told a former colleague that she was in a relationship with the father in a case on which she was the assigned caseworker. The caseworker told the former colleague that she began to feel an attraction to the father while she was supervising visits in his home. She invited him to attend church with her and her children. The father and his son met the caseworker at church and went out to lunch with the caseworker and her children three times. The caseworker did not document these contacts in the State Automated Child Welfare Information System (SACWIS).

The former colleague encouraged the caseworker to notify her supervisor of the relationship. The caseworker did not want to admit her attraction to her client because her colleagues had an unfavorable opinion of him. She also knew the relationship might create an appearance she was favoring him. She told her colleague she hoped the case would close that day in court.

The former colleague notified the DCFS attorney of the relationship. When the caseworker arrived to testify in the child's case proceedings, the DCFS attorney asked her to leave the courtroom due to a conflict of interest. The hearing had to be continued, delaying the child's placement with his father because the caseworker was not available to testify to the basis for her recommendation. After the caseworker's supervisor learned of the conflict of interest, she directed the caseworker not to contact the father again.

The cell phone records of the caseworker show that in the eight days after she was directed not to contact the father, the caseworker texted the father more than 300 times. At the time of her OIG interview, the caseworker remained in contact with the father and viewed herself as his spiritual advisor.

The caseworker resigned her position with the private agency.

ANALYSIS The caseworker's personal relationship with the father created a conflict of interest, which violated DCFS Rule 437.40(b) and the DCFS *Code of Ethics for Child Welfare Professionals*, Section 1.07, Conflicts of Interest, subsection (a), Multiple Relationships…

"Child welfare professionals should take into consideration the potential harm that intimate, social or other nonprofessional contacts and relationships with clients . . . could have on those with whom they have professional relationships and on their professional objective judgment and performance."

RECOMMENDATION **1. OIG issued charges against the employee's CWEL.**

The employee's CWEL license was revoked.

GENERAL INVESTIGATION 9

COMPLAINT OIG received a complaint alleging that a private agency intact family services worker and her supervisor falsified a contact note documented in the State Automated Child Welfare Information System (SACWIS).

FACTS From October 2017 to February 2018, a private agency intact family services worker and her supervisor provided intact services to a family that first came to the attention of DCFS when the mother was indicated for abuse to her five-year-old child. Prior to case closure, on February 6, 2018, the intact worker conducted a home visit and documented in a contact note that, during the home visit, the intact worker met with the mother and child however the father was not present. The child welfare specialist documented that the mother had learned a lot from parenting classes, cooperated with all services, and learned other ways to manage the child's behavior besides physical discipline. Also, the child's therapist had helped the child develop ways to manage her anger issues. Following the visit to the home, the intact worker submitted the case to her supervisor for closure. The supervisor, in turn, submitted the case to the private agency's quality assurance manager for closure.

On February 26, 2018, the supervisor learned that the private agency's CEO had approved the case for closure

so long as there was a final visit and documentation from the parents describing how they would avert similar conflicts with the child in the future. The intact worker reported that the supervisor disagreed with the CEO's request and told her a final visit was unnecessary and suggested that the intact worker falsify the note.

On February 28, 2018, the intact worker entered a long and detailed note in SACWIS claiming to have conducted an in-person visit with the family, including the father at 5:00pm the previous day. The note closed with a statement that the family thanked the intact worker and supervisor for all their help. The case was then approved for case closure.

Private agency management were alerted to the falsified note and verified with the parent that the visit on February 28th never occurred. When private agency management questioned the intact worker about the falsified note, she admitted that the note was falsified. The intact worker initially claimed that the note was based on a phone call, but then later admitted that she had not spoken to the family that day. The intact worker stated that her supervisor had suggested she falsify the note. The supervisor denied the allegations. Both the intact worker and supervisor were discharged from the agency.

ANALYSIS

There is no question that the child welfare specialist falsified the case note regarding the purported February 28, 2019 home visit, as she admitted to doing so to OIG investigators. The child welfare specialist claimed that she falsified the case note because she was instructed to do so by her supervisor. For her part, the supervisor denied instructing the child welfare specialist to falsify the case note. However, the totality of the other evidence considered by OIG, including e-mails, witness interviews, and reports of the supervisor's behavior regarding and after the alleged February 28, 2019 home visit, made the supervisor's denial less than credible.

RECOMMENDATIONS

1. OIG will file charges against the Child Welfare Employee Licenses of both the child welfare specialist and supervisor.

Following a review of available evidence, charges were not filed against the former employees' Child Welfare Employee Licenses.

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

OIG shared the report with the private agency.

3. The private agency must ensure through training and policy that their workers are alerted to a neutral person that they can go to help them resolve ethical dilemmas. They should also be reminded that they can seek advice from the DCFS Ethics Officer or file a complaint with OIG or the Office of the Executive Inspector General.

DCFS Licensing and Monitoring will remind private agency staff that they may seek advice from the DCFS Ethics Officer and may file complaints directly with the DCFS OIG and/or the Executive Inspector General. Additionally, the Department will email the leadership staff of private agencies to remind them that they must have their own Code of Ethics pursuant to DCFS Rule 401.11(c)(6).

GENERAL INVESTIGATION 10

COMPLAINT

A child welfare specialist was alleged to have had an inappropriate sexual relationship with a former client for whom he had been a case manager prior to becoming a child welfare specialist with the Department.

FACTS

In April 2019, the child welfare specialist was hired by DCFS. Prior to his employment with DCFS, the child welfare specialist was a case manager with a Department of Human Services contracted agency. In May 2019, an Adult Protection Services Investigator reported having interviewed a former client of the child welfare specialist who reported that she had engaged in a sexual act with the new DCFS hire. The former client told the Adult Protection Services Investigator that in April 2019, after the child welfare specialist's last day at his prior employer, the child welfare specialist began texting the client and they had discussions of a personal nature. The child welfare specialist reportedly asked the client several times if he could pick her up from her residence and take her back to his home. The former client reported that she made up excuses not to go but the child welfare specialist was insistent, and she finally agreed to visit him in May 2019.

The former client reported while at the child welfare specialist's home, they watched a movie while sitting on his couch. The child welfare specialist then pulled out his penis, grabbed her by the hair, and attempted to force her to perform oral sex. The former client initially pushed him away, but said she later complied when he convinced her to perform oral sex on him. The adult services protection investigator documented that the former client said, "I did not like to perform oral sex but thought after several months of getting close to [the child welfare specialist], I thought he had feelings for me. [The child welfare specialist] was my counselor for 10 to 12 months and knew all my weaknesses and how to get me to do things. I felt manipulated and used." The former client further reported that the child welfare specialist told her "since he was no longer her counselor previous boundaries were eradicated." The investigator also documented the former client reported that the child welfare specialist threatened the woman saying if she were to tell anyone, no one would believe her, and she would be arrested for lying. The former client said she was not sure she wanted to pursue charges as she did not want him to go to jail, but she believed he should no longer be employed or licensed.

In June 2019, police interviewed the former client and the child welfare specialist about the incident. According to the police report, both admitted an incident occurred in the child welfare specialist's apartment. The former client reported that they exchanged text messages that had become increasingly more intimate including him sending a picture of his genitals. The former client told police that she performed oral sex freely and of her own will and did not want to report it but when she heard that the child welfare specialist was now working for DCFS, she had to report the incident fearing he might attempt to manipulate the mothers or teens and felt it was important to share what happened to her. Police did not pursue criminal charges against the caseworker.

The child welfare specialist told OIG investigators that he was the former client's counselor from September 2018 through April 2019. He admitted contacting the woman the day after he left the social services agency, and she responded a week later saying she wanted to be friends. He reported that their conversations evolved from friendly to intimate and they did have a one-time sexual encounter. The child welfare specialist said he was surprised to be contacted by police because he believed that since he was no longer working with her, the relationship was not improper.

ANALYSIS The child welfare specialist is a licensed social worker with an MSW degree. According policy handbook of the university he attended: "Students are required to know the contents of and are bound by the National Association of Social Workers."

The child welfare specialist knowingly violated Section 1, part 1.09 subsection (c) of the Social Work Code of Ethics which states that "Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibit is warranted because of extraordinary circumstances, it is social workers-not clients- who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally."

These same standards were reiterated in the employee handbook of the social services agency at which he had previously been employed. In addition, his personnel record from the agency indicated that he participated in two clinical supervisions addressing "Ethics and Boundaries" and a training on DHS OIG Rule 50 which discusses abuse and neglect of disabled adults. The Code of Ethics for Child Welfare (1.07 Conflict of Interest and 2.05 sexual relations with clients) similarly states that because of the potential for harm to the client and possible abuse of power, child welfare professionals should not engage in in sexual activities with current and former clients.

RECOMMENDATIONS

1. The child welfare specialist should be disciplined, up to and including discharge.

The employee is no longer with the Department.

2. OIG will refer this incident to the Illinois Office of Professional and Financial Regulation.

The incident was referred to the Illinois Office of Professional and Financial Regulation.

GENERAL INVESTIGATION 11

COMPLAINT OIG received a complaint alleging inconsistencies during bilingual testing of a Department employee seeking a promotion that required bilingual certification.

FACTS A Human Resources representative found involved employee on the upward mobility list and offered her a specific salary for a position as a Spanish-speaking day care licensing representative. After the employee accepted the offer, HR staff advised her that DCFS required bilingual certification. The employee was provided the bilingual certification test and the examiner concluded that the employee failed the test. The employee requested a retest as she felt rushed and discouraged by the examiner.

The second examiner found that the employee struggled somewhat while reading a paragraph in Spanish and took a little extra time in translations, but the examiner passed her since she was not applying for a high-risk child welfare or child protection position; she had a day care background; and he thought she could do the job.

The second examiner told OIG investigators that he remembered passing two candidates after the first examiner failed them, but he could only remember one name. OIG investigators obtained the other

candidate's tests. The first examiner failed the candidate with a score of 78%. Three months later, the second examiner gave her a 98% score and passed her. On the translation to Spanish examination, the first examiner counted four errors and the second examiner counted no errors; on the translation to English examination, the first examiner counted three errors and the second examiner counted no errors.

Due to the inconsistencies in the test scores, the supervisor of the two examiners asked a Department of Health and Human Services employee to test the employee a third time. He also assigned a work team to create a more standardized test and protocol, which he planned to use for the third test.

While the supervisor was on vacation, the acting supervisor emailed the employee to schedule a third test. A human resources staff person advised the acting supervisor that they had already offered the employee the job and requested that the acting supervisor cancel the retest. The acting supervisor and the attorney determined they had no authority to certify a candidate as bilingual and decided not to cancel the test. The human resources staff person advised the employee not to appear for the retest. The employee then voluntarily resigned from the position within a few days.

While the OIG investigation was still pending, DCFS made several changes to the 2014 bilingual-certification test protocol, including:

- Deleting provisions that the examiner should not comment on the candidate's job qualifications and oral exams should be digitally recorded and maintained for 60 days
- Changing the time limit for the written exam from one hour to "a reasonable amount of time" or about 90 minutes
- Deleting the provision that, after failing three tests, to retest DCFS would require the candidate to document completion of a language-skills class or immersion program
- Adding "The test is graded requiring a minimum of 80 percent to pass" and specifying the percentage each part of the test counted toward the final score
- Adding licensing workers will administer oral bilingual tests to foster parents with Spanish-speaking foster children

ANALYSIS

OIG investigation found that the grading between the two tests was highly inconsistent. Grading of the certification tests of the two candidates demonstrated a lack of standardization and objectivity in DCFS's Spanish-bilingual certification procedure.

RECOMMENDATIONS

1. Since other state agencies adopted DCFS's bilingual certification process, DCFS cannot look to them for a better process. DCFS should explore the bilingual-certification programs adopted by California, Washington, and Spain, and the testing approved by the American Council on the Teaching of Foreign Languages and the Consortium for State Court Interpreters.

The Department improved its bilingual certification process.

2. Examiners should create an answer key for each translation, specify how to count incorrect answers, and decide how many errors cause a one-point reduction in the percentage score for each test.

This recommendation has been implemented. There is an answer key and each word is assigned one point. The applicant cannot get more than 10 wrong per page. The grading process is explained to the applicant before taking the exam.

3. While the 2019 Protocol calls for a time limit on translations, examiners are not asked to document

the time the applicant worked on each test. The Verification form should provide a place to note that time, in case two applicants have the same score.

This recommendation has been implemented. On the exam results page there is a section to record the time it took to complete the exam. The testing protocol is explained to all the applicants at the beginning of the exam.

4. Oral test questions should be job-related and reflect the type of communication used in an applicant's daily work.

All questions are related to child welfare, past experiences with conducting interpretation and working in the child welfare field.

5. The 2019 Protocol should reinstate language deleted from the 2014 Procedure that the examiner should not comment on the applicant's job qualifications. Further, oral exams should be *recorded* and *maintained* for more than 60 days, as applicants have 180 days to file employment-discrimination claims.

This recommendation has been implemented. Comments are not made on job applicants' qualifications. Records are maintained for at least one year. Each applicant has a file created for them which is maintained by the Office of Affirmative Action. All oral conversational exam portions and verbal reading portions are recorded and kept on file for at least one year. A database of each applicant's name, date and their agency, if a Purchase of Service applicant, whether the applicant passed or failed, and when they were notified.

6. The 2019 Protocol should be revised to include specific provisions on when an applicant can be retested, who will administer the retest, the time frame to wait for a retest, and the specific reasons for the retest. The retest should have different passages to read and translate and should be administered by a different examiner.

The protocol was revised. If an applicant fails the initial test, they can request to be retested, or the supervisor can request that the person be retested due to complaints or concerns regarding that person's ability to communicate in Spanish. An applicant can be retested in 45 business days, and a different person will administer the retest from the initial examiner.

7. The Department should consider making a conditional offer of employment, contingent upon passing any job-related test. The 2019 Protocol requires a request for bilingual certification before an applicant is placed in a bilingual-certified position. This did not happen in the case of the involved employee, who was offered a position at a specific salary, which she accepted. After the involved employee failed the certification test, this offer was withdrawn. Similar actions may subject DCFS to liability for breach of contract in the future.

The Department agrees. Hiring for bilingual positions will be contingent on passing the test to be bilingual.

8. The Department should reconsider and clarify procedures for any language testing for Spanish-speaking foster parents. The 2019 protocol provides that licensing workers will be administering verbal tests to all foster parents with Spanish-speaking foster children. Unless the Department establishes a standard of fluency, this provision may result in grading disparities like those identified in employee-certification testing.

A policy proposal has been drafted and submitted to the Office of Child and Family Policy to finalize a process for Spanish-speaking foster home licensing staff to evaluate whether or not a foster home can verbally communicate effectively with Spanish-speaking youth-in-care, before being designated as a Spanish-speaking home.

GENERAL INVESTIGATION 12

COMPLAINT OIG received a complaint alleging that a DCFS caseworker had engaged in a sexual relationship with the father of a child on her caseload and was involved in the distribution and sale of cannabis.

FACTS The DCFS Hotline was contacted after the mother and the mother's paramour engaged in a domestic dispute while under the influence of drugs and alcohol. The mother's four children, whom were half siblings, were at the home at the time of the incident. Protective custody was taken and two of the children were placed with their biological father and the other two children were placed with their biological father. The investigation was indicated against the mother and her paramour for substantial risk of physical injury by neglect. A placement case was opened for the family.

Five months after the permanency case opened, the case was transferred to a different caseworker. Three months after the new caseworker was assigned the permanency case, legal custody of two of the children was granted to their father and wardship for those two children was terminated. The caseworker continued to service the remaining two children who were living with their biological father and participating in supervised visitation with their mother.

Throughout the case, the children's mother was unsuccessful with completing services which included domestic violence services and substance abuse services. In addition, the mother was inconsistent with required toxicology screenings and on two occasions tested positive for cocaine. It was also reported that the mother was inconsistent with parent child visitation.

The father of the other two children was also granted custody of his children and wardship was terminated 15 months after the caseworker was assigned the case. The DCFS family case remained open for an additional four months after wardship terminated and the caseworker documented visits to the home to check on the children, finalize the service plan and complete the closing CERAP.

While the DCFS family case was open, the Hotline was contacted following a police raid to the father's home which resulted in the father being charged with possession of cannabis with intent to distribute. During the police raid, the father's cell phone was confiscated. Police found text messages between the father and the caseworker that demonstrated both a working relationship and romantic relationship. In the messages, the caseworker and father detailed a romantic relationship in which they discussed their sexual encounters, child-rearing activities, domestic responsibilities, and their financial situation, as well as expressing a desire to move in together. The text messages also frequently mention the caseworker spending the night at the father's home. Additionally, the text messages detail the caseworker and father discussing purchasing, selling, and smoking cannabis.

The caseworker was placed on administrative desk duty after the text messages were revealed. The caseworker took vacation benefit time following the administrative desk duty and when she returned to work her DCFS-issued cell phone was confiscated. The cell phone had no calls, texts, or emails on the phone when

it was received.

The caseworker acknowledged to OIG investigators that she first began seeing the father socially after wardship terminated. The caseworker reported that initially they were friends but then the relationship progressed into a romantic relationship. The caseworker stated that she did not consider the father to be a client because the finding of neglect was not against him. The caseworker denied using cannabis but acknowledged that she knew the father did. The caseworker also denied erasing data on her DCFS-issued cell phone.

ANALYSIS

The DCFS caseworker was accused of engaging in a romantic relationship with a father on her caseload. OIG investigators confirmed that the caseworker and the father were involved in a romantic relationship, which began while the case was still open and assigned to the caseworker. In addition, the caseworker documented a home visit to the father's home during the time of the romantic relationship.

The caseworker violated Department Rule 437.40, Prohibition of Employee Interests and Conduct Creating Impropriety or the Appearance of Impropriety as well as the Code of Ethics for Child Welfare Professionals when she engaged in a romantic relationship with a client.

OIG has filed charges against the caseworker's Child Welfare Employee License.

RECOMMENDATIONS

1. The caseworker should be disciplined, up to and including discharge, for violating the Code of Ethics for Child Welfare Professionals and Rule 437, Employee Conflict of Interest, by engaging in an inappropriate relationship with a client.

The employee was discharged from the Department.

2. To reiterate recommendations made in the Confidential Memorandum dated September 9, 2019 regarding state issued equipment for employees on desk duty or administrative leave—in order to ensure a thorough investigation into allegations of employee misconduct:

a) DCFS should immediately develop a protocol on how and when electronic devices are retrieved from employees during an investigation of misconduct of that employee. All supervisors, including Area Administrators, Regionals Administrators, and Public Service Administrator's should be informed about the procedure and when the procedure should be utilized.

b) At the earliest indication that an employee will be placed on administrative leave or desk duty their DCFS-issued electronic devices should be retrieved from the employee's possession. The items should be taken before the employee is informed that their duties have been reduced.

If an employee is placed on desk duty, their work functions and access are restricted, but electronic devices remain in their possession. It is the Supervisor's responsibility to inform IT of their restricted access. If the employee is placed on administrative leave or suspension, it is the supervisor's duty at the time of notification to collect the electronic equipment and return it to IT. The Department will work on a protocol to ensure these procedures are formalized.

GENERAL INVESTIGATION 13

COMPLAINT

OIG received a complaint alleging that a private agency worker adopted a child from a mother that had previously been a client of the caseworker. The complaint also alleged that a case aide from the same agency also adopted the mother's first child.

FACTS

The mother's first child was removed from the mother's care in 2017, after being diagnosed with non-organic Failure to Thrive. The infant was initially placed with the paternal grandmother. When the child was 10 months old, the paternal grandmother told the private agency caseworker that she could no longer care for the child. A search for relatives failed to find any other viable relative placements for the child and private agency staff decided to place the child with the agency's case aide, as fictive kin. Agency staff made the decision based on the fact that the case aid had developed a relationship with the child while transporting the child to and from visits. Agency staff consulted with the DCFS Ethics Officer prior to approving the placement with the case aide. As a result of the placement with the private agency employee, the case was transferred to DCFS and assigned a new caseworker.

Prior to the transfer of the case to DCFS, the private agency caseworker learned that the child's mother was pregnant again. The private agency caseworker contacted the newly assigned DCFS caseworker and asked if she could approach the mother about adopting her second child. The DCFS caseworker contacted the DCFS Ethics Officer, regarding the issue. The Ethics Officer determined that the issue should be referred to OIG for further review and investigation.

The mother's second child was born exposed to methamphetamines and marijuana. Based on the private adoption agreement between the mother and the private agency worker, the court awarded temporary guardianship of the mother's second child to the private agency worker. Per the private agency worker's personal adoption attorney, both the court and the private agency worker's supervisor were informed about the adoption and the prior professional relationship. Five days after the child's birth, the adoption was finalized.

The mother reported to the DCFS caseworker that she did not feel pressured to agree to the private adoption but rather felt relief. The DCFS caseworker also learned from the private agency's personal attorney that while no money had exchanged hands, the private agency caseworker had paid for the mother to stay in a hotel for 60 days.

ANALYSIS

The Code of Ethics for Child Welfare Professionals has provisions that generally apply to this matter. For example, the Code instructs child welfare professionals to avoid conduct that might suggest that the professional was motivated by bias or personal interest in the performance of her duties. Also, the Code forbids child welfare professionals from engaging in conduct that conflicts or appears to conflict with her professional duties. However, DCFS has no specific guidelines covering this scenario.

RECOMMENDATION

1. DCFS should develop guidelines, training, and Rules applicable to child welfare staff considering adoption of a child from a family that the staff (DCFS or private agency) had professional involvement with. The guidelines should contain the following elements: 1) ensuring the involvement of a neutral third-party adoption agency as the decision maker; 2) advising that staff should not approach former clients directly or with current workers, because there is too much risk of role confusion or inadvertent coercion; and 3) advising that staff should respect former clients' privacy and not use their contact information for personal reasons.

The Department agrees with this recommendation and is considering amendments to Department Rules and

Procedures to address circumstances where Department or private agency staff are considering adopting a child from a family with whom staff had professional involvement. The Department will model any recommended changes to Rule 401.540 after the requirements in DCFS Rule 437, Employee Conflict of Interest. Rules 401, Licensing Standards for Child Welfare Agencies, are currently in approval to post for review.

GENERAL INVESTIGATION 14

COMPLAINT

OIG received a complaint alleging that a 15-year-old youth in care was handcuffed and shackled with metal ankle cuffs during transport from a therapeutic shelter to a different shelter.

FACTS

In June 2018, DCFS first contracted with the transport company to provide secure transportation, when it was clinically determined that transport by standard means (*i.e.*, a DCFS or Purchase-of-Service caseworker or supervisor, foster parent, or relative driving a youth) was unsafe for the youth or transporter, due to the youth's history of elopement, aggression, or documented unstable or unsafe behavior. The transport company also had a contract with the Division of Youth Services in a nearby state, which required the transport company to transport all youth in custody to be transported in full restraints. The transport company's procedures for DCFS required that all state-custody children over the age of 12 be transported in the "same manner" as the nearby state.

The transport company reported that during the course of two years there were a total of 24 Illinois youth in care that were restrained during transport: one youth was handcuffed and shackled with ankle cuffs during the entire trip; nine youth were handcuffed and shackled with ankle cuffs during part of the trip; five youth were shackled with ankle cuffs for the entire trip; and nine youth were shackled with ankle cuffs for part of the trip.

OIG investigators interviewed the driver of the transport company, regarding the 15-year-old identified in the initial complaint. The driver reported to OIG investigators that on that day he was first instructed by therapeutic shelter staff to handcuff and shackle a 17-year-old youth in care, during transport because the youth was a flight risk. The driver reported that after transporting the 17-year-old youth the driver returned to the therapeutic shelter to provide transportation for a 15-year-old youth in care. When the driver entered the building, shelter staff told the driver that the 15-year-old youth also needed secure transportation, and he should go get his "equipment." The driver returned to his car to get his handcuffs and shackles and used them to transport the 15-year-old to another shelter.

Several DCFS staff told OIG investigators that they knew "secure transport" meant metal restraints could be used to transport youth. An example provided was a youth in care that needed secure transport due to a history of kicking out police car windows, threatening to kill his caseworker, and wreaking havoc in a hospital emergency department. Another example provided was a time that secure transport of two girls who had been human trafficked was requested because when van drivers transporting one of the girls to a locked residential facility stopped at a stop light, the girl fled and ran to a car of traffickers who had been following the van, and the traffickers sped away with the girl. Other DCFS staff were unaware that secure transport meant the use of metal restraints and thought "secure transport" meant that two drivers placed the youth in the backseat of a car, which had door locks operable only by the drivers.

ANALYSIS

Following a preliminary investigation, OIG issued a memo to DCFS advising that there was credible evidence that the transport company DCFS contracts with had used metal handcuffs and shackles to transport youth in care from one shelter to another. The memo recommended that DCFS cease transporting youth in metal handcuffs and shackles.

The Department notified the transport company that the Department prohibited the use of handcuffs and shackles and was developing a protocol for the use of soft restraints. While the OIG investigation was still pending, on December 9, 2019, DCFS issued Policy Transmittal 2019.09, DCFS Criteria and Procedures for Transporting Youth via Secured Transport, which prohibited metal restraints during secure transport. The policy provided guidelines on the use of secure transport and the use of soft restraints. The policy transmittal stated that soft restraints may be used, if a judge or psychiatrist orders them in writing, and the DCFS Chief Deputy Director and the Chief Deputy Director of Clinical and Child Services gives written approval.

RECOMMENDATIONS

1. DCFS should amend its Criteria and Procedures for Transporting Youth Via Secured to define "soft restraints." The Department should consider the following as it revises these procedures: define levels of transport from the most restrictive (ambulance or even law enforcement for youth with the highest need) to the least restrictive (caseworker or investigator driving youth in the caseworker's (CW) or investigator's (CPI) private vehicle); establish criteria for when a CW or CPI should transport youth and when it is appropriate to ask for a higher level of transport; ensure that any person authorized to transport youth receives training in de-escalation techniques and in performing proper physical restraints; before the transport, transporters should introduce themselves and explain where they are taking the youth and how the transport will be conducted (e.g., use of soft restraints if authorized; supervised breaks for meals, using the washroom and stretching legs); youth should have the opportunity to ask questions and have concerns addressed; transporters should ask youth to turn over their cell phones prior to transport and explain the cell phone will be returned when the youth is safely delivered to the receiving placement; distraction activities should be provided - books, sketch pads, music, perhaps even tablets with movies, shows, or games downloaded, but not with cellular data; the youth should be asked what things they might like for the trip, especially if it is a long one; the Department may want to consult with the Illinois State Board of Education, the Department of Human Services, and residential facilities about how they transport clients and which service providers they use for transport.

The Department issued Policy Guide 2020.14, Secure Transportation Services on October 2, 2020. In addition, the Department terminated its contract with the transportation company involved in this report.

2. DCFS should ensure the Criteria and Procedures for Transporting Youth and Information Transmittal 2019.09 issued December 9, 2019 are adopted as a Procedure and made available to DCFS and POS employees by posting on DNET and DCFS website, and that employees are trained accordingly on this Procedure.

The Department issued Policy Guide 2020.14, Secure Transportation Services on October 2, 2020. In addition, the Department terminated its contract with the transportation company involved in this report.

3. DCFS should share this report with the *B.H.* Special Master.

The report was shared.

GENERAL INVESTIGATION 15

COMPLAINT

OIG received a complaint alleging that a private agency foster parent offered money to a biological mother if she would allow her son to remain in her foster home. It was also alleged that the foster mother's fiancée made a similar offer to a maternal relative.

FACTS

The biological mother was indicated for substance misuse after she and her son tested positive for substances at birth. The infant and his older sister came into care and were placed in a traditional non-relative home with the foster mother after biological mother failed to participate with intact services. There were two other unrelated foster children already placed in the home. Several months after coming into care, the infant's older sibling died in an accidental drowning while in the foster parent's care.

Following the drowning, maternal relatives requested that the infant be removed from the foster home and placed with relatives. An internal clinical staffing was held by the private agency to discuss placement; and a decision was made to place the child with maternal relatives out of state. An interstate compact was approved, and pre-placement visitation began. The foster parent and guardian *ad litem* appealed the decision to place the child with the maternal relatives. A clinical placement review was held, and it was determined that it was in the best interest of the minor to remain in the traditional foster home. The Assistant Public Defender for biological mother filed an appeal to the clinical placement review's decision on mother's behalf.

The case was subsequently transferred to another private agency; and a Notice of Change of Placement was issued with plans to remove the minor from the foster home and place with relatives out of state. The foster parent and the guardian *ad litem* again appealed; and a second clinical placement review determined that it was in the best interest for the minor to be placed with relatives. The foster parent appealed the clinical placement review decision, which was pending at the time of this complaint. The child remained in the foster home while the appeal was pending.

The biological mother reported that following her daughter's death, the foster parent offered her $10,000 if she would let her keep her son. Initially both the foster mother and her fiancée admitted to meeting with the biological mother but denied the allegation that money was offered to the mother. Subsequently, the fiancée changed his story and told OIG investigators that the foster mother did offer the mother money during that meeting; that he did not witness the offer because he left the restaurant after only 15 minutes, but that the foster mother told him that she made the offer. He denied that he made any offer to the biological mother or to a maternal relative. Additionally, he made several allegations against the foster mother and expressed concern about the safety of the youth still in her home as he reported no longer residing in the home.

ANALYSIS

OIG was unable to substantiate the allegations that the foster mother or her fiancée offered the biological mother or any other family member monetary gifts or assets to keep the child in their home. OIG investigators were never able to interview the biological mother about her allegation, despite several attempts to contact her, and were therefore unable to assess her credibility. There were no witnesses to the purported offer and no other evidence exists to support the claim that an offer was made. It was never alleged by anyone that money was in fact exchanged between the mother and foster parent. However, OIG investigators did find that the foster mother and her fiancée were not truthful and did not inform the monitoring private agency of significant events that occurred in the home and impacted the foster children in their care, including changes in the household composition.

RECOMMENDATIONS

1. The Deputy Director of Clinical Services should issue a final decision as to the placement of the minor within 60 days.

The Department agrees. A final Clinical Placement Review Decision was made in February 2020.

2. The foster home licensing agency should re-assess the stability of the children in the foster home and the foster mother's ability to care for the minors' long-term needs.

The DCFS Agency Performance Team monitor will address the recommendation with the agency.

3. This report should be shared with DCFS Clinical, the foster home licensing agency, and the guardians *ad litem* for the children.

The report was shared with DCFS Clinical, the foster home licensing agency, and the guardians *ad litem*.

GENERAL INVESTIGATION 16

COMPLAINT

OIG received a complaint alleging that a DCFS employee used the state email system to plan her high school reunion.

FACTS

The DCFS employee had volunteered to be vice president of her high school reunion committee. One project involved creating a list of all potential attendees from her graduating class through researching and compiling the graduating class's contact information.

OIG investigators obtained the employee's Department emails and found several emails related to high school reunion correspondence and planning. Many of the emails contained large non-work-related attachments that had been saved to the employee's DCFS computer. The employee reported that she had asked other reunion committee members to use her Department email for correspondence if they needed a response quickly, but to use her personal email for non-urgent issues.

Additionally, the employee's Department email address was printed on the reunion invitations asking attendees to RSVP and send pictures of themselves to that email, instead of her personal email. After learning of the incident, the employee told DCFS administrators that her Department email was unintentionally placed on the invitations and she was taking steps to remedy more responses from coming into her Department email. However, the employee was not transparent about her personal correspondence and document storage use on her DCFS computer.

ANALYSIS

The employee violated Administrative Procedures #20, *Electronic Communication and Distribution Certificate of Understanding*, which states that employees understand that the use of computer equipment and the electronic mail system is for State of Illinois business only, when she used her Department issued computer to store personal documents, email for personal correspondence and for document transfer. The employee also failed to disclose the full extent of using her DCFS computer for personal business to Department administrators.

RECOMMENDATIONS

1. The employee should be disciplined as deemed appropriate for not following Administrative Procedure 20.

The employee received an oral reprimand.

2. The Administrator of the involved unit should provide and ensure the employees of the unit review and acknowledge an understanding of the provisions of AP #20.

The Administrator reviewed Administrative Procedure 20 and the appropriate use of DCFS email and internet with staff.

3. Labor Relations should ensure that staff in this unit understand guidelines for non-disciplinary counseling.

The Office of Employee Services will conduct a training for the unit staff in FY 2021.

GENERAL INVESTIGATION 17

COMPLAINT

OIG received a complaint alleging falsification on travel vouchers submitted by two Department employees.

FACTS

The involved employees attended a training on the same day and stayed in the same hotel, in separately reserved rooms. Clerical staff from the employee's respective offices made the hotel reservations. After the training, the Department's Division of Budget and Finance received separate travel vouchers and receipts from the two employees, 30 days apart from one another. Upon review, the Department staff noticed that both travel vouchers and receipts had the same home address, the same date of travel and the same hotel room printed on the hotel receipts; causing the Department staff to suspect falsification by the two employees to attempt duplicate payment.

ANALYSIS

OIG investigated and after reviewing all relevant travel documents and interviewing all involved employees, found that the two employees had in fact stayed in separate hotel rooms and did not intentionally submit identical travel vouchers for payment. Rather, a series of errors by both hotel staff and DCFS clerical staff caused the two Department employees to submit incorrect travel vouchers and receipts for payment.

RECOMMENDATIONS

1. The first employee should contact the hotel to obtain a corrected copy of his travel documentation and resubmit the proper documents for payment.

The travel voucher was corrected and paid.

2. The second employee should contact Department clerical staff and ensure that his correct address is printed on future travel vouchers.

The Area Administrator issued the employee a memo to ensure clerical staff had the correct address on file.

GENERAL INVESTIGATION 18

COMPLAINT

OIG received a complaint alleging that a DCFS employee improperly shared a caseworker's medical records by sending the caseworker's completed Physician's Statement to the caseworker's supervisors.

FACTS

In October 2019, the employee sent an email to the caseworker which contained a letter to the caseworker's physician, the caseworker's job description, a Release/Authorization for Clarification form, and the caseworker's previously completed and submitted Physician's Statement. The caseworker's supervisors were also included in the email. The caseworker had previously informed the included supervisors that he did not want medical records shared with either of them and would not sign a consent to release medical information to DCFS. The inclusion of the completed Physician's Statement was thought to be a privilege breach of medical privacy.

The employee confirmed to OIG investigators that the completed Physician's Statement should not have been sent to the caseworker's supervisors and attached the completed Physician's Statement to the email in error. However, the error did not constitute a breach of privilege, because Physician's Statements are not considered privileged documents under the Health Insurance Portability and Accountability Act (HIPAA).

ANALYSIS

The caseworker reported having met with one of the supervisors on three occasions and each time was asked to sign a "consent to release medical records" to DCFS but refused. According to the employee, the request for a "consent to release" came from the Office of Employee Services (OES), in order to seek clarification directly from the caseworker's physician. OES sought to determine whether the caseworker's job duties were understood by the caseworker's physician when the caseworker was cleared to return to work. The caseworker perceived the repeated requests as harassment and the supervisor wanting the medical documentation personally. If OES had addressed their concerns directly with the caseworker and requested the consent, then likely the caseworker would not have felt harassed by the supervisors. The caseworker does not have to work with OES on a daily basis but does have to work with the supervisors daily and hindering that relationship is not in anyone's best interest.

Physician's Statements are not considered medical records and there is no rule governing their disclosure. It is the practice of CMS and OES not to share Physician's Statements with supervisors; however, there is not a rule against it. CMS and OES handle each case individually and disclose the statement when an employee's medical condition could affect their job duties, which was exactly the concern DCFS had in the caseworker's case. The employee did not intentionally send the completed Physician's Statement to the supervisors and by their own admission made an error. While the employee does need to be more careful and pay closer attention when sending documents that contain an employee's medical conditions, the employee did not violate any rule laid out by DCFS or CMS. Therefore, no discipline was recommended.

RECOMMENDATIONS

1. This report should be shared and reviewed with the employee for supervision purposes. No discipline is recommended.

The report will be shared with the employee.

2. The Office of Employee Services, not employees' supervisors, should directly request DCFS employees sign medical releases.

When there are specific questions about medical information received from an employee's doctor, that information will not be shared with the employee's supervisor unless the employee, via Office of Employee

Services, signs a release of information allowing that information to be shared with the supervisor.

GENERAL INVESTIGATION 19

COMPLAINT

OIG received a complaint alleging that an employee sent personal correspondence from her State-issued email account while she worked at a private child welfare agency and later as a DCFS employee. The complaint alleged that the employee sent email correspondence regarding children who were her fictive kin to the children's caseworker and their guardian *ad litem* with her State-issued email account. The complaint also questioned how the employee had obtained personal and confidential information about the children and their services.

FACTS

The employee admitted to OIG investigators that she used her State-issued email account to send personal email messages. The employee added that her DCFS supervisor spoke with her after she completed her training and emphasized the importance of using her State-issued email and computer for only work-related matters. This conversation took place about mid-September 2019, and the employee sent the last personal email from her professional account in August 2019.

The supervisor confirmed that this discussion occurred, and she added that she tries to have this conversation with all new staff under her supervision within six months of their start date. The supervisor stated that she has had to correct former private agency staff who have also used state computers for personal matters. She advised that private agencies may have looser restrictions regarding staff attending to private matters while utilizing work-related resources.

Additionally, a DoIT SACWIS specialist verified that the employee did not have access to the children's information on SACWIS. An OIG investigator then reviewed the information referenced in the employee's emails and determined that none of it was documented in the SACWIS database. When OIG investigators questioned the employee on how she had obtained the information, she replied that the children had told her since they spent much of their time at the employee's residence.

ANALYSIS

The employee violated Administrative Procedure 20, Electronic Communication and Distribution Certification of Understanding by using her State-issued email address for private matters, but these emails stopped after her supervisor talked with her about the DCFS rules and emphasized to her why these procedures are in place.

RECOMMENDATIONS

1. This report should be shared with the employee's supervisor, Area Administrator, and Associate Regional Administrator to make them aware of the employee's conduct.

The report was shared.

2. The employee should be counseled for inappropriate use of her State-issued email.

The employee was counseled.

ERROR REDUCTION

In 2008, the Illinois General Assembly enacted Error Reduction legislation requiring OIG to develop Error Reduction implementation plans intended to remedy child welfare practice errors that compromise or threaten children's safety, based on findings of OIG investigations and by Child Death Review Teams. 20 ILCS 505/35.7.

As a result of this legislation, over the past decade, OIG has developed Error Reduction Training curricula and provided statewide trainings to over 1,900 DCFS and private agency child welfare workers and administrators, including clinical and legal staff, and permanency, intact and child protection workers.

The basis for the Error Reduction program is recognition that individual error is only one factor and that flawed organizational practices contribute to potentially tragic outcomes for children. OIG's training curricula is built on the concept of error management through use of systems perspective and root cause analysis.

Error Reduction Trainings – A Historical Perspective

The initial set of Error Reduction trainings began in 2009 and focused on child protection investigations of cuts, welts, and bruising following several OIG investigations where the death of a child was preceded by an unfounded cuts, welts, and bruises investigation. In those investigations, bruising on children as young as a few months old was often minimized. OIG recognized the need for a cultural change in investigative practices. A new tool, now regularly used by investigators, was created to facilitate better communication and documentation of physicians' evaluation of injuries. The training was followed by reviews of child protection cases closed six months after the trainings, conducted by OIG and DCFS's Office of Quality Assurance. The review measured child protection teams' application of the Error Reduction trainings to their investigations, and DCFS administrators and managers were given region-specific feedback. The cuts, welts, and bruises Error Reduction training curriculum has since been incorporated into core training for new child protection investigators.

In 2010 and 2011, OIG conducted a second round of trainings focusing on intact families with parents who suffer from mental illness. In these cases, identified problematic practices mirrored practices previously recognized in cuts, welts, and bruises investigations, that is, intact family services workers not routinely obtaining relevant records or sharing relevant facts with treating clinicians to close information loopholes. By the end of 2012, OIG staff had trained DCFS and private agency intact family services staff in the Southern and Central Regions and Cook County. To support these trainings, the Department issued policy guidelines directing child protection investigators to ask parents/caregivers about mental health issues and requiring the investigator to obtain the relevant mental health records (*see* Policy Guide 2011.07, *Obtaining Records of Patients with Mental Illness).* Ultimately, in 2012, the mental health trainings for DCFS intact family workers were postponed due to budget cuts, which led to the elimination of DCFS intact family teams.

In 2013, the Department's reorganization/realignment resulted in the creation of high-risk intact specialists. The Division of Training requested assistance from OIG to train this new class of workers in Mental Health Error Reduction principles. OIG staff provided an overview of the mental health training

and facilitated discussions on communication with mental health professionals, obtaining relevant documents, and working with families with parents who have mental illness.

In 2014, OIG conducted five Multi-System Error Reduction trainings for select private agency and DCFS staff. The training provided an overview of three Error Reduction initiatives, including Young Parent Training, Bruising Training, and Grief and Loss Training.

OIG training staff expanded its curriculum to inform both administration and front-line staff, and to promote critical thinking and decision-making. Several OIG death or serious injury investigations involved cases of egregious abuse or torture of young children. The investigations revealed that – despite the gravity of the egregious abuse – the Department had a practice of offering standard parenting services, for which there was no evidence to support the notion that such services could ameliorate the risk of harm for these children.

In 2015 and 2016, OIG provided Egregious Acts training, centering around a five-topic Error Reduction training curricula: *Lessons Learned from Physical Abuse Fatalities*, and specifically, "Systemic Errors in the Legal System, High Risk Specialized Assessments *(Topic 5)"* Those trainings were presented to clinical staff, private agency staff, Department child protection, permanency, intact staff supervisors and managers. To help the field conceptualize the continuum of physical abuse, OIG created the *Maltreatment Continuum*, a visual tool illustrating the characteristics, spectrum, and severity escalation from minor assaults to egregious acts of physical abuse. The training focused on ensuring that a family is appropriately assessed, with a determination of whether there are any evidence-based services that could realistically alleviate safety threats to a child in that home.

In 2017, 2018, and 2019, OIG continued its Error Reduction efforts by conducting trainings for multi-disciplinary groups of intact family services supervisors, administrators, local State's Attorneys, and DCFS Legal staff in the Southern, Cook, and Central regions. A local State's Attorney (who had collaborated with OIG in Error Reduction trainings) reached out to OIG regarding a physical abuse case that had not been brought to the attention of the court, even for a protective order, because of the worker's belief that it would not pass legal screening for custody.

The principles addressed in the training were meant to be used in two types of cases: 1) where the risks are too high to *not* provide services and monitoring, but not high enough to remove children from parents' custody; or 2) in return home cases where the Department requires supportive services and supervision in the transitional period. In the case that prompted the follow-up training, although there was ample evidence to indicate the mother for physical abuse, and police expressed their intention to prosecute her criminally for domestic battery (she was later prosecuted), the mother was able to refuse voluntary intact family services with no repercussions from the Department.

During FY 2018 and FY 2019, OIG worked toward completing a hand-off of the Egregious Acts of Physical Abuse training to the Department's Division of Training and Professional Development, to incorporate into their ongoing training curricula. However, cases came to OIG's attention showing that physical abuse cases meeting the egregious acts criteria meant to expedite termination of parental rights either were not being identified as egregious acts of physical abuse at the onset, so timely and appropriate clinical and legal actions could be taken, or they were identified and the legal system and Department were not working together as they should for these rare cases. It seemed the clinical and legal systems were not functioning practically or efficiently, and the deficiencies were working against the best interest of the children in Department care, who have suffered some of the most extreme harms at the hands of their caregivers. To that end, OIG suspended trainings on this subject while collaborating with DCFS Clinical, Child Protection, and Legal staff to examine problems and develop a system of checks and

balances that are practically functional. In addition, reduction of the OIG's training staff dedicated to Error Reduction has hampered efforts towards collaborations and dissemination of information to the field.

Moving Forward

In 2020, the unexpected challenges and restrictions brought by the COVID-19 pandemic were unprecedented for essential child welfare workers. Direct service staff and administration focused on strategies to navigate both shelter in place orders, maintaining workers' health and safety while meeting the legal mandates required by policy, procedures, and their positions. As such, OIG is reworking plans for subsequent Error Reduction training initiatives.

In keeping with OIG's Error Reduction mandate, OIG has and will continue to identify and review patterns of problematic practice that compromise or threaten the safety of children. The following are areas under consideration for 2021:

- Reprise Cuts, Bruises, and Welts Error Reduction training: refresher/review discerning accidental vs. inflicted injuries to children with a focus on how that knowledge influences assessing safety and risk.
- CERAP: Review the daily application of the Child Endangerment Risk Assessment Protocol and efficacy in decisions related to child safety in the face of uncertainty.
- *BH* and *Norman* Consent Decrees: Examine the impact the consent decrees have on decision making in the field (i.e., the *BH* requirements' impact on the timeframes in which both investigations and open cases are closed and the influence the *Norman* Consent Decree has on assessing for future harms to children regarding allegation of environmental neglect).
- Supervision: Review of current formal or specialized training for supervisors and areas of additional or on-going support that may be beneficial.
- History: Focus on how the assessment of the total sum of circumstances and how that influences the inherently difficult decisions made daily by frontline child welfare staff.[1]

A New Approach

Restrictions related to the COVID-19 pandemic notwithstanding, OIG will continue to develop, and plans to deliver, Error Reduction trainings targeted regionally to address specific problematic practices using cases and events specific to each region and/or office. The target audience will include: Area Administrators, Supervisors and Advanced Specialists noting how management can support the frontline. This approach to Error Reduction training has multiple objectives, such as reviewing locally identified problematic practices while addressing associated systemic factors that impact, impede, and influence practice.

The laudable and dedicated service provided by the Department's first responders -- child protection workers, intact, permanency, and placement workers, supervisors and administrators -- to ensure the safety and well-being of children during these times is to be applauded.

[1] *Total Sum of Circumstances:* This phrase references situations where there are numerous identifiable factors that are seemingly not being connected in the overall assessment of immediate safety threats and risk factors impacting the parent/caregiver's level of functioning. These cases commonly involve some combination of two or more of the areas of domestic violence, substance abuse (opioid and alcohol and impacts on parenting), mental health (sporadic compliance with treatment including medication) and paramour involved families.

LAW ENFORCEMENT AGENCIES DATA SYSTEM (LEADS)

The Department is required by statute to assess the relevant criminal history of caretakers prior to the placement of children and to accomplish its other statutory duties. (20 ILCS 505/5(v)). Criminal History Record information (CHRI) is accessed through fingerprinting. However, the legislature has noted that the Department may need more immediate information to assure the safety of children. "LEADS is a multistate law enforcement, computerized telecommunications system designed to provide services, information, and capabilities to the law enforcement and criminal justice community."[1] Though LEADS may be used for immediacy, fingerprint checks are required for confirmation.

OIG meets the definition of a criminal justice agency in the Department of Justice Regulations on Criminal Justice Information Systems (Title 28, Code of Federal Regulations, Part 20, Subpart A). Because of its status as a criminal justice agency, OIG, unlike the Department, has access to criminal history outside of Illinois within limits set by the *National Crime Prevention and Privacy Act*.

DCFS Administrative Procedure

DCFS Administrative Procedure 6 (AP #6), specifies the use of the LEADS system for DCFS. AP #6 describes people authorized to receive LEADS information as "the Investigation Supervisor and Investigation Specialist investigating a report of child abuse/neglect, the placing worker evaluating the appropriateness of a placement with an unlicensed relative, the child welfare supervisor and child welfare worker assigned to a child welfare case, and the managers in their chains of command."

Workers receiving LEADS responses are cautioned that "LEADS criminal history checks are name based and may not provide an accurate criminal background for the subject. The only way to accurately identify a person's criminal background is through a fingerprint check."[2]

DCFS and Purchase of Service Agency (POS) staff assess LEADS information to identify its potential impact on child safety for the purposes of placement. If there is reason to suspect that the subject has a criminal record outside of Illinois, the staff are required to contact the OIG Bureau of Investigations by facsimile at 217/557-8843 or 312/433-3245 to request an out-of-state check.

Placement Clearance Desk Criminal Case Disposition Requests

When the Placement Clearance Desk is deciding on a non-licensed home for placement and the Illinois LEADS contains an arrest which may pose a safety threat to a child, but there is no disposition information, OIG provides technical assistance in obtaining the disposition. The Placement Clearance Desk may also request an out of state LEADS check for approving a home for immediate placement of children.

[1] Department of State Police, Adopted Rules, Title 20, Chapter II, Part 1240, page 1.
[2] Illinois State Police LEADS Daily Briefing 010818.

LEADS Restrictions

The LEADS system, as dictated by state and federal law cannot be used to do background checks for employment or licensing purposes. The Illinois Administrative Code restricts the use of the LEADS network and LEADS data for personal purposes.[3] It states that the information available via LEADS is for criminal justice purposes only and notes that "Violations of the misuse of information from the LEADS system can result in suspension, termination and even a criminal charge."[4]

[3] Ill. Admin. Code tit. 20, pt. 1240.
[4] Illinois State Police LEADS Daily Briefing 040418 and 040518.

CHILD WELFARE EMPLOYEE LICENSES

The following cases represent action taken against Child Welfare Employee Licenses (CWEL) in FY 2020.

License Revocation

- One employee had a CWEL revoked for transporting a child without a valid driver's license.

License Relinquished

- One employee relinquished a CWEL after OIG investigation substantiated an allegation of falsification.
- One employee relinquished a CWEL after OIG investigation found the employee conducted an inadequate child protection investigation, including failing to interview the child victim or observe the home environment.
- One employee relinquished a CWEL after OIG investigation substantiated an allegation of an inappropriate intimate relationship with a former client.

Charges Filed

- Charges were filed against an employee's CWEL for engaging in an inappropriate personal relationship with a client.
- Charges were filed against an employee's CWEL for failure to cooperate with a CWEL investigation.

APPENDIX

APPENDIX A

OFFICE OF THE INSPECTOR GENERAL
Department of Children and Family Services

REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File No: 19-0817

Subject: Serious Injury

Children: Seth Owens (DOB: 07-2015) and Tina Perkins (DOB: 07-2016)

SUMMARY OF COMPLAINT

On September 24, 2018, medical staff from Alpha Hospital contacted the Hotline to report a suspicious near-drowning incident involving three-year-old Seth Owens. Seth's mother, Verona Redemann, a former youth in care, initially reported that she had left Seth in the bathtub momentarily to care for her two-year-old in another room and when she returned Seth was turning blue and floating in the water. Later, when interviewed by police, Verona admitted that she pushed Seth's face underwater and held him there until foam came out of his mouth. Verona was indicated for torture and substantial risk of harm on October 19, 2018. Verona has been charged with aggravated battery to a child and attempted murder. The criminal case is pending.

The Office of the Inspector General (OIG) investigated the serious injury pursuant to its directive to investigate the deaths and/or serious injuries of children whose families have been involved with the Department of Children and Family Services (DCFS) within the preceding 12 months. In May 2018, four months prior to the near-drowning incident, Verona Redemann turned 21 and aged out of DCFS care. While a youth in care, Verona was indicated three times for substantial risk of harm for ongoing domestic violence between Verona and the father of her youngest child.

INVESTIGATION

Verona Redemann's History with the Department

Verona Redemann (age 9) and her siblings Willow Redemann (age 4) and Zayan Seward (age 3) were placed in the custody of DCFS in 2006 after their mother, Ainsley Redemann, left them with their 85-year-old grandmother without a care plan or way of reaching her. When their mother learned they were in DCFS custody, she admitted to cocaine use and failed to appear at court. The three children were adjudicated youth in care in January 2007.

Throughout Ainsley Redemann's history with DCFS, she continued to struggle with drug use and did not complete services. Zayan Seward's father, Blaine Seward, completed services and Zayan was returned to his father's care in June 2015. Willow Redemann resides in a specialized foster home with a goal of substitute care pending independence. Willow has a two-year-old child and is pregnant with her 2nd child due in April 2020.

In December 2012, when Verona Redemann was 15 years old, her permanency goal was changed to substitute care pending independence. A July 2014 Integrated Assessment (IA) noted that Verona appeared happy after moving to the traditional foster home of Cleo Terrell, where her younger sibling was living. The IA stated that Verona had successfully completed the 11th grade at Beta High School. The IA stated that Verona attended weekly individual therapy to address her feelings around foster care and her relationship with her mother. In November 2014, Ms. Terrell informed the caseworker that Verona was pregnant. Verona reported that the baby's father, Deandre Owens, and his family were very supportive.

In March 2015, Verona moved to Delta Agency's Transitional Living Program for Teen Parents. The Delta program is a residential facility designed to teach independent living skills to pregnant and parenting teen girls between the ages of 17-21.

In July 2015, Verona (age 18) gave birth to Seth Owens at Eta Hospital. Seth Owens' father is Deandre Owens, who was 19 at the time of Seth's birth. Following the birth of Seth Owens, Teen Parent Service Network (TPSN) staff completed the New Birth Assessment with Verona. The assessment noted that Verona was bonded and attuned to Seth and responsive to his cues. The assessment stated that according to the Edinburgh Postnatal Depression Scale, Verona did not display depressive symptoms and there were no concerns with substance use or domestic violence. The assessment noted that Verona had a history of leaving her placement without authorization and recommended that Verona be educated about the potential consequences of running away with her son and the benefits of providing him with a routine and a predictable environment. The assessment also stated that Verona does not seem to handle relationship stress well and would benefit from education on how to appropriately handle stressful situations.

One year later, in July 2016, Verona (age 19) gave birth to her second child, Tina Perkins. Tina's father, Eric Perkins, was 46 years old. Following the birth of Tina Perkins, the TPSN staff again completed the New Birth Assessment with Verona. The assessment stated that staff at the Delta Transitional Living Program voiced concerns regarding how Tina's father, Eric Perkins, treats Seth due to a recent incident when Verona reported that Mr. Perkins was emotionally abusive towards Seth, citing examples of name calling, and ignoring him. The plan to address service needs related to personal and emotional health stated:

> Verona has a history of run behaviors. There are current concerns with potential DV [domestic violence] in her relationship with Mr. Eric Perkins. Verona's case worker reported that Verona was recently stranded with her children and TLP [Transitional Living Program] staff went to pick them up. Following this incident, Verona reported to them that Mr. Perkins has been physically abusive towards her and emotionally abusive towards Seth (name calling), Verona was instructed to take out an order of protection against Mr. Perkins but she did not. A subsequent hotline investigation is currently pending. It is recommended that Verona be referred for domestic violence counseling and support. It is also recommended that Verona continue to be educated on the potential dangers caused by run behaviors, her involvement in a DV [domestic violence] relationship and the impact of the hotline calls on her life and the lives of her children.

In May 2017, Ainsley Redemann was indicated for substantial risk of physical injury to Willow Redemann, age 15 (SCR# 1111D). The rationale for the indicated finding stated:

> …The minor [Willow Redemann] reports that the mother attacked her with a crowbar after an altercation regarding her being on run from her foster placement and at a boyfriend's home. The mother retrieved the minor and took her to the police station. The minor was later admitted to the psychiatric unit at Epsilon Hospital. Although the police and the hospital staff did not observe any injuries to the minor at the time of her admission to the hospital, the mother later admitted to hitting the minor with the crow bar during the altercation and then justifying her actions by posting the details of the incident on social media…

Eric Perkins' Prior History with the Department

In 2010, Eric Perkins (age 39), the father of Verona's youngest child, Tina Perkins, was indicated for sexual molestation for SCR# 2222A. According to the investigation, during a victim sensitive interview, the nine-year-old daughter of Eric's paramour reported that Eric had touched her private area and buttocks on more than one occasion. Eric Perkins was indicated for sexual molestation. In 2013, a subsequent call (SCR# 2222B) was made to the Hotline alleging that Eric Perkins was having unsupervised contact with the children. The investigation was unfounded and expunged. According to police department records, Eric Perkins was arrested on May 6, 2010 for criminal sexual abuse and released without being criminally charged.

Eric Perkins' prior Criminal History

Eric's criminal history dates back to 1989 when he was arrested on drug charges and in February 1990, found guilty of manufacturing and delivering controlled substances and manufacturing and delivering 15 grams or more of cocaine or an analog thereof. Eric was sentenced to four years imprisonment. In 1993, Eric was found guilty of criminal trespassing to a vehicle and sentenced to 60 days imprisonment. In 1995, Eric was arrested for disorderly conduct which was stricken off with leave to reinstate. In 1996, Eric was arrested and charged with forgery. In 1998, Eric was found guilty of the forgery charge. In 1999, Eric was arrested for domestic battery, but no charges were filed. In March 2000, Eric was found guilty of aggravated false personation of police and sentenced to one-year imprisonment. In November 2000, Eric was found guilty of theft of labor or services. In 2006, Eric was arrested for domestic battery causing bodily harm and an ordinance violation. The domestic battery charge was stricken off with leave to reinstate and Eric was found guilty of the ordinance violation and sentenced to 26 days imprisonment. In 2007, Eric was found guilty of escaping his electronic monitoring device. Eric was sentenced to two years imprisonment. In May 2010, Eric was arrested and released without being charged for criminal sexual abuse related to the indicated child protection investigation involving sexual molestation. In June 2010, Eric was found guilty of knowingly damaging property and sentenced to five days imprisonment. In January 2016, Eric was arrested and charged with domestic battery physical contact. According to police department records, Eric's girlfriend at the time, Freyja Vance, reported to police officers that during a verbal altercation with her ex-boyfriend, Eric became irate, grabbed her by the hair, and pulled her to the ground. The charge was stricken off with leave to reinstate.

SCR# 3333A (Verona Redemann) and SCR# 4444A (Eric Perkins)

On August 17, 2016, one month after Verona gave birth to her second child, a staff person from Delta Agency contacted the Hotline to report ongoing domestic violence issues between Verona Redemann and Eric Perkins. The reporter stated that Verona disclosed that Eric choked Verona while she was at his home with her two children, Seth (age one year) and Tina (age one month). Verona reported that Seth witnessed the incident and began screaming and yelling. Verona also told the reporter that there was also an incident the previous week in which Eric scratched Verona near her eye. The reporter stated that Verona and Eric frequently fought, and Verona continued to take the children to his home. Separate child protection investigations against Verona and Eric Perkins were opened for investigation.

SCR# 3333B (Verona Redemann)
While the August 17 child protection investigations were pending, a subsequent call was made to the Hotline. On October 4, 2016, another staff person from the Delta Transitional Living Program (TLP) contacted the Hotline to report that Verona and her children, Seth (age one year) and Tina (age three months) had to be brought back to the TLP by local police due to a domestic altercation between Verona and Tina's father, Eric Perkins. The reporter stated that according to the police, Verona had attacked Eric and they were going to arrest Verona but decided to bring her back to the transitional living program instead. The reporter stated that Verona was not supposed to be at Eric's home because of the pending investigations against Verona and Eric.

On November 13, 2016, Verona Redemann and Eric Perkins were indicated for the August 17th investigations (SCR# 4444A and 3333A). Verona and Eric were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. The October 4th investigation against Verona Redemann (SCR# 3333B) was closed on December 2, 2016 and Verona was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Following the domestic violence incidents, Verona signed a client contract agreement with Delta on October 31, 2016. The contract included an agreement to participate in parenting services, domestic violence services, and an agreement to refrain from visiting or having physical contact with Eric and developing a visitation plan for Eric Perkins and Tina Perkins until a court ordered visitation plan could be developed. Following the contract agreement, Verona continued to meet with her therapist twice a week, was assigned a parenting coach and Delta staff referred both Verona and Eric Perkins for domestic violence services. Eric Perkins did not engage in domestic violence services. Verona completed domestic violence services at Gamma Agency and received a certificate of completion in February 2017.

Ian Zamudio[1] was the assigned Delta Agency case manager for Verona Redemann from October 16, 2017 until Verona emancipated in May 2018. During the six-month period, there were 10 contact notes created by Ian Zamudio in SACWIS and three supervisory contact notes created by Director Jordan Atkinson, from Delta. The supervisory contact notes were dated December 8, 2017, December 29, 2017 and February 2, 2018. The supervisory contact notes dated December 29, 2017 and February 2, 2018 were not entered in SACWIS until November 16, 2018, almost a month after the near-drowning incident.[2]

In an interview with OIG investigators, case manager Ian Zamudio reported that at the time he was assigned Verona's case in October 2017, the client contract signed by Verona in October 2016 was no longer being followed. Mr. Zamudio stated that there was never a court ordered visitation plan in place but there was an informal safety plan in which Verona was not to leave her children unsupervised with Eric Perkins due to Eric's history with Verona and DCFS. When asked why the contract was no longer followed, Mr. Zamudio stated that following an argument or incident with Eric, Verona often would feel in need of support from Delta staff and would agree to services but then after a week or two she would quickly change her mind and no longer want assistance.

November 2017 Quarterly Staffing
According to Teen Parent Service Network records, TPSN Clinical Consultant Lillian Barkley documented that on November 28, 2017, she met with Jordan Atkinson, Ian Zamudio, Verona Redemann,

[1] Ian Zamudio's employment with Delta was terminated on August 15, 2019 unrelated to this investigation. On November 21, 2019, Ian Zamudio began employment with Iota Agency as a child welfare specialist.
[2] In an interview with OIG investigators, Delta TLP Director Jordan Atkinson reported that when she found out about the serious injury to Seth Owens, the case was still open in SACWIS, which allowed her to input the December 29th and February 2nd contact notes from her records.

Kamilah Chase (DCFS Monitor), and Marilyn Dorsey (Delta youth worker) for a quarterly staffing. Ms. Barkley documented the following regarding the meeting:

> …Placement: The youth is currently in placement at Delta's Parenting TLP. There were no concerns to report about this youth's placement. The caseworker reported that the youth does a budget consistently, plans and cooks healthy meals, keeps her apartment clean and is cooperative with the placement rules.
>
> Parenting/Pregnancy: The youth currently has two children, whom are both in her care. The youth was previously engaged in parent coaching. However, she was successfully discharged from parenting services. The youth's caseworker reported that the youth does a good job keeping her children on a schedule. The youth has a strong bond with both of her children. The youth reported that she was pregnant in September 2017. However, the youth received a termination for this pregnancy in October 2017. The youth obtained a 5-year IUD [intra uterine device] following this termination.
>
> Employment: The youth is currently employed at a factory. The youth reported that she obtained this job via a staffing agency. The youth informed the participants of this meeting that she has enlisted in the military, National Guard. The youth reported that she has been working with a recruiter for the past month and she signed her commitment paperwork for the National Guard. The youth also reported that she will ship out on February 6, 2018. The youth reported that her children will be with their respective fathers while the youth is in basic training. The youth agreed to provide this documentation to Delta.
>
> Education: The youth is not currently enrolled in an educational program. The youth has previously obtained a high school diploma [at Kappa High School on July 29, 2016]. The youth reported that she will revisit a post-secondary educational program after the military.
>
> Recommendations: It was recommended that the caseworker refer this youth for a housing advocate right away to ensure the youth begins post emancipation housing planning before she leaves for basic training. It was recommended that this youth's 20.9 D-CIPP[3] is scheduled before the youth leaves for basic training. It was also recommended that Delta monitor the children while they are with their fathers in the youth's absence via visits and check-ins. Delta will assess the youth's children's needs while the youth is away. Reassessment: January 2018

According to Ian Zamudio's SACWIS contact note documentation of the November 28th quarterly staffing, Verona reported at the staffing that she planned on enlisting with the Army National Guard in January for 10 weeks of basic training outside of Illinois. The contact note stated that the plan was for Verona to receive services from DCFS when she returned from basic training prior to her emancipation. The plan was for Seth and Tina to stay with their respective fathers while Verona was at basic training.

Domestic Violence Incident- December 29, 2017

Delta caseworker Ian Zamudio documented in a SACWIS contact note that on December 29, 2017, Verona was arrested for domestic battery and returned to the Delta Transitional Living Program.[4] In an

[3] Discharge-Clinical Intervention for Placement Preservation (D-CIPP) is a facilitator-guided team planning process with the youth, permanency worker, caregiver, family and other stakeholders to help identify the youth's adult connections/relationships and determine the array and intensity of supports and services needed to assist the youth in planning for a successful emancipation from DCFS.

[4] The police department had no record on file regarding the arrest on December 29, 2017 nor was it revealed in a Law Enforcement Agencies Data System (LEADS) check.

interview with OIG investigators, case manager Zamudio recalled that following the December 29, 2017 incident between Verona and Eric, the responding officer contacted Delta staff to report that Verona had been arrested after police observed her being very aggressive and attempting to punch Eric while at his apartment. The police officer requested that Delta staff come to the police station to pick up Verona. Mr. Zamudio stated that when he arrived at the police station, he explained to the officer that Verona would be going to the military very soon and the police officer told him that he was going to give Verona a break and release her. When asked by OIG investigators if the children were present during the incident, Eric stated that he could not recall where Tina was at the time but recalled that Seth was present because Verona told him that Seth was pushed by Eric and fell off the bed or couch and that was the reason Verona became angry with Eric. Mr. Zamudio stated that Verona often left Seth with her mom, Ainsley Redemann, because Eric did not like Seth. Mr. Zamudio also reported that following the incident, he tried to get Verona enrolled in the domestic violence program at Mu Agency, however Verona refused because she was leaving for basic training.

The December 29th domestic violence incident was reported to the Hotline on December 31, 2017 (SCR# 3333C). Delta caseworker Ian Zamudio reported that two days earlier, Verona Redemann (age 20) was arrested by the police department as the aggressor in a domestic violence incident that took place at the home of Eric Perkins, the biological father of Verona's daughter, Tina Perkins. According to the Hotline narrative, "…when the police arrived they saw Verona hitting him [Eric] across the shoulders and in his face. Both children [Tina Perkins and Seth Owens] were present but not injured. Eric had the charges dropped."

The significant event report required in Procedures 331 *Significant Event Reporting* for the December 29th incident was not entered in SACWIS until 10 months later, on November 16, 2018, the same date that Delta TLP/ILO Director Jordan Atkinson entered two supervisory contact notes. In an interview with OIG investigators, Ms. Atkinson reported that she was able to enter additional information in SACWIS because although Verona's case was closed in May 2018, the case had not been closed in SACWIS at the time of Seth's near-drowning.

On December 31, 2017 mandated child protection investigator Nino Eberhard left voicemail messages for the reporter, Delta worker Ian Zamudio and Tina's biological father, Eric Perkins, requesting return calls. This same day CPI Eberhard made an unsuccessful attempt to interview Verona at the Delta transitional living program.

On Tuesday, January 2, 2018, the child protection investigation was assigned to Maisy Gould. This same day, CPI Gould interviewed Verona's Delta case worker, Ian Zamudio by phone. Maisy Gould documented in a SACWIS contact note that Mr. Zamudio reported that Verona is a "great mother" and her children are always clean and well cared for. Mr. Zamudio also reported that Verona's problems were domestic with Eric Perkins and that Verona was usually the aggressor. Mr. Zamudio stated that Verona had been at the transitional living program on Friday, December 29, 2017 but was currently on run.

CPI Gould documented unsuccessful attempts to see Verona and her children in-person on January 3, January 5, January 14, and January 17, 2018 at Delta and Eric Perkins' home. CPI Gould also documented that she attempted to interview Eric Perkins by phone on January 1 and January 27, 2018, but there was no answer and no way to leave a voicemail.

According to the placement history screens in SACWIS and CYCIS, Verona was at an unauthorized placement on January 3, 2018 and returned to her placement at Delta on January 9, 2018. In an interview with OIG investigators, Delta caseworker Ian Zamudio reported that following the incident, Verona probably went to her mother's home. Mr. Zamudio stated that even when Verona would be out of placement, she always kept in contact by phone with Delta staff.

According to TPSN records, on January 9, 2018, TPSN Clinical Coordinator Lillian Barkley emailed Ian Zamudio and Jordan Atkinson. The email stated that Ms. Barkley received an incident report involving the recent DCP investigation. In the email, Ms. Barkley requested an update on the DCP investigation as well as whether or not this would impact Verona going to basic training and her plan to have Eric Perkins care for Tina while she was at basic training.

According to TPSN records, on January 11, 2018, a critical incident staffing was held with Lillian Barkley (TPSN Clinical Coordinator), Natalie Farmer (D-CIPP Facilitator), Verona Redemann, Omar Hebert (Guardian ad Litem), Ian Zamudio (Delta Case Manager), and Jordan Atkinson (Delta Supervisor).[5] Clinical coordinator Lillian Barkley documented the following regarding the meeting:

> …Purpose: The purpose of this meeting was to conduct this youth's D-CIPP [Discharge Plan]. This D-CIPP was conducted early as the youth has enlisted in the National Guard and will be leaving town soon to begin basic training.
>
> Placement: The youth continues to reside at Delta parenting TLP. However, she will be leaving the TLP placement February 6, 2018 for approximately 10 weeks for basic training as the youth has enlisted in the National Guard.
>
> Parenting: The youth has two children that are both in her care. The youth has a positive and appropriate relationship with her children. However, the youth has Domestic Violence concerns with her daughter's father. The youth was indicated for a domestic violence incident with her daughter's father. The youth's daughter's father was also indicated for a separate domestic violence incident. At the time of this DCIPP a Hotline call was made for a subsequent domestic violence incident with her daughter's father. The investigation is pending at this time. The youth did not want to discuss this matter. The youth has also decided to place her children [with a host family through a Safe Families Program[6] through] Omega Agency while she is in basic training.
>
> Strengths: The youth and participants of this meeting discussed this youth's strengths. The following strengths were discussed: Verona is clean and organized; Verona keeps her children on a schedule; Verona has a positive family structure; Verona is helpful with others; Verona is goal oriented; Verona is liked by her peers; Verona graduated form High School; Verona maintains employment; Verona is very pleasant; Verona is a great mom.
>
> Concerns: This youth expressed that she wanted to discuss the following concerns: Housing, Employment and Financial.
>
> Action Plan: The youth will contact her caseworker during basic training if a Youth Housing Advocate is needed by 4/20/2018. The caseworker/agency will request $300 from Youth Housing Advocate program by 2/6/2018. The youth will apply for a job at the post office after basic training during 4/20/2018-4/27/2018….

In an interview with OIG investigators, Delta TLP Director, Jordan Atkinson reported that prior to Verona leaving for basic training, an emergency staffing was held to discuss placement for the children given the recent domestic violence incident between Verona and Eric Perkins. Ms. Atkinson reported that Verona initially wanted the children to go with their fathers, Eric Perkins and Deandre Owens, or for the

[5] The January 11, 2018 meeting was not entered in a SACWIS contact note.

[6] According to https://safe-families.org, the Safe Families model Omega Agency uses provides support for parents in crisis, giving them time to get back on their feet while their children are cared for in a safe environment by volunteers who host children in their homes.

children to go with their maternal grandmother Ainsley Redemann, while she was at basic training. Ms. Atkinson stated that staff discussed with Verona that given Ainsley Redemann's history with the Department, she was not an appropriate caretaker and suggested placing the children in an Omega Agency home while she was at basic training and Verona agreed. Ms. Atkinson stated that she, Verona, and Ian Zamudio attended the staffing in person and the TPSN workers attended by phone.

In separate interviews with OIG investigators, TPSN workers Lillian Barkley and Natalie Farmer both reported they did not recall any discussion about Ainsley Redemann caring for the children. Both Ms. Barkley and Ms. Farmer recalled that during the January 11, 2018 meeting, staff discussed with Verona having the children stay with Omega Agency instead of having Tina stay with Eric Perkins.

There were no documented contacts in Verona's Delta record in SACWIS between January 11, 2018 and February 2, 2018.

February 2018 Domestic Violence Incident

According to Delta TLP Director Jordan Atkinson's SACWIS supervisory contact note dated February 2, 2018[7], Delta caseworker Ian Zamudio contacted Ms. Atkinson by phone and reported that Verona had been assaulted by Eric Perkins. Supervisor Atkinson documented that a police report and protective order was completed.

In an interview with OIG investigators, case manager Ian Zamudio stated that on February 2, 2018, while at his home, he received a call from the after-hours staff at Delta reporting that staff saw Verona arguing with Eric through the surveillance cameras in front of the building. Mr. Zamudio reported that Verona was bringing her belongings back from Eric's apartment because she was scheduled to leave for basic training. Mr. Zamudio stated that the staff contacted the police after Eric punched Verona in the mouth, giving her a bloody lip. Before police arrived, Eric fled the scene in his car. Mr. Zamudio stated that he thought both children had been in Eric's car, which was parked in front of the building, but could not recall if Verona got the kids out of the car before Eric drove off. Mr. Zamudio stated that Eric later drove to the police department to turn himself in, at which time he was arrested. Mr. Zamudio stated that the next day, he went to domestic violence court with Verona and an order of protection was issued against Eric Perkins. Mr. Zamudio reported that the state's attorney wanted to prosecute the case but once Verona left for basic training and was unable to attend the next court hearing, the judge stated that without Verona present, he could not hold Eric in jail any longer.

In separate interviews with OIG investigators, Delta TLP Director Jordan Atkinson and Ian Zamudio both reported that they thought a Hotline call had been made regarding the February 2 domestic violence incident and noted that if the Hotline was not called, it should have been. There is no record of a Hotline call regarding the incident in SACWIS. In addition, the significant event report required in Procedures 331 *Significant Event Reporting* for the February 2, 2018 incident was not entered in SACWIS until November 16, 2018.

According to police department records subpoenaed by OIG investigators, on February 1, 2018, police officers were dispatched to Verona's residence in response to a domestic disturbance. Verona reported that during a verbal argument her ex-boyfriend, Eric Perkins, he struck her about the face with a closed fist, causing her bottom lip to swell. The police report stated that Eric Perkins fled the scene but was later located and arrested.

According to the local county circuit court records, on February 2, 2018, Eric Perkins was charged with domestic battery. This same day, an order of protection against Eric Perkins was issued protecting Verona

[7] The February 2, 2018 contact note was created on November 16, 2018 after the near drowning of Seth Owens.

Redemann, Seth Owens, and Tina Perkins. The charges against Eric Perkins were continued at court on February 16, 2018 and on April 25, 2018 the charges were stricken off with leave to reinstate and the order of protection expired.

According to the child protection investigation, CPI Gould documented that on February 7, 2018, she contacted Ian Zamudio by phone. CPI Gould documented that Ian Zamudio reported that Verona had left for basic training. CPI Gould documented that Mr. Zamudio stated that he forgot about the investigator needing to see Verona's children and reported that the children were residing with Omega Agency. Mr. Zamudio agreed to send the contact information to the investigator.

In an interview with OIG investigators, CPI Gould reported that when she spoke to Ian Zamudio on February 7, 2018 and learned that Verona had returned to her placement at Delta and then subsequently left for the military, she was upset with Mr. Zamudio for not informing her of Verona's return. When asked by OIG investigators if she was aware of the February 2, 2018 domestic violence incident, CPI Gould reported that she was unaware of the incident and that it was never mentioned during her phone call with Ian Zamudio on February 7, 2018. CPI Gould stated to OIG investigators that she was aware of the order of protection but thought that was a result of the December 2017 incident.

Omega Agency's Safe Families Program

According to Omega Agency records, Seth Owens and Tina Perkins were placed in an Omega Agency home on February 5, 2018 so that Verona could attend basic training for the military. Caseworker Ian Zamudio did not document in a SACWIS contact note that Seth and Tina were placed with an Omega Agency Safe Family's host family while Verona was at basic training.

In an interview with OIG investigators, Ian Zamudio reported that he assisted Verona Redemann with securing assistance from Omega Agency for Seth and Tina. According to https://safe-families.org, the Safe Families model Omega Agency uses provides support for parents in crisis, giving them time to get back on their feet while their children are cared for in a safe environment by volunteers who host children in their homes.

The preliminary intake form for Omega Agency dated January 29, 2018, noted, "Verona will be attending a 10-week army training in Virginia. After training, child will be going to the grandmother until mom can secure housing." The Preliminary Intake form identifies Delta Community Care worker Ian Zamudio as the caseworker assigned to Verona. The intake checklist also states:

> Mom is a DCFS ward. No open investigations. Seth's sibling Tina staying with her bio dad, who offered to take Seth but Seth's bio dad refuses. Seth's bio dad getting evicted. 1/31- Seth will be returned to grandmother at end of hosting. Can't stay with Grandma during training because Grandma is preparing to have stepson return to his mother. Grandma # Ainsley (XXX)XXX-XXXX and worker said mom comes back April 21st.

According to Omega Agency records, on February 5, 2018, Verona Redemann signed forms titled, "Parental Consent for Participation in Omega Agency for Children with Appointment of Short-Term Legal Guardian and Power of Attorney for Health Care of a Minor Dependent" for Seth Owens and Tina Perkins. Delta caseworker Ian Zamudio signed as the witness. On the Parent Information form dated February 5, 2018, Verona states that her reason for seeking temporary placement as "Leaving for Military Training." Tina Perkins and Seth Owens remained in a Safe Families home from February 5, 2018 to May 11, 2018.

According to Omega Agency records on February 9, 2018, Safe Families worker Poppy Irwin spoke to Verona Redemann by phone. Verona reported that she was in South Carolina to start basic training with

the Army and would be unable to communicate by phone for the 10 weeks that she is there. Verona reported that the biological fathers, Eric Perkins [Tina Perkins' father] and Deandre Owens [Seth Owens' father] were allowed to contact the kids. Verona stated that she would return April 19, 2018.

In an interview with OIG investigators, Omega Agency's Safe Families intake coordinator, Ms. Juarez reported that although she does not recall the specific intake involving Verona Redemann, typically when a social service agency worker is involved, the worker is the one contacting Omega Agency by phone and submitting the intake paperwork on behalf of the client. Ms. Juarez stated that given that Ian Zamudio signed as the witness on the forms it is most likely that Ian Zamudio assisted in arranging care for his client. Ms. Juarez reported that it is not uncommon to not have in-person contact with the biological parent when a social service agency is involved. Ms. Juarez reported that the worker at the social service agency usually faxes or emails the documentation to Omega Agency once it has been completed by the parent and at that point, Omega Agency Staff will locate a home for the children. Ms. Juarez also stated that intake staff always ask whomever is calling if the parent has an open child protection investigation, and in this case, since it was marked no, she believes she was told by Ian Zamudio that there was not a pending child protection investigation. In an interview with OIG investigators, Mr. Zamudio stated that he could not recall being asked by Omega Agency intake staff whether or not there was a pending child protection investigation but stated that if asked, he would have said there was a pending investigation.

According to Omega Agency's Safe Families records, on February 9, 2018, Eric Perkins contacted Omega Agency Worker Poppy Irwin to find out what he needed to do to see his daughter, Tina Perkins, since there was a pending DCFS child protection investigation. Omega Agency worker Poppy Irwin documented that she was unaware of a DCFS child protection investigation and told Mr. Perkins that she would call him back.

This same day, Omega Agency worker Poppy Irwin documented that she spoke to Delta case manager Ian Zamudio. According to the Omega Agency record, Ian Zamudio told Poppy Irwin that there was an order of protection filed against Eric Perkins that prohibited contact with both Seth and Tina. Ms. Irwin also documented that Ian Zamudio reported that there was a DCFS investigation open because he made a Hotline call due to domestic violence between Eric and Verona. Ian Zamudio also reported to Ms. Irwin that there was a court date on February 16 that he would attend since Verona was unavailable. Ian Zamudio provided Ms. Irwin the name and contact information for the child protection investigator, Maisy Gould.

Omega Agency worker Poppy Irwin then contacted child protection investigator Maisy Gould, Ms. Irwin documented in the Omega Agency record that she informed CPI Gould that Eric Perkins had contacted her about whether or not he could visit his daughter while she was with Omega Agency. CPI Gould reported to Ms. Irwin that she had tried to contact Eric Perkins, but he had not called her back. Ms. Irwin stated to Ms. Gould that she would ask Eric Perkins to contact CPI Gould.

On February 9, 2018, Omega Agency worker Poppy Irwin documented that she called Eric Perkins after speaking to the Delta worker and the DCFS child protection investigator. Ms. Irwin informed Mr. Perkins that he could not have contact with Tina or Seth due to the order of protection.

In an interview with OIG investigators, former Omega Agency worker Poppy Irwin reported that her understanding of the child protection investigation was that Eric Perkins was the aggressor in a domestic violence incident with Verona. Ms. Irwin stated that at no point was she told about a pending child protection investigation in which Verona was the alleged perpetrator of the child protection investigation. Poppy Irwin reported that she received a copy of the order of protection from Ian Zamudio. Ms. Irwin

confirmed that the order of protection in the Omega Agency record was the order she received from Delta caseworker Ian Zamudio.[8]

On February 10, 2018, CPI Gould documented in a SACWIS contact note that she contacted Eric Perkins by phone. Mr. Perkins reported to CPI Gould that he did not know that DCFS was looking for him and that he would be available to speak with CPI Gould Monday through Friday from 8:30am to 5:00pm.

On February 12, 2018, CPI Quincy Kennedy went to Omega Agency Daycare, where Seth attended daycare. While at the daycare, CPI Kennedy observed Seth Owens sleeping and interviewed the preschool director. CPI Kennedy reported that Seth Owens is a very quiet and shy student, but that he is very intelligent. The preschool director reported no concerns or behavioral issues with Seth Owens.

According to Omega Agency records, on February 15, 2018 during a home visit, the Omega Agency host parent reported to Omega Agency worker Poppy Irwin that Delta worker Ian Zamudio called and told her that Seth and Tina's maternal grandmother, Ainsley Redemann would be taking the children for weekend visits every other weekend starting this weekend. Omega Agency worker Poppy Irwin documented that she contacted the child protection investigator Maisy Gould to confirm the visitation plan and CPI Gould reported that she had just spoken to Mr. Zamudio and he told her that was the plan. Ms. Irwin documented that CPI Gould stated that according to Mr. Zamudio, the maternal grandmother, Ainsley Redemann, was "…okay because she had completed the required services." CPI Gould reported that she would visit the children at the grandmother's home this weekend.

In an interview with OIG investigators, Ian Zamudio stated that Verona's mother, Ainsley, was a strong support person for Verona and although he did not think that Ainsley could care for the children seven days per week for eight weeks, he did think she could care for the children on the weekends. Ian Zamudio stated that his supervisor, Jordan Atkinson, was aware that the children were staying with their grandmother on the weekends. Mr. Zamudio denied stating to CPI Gould that Ainsley had completed all services but did report that he identified Ainsley as a safe contact.

In an interview with OIG Investigators, TLP Director, Jordan Atkinson reported that Ian Zamudio had told her that the Omega Agency Safe Families host parent would meet Ainsley halfway for supervised visits with Seth and Tina while the children were with Omega Agency. Ms. Atkinson stated to OIG investigators that she was not aware that the children were staying with Ainsley on the weekends and stated that Ian Zamudio and "everyone on Verona's team were aware that Ainsley was not an appropriate caretaker for Seth and Tina."

On February 17, 2018, at 11:30am, CPI Gould documented that she observed Tina Perkins and Seth Owens at the home of their maternal grandmother. CPI Gould documented that she observed Seth and Tina playing together and noted that the children were clean, and no marks or bruises were viewed. While at the home, CPI Gould interviewed the maternal grandmother and documented the following:

[8] Located in the Omega Agency record was a copy of the local county Circuit Court - 3501 Petition for Order of Protection form completed by hand. The petition states that "On 2/01/18 at Verona's residence, respondent [Eric Perkins] struck petitioner [Verona Redemann] about her face with a closed first causing her lip to swell. Respondent has been abusive in the past. Fearful of further abuse. Petitioner [Verona Redemann] has swelling, cut and sores about her lip area." The petition requests that the following be protected, "Verona Redemann, Tina Perkins and Seth Owens." The petition was signed by Verona Redemann. Also located in the Omega Agency record was a copy of the Circuit Court of Local County Emergency Order of Protection page 1 of 3. The Emergency Order of Protection states that the persons protected by the order are: Verona Redemann and Seth Owens. Tina Perkins is listed as "The minor child/ren referred to herein." Pages 2 and 3 of the Emergency Order of Protection were not in the Omega Agency record. The order states that the order will be in effect until February 16, 2018.

> …[Ainsley Redemann] Stated that she just wants to be able to see her grandchildren. Reported that she used to go to the TLP to see them when she was there like she was supposed to. Reported that the oldest child's father [Deandre Owens] also visits with him. Reported that he [Deandre Owens] lives with his father and his father supports him as he is currently not working. Reported that Seth knows his father [Deandre Owens]. Reported that Tina knows her father [Eric Perkins]. Reported that she will do whatever is needed.

Also, on February 17, 2018, CPI Gould documented that she interviewed Eric Perkins in person. Eric Perkins reported that he called the police during the December 29th altercation. Eric Perkins reported that Verona had told him that she did not want to be at his house, so he began packing up her things and putting them in his van. Eric reported that Verona kept talking and started to hit him, so he called the police because she was getting out of control. Eric stated that when the police arrived, she was aggressive in front of them, so they took her to the police station.

On February 22, 2018, CPI Gould interviewed Verona Redemann's Guardian Ad Litem, Reyna Lehman, by phone. CPI Gould documented the following regarding the phone interview:

> This investigator received a return call from the assigned. She reported that while her client is in basic training the children are [staying with a Safe Families host family]. Reported that there really isn't a way to get in touch with her as she is not supposed to take phone calls just mail can be received. Discussion was that they made the plan for Omega Agency for the ten weeks. The GAL [Guardian ad Litem] reported that she didn't know that her client had a new investigation but she does remember the incident. This investigator explained that she does see that it appears as though she is making better choices in her life but that she has to understand her role and that her children were present in the home with her. Ms. Lehman reported that her case is still open, and that Ian will have to work with her when she returns. That the case will stay open until after her training and she returns…

The child protection investigation was indicated and closed on February 27, 2018. Verona Redemann was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect to both Seth and Tina.

On March 20, 2018, Omega Agency worker Poppy Irwin documented that she informed Ian Zamudio that Seth and Tina would be staying with their maternal grandmother from March 25 to March 31 while the Safe Families host parents were on vacation. Ian stated that was fine and that he would visit the children at the maternal grandmother's home to check on how things were going.

On April 6, 2018, Omega Agency worker Poppy Irwin documented that she received a call from the Safe Families host parent. The host parent reported that when Tina and Seth returned from the grandmother's home, they did not return with all of their clothes. The host parent stated that when she questioned the grandmother, the grandmother reported that Tina spent Tuesday-Sunday with her dad, Eric Perkins, and he did not return all of the clothes.

Omega Agency worker Poppy Irwin documented that she then contacted Delta worker Ian Zamudio about the situation. Ms. Irwin documented that Mr. Zamudio told her that after he talked to the Omega Agency host parent, he contacted the grandmother, Ainsley Redemann and she told him that the real reason she did not return the clothes was because she lost them at the laundry mat. Ms. Irwin documented that Mr. Zamudio told her that he did not believe the grandmother and reminded the grandmother that Eric Perkins is not supposed to have contact with the children.

On April 12, 2018, Omega Agency worker Poppy Irwin documented that she talked to Ian Zamudio by phone. Mr. Zamudio reported that he was trying to get in contact with Verona because he thought it would be better for the children to stay with Safe Families until Verona returns instead of having them move to the grandmother's home as planned. Ian Zamudio also reported that there was a court date scheduled on April 25th regarding the order of protection against Eric Perkins. Ian Zamudio informed Omega Agency worker Poppy Irwin that he planned on going to court and renew the order of protection on Verona's behalf but did not think the Judge would renew the order since Verona would not be there.

On April 12, 2018, Omega Agency worker Poppy Irwin met with the Director of Omega Agency, Simone Newsom to discuss concerns about returning the children to the maternal grandmother since the grandmother had been allowing Tina's dad to care for her despite the order of protection. Simone Newman instructed Ms. Irwin to urge Mr. Zamudio to get in contact with Verona to find out what she wanted.

This same day, Poppy Irwin contacted Ian Zamudio by phone to discuss Omega Agency's concerns with returning the children to their maternal grandmother since she has been allowing Tina's dad to care for her despite the order of protection. Ian Zamudio reported that Verona would not see that as a reason to not let the kids go to her mom's house since she has no issue with Tina's dad, Eric Perkins. Ian Zamudio reported that he would try to persuade Verona to keep the children with Safe Families because he is concerned that the maternal grandmother will get overwhelmed caring for two children but ultimately it would be okay if the children are returned to the maternal grandmother because he would be checking on them weekly.

On April 17, 2018, Poppy Irwin documented that she contacted Verona's sergeant in order to find out if Verona wanted the children to remain with Safe Families or be returned to their maternal grandmother. Verona reported that she would like the children to remain with Safe Families but that the maternal grandmother could still keep them on the weekends. Poppy Irwin explained concerns that the maternal grandmother was allowing Eric Perkins to care for the children despite the order of protection. Verona stated that she did not care if Eric visits the children, but she did not want him to have full custody.

Delta worker Ian Zamudio documented in a SACWIS contact note that on April 25, 2018, a court hearing was held regarding the order of protection that was issued against Eric Perkins and the case was dismissed due to Verona not being able to attend. The order of protection expired on April 25, 2018.

Delta worker Ian Zamudio documented in a SACWIS contact note that in May 2018, Verona Redemann emancipated from DCFS custody. In an interview with OIG investigators, Ian Zamudio reported that when Verona returned from basic training, she moved to an apartment in the same building as her mother.

According to Omega Agency records, Seth and Tina remained with the Safe Families host parent for the duration of Verona's time at basic training and were returned to Verona's care nine days after Verona emancipated from DCFS custody.

Twenty days after Verona emancipated from DCFS custody, Omega Agency supervisor Talia Montgomery contacted Verona Redemann by phone and documented the following:

> Verona did not complete the requirements to pass basic training camp. She was allowed to stay for an extra two weeks to try to accomplish it but she was unable to pass the two-mile run, according to her sergeant. Verona seems to be feeling upset about this. When I spoke to her on the phone expressing my sympathy, she hung up on me. She turned 21 in May and is no longer a ward of the state. She asked for her kids to be returned to her and she and the kids are staying with Verona's mom.

Post Emancipation

According to police department records, three months following Verona's emancipation, on August 26, 2018, officers from the police department were dispatched to the home of Eric Perkins for a domestic disturbance. The incident report stated that while Verona Redemann was at the home to pick up her daughter, Tina Perkins, she confronted another woman that was in another room within the apartment. The police officers gave Verona multiple opportunities to leave but Verona refused. After Verona charged at the room to get to the woman, the police officers detained Verona by placing her in hand cuffs. As the police officers escorted Verona out of the apartment, Verona made multiple verbal threats to Eric and stated, "I'll have your ass dead." Eric Perkins declined to sign a complaint and the police officers signed the complaints on behalf of Eric due to the nature of the incident and proximity of Verona's residency. The incident report stated that Tina Perkins (age 1) was present during the incident. According to a criminal history search (LEADS) request, Verona Redemann was charged with assault but not convicted.

Two months later, on September 24, 2018, Verona Redemann was arrested and charged with aggravated battery to a child and attempted murder for attempting to drown her three-year-old son, Seth Owens. According to police department records, Verona Redemann admitted that prior to Seth's drowning, she had lied to Eric Perkins and friends on social media by stating that Seth had cut his finger in a blender and died while having emergency surgery. Verona reported that when it was discovered that she had lied about Seth's death, Verona pushed Seth's face under the water and held it there until foam came out of his mouth and then called 911. According to the police report, a search of Verona Redemann's phone revealed that Verona Redemann had searched the internet for "instructions on how to suffocate, murder or poison a person, how it feels to kill someone, how long it took to suffocate someone, how to kill a human without a trace, how long it takes to kill someone and untraceable poisons." The searches began on September 12, 2018 and continued through September 22, 2018, the day before Seth's near drowning.

On September 24, 2018, medical staff from Alpha Hospital contacted the Hotline to report the near drowning of Seth Owens. The investigation was closed on October 19, 2018. Verona Redemann was indicated for torture, substantial risk of physical injury/environment injurious to health and welfare by neglect, and inadequate supervision. Eric Perkins was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect due to his history of domestic violence and failing to cooperate with services.

On January 25, 2018, while awaiting trial at the local county jail, Verona Redemann caused bodily harm to an inmate by striking her to the facial area with a closed fist. Verona was charged with battery/bodily harm. The next scheduled court date for the charges of aggravated battery to a child and attempted murder to Seth Owens were scheduled for April 21, 2020.

In an interview with OIG investigators, Delta TLP Director Jordan Atkinson described Verona and Eric's relationship as conflictual and toxic. Ms. Atkinson reported that Eric had a lot of influence over Verona and while Verona was at the TLP, Delta staff would hear Verona get into verbal arguments with Eric on the phone and staff would process it with her. Ms. Atkinson stated that when Verona emancipated, she did not believe that Verona had safe people to process things with. Ms. Atkinson stated that the drowning incident was surprising because Verona was very protective of her children and was one of the few mothers in the TLP that had a routine for her children and staff never had to intervene as far as her parenting was concerned.

<u>Current update on Seth Owens and Tina Perkins</u>

Following the near-drowning, Seth was brought by ambulance to the emergency room at Alpha Hospital. Seth arrived alert and crying but subsequently went into cardiac arrest and had to be incubated and placed in a medically induced coma. Seth survived the near-drowning and was discharged from Alpha Hospital

on October 2, 2018 to the care of his father, Deandre Owens. Custody was granted to Seth Owens' father, Deandre Owens.

On October 1, 2018, protective custody of Tina Perkins was taken and DCFS was granted temporary custody on October 2, 2018. Tina was placed in a relative foster home. The case was assigned to Omicron Agency. Verona Redemann's parental rights of Tina Perkins were terminated on April 30, 2019. On January 15, 2020, Tina's permanency goal was changed from return home to guardianship due to Eric Perkins' failure to comply with the service plan and lack of visitation. As of this date, according to SACWIS contact notes, Tina (age 3) is stable in her placement; however, she has demonstrated aggressive behaviors with her teachers and classmates.

ANALYSIS

Prior to her emancipation, Verona Redemann's last four months as a client of the Department entailed two domestic violence incidents involving her 47-year-old boyfriend and a hope that enlisting in the military would rid her of the chaos caused by their tumultuous relationship and put her on a new path of opportunity. As both the Delta caseworker and supervisor expressed in separate interviews, they believed a separation of Verona and Eric would lead to a better outcome for Verona. Unfortunately, Verona did not complete basic training and returned to Illinois after her emancipation date. No longer having the support of Delta staff, the Teen Parent Service Network, or access to DCFS services, her main support system included her biological mother and her boyfriend.

Post emancipation for pregnant and parenting youth can be a difficult transition, particularly for those that have never lived on their own and lack a positive support system outside of DCFS care. The Department should consider assisting this population through the Family First Prevention Services Act (FFPSA). Currently the Act allows for Title IV-E reimbursement for preventative services to Pregnant and Parenting Youth without having to identify their children as being at imminent risk for entering care. The services can be for substance use treatment, mental health and in-home parent skill-based programing. Currently there are three home visiting programs approved through the FFPSA Act Clearinghouse: Nurse-Family Partnership (NFP); Healthy Families America (HFA); and Parents as Teachers.[9] To better support the pregnant and parenting youth population post emancipation, the Department should utilize the provision of FFPSA allowing for reimbursement of in-home parenting skills for this population in order to establish services for this population. The Department should add participation in an in-home parent skill-based program to all pregnant and parenting youth service plans (including non-custodial fathers) prior to emancipation. If a service provider determines a pregnant and parenting youth would benefit from further in-home skill-based training, the Department should offer the service to emancipating youth as a continued service beyond emancipation. The services at that point may now be reimbursable under the imminent care provision. In addition, the Department should consider adding a six-month and 12-month check-in with pregnant and parenting youth who have emancipated in order to offer preventative services.

Documented throughout the case as well as stated in interviews with OIG investigators, Verona was described as "a really good mom," a mother that consistently attended to her children's needs, and a mother that other teens at the Delta Transitional Living Program looked up to. Because of Verona's strong parenting skills, it appears staff minimized the adverse effects and risk that exposure to domestic violence could have on Verona and her children.

[9] The three programs through the FFPSA Act Clearing house are different versions of home visiting, that involve trained professionals providing guidance and assistance to new or young mothers. In combination with the Affordable Care Act's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, (recently reauthorized at $400 million per year) the federal government allocates spending for the home visiting programs.

At just three years old, Tina Perkins has already begun displaying aggressive behaviors towards adults and peers at preschool. While with their mother and Eric Perkins, Seth and Tina witnessed several arguments and physical altercations as well as even being in the middle of assaults at times. Domestic violence is classified as one of the 10 major adverse childhood experiences defining an individual's life outcome and development (Child Trends, 2019).[10] Studies show that young children are usually the most affected by domestic violence (Hester, 2007).[11]

Delta staff could have at a minimum ensured that a court ordered parent-child visitation plan be developed as planned for in the client contract dated October 2016. Given Eric Perkins' criminal history and DCFS history, a visitation plan that required supervised visitation by someone other than Verona could have aided in ensuring the safety and well-being of Tina. In addition, given that Verona often reported that Eric Perkins was emotionally abusive towards Seth Owens and treated him differently, Delta staff should have considered obtaining an order of protection against Eric Perkins in order to further protect Seth.

Poor documentation by Delta Agency Staff

During the final six months prior to Verona's emancipation, there was a lack of communication and documentation by the assigned caseworker, Ian Zamudio,[12] and his supervisor, Jordan Atkinson. There was a November 28, 2017 contact note by Ian Zamudio documenting Verona's plans to enroll in the Army National Guard but there were no contact notes documenting when she left or when she returned. There were also no Delta contact notes regarding Seth and Tina's placement with Omega Agency's Safe Families program. Nor were there contact notes regarding visits by Delta staff to see the children while the children resided in a Safe Families home. OIG investigators identified multiple contacts between Delta caseworker Ian Zamudio and Omega Agency staff, as well as child protection staff, that were never documented in Verona's placement record in SACWIS.

On February 2, 2018, Eric Perkins assaulted Verona Redemann on Delta Agency property. Delta staff failed to contact the Hotline regarding the incident and failed to inform the child protection investigator assigned to the pending child protection investigation. In addition, on November 16, 2018, following Seth Owens' near drowning, Delta Agency ILO/TLP Director Jordan Atkinson created two contact notes dated December 29, 2017 and February 2, 2018, documenting the two domestic violence incidents that had occurred months earlier, while Verona was still a youth in care. Also, on November 16, 2018, Ms. Atkinson completed two significant event reports in SACWIS for the December 29, 2017 and February 2, 2018 domestic violence incidents. Procedures 331.70, *Alleged Child and Youth Incidents and Contributing Circumstances*, requires that "…All child/youth incidents must be recorded in SACWIS and each event/incident must be recorded after it occurs or immediately after the event/incident becomes known, but no later than within 24 hours, excluding weekends and holidays, of the event/incident or upon learning of the event/incident. No exceptions are permitted."

Lack of communication and coordination between service providers

In interviews with Omega Agency staff, OIG investigators found that Omega Agency staff were unaware of the pending child protection investigation at the time of Seth and Tina's placement with Safe Families. They later became aware of the February 2, 2018 incident in which Verona was assaulted by Eric but thought the pending child protection investigation was due to the February 2, 2018 incident. Omega Agency staff remained unaware that Verona Redemann was the alleged perpetrator regarding the pending child protection investigation. In addition, the child protection investigator was never informed of the

[10] Child Trends. (2019). Adverse experiences**.** https://www.childtrends.org/?indicators=adverse-experiences

[11] Hester, M. (2007). *Making an Impact - Children and Domestic Violence : A Reader: Vol. 2nd ed. Jessica Kingsley Publishers.*

[12] Ian Zamudio was no longer employed by Delta Agency at the time the OIG investigation was issued.

February 2, 2018 incident. Anytime there are multiple providers involved in a case, communication and coordination is paramount to successful service provision. If the Department plans to continue to utilize Safe Families for the children of youth in care as well as during intact and child protection investigations, then the Department must develop a protocol for working with Safe Families. The protocol should address the need to share information by way of a staffing with all involved parties (i.e. Safe Families staff, child protection investigator, child protection supervisor, intact worker and supervisor, etc.) and ensure that the return home plan does not create an unsafe environment for the children.

RECOMMENDATIONS

1. To better support the pregnant and parenting youth population post emancipation, the Department should utilize the provisions of the Family First Prevention Services Act (FFPSA) allowing for reimbursement of in-home parenting skills for this population in order to establish services for this population. The Department should add participation in an in-home parent skill-based program to all pregnant and parenting youth service plans (including non-custodial fathers) prior to emancipation. If a service provider determines a pregnant and parenting youth would benefit from further in-home skill-based training, the Department should offer the service to emancipating youth as a continued service beyond emancipation.

2. As previously recommended, if the Department plans to continue to utilize Safe Families for the children of youth in care as well as during intact family services and child protection investigations, then the Department must review the contract program plans to address the need to share information by way of a staffing with all involved parties (i.e. Safe Families staff, child protection investigator, child protection supervisor, intact worker and supervisor, and placement worker and supervisor etc.) and ensure that the return home plan does not create an unsafe environment for the children.

3. This report should be shared with Delta Agency.

4. Delta Agency should share and review this report with the Director of the Transitional Living Program as a teaching tool to improve supervision.

5. Delta Agency staff should receive additional mandated reporter training to ensure that the Hotline is contacted when a child is at risk due to domestic violence.

APPENDIX B

OFFICE OF THE INSPECTOR GENERAL

Department of Children and Family Services

REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File No: 2019-2498

Child: Aiden Huber (DOB 07/2016; DOD 03/2019)

Subject: Child death

SUMMARY OF COMPLAINT

In March 2019, two-year-old Aiden Huber was found unresponsive by his 28-year-old mother. He was transported by ambulance to Zeta Hospital where he was pronounced deceased. Aiden and his five-year-old sibling were left in the care of their mother's 21-year-old paramour while she worked. Shortly after returning home, the mother found Aiden unresponsive, with drool coming from his mouth. The autopsy determined that Aiden suffered a lacerated liver, lung contusions, several broken ribs, abdominal injury, healing and healed broken bones, and bruising. His cause of death was determined to be from multiple injuries due to child abuse and the manner of death was ruled homicide. The paramour was charged with first-degree murder and the mother was charged with child endangerment.

The Office of the Inspector General (OIG) investigated the death pursuant to its directive to investigate the deaths of Illinois children whose families have been involved with the Department of Children and Family Services (DCFS) within the preceding 12 months. There was an open intact family services case at the time of Aiden's death and several unfounded child protection investigations within the year preceding his death.

An interim report, issued June 11, 2019, only addressed concerns raised about two contact notes documenting the Xi Agency intact family caseworker's March 16 visit to the family home and possible falsification.

FINDINGS

Two-year-old Aiden Huber died after his mother's paramour beat him. Aiden's mother, Claire Ives, had a long and significant history with DCFS and a history of multiple domestic violence relationships. Aiden died of multiple injuries due to child abuse and the manner of death was ruled a homicide. Claire's paramour is being charged with first degree murder. Claire is being charged with felony child endangerment. Claire Ives was a single parent to five-year-old Brodie and two-year-old Aiden, with little to no identified support. Not only did she have a history with DCFS that included her three oldest children

being removed from her care, two of whom she never regained custody of, but Claire also had a significant and on-going history of domestic violence with multiple partners, and was fleeing a domestic violence relationship prior to the opening of her intact family services case.

For cases involving *domestic violence*, Policy Transmittal 2010.23 and Procedure 300 Appendix J requires that private agency and DCFS workers and child protection investigators consult with Clinical Domestic Violence Specialists in the Domestic Violence Intervention Program under the Division of Clinical Services. Specialists in this program provide clinical case consultation, technical assistance, referrals, resources and support on domestic violence cases. There is no documentation that anyone in this case consulted with the Clinical Domestic Violence Specialist, although Claire was already receiving domestic violence services prior to the Department's most recent involvement.

When a *paramour* is suspected of being a part of the family, the investigator is to assess the level of risk and safety and consider those factors in safety plan development or implementation. The Paramour Assessment Checklist has been designed to aid in the identification of risk and safety issues specific to paramour involved cases. A 'yes' response to any of the listed factors requires that the factor or factors be considered when completing the CERAP, safety plan development/implementation and/or service planning (See Appendix H-Paramour Involved Families). The Paramour Assessment Checklist was never completed.

Further in the G sequence investigation for cults, welts bruises, abrasions, and oral injuries by abuse, involving a *child under three years*, the case should have been referred to the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC). In addition, this case should have been reviewed by upper management. In OIG investigation 2017 IG 2911, OIG recommended that any family with *three investigations in a year* (as was the case with this family) should be reviewed by upper management. The Department responded to that recommendation by noting that they had put practices in place to address cases with multiple child protection investigations. That did not happen in this case.

Child welfare workers ignored the *totality of circumstances* by not factoring in the young age of the child, reports by Aiden's sibling of being fearful in the home, and the mother's significant history of being in relationships with violent men.

The importance of collaboration and communication between systems is paramount when working with families experiencing domestic violence, as is interviewing child-centered collaterals and listening to children who are verbal and clearly able to express fear. The department missed all these opportunities to protect Aiden.

INVESTIGATION

Background

Aiden was the fourth child born to Claire Ives (DOB 03/1991). Her older children are: Dylan Ives (DOB 02/2010); Emerson Kemp (DOB 05/2012); and Brodie Huber (DOB 05/2013). Frank Lydon (DOB 01/1986) is Dylan's biological father. Emerson's biological father is Gannon Kemp (DOB unknown). Hector Marks (DOB 07/1990) is Brodie's father[1] and Isaac Huber (DOB 10/1969) is Aiden's biological father. The Department previously removed Dylan, Emerson, and Brodie from Claire's care. Neither Dylan nor Emerson returned to her care. At the time of his death, Aiden resided in a home with his mother, sibling Brodie, and mother's 21-year-old paramour Jordy Novak (DOB 03/1998).

[1] Per order of paternity entered 04/22/2014.

Prior DCFS Involvement

DCFS first became involved with this family in 2010. From 2010 to 2013, there were four Hotline calls for allegations of inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect.[2] Dylan was removed from Claire's care in 2010, when she was eight months old, after reports that Claire repeatedly left Dylan to be cared for by her mother and sisters for days without their consent and concerns about drug use. The court granted DCFS temporary custody of Dylan in October 2010. Claire gave birth to Emerson in May 2012; he was removed from her care and the court granted DCFS temporary custody in June 2012 as Claire was not engaging in services to regain custody of Dylan. Brodie was removed at the time of his birth and temporary custody was granted to the Department on May 23, 2013 as Claire continued to have an open case with DCFS, was reported to be homeless, was non-compliant with services, and the court was pursuing termination of parental rights as to Dylan and Emerson. According to CYCIS, Dylan's case was open from October 2010 to March 2015, when it was closed as court order release. Dylan's biological father was given custody. Claire and Gannon Kemp's parental rights were terminated as to Emerson and he was adopted; his case was closed as completed adoption in May 2017. According to CYCIS, Brodie's case was open from May 2013 until it was closed in June 2015 as court order release; Brodie returned to the care of his mother. Aiden was born in July 2016 after court involvement.

SCR #1111E – Ives, Claire – Reported 11/16/2017; Unfounded 01/11/2018

On November 16, 2017, an anonymous reporter contacted the Hotline. According to the Hotline narrative, the anonymous caller stated:

> Reporter states she observed Claire (mom) and Odin (paramour) bagging up Marijuana and Cocaine and selling it out of the home last week. Reporter states she also witnessed Claire slap and choke Brodie (age 4) a few weeks ago. Claire kept Brodie out of school for a few days because he had marks on him from the incident. Reporter states she observed mice running throughout the house last week. Reporter states there is a mice infestation and it is unsafe for Brodie and Aiden (age 1) to live there. Reporter stated the family has had prior DCFS involvement involving Isaac Huber (dad) who is currently incarcerated for battering Claire in front of the kids a month ago. Reporter wanted to remain anonymous because she doesn't want the family to come after her.

Allegations of substantial risk of physical injury/environment injurious to health and welfare by neglect and environmental neglect to Brodie and Aiden by their mother and substantial risk of physical injury/environment injurious to health and welfare by abuse to Brodie by mother were taken for investigation.

The next day, on November 17, 2017 Child Protection Investigator (CPI) Kara O'Connell made an unannounced visit to the home. According to her contact note, Claire would not allow CPI O'Connell into the home saying she was tired of DCFS. She agreed to allow the CPI to see her children through the door. The CPI noted she observed no marks or bruises on the children. Brodie was observed without a shirt on; the mother lifted Aiden's shirt and pants. The CPI also saw the front room, which did not appear dirty but was sparse in furniture and there were some clothes lying around. The CPI did not observe mice running around at that time. The mother told the investigator that she believed this was a false report. She stated that the father of her children, Isaac Huber, had physically abused her on October 9, 2017. She showed

[2] SCR #1111A, 09/27/2010, Indicated for inadequate supervision to eight-month-old Dylan Ives; SCR #1111B, 05/12/2012, Unfounded due to appeal for substantial risk to one-month-old Emerson Kemp; SCR #1111C, 03/07/2013, Unfounded for substantial risk to unborn baby; SCR #1111D, 05/20/2013, Unfounded due to appeal for substantial risk to Brodie.

the CPI an emergency Order of Protection against him and told the investigator that her next court date was on November 22. The mother stated that Isaac stomped on her while in the front yard. She stated that since he has been in jail, his sister, Leona Pettis, has been harassing her, telling lies, and sending the police to her home for well child checks. She said the last time the police were out was the previous week.[3] The mother reported years of domestic violence with Isaac that she did not previously report. The mother denied environmental neglect and denied that she had an infestation of mice. CPI O'Connell asked who Odin was and mother stated that he is the father to an older child who was adopted. The mother denied using drugs or preparing drugs for sale and selling them.

CPI O'Connell completed a SAFE CERAP on November 17, 2017, approved by Miah Rivers, noting the following:

> Anonymous reporter called the hotline. Mother denies harming children, denies mice in the home, denies drugs or selling drugs. She reports that the children's father is currently in jail for a domestic battery towards her. She showed CPI the Order of Protection. Mother reports that his sister is harassing her and she has sent out the police to her home for well child checks. Mother opened the door so CPI could observe Aiden and Brodie who was not wearing a shirt. Both boys have no unusual marks on them. Aiden and Brodie did not appear to be afraid of their mother. The boys did not look dirty.

In a supervisory note dated November 30, 2017, Miah Rivers noted: "Worker needs to get back out to the residence to see the mother and the children on the report." Also on this date, CPI O'Connell documented in a contact note that mother left a message that she moved out of her home in Pecan and in with her mother in Mahogany. There was no additional investigative activity or contacts documented until December when the investigation was transferred to a new investigator.

On December 7, 2017, an anonymous reporter contacted the Hotline with related information. The narrative reads:

> ***RELATED INFORMATION*** No added subjects or allegations.
>
> Reporter states that this morning, mother and the children (4 yo Brodie Huber and 1 yo Aiden Huber) were kicked out of grandmother's home where the family has been staying for the past few weeks. It is not known where mother went to stay with the children. Reporter states that mother is addicted to drugs and takes the children to stay in houses where there is drug activity. There were concerns that mother uses cocaine with the last incident being this morning. Mother is reported to get irate when she uses cocaine and yells, screams, grabs and yanks the children. Reporter states that around 3-4 days ago, mother was yelling and grabbing the children. Reporter also noted that mother has been hanging around with a man named Gannon. Mother and Gannon have a child (name unknown) together but their parental rights were terminated on this child, per reporter. Reporter had concerns that mother is sometimes seen without the children and reporter believes the children are with Gannon or other people.

On December 14, 2017, the newly assigned investigator Natalie Tucker contacted Claire by phone to schedule a visit. She arranged to meet the family the next day at maternal grandmother, Pia Ives' home, where Claire and her children were reportedly living. On December 15, when the investigator went to the

[3] On November 20, CPI O'Connell requested all police records from the Pecan Police Department regarding Claire Ives and Isaac Huber for the past three years. These records are part of the hard copy attachments to the child protection investigation and include an arrest of Isaac Huber on 10/09/2017 for domestic battery.

home, Claire and her children were not there; they had reportedly stayed at a paternal aunt's home the night before and Claire's car would not start in the morning. The investigator observed the home and interviewed maternal grandmother. According to her contact note, CPI found the home to be appropriate. Maternal grandmother reported no concerns with children's safety in the care of mother and denied knowledge of substance use. She was not concerned with discipline and believed the children were doing fine in mother's care.

On December 18, 2017, CPI met with Claire and her children at the DCFS office. Claire told the investigator that Gannon Kemp aka "Odin" is an ex-boyfriend that she was no longer involved with and denied having contact with him. She also denied contact with her children's father, Isaac. She told the investigator that she was staying at maternal grandmother's home until she found a new apartment. She had a section 8 voucher and was actively looking for housing. She reported moving on November 30, 2017. For discipline, she reported putting her children in the corner for three minutes or tapping them on the hand. Claire denied mental health issues. She told the investigator she was employed at a temp agency. Claire told the investigator that Brodie did not go to preschool anymore; she pulled him out when she moved in with her mother. CPI observed Aiden and Brodie with no marks or injuries. Brodie told the investigator that he was living at his grandmother's home.

Claire said that she had been drug free for about six years, having stopped her marijuana use. She denied cocaine or any other drug use. The investigator requested that Claire complete a toxicology screening; she completed a toxicology screening on December 27. According to a contact note, the investigator checked the toxicology screening results on January 3, 2018 and the results were "adulterated." Claire completed another toxicology screening on January 5, 2018. On January 8, the investigator spoke by phone with recovery coach, Rebecca Simms. Ms. Simms reported that she met Claire about eight years ago when she was staying at the Juniper County Health Department recovery house; she was her mentor and kept her on her caseload. Claire's drug of choice was marijuana. She reported speaking to Claire about one to two times per week. She said that Claire had grown a lot in the past few years. She reported periodically requiring Claire do toxicology screenings whenever she had suspicion. The last time she was screened about four months prior; she advised that Claire tested negative for substances. Ms. Simms told the investigator that she had no suspicion of drug use. She never had any concerns with cocaine or any other drugs. She reported that Claire was living in Pecan and having a lot of problems with the children's father, Isaac. Ms. Simms had no safety concerns for the children; no concerns regarding discipline; or the children's needs being met. She reported seeing them often and had never seen any marks or injuries; she reported that Claire brought the children to see her the day before Christmas Eve. She felt the children were safe with Claire.

The investigator also had phone contact with Gannon Kemp on January 8, 2018. According to the contact note, he stated that he did not go by "Odin" and did not know who Odin was. He reported that he and Claire had a child together that was placed in foster care and ultimately adopted. He said he last saw Claire in the beginning of October when he heard that her paramour Isaac Huber had beat her up. He went over to make sure she was okay and he called the police. He had no safety concerns for the children. He reported that Claire uses appropriate discipline and was certain that she was not using or selling drugs.

On January 9, 2018, the investigator met with seven-year-old Dylan's father, Frank Lydon. He reported that he had full custody of his daughter and Claire had visits every other weekend. He stated he had no concerns for his daughter's safety while in the care of her mother. He believed Claire was not using or selling drugs and was no longer with Gannon Kemp aka Odin. Dylan was observed and interviewed. She reported that she had fun when she was at her mother's house and enjoyed seeing her siblings. She said she felt safe and happy at both mother and father's home. Dylan reported that she was going to her grandmother's home this weekend because that was where her mother was staying.

On January 11, the investigator spoke by phone with Isaac Huber. He told the investigator that he had no safety concerns, concerns about inappropriate discipline, or suspicions about drug use.

A final SAFE CERAP was completed, noting: "Children have no injuries and report they feel safe. MGM has no concerns for children's safety. Mother completed drug screen and is compliant with CPI." Following the formal investigation, the report was unfounded on January 11, 2018 as the allegations could not be substantiated.

SCR #1111F – Ives, Claire – Reported 05/24/2018; Unfounded 07/18/2018
SCR #2222A – Gannon Kemp – Reported 05/24/2018; Unfounded 07/18/2018

Five months later, on May 24, 2018 law enforcement (Cedar Police Department) contacted the Hotline and reporting:

> Reporter stated that on 5/21/18 there was a call regarding an injured man and OPWI [Gannon Kemp] said that he had cut himself on a window, but would not tell Reporter the name or apartment number of where this happened. Reporter found the apartment with the broken window and spoke with Claire about the incident. Claire stated that the previous evening (5/20), she and her two children Aiden (1) and Brodie (5) had been at Claire's mother' house for Brodie's birthday party. Claire and her children returned home at about 2:30 a.m. Claire stated that OPWI [Gannon Kemp] was there and started an argument. Claire asked OPWI to leave and tried to break up with him. OPWI then put his hands on Claire in front of Brodie and Aiden and Brodie stepped between Claire and OPWI. Claire told Reporter that OPWI pushed Brodie out of the way and then Claire put her hands on OPWI. OPWI then broke her window with his elbow during the domestic battery incident. Claire told Reporter that OPWI didn't leave after he broke her window, but stayed the night and then left in the morning. Claire told Reporter that there was one other incidence of domestic violence between her and OPWI which she did not report because she was afraid of losing her housing. Police report #XX-XXXX.

Allegations of substantial risk of physical injury/environment injurious to health and welfare by neglect to Brodie and Aiden by mother were taken for investigation. Gannon Kemp was investigated for substantial risk of physical injury/environment injurious to health and welfare by abuse to Brodie and Aiden in a companion report/investigation. Sophie Trotter, supervised by Tisha Unsworth, was the assigned child protection investigator on both investigations.

On May 24, Claire requested an emergency move from the Juniper County Housing Authority noting that she was involved in a domestic incident with Gannon Kemp and did not feel safe; he busted out her kids' window and texted her that he was going to kill, stalk, and harass her. Claire also petitioned the Juniper County Court for an Order of Protection on this date; an Emergency Order of Protection was entered and was effective until June 13, 2018.

The next day, on May 25, CPI Trotter made a good-faith attempt to see Claire and the children. No one answered the door, and the investigator left a card under the door.

On May 31, 2018 CPI Trotter interviewed Claire and observed the children at their home in Cedar. According to a contact note, Brodie was observed to have no bruises, welts, or marks. The investigator attempted to speak to Brodie, but Brodie did not respond to CPI Trotter's questions. Aiden was also observed to be clean with no bruises, marks or welts. He was being held by his mom. Claire stated that she lived in the home with her two children. She denied that Gannon lived in the home with her and said he was just her boyfriend at the time. Claire stated that she did not know where Gannon was and stated

that she obtained an order of protection against him. Claire stated that they had been on and off for two years. Claire stated that she was done with him and would not be seeing him again. Claire stated that she was moving out of her apartment in Cedar and would be staying with her mother in Mahogany for a couple of weeks until she can get her own place. Claire stated that she was planning on moving to Poplar. Claire was very vague about the incident and stated that her boyfriend Gannon got upset and punched the window, causing his hand to bleed. She stated that the children were in the living room when it happened. Claire stated that Gannon called 911 for an ambulance and that was when the police came. Claire denied that Brodie ever got pushed out of the way and stated that the police made her write that. Claire denied that there was anything physical that happened and stated that it was only verbal. Claire stated that she obtained an order of protection because she was just done with him. She stated that he was not the father to the children and that the father was Isaac Huber who did not see the children anymore because he was abusive to her. A home safety checklist was completed. Home was observed to be clean with no immediate safety concerns. CPI observed the bedroom where the window was broken, and Claire had that door closed and locked. Claire stated that they were going to be moving out that weekend. Substance abuse and domestic violence screens were completed. Claire stated that she did not want an intact case because she had one with DCFS before and it was horrible. Claire denied mental health and substance abuse issues. CPI Trotter completed a SAFE CERAP and noted: "Claire obtained an Order of Protection and stated that she is moving with the children in with her mother. CPI observed the children to be clean with no bruises, marks, or welts. Claire denied that the children were in the room during the argument."

Also on May 31, 2018, CPI Trotter spoke with Officer Vance from the Cedar Police Department by phone. Officer Vance stated that they were called to assist with the ambulance. Officer Vance stated that they learned of the domestic incident when they started talking to Gannon. They drove around the parking lot and found the apartment with a broken window. Officer Vance stated that they tried to talk to Claire but she was pretty uncooperative. Officer Vance stated that the children looked fine at the time and that no arrests were made. The investigator requested all police reports from the Cedar Police Department involving Claire Ives and Gannon Kemp.[4]

There was no further activity documented until a supervisory note entered July 3, 2018 by Miah Rivers in which she noted, "Mother has left the area and moved to Poplar, worker still needs to interview the offender. Police report still need to be obtained, it has been requested."

On July 13, 2018, CPI Trotter attempted to contact Claire by phone at Upsilon Shelter, as she had left a message earlier in the week saying she could be contacted there. The receptionist at Upsilon Shelter stated that they were not allowed to confirm or deny whether a person was there. The same day, CPI Trotter had phone contact with two collaterals, the primary care physician for the children, and the investigator on the prior investigation. Both collaterals reported they had no concerns for the children in Claire's care. The primary care physician reported that Brodie was last seen on October 23, 2017 for a cold; Aiden was last seen April 16, 2018 for a well child check; and there were no concerns for abuse or neglect. The investigator on the previous investigation, Natalie Tucker, told CPI Trotter that the family had a history of domestic violence and it would be good if an intact case were opened.

The case was assigned to a parallel investigator and on July 16, 2018, CPI Verity Walters met with Claire at Upsilon Shelter in Poplar. Claire told the investigator that her Poplar Housing Authority approval came in and she would be moving into her own place soon. Claire said everything had been good; she had not had contact and no attempts to contact had been made by the man involved with the case. The investigator asked Claire if she wanted any services; Claire said the only thing she needed help with was paying her light bill. The investigator observed Aiden and Brodie at the shelter with no marks or bruises. CPI Walters completed a final SAFE CERAP noting, "The minors appear well cared for with Claire. The

[4] These records were part of the hard copy attachments to the child protection investigation.

minors did not display or disclose any fear of being with Claire. Claire and the minors are currently in a shelter where their basic needs are being met, and the environment is safe. The minors did not have any visible bruises or injuries to their bodies. At this time, the minors appear safe and the risk appears to be low."

Despite attempts, the investigator was unable to reach Mr. Kemp for an interview. On July 18, 2018, both investigations were unfounded.

SCR #3333A, B, C, D – Theta Daycare – Reported 08/23/2018; Unfounded 10/31/2018[5]

A nurse from Tau Hospital contacted the Hotline on August 23, 2018 at 12:06am and reported the following:

> Reporter stated on 8/22/18 source [Claire] took Aiden (2) and Brodie (5) to the hospital because over the last two days Aiden had been crying and not wanting to go to Theta Daycare and today after source got back home she noticed swollen welts on Aiden's lower left butt cheek and upper thigh. Brodie (5) got bit by a 3-year-old person (unknown name). Aiden and Brodie go to Theta Daycare from 8 a.m. to 3 pm then go to Upsilon Shelter daycare from 6:15 p.m. to 7:15 p.m. but the children do no[t] mind going to that daycare.[6] The reporter stated that source plans to go talk with Theta Daycare but will not have them watch the children again.

The narrative further noted that Poplar Police Department and the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) were notified. Allegations of human bites by neglect to Brodie and cuts, welts, bruises, abrasions, and oral injuries by abuse to Aiden by unknown daycare staff were taken for investigation. Winona York, supervised by Yvetta Zamora was the assigned investigator.

Law enforcement also contacted the Hotline. The report was taken as related information with no new allegations or subjects.

PSA Ziva Ashton immediately contacted the reporter/nurse by phone. The reporter confirmed the information given to the Hotline. According to the reporter, mother went to the Upsilon Shelter Daycare and reviewed the videotapes. There was nothing on the tapes indicating that Aiden was hit there, therefore, it was believed that he was hit at Theta Daycare. Reporter stated that Aiden had red welt marks and they looked like fingerprint marks. Reporter stated that the mother took pictures. According to reporter, the mother brought the minors in to the ER around 10:30pm the previous night and they were discharged at 11:50pm.

A supervisory note by Yvette Zamora, dated August 23, 2018, instructed CPI York, amongst other things, to check with MPEEC and Poplar Police Department, meet the mandate within the required time frame, complete paramour checklist if there is an identified paramour, and review all prior DCFS involvement with the family. Later that evening, CPI York went to Upsilon Shelter and had in person contact with the family. CPI York observed Aiden and noted that the minor appeared to be cared for and was appropriate for his age. The investigator attempted to interview Aiden but was unsuccessful due to his age and development. CPI York noted that interactions with his mother were appropriate. CPI York completed a body chart on minor and noted a "red bruise shape like circle" on his left lower buttock. CPI York also

[5] There were four employees investigated as possible perpetrators: Beatrice Brown, Callista Carey, Dahlia Douglas, and Esme Ellison.

[6] During the investigation, the investigator learned that Upsilon Shelter does not offer a daycare, but rather offers babysitting for one hour.

observed Brodie and noted that he appeared well cared for. The investigator asked Brodie what happened to his stomach and was told that a classmate named Angelo bit him when he wouldn't give him a toy that he wanted. Brodie said he told his teacher that Angelo bit him and he denied being afraid of his mother or anyone at the daycare center. The investigator completed a body chart documenting a healing bite mark on his stomach.[7] CPI York interviewed mother who reported that her children began attending Theta Daycare on Monday, August 20. On Wednesday, she noticed the bite mark on Brodie and the red mark on Aiden's bottom. She went back to the daycare and spoke with the Director, who told her Brodie had been bitten by a classmate after an argument over a toy; the director did not know the origin of Aiden's mark. However, the Director did state that Aiden cried the whole day. Mother denied that Aiden complained of any pain, but due to his age was unable to explain how he got the bruise. Mother stated that she didn't think anyone at the daycare harmed her children but that she was urged to take the kids to the ER by the shelter case manager. Mother stated that she was only staying at the shelter for a few more weeks and would be moving to 100 Freesia St in Poplar. CPI York conducted an adult substance abuse screening. The mother admitted to smoking marijuana on June 25th and reported that in 2012, she went to Sigma Agency for substance abuse treatment. CPI York conducted a domestic violence screening. The mother stated that she was staying at the shelter fleeing a domestic situation with her children's father, Isaac Huber, who was in custody for assaulting her. Claire admitted to being hit and said she obtained an order of protection against her son's father.

On August 27, 2018 CPI York went to Theta Daycare and met with the Director, Georgia Fox. Ms. Fox stated she was aware of the allegations involving the Huber brothers. She shared that both children only attended the daycare from August 20-22. Ms. Fox denied that anyone abused Aiden and reported that Brodie was bitten by a classmate when they got into an argument over a toy. She explained that Brodie was in a mixed age classroom when he was bitten by a classmate during free play from 9:30am-10:00am. Ms. Fox reported that she was in the classroom on August 21 when Brodie was bitten, but didn't witness the incident directly. Ms. Fox stated that Brodie's teachers, Ms. Brown and Ms. Douglas, were in the classroom as well. She stated that she observed teeth marks on Brodie's stomach. She denied that his stomach was bleeding and reported that she cleaned off the injury with soap and water. Ms. Fox stated that there were about 20 kids in the classroom when the incident occurred. She stated that Ms. Ives was notified at pick up of the incident, and she didn't express any issues or concerns. Ms. Fox stated that the daycare conducted daily health checks and no signs of abuse or neglect were observed. She stated that they did not remove clothes but if a mark was observed, a report would be made. Ms. Fox stated that Aiden received diaper changes at the daycare and no bruises were observed. She provided the investigator with Aiden's diaper log, the incident report, and attendance report.[8]

Also on August 27, the investigator attempted phone contact with law enforcement, leaving a message for Detective Ford Gersch, requesting a return call. CPI York followed up her phone call with an e-mail requesting the same.

CPI York interviewed Beatrice Brown, Callista Carey, Dahlia Douglas, and Esme Ellison individually on August 29 at Theta Daycare. Ms. Brown reported that she was Brodie's teacher. She said that Brodie was bit by another student at approximately 8:20am. Ms. Brown stated that the incident occurred when the classes were getting ready for a field trip and were in a common area. Ms. Brown said that Brodie and Angelo were playing together. She said that Brodie took a block from Angelo and he got upset. Ms. Brown reported that as she was telling Brodie to give the block back, Angelo quickly bit Brodie. Ms. Brown stated that she separated the children, talked to them about the incident, and read a book to them about sharing and not biting each other. Ms. Brown stated that the incident happened on the first day

[7] CPI took photos of both minors that were uploaded to SACWIS on 8/24/18.

[8] The diaper log, accident/incident report, and attendance report were part of the hard copy attachments to the investigative file.

Brodie attended the daycare. Ms. Douglas stated that she was Angelo's teacher. She stated that she did not observe Angelo bite Brodie but heard him crying and when asked, he reported that Angelo bit him. Ms. Douglas stated that the director looked at the bite mark and cleaned it off. Ms. Carey reported that she was Aiden's teacher. The investigator showed Ms. Carey photos of Aiden's injury; she denied observing marks on Aiden. Ms. Carey reported that they conducted daily health checks on minors and nothing was observed. She stated that during the short time the minor attended the daycare center he didn't really interact well with peers and had problems sitting on the floor and during table time. Ms. Carey denied that Aiden ever expressed any pain or discomfort. Ms. Ellison reported that she was one of the teachers for Aiden. She also stated that daily health checks were done at the daycare center and no injuries were observed on Aiden. Ms. Ellison stated that Aiden mainly liked to sit alone for the three days he was at the center. She denied that he was ever hit by any classmates with any toys and said he never showed any signs of abuse or neglect. Staff all confirmed that Brodie and Aiden only attended the daycare from August 20-22.

That same day, CPI York also had phone contact with DCFS daycare licensing representative Inaya Hanks. Ms. Hanks reported that she went to the daycare center on August 28 and reviewed video of Aiden's classroom for August 22, 2018. Ms. Hanks stated that she watched the tape from the time minor was dropped off to being picked up by his mother and nothing unusual occurred. Ms. Hanks denied that the daycare has had any serious violations or been shut down. Ms. Hanks stated that she looked at the diaper log for Aiden and no signs of trauma were noted. Ms. Hanks also stated that she reviewed the incident report from Brodie being bitten.

There is no documented investigative activity in September.

A MPEEC review was completed on September 24, 2018. The following materials were reviewed by MPEEC: police report, Tau Hospital ER records, photo day 1, photo day 7. In a memo to the assigned detective, Dr. Hope Jarvis noted the following:[9]

> After reviewing the materials, we noted that the ER physician gave a non-specific diagnosis of "hyperemic macular non-blanching lesion" aka flat red spot. We decided to ask a few of our colleagues their opinions as to what this mark to the back of the thigh might be. All three had a different impression of what the lesion in the picture represented. I've included their specific replies below.
>
> From a medical standpoint, since medical providers cannot agree on what the lesion actually is, it is exceedingly difficult to offer concrete advice on how to further investigate this case.
> Dermatologist:
> "The shape and configuration are very suggestive of a contact reaction to something external. Hard to say what item caused it (thermal vs chemical) or whether it was malicious or accidental."
> Burn and plastics surgeon:
> "Looks like she sat on something to me."
>
> Pediatric emergency room physician:
> "With the redness it could be a patterned contact burn if he was placed on or leaned up against something hot however the picture makes it look more like bruising rather than a superficial burn (but I know a picture cannot distinguish that – it just looks more like

[9] This memo is found in the hard copy attachments to the child protection investigation.

bleeding under the skin rather than thermal injury to the top layer of skin based on kids I've seen in the ER)."

On October 17, 2018, the investigator received a phone call from Dr. Hope Jarvis to discuss the case; Dr. Jarvis informed the investigator that the results were inconclusive. According to the contact note documenting the conversation, Dr. Jarvis reported that three physicians in various specialties (Burns, Dermatology, ER) reviewed the case and were unable to determine what the mark was. CPI York also followed up with law enforcement on this date and was informed that their case had been suspended as there was no definitive answer as to how or what minor Aiden's injury was and three physicians reviewed the case and all three had different opinions per Dr. Jarvis.

CPI York went to the Upsilon Shelter on October 17 and spoke with the afternoon childcare provider Journey Kalfus. Ms. Kalfus told the investigator that she cared for children at the shelter from 6:00pm to 7:00 pm and 7:30pm to 8:30pm while parents attended required classes (community parenting and life skills). She reported that she cared for both Aiden and Brodie Huber on the day in question. She said that per rule, parents must change their child prior to minor being left; she did not change Aiden's diaper on the day in question; and she remembered this day because after the mother picked up her children, she came back and mentioned the bruise on Aiden's bottom. Ms. Kalfus denied that she ever saw mother being physically abusive toward the children but said she had observed the mother yelling at the children.

Also on October 17, CPI York spoke with Upsilon Shelter worker Kendall Levine, who informed the investigator that Claire Ives had successfully completed the program at Upsilon Shelter and no longer resided there. Ms. Levine stated that mother provided an address of 200 Daffodil Rd in Cedar, IL. The next day, October 18, the investigator called the Cedar Police Department and requested a well-being check for Brodie and Aiden at the provided address. Later that day, the investigator received a phone call from a Cedar Police Operator who informed her that Claire did not reside at that address and that the new apartment occupant reported that they moved into the unit on the October 1.

On October 19, at approximately 10:35am, CPI York made an unannounced visit to the address provided to her by Claire during her previous interview (100 Freesia St, Poplar) in an attempt to locate the family. According to her contact note documenting this visit, while CPI York was standing outside of the door, she heard a male voice saying, "lay down, lay down" and heard loud smacking noises. The male, who was later identified as Jordy Novak, answered the door and went to get Claire from the back of the apartment. The investigator explained to the mother what she heard and asked to do a body chart on Aiden. CPI York completed a body chart and observed numerous raised welt/lash marks on Aiden's buttocks. She noted in her contact note that the lines were a clear indication that Aiden was hit. Jordy denied striking Aiden and had no explanation for the marks to his buttocks. The mother denied that anyone hit her son. She stated that the marks were from Aiden lying on Jordy's coat. CPI York told mother that marks like that would not be caused from lying on a coat and she needed to take her son to Zeta Hospital immediately. CPI York told OIG investigators that she observed the jacket and said there was no way the marks to Aiden were from the jacket. She said she contacted her supervisor by phone to inform her of the incident and a critical decision was made that Aiden be seen at the nearest hospital and that she contact the Hotline. CPI York said she made the Hotline report from her car while driving to meet Claire and Aiden (who had taken the bus) at the hospital. Supervisor Zamora told OIG investigators that the decision to not take protective custody of Aiden was made because Claire agreed to take Aiden to the hospital.

According to a contact note, the investigator met with the hospital social worker at approximately 12:30pm, provided the case details, and showed her a photograph of minor's injury taken when she arrived at the home at 10:35am. The social worker stated that she would note in the case file that the minor should not be released until DCFS gives clearance. A photo was taken by CPI York and uploaded to SACWIS that showed welts on the legs and buttocks.

Claire continued to deny that anyone hit her son. When the investigator inquired how long the mother had known Jordy, Claire said she had known him for about nine months. She reported meeting him when she resided at Upsilon Shelter. CPI York informed the mother that a new DCFS report was made for this new allegation (SCR #1111G, discussed in detail below).

Following formal investigations, the four reports against the Theta Daycare employees were unfounded on October 31, 2018. Aiden was observed to have a strange red mark on his bottom that could not be explained, but there was no evidence to suggest Aiden's mark was the result of abuse or neglect. Brodie was observed to have a human bite mark on his stomach area, which was confirmed to have occurred by a classmate.

SCR #1111G – Ives, Claire – Reported 10/19/2018; Unfounded 12/18/2018

On October 19, 2018, child protection investigator Winona York contacted the Hotline at 12:01pm and reported the following:

> ACTION NEEDED: 2-year-old with welts on bottom.
>
> Reporter went to the home for a 30-day visit and could hear "hitting" and a male voice saying "lay down, lay down" multiple times. Jordy then answered the door and Aiden was laying down on a bed. Reporter asked to see Aiden's body and found numerous linear welt marks on Aiden's bottom. Jordy denied hitting Aiden. Claire denied that Jordy hit Aiden as well. Claire did not have an explanation for the welts. Reporter states that Claire was in another room and the television was loud so Claire may not have heard what was going on. Jordy provided his identifying information but did not show reporter an ID.[10] Claire has taken Aiden to Zeta Hospital and is currently there to get checked out. LEADS requested. Claire has a history of domestic violence.

An allegation of cuts, welts, bruises, abrasions, and oral injuries by abuse to Aiden by Jordy was taken for investigation. Lenora Mullen was the assigned child protection investigator, supervised by Martha Nash.[11]

That day, CPI Mullen had phone contact with the reporter/CPI York. Ms. York confirmed her report to the Hotline. She stated that she was getting ready to close a pending facility case investigation involving the alleged child victim Aiden and went to the home to see the family for the 30-day visit. Ms. York stated while she was outside the door, she heard a male voice say, "lay down" multiple times. CPI York stated that when she went inside the house, she observed Aiden lying on the bed with his pants down and Jordy standing there. She stated she observed Aiden to have numerous raised welts on his bottom. CPI York stated that she told the mother that the minor needed to be seen at the hospital and that she was on

[10] The investigator later learned that Jordy provided her with an incorrect last name.

[11] Ms. Nash has been employed with DCFS for 21 years; most of her experience has been in placement. Ms. Nash told OIG investigators that she was a supervisor in child protection from June 2014 to April 2016 and again from August 2017 to March 2019. Ms. Mullen has been employed with the DCFS as a child protection investigator for three years. In those three years, she reported having six different supervisors. She reported a chaotic work environment and said she did not always receive adequate supervision. CPI Mullen told OIG investigators that Ms. Nash supervised her from October 2018 to February 2019 while her supervisor was on medical leave. She reported high caseloads at the time and said she felt like a burden. According to DCFS Protective Service Teams By Worker Report, CPI Mullen was assigned 17 investigations in October 2018 and 13 in November 2018.

her way with the minor to Zeta Hospital.[12] CPI Mullen told OIG investigators that she observed the photograph taken by CPI York of Aiden's injuries. She stated they did not look like jacket marks.

CPI Mullen met mother and Aiden at Zeta Hospital where they were waiting to be seen by an ER doctor. CPI Mullen did not interview Aiden as he was not verbal due to his age. The investigator interviewed the mother. Claire stated that she had only known Jordy for about nine to ten months. Claire stated that she left a domestic violence situation in Juniper County and moved to Poplar. She stated that she was at Upsilon Shelter for three months. Claire denied Jordy hit her son and stated that she was the only one that hits her children. When asked about the marks that were observed, Claire stated that her son was on the bed naked and stated that it could have been the jacket lying on the bed that made the mark. Claire stated, "how could my son be hit, the lady didn't hear my son scream if he was hit." She said she was in the middle of cooking breakfast and she would have heard if he whooped him. Claire admitted to smoking marijuana and going to Sigma Agency for rehab in 2012-2013. Claire stated that she has other children that were not in her care. Claire stated that she and the father share custody of her daughter and stated that her oldest son was adopted through DCFS. Claire stated that she had Intact Services through Rho Agency for five years and stated that Rho Agency got her housing. CPI Mullen completed domestic violence and adult substance abuse screenings. Claire reported a domestic violence history including an incident in October 2017 with Isaac Huber and a relationship in May 2018 with someone else. Although Jordy was identified as Claire's paramour, it was noted in the domestic violence screening that he lived out of the home. A paramour checklist was not completed. Claire could not identify anyone in the city to care for her children while in a safety plan. Claire got defensive and stated she didn't understand why DCFS needed a safety plan because there were no marks on her son. CPI Mullen discussed Safe Families[13] as an option of safety planning since mother didn't have anyone that the children could be placed with. The mother eventually agreed to Safe Families and completed the paperwork. CPI Mullen referred Brodie and Aiden to Safe Families for Children. The reason for referral was: "There was a report of marks on the children. There is a DCFS history on Mom. Mom's bf is one of the concerns because of his Criminal case (inflicted the marks). Might proceed to intact family." An initial request was made for three-month hosting.

CPI Mullen told OIG investigators that she felt "something was not right about mom." She said she contacted her supervisor with her concerns from the hospital and her supervisor instructed her to implement a safety plan. Ms. Mullen stated the reason she referred the family to Safe Families was because Claire was unable to identify any supports for a safety plan. She described the mother as difficult and said she had a hard time getting her to agree to the safety plan. Supervisor Nash told OIG investigators that there was no discussion of taking protective custody because the mother agreed to the safety plan with Safe Families and to intact services.

[12] Zeta Hospital medical records noted that two-year-old Aiden was brought to the ER on 10/19/18 by DCFS for medical evaluation for possible physical abuse by mother's boyfriend after investigator was at home and heard child possibly being hit by an adult in the home.

[13] Safe Families for Children program plan describes services as a network of host families who volunteer to take children into their homes whose families are experiencing an emergency or crisis. The voluntary and non-coercive nature of the program is meant to provide the parent with a temporary place for their child without the threat of losing custody. An objective of the Safe Families for Children program is to be an alternative to child welfare custody and reduce the number of children entering the child welfare system by giving child protection investigators a "new third option" for protecting children. According to the program plan, referrals to Safe Families for Children come directly from investigators, intact workers (DCFS and POS), teen parenting programs, and the DCFS hotline. Families are assigned a "Case Coach" who monitors the child living with a host family and helps the parent get the resources they need for their children to be safely returned to their care.

Aiden was seen at the hospital at approximately 3:30pm. The welts were no longer visible when the doctor examined the minor and the following was noted in the medical records:[14]

> Exam shows no current signs of physical abuse, and previous photo of right gluteal welts were examined and on presentation are no longer visible. No further signs of physical abuse seen on examination, oral dentition appropriate no signs of cavitary lesions, no signs of neglect and he is in the 30th percentile of the growth chart. Although there were no acute signs of trauma, patient has unclear history concerning for physical abuse as well as pattern of previous injury (per photo by DCFS on site that has since resolved on presentation) that could be aligned with pattern of abuse. Otherwise benign examination.

The medical records further noted:

> Assessment: Marks to buttock in context of presumed spanking/physical punishment to the child heard by a DCFS worker – no marks or bruises now.
> The determination of physical abuse in this case in the purview of DCFS. **Hitting a child this young and leaving marks even if they fade would constitute physical abuse** (emphasis added**)**."
> Plan: DCFS involved/ police report made by DCFS/ skeletal survey/ discharge to safety plan per DCFS.[15]

Five-year-old Brodie was brought to Zeta Hospital that afternoon after school was dismissed. According to the hospital records, he was also evaluated for physical abuse with no signs of injury on exam. CPI Mullen interviewed Brodie while at the hospital. According to her contact note, the investigator did not observe any marks or bruises on the minor nor any outward signs of abuse or neglect. Brodie told the investigator, "I don't like Jordy." When asked why, he stated, "cause he be whooping on us." When the CPI asked where he gets whooped and what does he use to whoop, Brodie stated, "My mama told me not to say anything and she said I'm going to get in trouble if I say anything." The minor shut down and did not disclose anything else to the investigator. When the investigator asked Claire about this, she said it was not true and denied that her boyfriend hit her children. Supervisor Nash told OIG investigators that she was aware of the statements made by Brodie to the investigator and that he was checked by doctors and no marks were observed.

CPI Mullen completed an UNSAFE CERAP on October 19, 2018. She identified risk to Brodie and Aiden and documented the following under intervention:

> There is some suspicion that minors have experienced physical abuse at the hands of mom's paramour. The mother has not shown that she can protect her children. The mother denies that paramour whoops her children but the oldest child states that mom's boyfriend whoops them. The youngest minor that is 2 years of age was observed with raised welts on his bottom. The mother is formerly homeless and unemployed. The children's father is incarcerated. The mother has limited support system. The children are currently residing with Safe Families home.

On October 24, six days after placement, CPI Mullen spoke with Noel Ochoa from Safe Families, who was identified as the family coach that would be responsible for arranging visits. According to her contact note, the investigator informed Ms. Ochoa that Claire was allowed to see her children, but that the visits

[14] Zeta Hospital medical records are part of the hard copy attachments to the investigative file.
[15] Later that night, after being discharged, Brodie and Aiden were transported to a DCFS office and subsequently to a Safe Families home.

needed to be supervised by Safe Families due to concern that if not supervised, mom might flee with the children. Ms. Mullen told OIG investigators that she was concerned that mom might flee because "mom was not super cooperative" and she did not trust mom at the time.

Investigator Mullen met with Claire at her home on October 29, 2018. The investigator observed the home to have working utilities; a fire and carbon monoxide detector; beds for the minors; and plenty of food. The mother told the investigator that she had spoken with her children by phone but had not seen them while in Safe Families. According to her contact note, the investigator advised the mother that Jordy was not allowed in the home around the children. Claire told the investigator that Jordy did not live with her and stated that she thought he might be staying out west. Claire expressed concern for her son Brodie because he had witnessed his father (Isaac) choking her and beating her up. CPI Mullen explained and offered Intact Family Services; the mother agreed to services. The transitional visit occurred on November 9, 2018. CPI Mullen and the intact worker from Xi Agency met with Claire at her home; services were explained.

CPI Mullen told OIG investigators that she never observed signs of a male living in the home.

CPI Mullen met with Jordy Novak on November 19, 2018 at the DCFS field office. He presented photo identification for the investigator and reported that he was residing at 300 Petunia Ct in Poplar. Jordy stated that he would never discipline Claire's children. Jordy said he did not know where the marks on Aiden came from. He stated, "I didn't touch him. The lady knocked on the door and I opened the door. Aiden was lying on my jacket. The marks could of came from my jacket."

On November 21, 2018, the host parent from Safe Families contacted the Hotline and the following was taken as related information:

> Reporter is expressing concerns regarding Brodie (5) and Aiden (2) who have been experiencing episodes of PTSD. Brodie reported Gannon AKA Odin, quote "Odin was on top of mom, I bit him, then Odin threw me and Aiden across the room on to our beds. Odin was angry and punched the window and glass went everywhere. I am afraid of Odin. Odin is around a lot because he is Aiden's dad." Reporter asked Brodie if he wanted to go home, Brodie stated, "yes" Reporter stated, "will you be safe?" Brodie stated "no." Reporter stated "why won't you be safe?" Brodie then stated, "Odin is always there." Reporter stated when the boys hear the word "Odin" they are traumatized and it takes up to 30 minutes to calm them down, or they will completely shut down. Brodie reported seeing his father Isaac Huber choke and hit his mother Claire, and said Isaac went to jail because of him hurting his mother. Brodie said, "I had to hide my face because I was scared." Unknown when this happened. Brodie and Aiden have very bad reactions to all of Claire's boyfriends when mentioned. According to reporter when Claire calls on the phone she tells Brodie not to lie [a]bout Odin because DCFS will take them away. Per reporter OPWI 1 [Penelope Ramsey] is the new intact worker and has not come to visit the children but sent a co-worker who was in the home two minutes. Reporter OPWI 2 [Noel Ochoa] have attempted to contact DCFS regarding the PTSD episodes and issues with no response. Reporter stated no investigator came to the home since the initial placement to speak to the children.

The next day, CPI Mullen had phone contact with reporter Quincy Schaefer. Mr. Schaefer confirmed his report to the Hotline; he stated that both boys appear to be experiencing some trauma in relation to what occurred in the home between mom and Odin.

On November 26, 2018, the investigator had a phone conversation with intact worker Penelope Ramsey regarding the related report. According to the contact note documenting that conversation, Ms. Ramsey told the investigator that she spoke with Reese and Noel at Safe Families and it appears that Brodie is traumatized with the relationship between Odie and his mother. Ms. Ramsey stated that Claire told her that there was a domestic violence incident that occurred between Odin and Claire; Brodie got in between the two of them and Odin threw Brodie across the room. Ms. Ramsey said that Claire was in a relationship with Odin in May or June but then she got away from him. She stated that Claire and Odin had a child that was given up for adoption. Odin recently got out of jail and she was working with the mother on getting an order of protection.

Claire petitioned the court for an order of protection on November 28, 2018 against Gannon Kemp. In support of her petition for an order of protection, an affidavit signed by Claire was filed and noted the following in part:[16]

1. I am the Petitioner in this matter and the Respondent is my ex-boyfriend. We dated from in or around 2010 and ended in or around May 2018. We lived together from in or around February 2018 until in or around May 2018. I have three children not in common with the Respondent, Dylan Ives (8 years old), Brodie Huber (5 years old), and Aiden Huber (2 years old). The Respondent has abused me as follows:

    a. On or about November 27, 2018, I was instructed by the Illinois Department of Children and Family Services to obtain an Order of Protection against the Respondent. I was instructed to do this so that DCFS would return my two youngest children (Brodie and Aiden) to my care. The children were temporarily placed in foster care on or about October 19, 2018, pursuant to a DCFS investigation arising out of an incident involving my current boyfriend. Upon information and belief, according to my best understanding of what the investigator has told me, the investigation has effectively concluded and the abuse allegations were determined to be unfounded. However, while the children were in foster care, Brodie made references to the incidents of abuse involving the Respondent that occurred approximately six months ago (see below). In response, the foster care provider contacted DCFS, mistakenly believing that the Respondent still has contact with myself and the children. There has been no such contact since the incidents described below. Because of this report, however, DCFS has conditioned my children's return on my obtaining an Order of Protection against the Respondent.
    b. On or about May 21, 2018, at approximately midnight, I was at my residence (400 Gardenia Pl, Cedar, IL) with the Respondent, Brodie and Aiden. I told the Respondent that I no longer wanted to be with him due to issues in our relationship. He became agitated as we argued about the relationship. The Respondent then struck me on the right side of my face with his hand. In order to defend myself, I responded by striking the Respondent's chest. My children woke up and came to the room we were arguing in to see what was happening. The Respondent then shoved me into the wall and my son, Brodie, stepped in between me and the Respondent to protect me. The Respondent then shoved Brodie out of the way. The Respondent then went

[16] The Order of Protection and affidavit are part of the hard copy attachments to this investigation. The attachments also include the May 2018 Order of Protection against Gannon Kemp and an Emergency Order of Protection and a Plenary Order of Protection against Isaac Huber dated 11/29/17 until 11/29/19.

> over to a nearby window and punched it, breaking the glass out. The Respondent injured himself from the glass and this injury ended the argument. I was able to get the children out of the room and we then stayed the night in a room separate from the Respondent. The Respondent agreed that he would leave, but would wait until the afternoon as it was too late in the evening for him to leave.

Claire also noted verbal abuse in the relationship, which included threatening to kill her and destroying her property. An Emergency Order of Protection was entered protecting Claire Ives, Dylan Ives, Brodie Huber, and Aiden Huber.

On November 28, Brodie and Aiden were seen in their Safe Families home by child protection investigator Skye Tate, who documented that the boys appeared happy and healthy. There were no concerns of abuse or neglect. CPI Tate attempted to interview Brodie. According to her contact note, Brodie would not talk; he squirmed around on the ground and avoided answering any questions. Brodie did tell the investigator that he felt safe with this home and was not afraid of anybody in the home and that he loved his mother. He would not say anything else.

CPI Mullen spoke with Claire by phone on November 30 regarding the related report. She told the investigator that Gannon Kemp got out of jail at the end of summer. She said she has an order of protection against him and was no longer involved with him. Claire stated that Gannon did attack her; he choked her, Brodie got in between them, and Gannon flipped Brodie onto the bed.

On December 4, 2018, a staffing was held regarding this case with CPI Mullen, her supervisor,[17] Xi Agency intact worker Penelope Ramsey, and Xi supervisor Tegan Valdez. The investigator noted: "The mother is currently engaged in services with the agency and she did obtain Orders of Protections against Gannon Kemp and Isaac Huber. The agency is currently working with the mother in terms of bringing her children back home."

On December 18, CPI Mullen followed up with law enforcement regarding the status of their investigation. The investigator was informed that their investigation had been suspended and they would not be pursuing charges because of too many conflicting stories.

A final supervisory note by Martha Nash dated December 18, 2018 reads:

> PSA has reviewed the case and is in agreement with the recommendation to unfound. There is no credible evidence to support the allegation. Reportedly, alleged child victims were whipped by alleged perpetrator's paramour; however, when they were examined by the treating physician could not find any evidence of abuse. Alleged perpetrator denied the incident occurred. Reporter observed the [alleged child victim] laying on the bed with his pants down and alleged perpetrator, birth mother's paramour, standing near the bed. Birth mother was in another room, she could not provide an explanation for the reported welts. The assigned detective states that the status of their investigation is suspended because there is too many conflicting stories as to how the minor got the marks. Detective states that they are not pursuing charges at this time.

[17] In her OIG interview, Supervisor Martha Nash said she did not recall participating in this staffing. However, CPI Mullen reported that Ms. Nash participated and Xi Agency intact worker Penelope Ramsey also documented that Ms. Nash participated in the staffing.

Following a formal investigation, the allegation of cuts, bruises, and welts to Aiden by Jordy was unfounded on December 18, 2018. The rationale noted: "It cannot be substantiated that an incident occurred. The following factors attributed to the findings. ACV [alleged child victim] is 2 years old and was unable to state whether or not he was whooped. The minor was examined by a physician at Zeta Hospital and there were no marks or signs of abuse present. It is recommended that this allegation is unfounded and the case is already open to Intact Family Services." An allegation of substantial risk of physical injury/environment injurious by neglect to Aiden by his mother (added by investigator) was also unfounded using the same rationale.

CPI Mullen and Supervisor Nash both acknowledged that the marks to Aiden faded over a relatively short period of time and were not observed by medical personnel upon examination. Ms. Nash told OIG investigators that in order to indicate for cuts, welts, bruises, abrasions, and oral injuries by abuse or by neglect, the welts needed to be seen and a doctor had to confirm that it was from abuse.[18] She told OIG investigators that the decision to refer the family for intact services was because Claire was willing to safeguard her children and wanting to do more. She said Claire needed to make better choices and needed supportive services that would empower her.

Intact Family Services

During the October 2018 child protection investigation, Claire Ives agreed to intact family services and CPI Lenora Mullen referred the family for intact family services. The intact case was opened to Xi Agency in November 2018. The case remained open at the time of Aiden's death. Penelope Ramsey,[19] supervised by Tegan Valdez, was the assigned intact case manager. According to the Intact Family Services Case Referral and Assignment Form, recommended services included: parental capacity assessment, zero to three developmental assessment for Aiden, counseling, and domestic violence services. At the time of case opening, Upsilon Shelter had already referred Claire to and she was engaged in services through the Community Agreements to Benefit Homeless Individuals Program (CABHI)[20] including individual therapy to address her domestic violence history.[21]

The transitional visit with the investigator and intact worker occurred at Claire Ives' home on November 9, 2018. According to the contact note, the home was considered safe; the minors were not present during the visit; a safety plan remained in place; and the minors continued to reside in a Safe Families home with Reese and Quincy Schaefer, where they had been placed since October. All visits with their mother were supervised by the Safe Families coach[22] as part of the safety plan per DCFS request.

[18] According to DCFS Procedure 300 Appendix B (3)(B), "to make a finding of abuse (Allegation #11), documentation of a medical opinion has been obtained that verifies that the child sustained cuts, bruises, welts, abrasions or oral injuries as a result of direct action of the perpetrator, or the perpetrator has admitted to harming the child. The Child Protection Supervisor must review the medical documentation to ensure report of finding does not conflict with medical opinion."

[19] Ms. Ramsey had been employed with Xi Agency since 2014 with no prior discipline. On March 22, 2019, Ms. Ramsey was placed on administrative duties and was prohibited from being involved in any child welfare cases in any capacity at the direction of DCFS due to concerns of possible falsification in this case. She was terminated from employment as an Intact Family Services case manager with Xi Agency effective May 9, 2019 due to Xi Agency's substantial programmatic and fiscal constraints.

[20] CABHI programs help people find housing and supportive services.

[21] Claire was accepted for admission on June 21, 2018 while waiting for her housing voucher to transfer from Juniper County Housing Authority to the Poplar Housing Authority. She requested an emergency transfer due to domestic violence. The family was housed in Upsilon Shelter and remained at the shelter until September 6, 2018 when they moved into their own apartment.

[22] The Safe Families coach was Noel Ochoa, supervised by Ursula Watson.

Prior to the minors return to Claire in December, Mr. and Mrs. Schaefer and the Safe Families coach Ms. Ochoa made several calls and documented concerns related to the safety of the minors if they were returned to Claire. On October 30, even before the intact case opened, Safe Families Coach supervisor Ursula Watson documented a conversation with host mom Reese Schaefer regarding an email sent expressing concerns about the minors' situation at home with the mother, including issues of domestic violence. The supervisor noted: "Want to hear concerns but also want her to look for ways to support parent, show empathy, discuss kids, what mom's done with them, what routine and schedule has worked well for them in the host home such as feeding and bed time, modeling to mom…"

A contact note written by coach Noel Ochoa documenting a parent/family visit on November 12, 2018 reads in part:

> Claire appeared from around the corner about 20-25 feet away. She proceeded from the train towards my car and Brodie started to hysterically scream and cry out, "no, no, please don't take me" when he saw her from a distance. I tried to calm him and said it would be okay. Claire entered the car and Brodie continued to cry and say, "no, no, no Odin." Claire told him that Odin wouldn't hurt him and not to cry. He continued hysterically crying for at least 10 minutes. Aiden was not crying. Brodie finally calmed down.

On November 21, the host family contacted the Hotline with concerns. This report was taken as related information to SCR #1111G (discussed above).

On November 27, a Xi Agency caseworker, Vivi Zimmer met with Safe Families host Mrs. Schaefer and minors Brodie and Aiden on behalf of caseworker Penelope Ramsey. According to the contact note, the worker observed the home to be safe and appropriate and the minors were appropriately dressed. The Safe Families host mom expressed her concerns to the Xi Agency worker during this visit. She reported that Brodie was afraid of the biological mother's paramour "Odin" and the minors cried when visiting with their mother. She was afraid the minors would be returning to an unsafe environment where they would continue to experience trauma. The worker stated that she would forward the information to caseworker Penelope Ramsey.

During a scheduled home visit with Claire on November 27, 2018, intact worker Penelope Ramsey spoke to Claire's therapist, Wendy Atkins, by phone. According to Ms. Ramsey's contact note, Ms. Atkins confirmed she was providing psychotherapy to Claire and agreed to provide documentation to the worker confirming that Claire was receiving services, the duration of services, and diagnosis if given.[23] The following letter written by Ms. Atkins is part of the intact case record:

> Date: 11/28/2018
> Client Name: Claire Ives
> Clinician Name: Wendy Atkins, MSW, LSW
> Summary:
> I know Claire Ives in the capacity of her Therapist at Upsilon Shelter. Ms. Claire Ives began undergoing psychotherapy on 07/12/2018. This client has reported experiencing severe PTSD symptoms such as frequent nightmares, flashbacks and hypervigilance daily. The client reported experiencing these symptoms following major life stressors regarding her past trauma, specifically domestic violence. Due to the reported onset and

[23] Claire signed a consent form on 11/27/18 allowing the Xi Agency intact worker to communicate with her therapist.

> duration of these symptoms, the client has been given a diagnosis of PTSD (post-traumatic stress disorder).
> While enrolled in the Upsilon Shelter CABHI program[24] Claire Ives has regularly attended induvial (sic) psychotherapy and therapy groups. She is a proactive participant in the groups and regularly exhibits a positive and motivated attitude. Claire Ives will continue to meet with me for weekly individual sessions as well as attend daily treatment and therapy groups. When discharged, Ms. Claire Ives, will be connected with referrals to community mental health centers for continued after care services.

OIG investigators interviewed Ms. Atkins, who reported that she was employed as a therapist for the CABHI program, located onsite at Upsilon Shelter, and specifically assigned as Claire's therapist. Ms. Atkins reported that she and Claire were scheduled to meet weekly for individual therapy sessions. She confirmed that she continued to work with Claire on her treatment goals after Claire no longer resided at the shelter. Ms. Atkins reported having little contact with Brodie or Aiden and reported no concerns regarding their care. She told OIG investigators that she referred Brodie for therapy after Claire told her that he witnessed a domestic violence incident and was exhibiting aggressive behavior. Ms. Atkins said that Claire reported having a new boyfriend and said she was working with Claire on understanding healthy relationships. She stated that Claire had no identified support, no friends, and a conflictual relationship with her mother. Ms. Atkins reported minimal contact with Claire's intact worker and said she was unaware of the reasons for the family's involvement with the Department. Ms. Atkins said she learned that Claire's children were removed from her care and residing in a Safe Families home on November 27, the same date she was contacted by the intact worker.

On November 28, host mom Reese Schaefer informed Safe Families staff that following a phone call with mom, Brodie was shaking and sobbing. Ms. Schaefer reported Brodie did not want to go home with his mom and that he was scared. According to a November 29, 2018 supervision note written by Ursula Watson, Safe Families Coach Supervisor, "Schaefers are adamant that the boys aren't safe to go back to mom's care." Additionally, an email dated December 2, 2018 from Ms. Schaefer to DCFS CPI Lenora Mullen, Noel Ochoa and Ursula Watson stated: "The boys just got off their phone call with Claire. Brodie asked who was in the background talking. Claire said it was Geordie 'Xeno'. Brodie told us that this was the boyfriend that whooped baby Aiden. We just wanted to make you aware. Thanks, Reese Schaefer."

Xi Agency intact worker Penelope Ramsey documented that she and her supervisor, along with DCFS investigator Lenora Mullen and her supervisor, participated in a staffing for the Ives case on December 4, 2018. The purpose of the staffing was to discuss the concerns made by Safe Families hosts, Mr. and Mrs. Schaefer, and the Safe Families coach Ms. Ochoa regarding the safety of the minors if returned home to their biological mother.[25] Ms. Ramsey noted that it was decided after all information was shared that the mother's home was safe and appropriate for return of the minors. Ms. Ramsey noted that Claire had actively been participating in services at Upsilon Shelter since August 2018, including therapy where she continuously discusses her past domestic violence history. Additionally, Claire's therapist, Ms. Atkins, provided the mother with referrals for counseling for Brodie.

The minors returned to their mother's care in December 2018, a day after the staffing. They were home for approximately three months prior to Aiden's death in March 2019.

[24] Upsilon Agency Community Agreements to Benefit Homeless Individuals Program (CABHI).
[25] No one from Safe Families participated in the staffing.

The assigned Xi Agency caseworker, Ms. Ramsey, made regular visits to Claire Ives' home.[26] The visits occurred weekly until December 17, 2018, when a critical decision was made and visits were reduced to twice a month. On December 6, 2018, the day after Brodie and Aiden were returned, Ms. Ramsey completed a scheduled home visit. She observed both minors with no signs of abuse or neglect. She documented in her contact note that the home presented with no environmental concerns; had working smoke detectors; and adequate amount of food in the refrigerator and cabinets. The mother was presented with a copy of her service plan, which she signed. Another home safety checklist was completed because the boys were back in the home. The worker transported the family to Poplar Elementary School so Claire could re-enroll Brodie into school for kindergarten, the mother completed the paperwork, and the worker met with the school principal to confirm the minors were back in the home.

On February 11, 2019, Ms. Ramsey conducted a scheduled home visit at the new residence. According to her contact note, the worker observed a newly rehabbed three-bedroom apartment with an adequate amount of food in the refrigerator and working smoke detectors. She completed a home safety checklist. Ms. Ramsey documented that mom had blow-up mattresses for the family and that she would submit Norman Funds requesting beds for the minors.[27]

Both the intact worker and her supervisor described the mother as being cooperative and proactive with services. Ms. Ramsey told OIG investigators that she never observed any signs of a male living in the home. She stated that the mother knew that she was not to have any adult males around her children; she frequently questioned the mother and the mother denied having her paramour in the home. Ms. Ramsey also stated that she spoke to the paramour by phone and he agreed not to be around the children. The intact worker reported that the mother informed her that she had been hired at a temp agency approximately two weeks prior to Aiden's death. There is no documentation in the case record that Ms. Ramsey explored childcare options with the mother. Ms. Ramsey received regular supervision on the case.

Children's Services

A zero to three screening for Aiden was completed on January 10, 2019, a month after return home. He was found to require early intervention services in the areas of communication skills, fine motor skills, and problem-solving skills. Starting in January, Aiden was receiving speech therapy with Xena Barker and developmental therapy with another therapist through Child & Family Connection Early Intervention program at Psi Hospital. Claire told the intact worker that she had informed both therapists from the program about her participation in intact services.[28] Prior to his death, Aiden met with the speech therapist three times and developmental therapist twice.

CABHI Social Worker Wendy Atkins referred Brodie for therapy with Upsilon Shelter psychotherapy extern Yasmin Castaneda. Brodie and his mother attended two out of five scheduled sessions on February 7 and February 21, 2019 and were late for both attended appointments. On March 11, 2019, the clinician completed a closing summary due to a change in the mother's work schedule.

Upsilon Shelter Records

OIG subpoenaed records from Upsilon Shelter. A review of those records showed that Claire Ives was accepted for admission on June 21, 2018 while waiting for her housing voucher to transfer from Juniper County Housing Authority to Poplar Housing Authority after she requested an emergency transfer due to

[26] At case opening, Claire was residing at 100 Freesia St; in early 2019, the family moved to a new address at 500 Lily Dr after the previous residence did not pass Section 8 inspection.

[27] The request was part of the intact family case record.

[28] According to records, on March 7, 2019, Claire gave verbal consent to Early Intervention Service Coordinator Zara Ewing to communicate with intact worker Penelope Ramsey.

domestic violence. She was housed in Upsilon Shelter's women's housing program. While Claire was living at Upsilon Shelter, she was enrolled in the CABHI program, where she was assigned a case manager, therapist, and a peer navigator. In July 2018, the staff at Upsilon Shelter documented that Claire was issued multiple consequences for not monitoring her children while in the residence. It was noted that her children were crying and walking the hallways unattended. On another occasion, Claire was issued a consequence for slapping one of her children on the arm in front of staff. When Claire was redirected by staff, she became aggressive and disruptive. In early September 2018, Claire returned to the residence under the influence of alcohol and was subsequently referred to Omicron Agency for a treatment program. She refused the referral and was asked to leave the shelter. Claire and her children moved into their own apartment on September 6, 2018. Although Claire no longer resided at Upsilon Shelter, she continued to be enrolled in the CABHI program. She continued to regularly see her therapist, case manager, and peer navigator from September until Aiden's death in March 2019.

A review of the CABHI records and contact notes revealed that during this time, Claire continued to struggle with gaining and maintaining stable housing, employment, childcare, financial and public aid benefits, and a healthy relationship. Claire struggled financially and frequently asked CABHI staff for assistance with obtaining public aid benefits. Claire reported that her TANF was discontinued because she was unable to comply with the volunteering for 20 hours a week. Claire's peer navigator assisted her with enrolling with Illinois Department of Human Services for cash assistance, but Claire refused to attend the classes that she was instructed to attend through Department of Human Services, so they reduced her cash benefits. In January, Claire asked her case manager to assist her with applying to Social Security Income for the children; she reported that her children were diagnosed with learning and developmental issues and she wanted to file a claim. Additionally, she expressed frustration that the boys' father was not contributing his child support payments and she was "tired of struggling with the boys alone."

In December 2018, Claire's apartment did not pass Poplar Housing Authority inspection for her Section 8 voucher, so she requested assistance from her case manager and her peer navigator to find a new apartment. They assisted her with locating available apartments and transported her to see the apartments. In January 2019, in a therapy session, Claire expressed to her therapist that she was recently triggered by a domestic violence incident that her roommate was involved in. This was the only mention of Claire ever having a roommate. When asked by OIG investigators, Ms. Atkins stated she recalled that Claire allowed a friend, who she met in Upsilon Shelter, to stay with her for a very short period of time. She told her case manager she needed assistance with an outstanding gas bill of $500 and needed help with the moving fee of $400. The case manager told her to contact Omega Agency for help. Claire and the boys moved into a new apartment in early February, but Claire's landlord told her case manager that Claire did not move any of her furniture from the previous unit because Claire reported not having enough money to rent a truck. At the new apartment, Claire did not have beds for the boys.

CABHI staff also helped Claire with obtaining things such as furniture, food, clothing, and transportation. When Claire first moved into her apartment, she reported she had no money for furniture, so her case manager referred her to a local non-profit that provides furniture. In December, Claire's peer navigator provided Claire's children with winter coats from the agency. Claire complained about the boys needing clothing and shoes, and the case manager helped her obtain a Goodwill voucher in January 2019. Claire contacted her peer navigator multiple times between September and December reporting she had no food for her or her children. The peer navigator would transport her to the food pantry, bring Claire to the shelter for a free meal, or bring Claire and the children groceries from the shelter. In January and February 2019, Claire was contacting CABHI staff at least weekly saying she and her children were without food. Claire asked for a bus card frequently because she reported no other means of transportation. CABHI staff gave her bus cards when available and drove her to and from different appointments and interviews when they were available. On February 11, Claire contacted her case manager and asked her to write a letter saying that Claire was homeless so that her son's school could

provide the family with bus cards. The case manager refused, stating that she could not use a homeless letter to receive assistance because Claire had just moved into a new Poplar Housing Authority apartment and therefore was not homeless.

Although Claire was reported employed multiple times between September 2018 and March 2019, it was unclear exactly when and where she was employed. She began job searching while still living at Upsilon Shelter and continued to interview at multiple places while living there and shortly after. At the end of November, Claire reported being employed at a temp agency, but stated that she did not like it. Her case manager encouraged her to go to the CABHI job fair in early December, where she reported she was hired by a company on the spot. She reported she worked part time in the mornings. At the end of December, she asked her peer navigator to transport her to pick up her paycheck from UPS. However, by January 2019, she expressed frustration that she had applied to several jobs but had been unsuccessful. The first week of March, Claire reported employment with a new company.

When Claire initially moved out of the shelter, she enrolled Brodie in school and reported that she would enroll Aiden in daycare at Nu Daycare. Approximately a week later, she told her peer navigator that she no longer needed day care at Nu Daycare because Aiden was enrolled somewhere else. However, over the next few months, she frequently complained that she was unable to work or go to interviews because she had no one to watch her children. In early January 2019, Claire told her therapist that she was going to lose childcare services at the end of the month due to non-compliance. On February 27, 2019, the peer navigator noted that Claire was in need of childcare for Aiden. The peer navigator assisted Claire with contacting Mu Agency; Claire would be able to receive 90 days of free childcare.

Although one of Claire's treatment goals in therapy was "decreasing dependence on intimate partner relationship while beginning to meet [her] own … needs, build confidence, and practice assertiveness," Claire reported to be in a new relationship as early as July 2018, while she was still living in Upsilon Shelter. Her therapist, Wendy Atkins, noted that Claire struggled with being alone and often felt "lonely" when not with an intimate partner. In August 2018, Claire told Ms. Atkins that she thought her new boyfriend was cheating on her. She expressed frustration and anger in her session, noting that she often felt "triggered" in this relationship. In October 2018, Claire's case manager noted Claire reported she had "put her boyfriend out because someone sent her a screenshot of her boyfriend belittling [her]," but a week later, the case manager noted Claire had "male company" at her residence when she arrived at Claire's home. By the end of November, Claire described the relationship to be "the best relationship that she has had" but said that sometimes she was still scared due to her past with domestic violence. However, in a session on February 25, 2019, Claire told her therapist that she believed she had "outgrown" her current relationship. Claire told her therapist that the relationship "will not last long" due to his immaturity.

Death
SCR #1111H – Ives, Claire – Reported 03/2019; Indicated 09/06/2019

An evening in March 2019, at 9:44pm, law enforcement contacted the Hotline to report Aiden's death. The narrative reads:

> ***EMERGENCY*** Child Death. Physician has taken PC of other youth in the home. Youth is currently at Zeta Hospital. ***COMPANION REPORT to Intake ID: XXXXXXXX***. Reporter received a call about a child who was found unresponsive. Reporter arrived at the home and witnessed a neighbor doing chest compressions on Aiden. Reporter stated that ambulance was called and Aiden was transported to Zeta Hospital. Reporter stated that while in the ambulance, the EMS revived Aiden and he had a slight pulse. Reporter stated that Aiden arrived at Zeta Hospital where he was

> pronounced deceased at 19:42. Reporter states that Aiden has bruising all over his body and sores on his face that look like burns according to the nurse. Reporter is unaware what the cause of death is at the time of intake. Reporter stated that when they arrived on the scene, Aiden was lying face up on the living room. Reporter stated that Dr. Denny of Zeta Hospital pronounced Aiden deceased at 19:42. Reporter stated that Claire mentioned that she was at work while the OPWI [Jordy] was watching Aiden. Claire stated that she came home from work and she found Aiden unresponsive shortly after. It is unclear if Claire had any interaction with Aiden before finding him unresponsive. Reporter stated that Aiden was last seen alive around 18:50 when the EMS was called. Aiden's sibling, Brodie was present in the home at that time.

Allegations of death by abuse; cuts, welts, bruises, abrasions, and oral injuries by abuse; and burns by abuse to Aiden by Claire and substantial risk of physical injury/environment injurious to health and welfare by neglect to Brodie by Claire were taken for investigation. The following came in as related information:

> RELATED INFORMATION***No added subjects or allegations***COMPANION REPORT***INTAKE ID: XXXXXXXX Reporter stated that Claire was working at Jimmy Johns, unknown how long she was away from home. Jordy was in charge of the children. Claire returned home from work. She saw that Aiden was lying down and checked on him when she got home. She noticed that there was drool coming from his mouth and he was unresponsive. Claire went to the neighbors and called the ambulance. Aiden was taken to Zeta Hospital and saw that there were multiple bruises on the body. Reporter stated that the cause of death is undetermined but is likely to be foul play due to the bruising that was present.

The Department also investigated Jordy Novak for allegations of death by abuse; cuts, welts, bruises, abrasions, and oral injuries by abuse; and burns by abuse to Aiden.

Claire and Jordy were questioned by police. Aiden's surviving sibling, Brodie, was taken into protective custody. Four days after Aiden's death, the Department was granted Temporary Custody of Brodie. Brodie was placed in the home of Mr. and Mrs. Schaefer, his prior Safe Families host family, after ruling out all other possible biological family. The Schaefers moved to a neighboring state in April 2019, and it was determined to be in the best interests of Brodie to move with them and remain in their care.

Following a formal investigation, on September 6, 2019, Claire was indicated for death by abuse to Aiden; cuts, bruises, and welts to Aiden and Brodie; and substantial risk of physical injury/environment injurious by neglect to Brodie. Jordy was indicated for death by abuse to Aiden and cuts, bruises, and welts to Aiden and Brodie. The rationale was that law enforcement reported that Jordy admitted to beating Aiden the day of his death and for days prior to his death, and Claire had found previous injuries and admitted knowledge that Jordy beat Aiden and still left him in Jordy's care. According to law enforcement, Claire knew of and actively sought to conceal evidence that Jordy had been physically abusing both Aiden and Brodie as proven by her search history on her browser. Claire and Jordy each admitted to physically abusing Brodie and Aiden. A physician at Zeta Hospital reported that Brodie had multiple bruises on his body as well. It is the medical examiner's opinion that Aiden died of multiple injuries due to child abuse and the manner of death is homicide. The allegation of burns by abuse was unfounded as there was no indication that Aiden suffered any burns. Jordy is being charged with first degree murder. Claire is being charged with felony child endangerment.

ANALYSIS

Claire Ives was a single parent to five-year-old Brodie and two-year-old Aiden, with little to no identified support, a pattern of unstable housing, and a significant and ongoing history of domestic violence. She also had a history with DCFS that included her three oldest children being removed from her care, two of whom she never regained custody of. An intact family services case opened after an unfounded October 2018 investigation of allegations of abuse to Aiden by the mother's new boyfriend.

Brodie gave ample information, which was corroborated by other evidence, for the G sequence investigation to be, at a minimum, indicated for substantial risk of harm, environment injurious. Brodie made clear statements that Jordy "whooped baby Aiden" and that he had been exposed to domestic violence. A child protection investigator heard Jordy yelling at the child, heard slaps, saw welts, and took photographs. The medical records indicated the physician, after observing the photos, opined that "the determination of physical abuse in this case…. hitting a child this young and leaving marks even if they fade would constitute physical abuse." Citing procedure 300 as a reason not to indicate is a corruption of the intent of child protection. Failure to factor in the young age of the child and the mother's significant history of being in relationships with violent men ignored the totality of circumstances. Further, as this investigation involved a child under three years, the case should have been referred to MPEEC. In addition, this case should have been reviewed by upper management. In OIG investigation 2017 IG 2911, OIG recommended that any family with three investigations in a year (as was the case with this family) should be reviewed by upper management. The Department responded to that recommendation indicating that there were practices in place to address these cases with multiple child protection investigations. That did not happen in this investigation.

Prior to the intact case opening, Claire was fleeing a domestic violence relationship and was receiving services through Upsilon Shelter's CABHI program. Despite the involvement of both systems, intact family services and Upsilon Shelter, there was limited communication and collaboration between the two systems. The intact family services caseworker contacted Claire's CABHI therapist for a progress report. There is no documentation that the worker knew that a case manager and peer navigator were also assigned through the program. OIG investigators spoke with Claire's CABHI therapist who reported she was unaware of the reason for child welfare involvement. Child welfare focused on the domestic violence victim history of the mother, minimizing the child abuse to Aiden. The self-report of the mother continued to be the main source of information about this family.

When a paramour is suspected of being a part of the family, the investigator is to assess the level of risk and safety and consider those factors in safety plan development or implementation. The Paramour Assessment Checklist has been designed to aid in the identification of risk and safety issues specific to paramour involved cases. A 'yes' response to any of the listed factors requires that the factor or factors be considered when completing the CERAP, safety plan development/implementation and/or service planning (See Appendix H-Paramour Involved Families). While the Paramour Assessment Checklist was not completed, CPI Mullen did complete and determine that the CERAP was UNSAFE, noting that "the mother's boyfriend has a history of whooping the children and leaving marks."

The Domestic Violence Screen was developed to assist in the identification of domestic violence in the home and associated risk and safety issues. CPI Lenora Mullen completed a screen during her investigation identifying the following significant indicators: *third party reports of domestic violence; self-reported incidents of domestic violence; and past and existing orders of protection.* In the screen, CPI Mullen documented that paramour Jordy Novak was out of the home.

For cases involving domestic violence, Policy Transmittal 2010.23 and Procedure 300 Appendix J requires that private agency and DCFS workers and child protection investigators consult with Clinical Domestic Violence Specialists in the Domestic Violence Intervention Program under the Division of

Clinical Services. Specialists in this program provide clinical case consultation, technical assistance, referrals, resources and support on domestic violence cases. There is no documentation that anyone in this case consulted with the Clinical Domestic Violence Specialist, however, Claire was already receiving domestic violence services prior to the Department's most recent involvement.

Studies indicate that domestic violence perpetrators not only victimize their adult partners as in many families where women are abused, but their children also are at risk of maltreatment; there is a 30 to 60 percent overlap of child maltreatment and domestic violence (Hamby, Finkelhor, Turner, & Ormrod, 2011; Taggart, 2011).[29] This includes hearing the abuse, witnessing the event, or being abused themselves, all of which contribute to feeling unsafe. Children who are abused physically or sexually tend to exhibit more developmental, cognitive, emotional, and social behavior problems, including depression and PTSD.[30] Those who are neglected physically or emotionally, or denied necessary services, also may exhibit a host of social and behavioral problems. Exposure to domestic violence can create just as dangerous a living environment for children, both for immediate safety and long-term effects. As noted in an earlier OIG report[31] on violence in the home, there is relatively strong evidence that the direct abuse of children and their exposure to domestic violence occur together, and that both increase the likelihood of a full range of psychosocial problems for youth and young adults (Herrenkohl, Sousa, and Tajima, 2008).[32] Brodie and Aiden had been exposed to and witnessed first-hand domestic violence incidents. Brodie's behavior described by the Safe Families host affirms this.

Multiple times Brodie voiced fear of his mother and his mother's paramours, including Isaac Huber, Gannon "Odin" Kemp, and Jordy Novak, yet little weight was given to his concerns, except by Safe Families. After multiple reports of concerns from the Safe Families host family and staff, because of Brodie's outcries and behavior, child welfare staff convened a staffing regarding the children's return home.

The staffing consisted of child protection and intact staff. Not included were the family coach and supervisor from Safe Families and the case manager, peer navigator and therapist from Upsilon Shelter's CABHI program. This led to a superficial staffing with limited information. Many of the professionals involved with this family appeared to operate under the rule of optimism. In her text Critical Thinking in Clinical Practice, Professor Eileen Gambrill, Ph.D. describes the rule of optimism as being the circumstances under which a professional inaccurately or inappropriately classifies their client and highlights the client's positives, while ignoring any problems or needs that would require additional resources or hinder the desired outcome.[33] The rule of optimism "refers to the tendency not to see pathology or behavior that harms others when it is actually there." The mother was described as cooperative, proactive in seeking services for herself as well as for her children, and willing to obtain orders of protection at the request of workers. In fact, the decision to return the children home, made during this staffing, appeared to be based on the mother's participation in therapy at CABHI. Yet the only real knowledge of those services was one report that the worker had requested from the therapist. The report solely confirmed that the mother was participating in individual therapy. The therapist, whose focus, appropriately, was on the mother as a victim of domestic violence, did not know the reason for

[29] Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). Children's exposure to intimate partner violence and other family violence. *Juvenile Justice Bulletin: National Survey of Children's Exposure to Violence*. Washington, DC: U.S. Department of Justice.

[30] Levendosky, A., Bogat, G., & Martinez-Torteya, C. (2013). PTSD symptoms in young children exposed to intimate partner violence. *Violence Against Women*, *19*(2), 187–201.

[31] 2012 IG 0917

[32] Herrenkohl, T.I., Sousa, C., Tajima, E.A. Herrenkohl, R.C., Moylan, C.A. (2008). Intersection of child abuse and children's exposure to domestic violence. *Trauma, Violence, & Abuse, 9*(2), 84-99.

[33] Gambrill, E. (2005). Critical Thinking in Clinical Practice, Improving the Quality of Judgments and Decisions. John Wiley and Sons, Inc. Publisher, pp 184-186.

DCFS involvement and did not know about the concerns expressed by Safe Families workers and the host family. The mere participation in domestic violence victim therapy, especially considering her long history, should not have been enough to mitigate Brodie's fears.

Children and young people who live with violence in the home are not being listened to and their own understanding of their situation is often overlooked, as are the ways in which they attempt to deal with it. Speaking with the children, independent from their parents, can provide the opportunity to better understand a child's life in the midst of hostility (Overlien & Hyden, 2009).[34] It also allows children to share information they otherwise might not. Ideally, the worker could have determined whether Jordy was in the home by speaking to Brodie outside the presence of his mother. In addition, it is important to identify child-centered collaterals who are people who know the child and/or have been identified by the child as protective. This practice was integrated into the training for DCFS with OIG Error Reduction trainings starting with investigations of cuts, welts and bruises in 2008. Previously, collateral contacts were only identified by the caretakers. Brodie was not asked for child-centered collaterals.

Outside of the history of domestic violence the worker seemed to know little about the family. The mother also had a history of substance abuse, unstable housing, and inconsistent employment. Though the worker assured that Brodie was registered in school, there were no documented conversations about daily life, including who cared for the children while the mother sought employment or attended services.

The importance of collaboration and communication between systems is paramount when working with families experiencing domestic violence. Each system has a specified identified role, and it may not be intuitive to each system what information may be needed to the other. Victims of child abuse and neglect need protection from further harm. Intervening effectively in the lives of children and their families is not the sole responsibility of any single agency or professional group. No one system serving the needs of abused and neglected children can work effectively by itself, and none can work when information is siloed, even within the agency itself. Child protection agencies, law enforcement, service providers, attorneys, and judges all play critical roles in child abuse and neglect cases. Workers need to be more inquisitive when working with service providers, asking about all their interactions with the family.

With the intent of enhancing and strengthening the effectiveness of child welfare interventions for families experiencing domestic violence, the Department has implemented a five-year pilot program of a domestic violence co-location program. This program is being implemented, initially, at two DCFS sites. The co-location program is a program administered in partnership with a co-location management entity, where domestic violence advocates who are trained in domestic violence services and employed through a domestic violence provider are assigned to work in a field office of DCFS alongside and in collaboration with child protection investigators and caseworkers working with families where there are indicators of domestic violence (325 ILCS 5/7.4a). An announcement about the launch of the program came out on the D-Net October 22, 2019. The coordinator of the Illinois co-location program told OIG investigators that the goal is to have multidisciplinary teams and regular staffings of cases.

Although adult and child victims are often found in the same families, child welfare and domestic violence have traditionally responded separately to victims. This focus on the safety and protection of only one victim can lead to unintended consequences. As the Illinois co-location is implemented and evaluated, OIG suggests and encourages that the Department consider opening additional sites and expanding the program, as allowed by statute.

[34] Overlien, C. & Hyden, M. (2009). Children's actions when experiencing domestic violence. *Childhood, 16*(4) 479-496.

A recent study reviewing the New York co-location program noted that one recommendation for improving the program is to develop effective strategies for sharing information. This pertains to sharing agreements, "especially policies regarding CPS contact with domestic violence shelters to verify client status", releases of information, and creating a system for domestic violence workers to update CPS workers on client information. Another recommendation emphasized the importance of cross training.

RECOMMENDATIONS

1. If the Department plans to continue to utilize Safe Families for the children of youth in care as well as during Intact and child protection investigations, then the Department must review the contract program plans to address the need to share information by way of a staffing with all involved parties (i.e. Safe Families staff, child protection investigator, child protection supervisor, intact worker and supervisor, and placement worker and supervisor etc.) and ensure that the return home plan does not create an unsafe environment for the children.

2. The Department should appoint a domestic violence coordinator in each region to liaison with domestic violence providers to enhance information sharing.

3. This report should be shared with Xi Agency.

4. This report should be shared, as a teaching tool, with the involved child protection staff.

5. This report should be shared with Upsilon Shelter and their Community Agreements to Benefit Homeless Individuals (CABHI) Program.

6. This report should be shared with the DCFS domestic violence coordinator and the Illinois co-location program manager.

7. As part of the Department's Safety Reboot Training, the Department should ensure that Appendix H, paramour involved families, as well as Appendix J, domestic violence, are reviewed and incorporated as part of how to assess safety and risk to children in cases where domestic violence and/or a paramour is present or suspected of abusing or neglecting the children.